

Trust Board Meeting in Public: Wednesday 11 May 2016
TB2016.40

Title	Patient Perspective
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Status	For information
History	Patient stories are regularly presented to Trust Board and Quality Committee

Board Lead(s)	Ms Catherine Stoddart, Chief Nurse			
Key purpose	Strategy	Assurance	Policy	Performance

Executive Summary

1.	The purpose of this paper is to tell the recent story of Ms M who was admitted to the John Radcliffe Emergency Department (ED), and was transferred to the Emergency Assessment Unit (EAU), then the Cardio-Thoracic Ward, then John Warin Ward. Ms M is also a staff member at OUH.
2.	This story provides an important opportunity to: <ul style="list-style-type: none">• Demonstrate the impact of professional and compassionate care and how this can ease anxiety for patients.• Recognise the need for additional sensitivity when providing care to a colleague.• Review the way care is provided to 'outliers' (patients who are staying on a ward but not under the care of the team), and the way that this affects the prescription and delivery of care.
3.	Recommendation The Trust Board is asked to reflect on the patient story and the learning.

Patient story

1. Purpose

1.1 The purpose of this paper is to tell the recent story of Ms M who was admitted to the John Radcliffe Emergency Department (ED), and was transferred to the Emergency Assessment Unit (EAU), then the Cardio-Thoracic Ward, then John Warin Ward. Ms M is also a staff member at OUH.

2. Background

2.1 The Patient Experience Team produced this story following a letter written by Ms M thanking staff for the positive aspects of her care. The Patient Experience Team also met with Ms M for an hour to discuss her experience. The ward sister and matron of each department in the story have also been contacted for their feedback.

2.2 This story provides an important opportunity to:

- Demonstrate the impact of professional and compassionate care and how this can ease anxiety for patients.
- Recognise the need for additional sensitivity when providing care to a colleague.
- Review the way care is provided to 'outliers' (patients who are staying on a ward but not under the care of the team), and the way that this affects the prescription and delivery of care.

3. Ms M's story

3.1 Overall, Ms M thought that staff members were caring and compassionate, and she felt safe in hospital.

3.2 While in the ED, Ms M thought her care, provided by the ED sister and a consultant, was professional, timely, and compassionate. The Lead Nurse, Patient Pathway Co-Ordination Team, let the ED staff know that Ms M was arriving and supported Ms M while she was in the ED.

3.3 Ms M was transferred to the EAU, and felt that the care provided by the consultant and team was professional and compassionate. The consultant made the preliminary diagnosis of Ms M's condition, which was confirmed the next day.

3.4 However, the staff members on EAU were very busy and there were no beds available so Ms M waited on a trolley for 16 hours. There were delays in delivering Ms M's fluids. This meant she was dehydrated with unstable levels of urea and electrolytes and impaired kidney function.

3.5 Ms M was relocated to a side room on the Cardio-Thoracic Ward (CTW) at midnight. Ms M identified one of the nurses as exceptional: she was very caring and efficient. Ms M felt that she made a very positive difference to her stay. This nurse immediately put Ms M at ease, welcoming her to the ward and helping her to put her nightclothes on. The nurse left Ms M to sleep as that was what she needed most, but made sure that Ms M knew how to contact her if needed. Ms M was impressed by the kindness of this nurse and her excellent organisational skills.

- 3.6 The staff on CTW tried to contact Ms M's medical team to get fluids prescribed; but were unsuccessful. Ms M was staying on CTW as this is where a bed was available. The ward team said that they could not prescribe Ms M any fluids, as she was not under the care of their team. This led to Ms M being without intravenous fluids for a considerable period of time.
- 3.7 Ms M was moved to John Warin Ward following her diagnosis. She stayed there for 4 days. All levels of staff were competent and caring. Ms M noted that despite being the ward being old, it was very well cleaned by the domestic staff. The care on John Warin Ward was exemplified by the competence of the nurses caring for Ms M. She felt that she was "in safe hands". For example, the staff ensured that her cannula was repositioned promptly when it stopped working, which enabled Ms M to receive IV fluids. The staff ensured they described what care they were providing and what care was planned, which gave Ms M confidence that she was getting the care that she needed. There were also many acts of kindness which impressed Ms M. For example, all staff introduced themselves. Ms M could not eat food as she was vomiting, but the staff provided her with squash with ice (rather than water) and discovered that she liked cream crackers so ensured she was provided with these. Ms M appreciated that her bed had been made while she was in the shower, which kept her disturbance to a minimum. When the heating broke down, all patients were offered extra blankets and portable heaters. The staff kept the patients up to date with progress on the heating being fixed. Ms M felt that she did not have to ask for things but that her needs were anticipated so she was offered what she needed.
- 3.8 Ms M felt that the consultants caring for her were very professional and skilled. They made Ms M feel comfortable, despite her initially finding it difficult to be cared for by people she knows.
- 3.9 During her recovery period, Ms M met the staff involved in her care to thank them for their care and compassion. The staff appreciated Ms M taking the time to give them feedback about the care they provided.

4. Conclusion

4.1 There is an opportunity for learning from the following positive aspect of Ms M's care:

- Ms M felt that the staff members looking after her were professional and caring. One staff member commented that the way the multidisciplinary team works together is at the core of the high quality care provided.

4.2 Ms M's care could have been improved in the following ways:

- Ms M waited on a trolley for 16 hours after admission before a bed was available.
- Ms M was admitted to CTW, while being under the care of a different medical team (an 'outlier'). This enabled Ms M to be given a bed on a ward. However, communication difficulties led to delays in Ms M receiving IV fluids. The AGM matron systematically reviews outliers to ensure their safety, and review their journey through the hospital. The AGM matron is supported to do this by senior medical staff when numbers of outliers are high. Wards with medical outliers

are encouraged to escalate to the matron any difficulties with contacting the patient's medical team.

5. Recommendation

- 5.1. The Trust Board is asked to reflect on the patient story and the learning.

Catherine Stoddart

Chief Nurse

May 2016

Report prepared by:

Ella Reeves, Patient Experience Manager