West Hertfordshire Hospitals NHS
NHS Trust

Agenda Item 40/11

Care & Compassion Report, by the Health Ombudsman

Background

On 14 February 2011, Anne Abrahams, the Health Service Ombudsman published a report into complaints made about the standard of care provided to older people by the NHS.

The report tells ten stories of patients over the age of 65 in NHS hospitals across England where poor care contributed to their deteriorating health and transformed them from alert and able individuals to people who were dehydrated, malnourished or unable to communicate. What the stories have in common is the patients' experience of suffering unnecessary pain, indignity and distress while in the care of the NHS and the anguish this caused their families and friends.

Introduction

This paper will identify the areas of poor care and provide assurance to the Board that West Hertfordshire Hospitals Trust understands the needs of Older People and can demonstrate that they receive the best care possible.

It will also discuss the issue of compassion and how as an organisation we must respond to the diminishing trust the public has in the manner with which care is delivered in the NHS.

Care

Failing	Ombudsmans Investigation	WHHT response
Nutrition and Hydration	• Drinks and food left out of reach. • Poor monitoring of nutritional intake and slow response to weightloss	• At WHHT we use a risk screening tool for every patient admitted and depending on the level of risk identified the screen is repeated at regular intervals and referral to appropriate services made. The Nutruition Nurse Specialist has also conducted a baseline audit of nutrition screening Trust wide and since January 2011 regular audits are completed monthly as part of the Nursing Quality Measures, that allow a continued focus on this important element of care to be maintained and addressed. • The Trust introduced a Red Tray system in 2008 and again this has been more successful in some areas than others. Further work on Nutrition, as part of Releasing Time to Care, is planned for 2011 and we would expect to see an improvement in this area.
Falls	• Poor record keeping and communication to family • Limited actions to mitigate falls	• All patients are assessed for risk of falls • Falls group is working with Safe Care Team to progress reduction in harm from falls. • Business case for funding to support Falls Specialist Nurse is being developed • Ongoing review and monitoring of falls themes in place to improve practice
Dementia Care	• Poor staff knowledge on how to care for patients with dementia • No active nutritional support for dementia patients	• Dr Bashford and Dr Angel are the clinical leads for implementing the Trust dementia strategy. • We have plans to appoint a Dementia Nurse specialist to support the clinical training requirements for staff. Currently we have a nurse seconded into this post • We have introduced Tip Tree boxes (memorabilia) across the organisation to support the care of patients with Dementia and have actively been recruiting volunteers to support the project • CQUIN targets on dementia for 2011/12 have been set by ourselves to ensure that the improvement continues
Personal care	• Patients not offered baths or showers • Patients not properly washed • Pressure ulcers allowed to develop	• New same sex accommodation shower facilities mean that patients can easily be offered showers on the wards • Good levels of staff on the wards who are employed to deliver basic care needs. A full review of the wards is scheduled for 2011 to ensure that with changing pressures this remains the case • Focused work in place on reducing the incidences of pressure ulcers led by the Matrons.

Failing	Ombudsman's Investigation	WHHT response
Pain management	• Poor response to patients in pain • Omission of medication	• At WHHT we have a well established pain team who provide active training for staff • We routinely carry pain audits and target areas of poor compliance with education and training for staff • Pharmacy is actively audit medicine errors and included in that are medicine omissions. These are now reported as an incident and are being actively managed to understand the route cause of medicine omissions and how we can reduce them. We are suggesting that reducing medicine omissions is a priority for our quality account in 2011/12
Documentation	• Poor nursing records • Poor patient observations • Poor response to deteriorating observations	• The Matrons are currently reviewing the nursing documentation to streamline the process, reduce duplication and allow systematic audit • Through the Releasing Time to care project wards audit the quality of patient observations on a monthly basis. Those areas that fall below an acceptable level are audit weekly. These results are reported at the Matron meeting and at the RTTC steering group • In October 2010 the Trust introduced an outreach service to support the identification and treatment of patients who may be deteriorating on the wards. The Trust is investigating the extension of that service to 24/7.
Discharge Process	• Poor discharge planning • Communication with family around discharge arrangements poor • Poor handover to GP of admission information	• The Trust held a discharge summit last month to review its processes and as a consequence has committed to improve the planning, communication and expectations of patients regarding a safe discharge • The Trust has an expectation that all patients will have a discharge summary sent to their GP within 24hours of discharge

Compassion

The NHS constitution states that "the NHS touches our lives at times of basic human need, when care and compassion are what matter most". What is most distressing to read in the patient stories presented by the Ombudsman report is the lack of respect, dignity and compassion offered to patients. The Ombudsman believed that the difficulties encountered by the service users and their relatives were not solely a result of illness, but arose from a dismissive attitude of staff, a disregard for process and procedure and an apparent indifference of NHS staff to deplorable standards of care.

The investigations carried out by the Ombudsman revealed an attitude, both personal and institutional, which failed to recognise the humanity and individuality of the people concerned and response that was sensitive, companionate and professional. The Ombudsman's view was that underlying the neglect in the basic care needs of these patients was a casual indifference to the dignity and welfare of older people. Although the comparison was not made in the report, there are some striking similarities in the patient stories as those found in the Frances Report (2010).

In analysis of our complaints in Q3 of 2010-2011 of the 92 complaints received 11 were classified as relating to poor attitude towards patients and their relatives by nurses and midwives. This of course does not capture those incidents that are not reported. The Trust has seen a marked improvement in the experience of patients attending Outpatients following the improvement programme and there are pockets of excellent feedback in clinical areas across the Trust, such as Cassio ward and Aldenham ward. "A fantastic service, genuinely good attitude" feedback on a comment card dated 03/03/11. However, despite many initiatives, patient experience is not reported by our community to be as good as it should be or as good as we want it to be. Numerous strategies over recent years have been implemented with limited improvements in the survey results.

Recommendations

The Trust response to the failures in care are already well underway as they mirror areas of concern highlighted in the Frances Report and areas for improvement in nursing care highlighted by the Chief Nursing Officer for England back in November 2009 in the High Impact Actions for Nursing. What requires more consideration is the need for the organisation to create a more compassionate workforce.

The Board is asked to consider the idea that a contented workforce is a productive compassionate workforce. If our focus was to develop an Organisational Development Strategy that created a workforce that is proud to work at West Hertfordshire Hospitals Trust and believes that they make a difference, then that workforce will not just care for our patients but care about them.

Natalie Forrest
Director of Nursing

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