Patient Story – Poor Experience of Care on Ward 28 Glenfield Hospital

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Executive Summary

A patient who wishes to remain anonymous attended the Glenfield Hospital outpatient clinic to undergo routine pacemaker checks. The results identified that the pacemaker was not working adequately and therefore the patient was admitted immediately to the Clinical Decisions Unit and then ward 28 for care.

The patient states they felt the environments were very busy but the multidisciplinary teams in both areas were ‘amazing’.

Unfortunately during this patient’s stay a number of incidents occurred that resulted in the overall experience of care being poor.

The patient did not wish to make a formal complaint but with the encouragement of the senior team has shared their story so lessons can be learnt and services/care improved.

Patient Experience

This patient’s experience will be shared with Trust Board using an audio recording. This recording illustrates the issues encountered:

1. Taken to X-ray by mistake as identity was not determined prior to leaving the ward
2. Given anti-coagulant medication, which the patient believes caused them to have a post-operative bleed from their wound site
3. Delay in discharge for one day due to medications being delayed

Response to Patient Feedback

The clinical team have demonstrated a very proactive response to this patient’s experience of care. They have written to this patient expressing their sincere regret and have instigated a number of improvements to ensure the team have learnt and this type of unacceptable event does not occur again.

<u>Taken to X-ray by mistake as identity was not determined prior to leaving the ward</u>

All staff have been informed of this incident and the process reiterated that all patients’ full name and hospital number should be checked prior to them leaving the ward. The adherence to this process is being closely monitored by the Matron team. The portering manager has also been informed and the portering staff has been updated to ensure they check the patient’s full details.

The staff obviously did not listen to this patient when they expressed concerns about where they were going and their absence from the ward. This breakdown of communication has been discussed and the important and consequences of not listening properly have been reiterated.

Also the staff have recognised the importance of acknowledging when an error has occurred, making sure a full explanation, apology and reassurance is provided.

Given anti-coagulant medication, which the patient believes caused them to have a post-operative bleed from their wound site

Reviewing this patient's medical notes identified that they were not on warfarin but was on a drug called Clopidogrel which is an anti-platelet drug. As this patient had past cardiovascular events the Consultant had reviewed the risk of a stroke and the risk of bleeding. The decision to continue with the Clopidogrel was the safest option for the patient. The patient was closely monitored for bleeding during the surgical procedure and there was no bleeding observed. Following the procedure the patient did bleed at the surgical site but to an acceptable degree.

However when this patient began to bleed overnight this must have been very distressing and it is obvious that inadequate reassurance was provided. Small amounts of bleeding from a wound site is common and the staff acted appropriately in this instance but there was inadequate awareness of the distress and worry this was causing this patient.

The patient's perception was that the doctor was a little 'sharp' and lacked compassion when discussing their drugs. The particular doctor who talked with this patient has heard this story and expressed deep regret that he was perceived in this way and wished to apologise personally. The whole medical team have been informed of this incident and the expectation of caring communication reiterated.

Delay in discharge for one day due to medications being delayed

The negative impact of this situation could have been relieved if the staff had provided clearer communication. Staff did not explain to the patient that although the consultant had deemed them fit to go home the medical staff needed to complete the tablets to go home prescription and then the pharmacy needed to dispense these in a dosette box.

It has been reiterated to all staff that during the ward round the likely time for discharge home should be made clear to the patient and their family.

Conclusion

The management of this patient and their family appears to lack sensitivity and none of the staff recognised their distress until near to discharge. If this had been identified earlier the patient and family could have been given clear explanation and reassurance.

The senior team have been very proactive in response to this feedback and identify a number of improvements to ensure they learn from this patient's experience. In particular the Matrons have arranged 'Listening into Action' events around 'Care and Compassion' for all nursing staff, health care assistants and support staff on the ward following this incident.

This type of feedback from ward 28 is rare and during the last recorded month (October 2015) 27 patients provided feedback surveys with a Friends and Family score of 100% recommend, 0% non-recommend and all free text comments very positive.

The Trust Board is asked to:

- Receive and listen to the patient's story
- Support the improvements instigated in response to this feedback.

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Not applicable
Consistently meeting national access standards	Not applicable
Integrated care in partnership with others	Yes
Enhanced delivery in research, innovation & ed'	Not applicable
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Not applicable
Financially sustainable NHS organisation	Not applicable
Enabled by excellent IM&T	Not applicable

2. This matter relates to the following **governance** initiatives:

Organisational Risk Register	Not applicable
Board Assurance Framework	Not applicable

3. Related **Patient and Public Involvement** actions taken, or to be taken:

Patient Story consists of feedback from a patient directly about their experience of care. In response to this feedback the trust identifies how best practice will be disseminated across the organisation.

4. Results of any **Equality Impact Assessment**, relating to this matter:

No equality issues identified as part of this patient story

5. Scheduled date for the **next paper** on this topic: January 2016

6. Executive Summaries should not exceed **1 page**. My paper does comply

7. Papers should not exceed **7 pages.** My paper does comply