Open Conversations with Patients and Families

Author: Dr Kate Russ, Consultant Sponsor: Carolyn Fox, Chief Nurse **Trust Board paper C**

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG) Quality & Safety Board - EM	Jan 20	Discussion
Executive Board		
Trust Board Committee		
Trust Board		

Executive Summary

Within Leicester's Hospitals there are on average over 200 patients a month who reach the end of their life whilst an inpatient; this can be an expected event or sudden and unexpected. This is sadly seen across all clinical areas and the communication and support of relatives at this very sensitive and sad time is essential.

This patient and family story is about a gentleman who sadly died whilst in hospital. The family members were not notified of the seriousness of his condition or of his clinical deterioration, which resulted in them not having the opportunity to be with him in his last moments and having the opportunity to say goodbye.

Why has this patient story been selected for Trust Board?

This story has been chosen as it highlights the need for open and honest conversations with relatives at what can be a distressing and stressful time. Relatives need to be fully informed of predicted outcomes and given the opportunity to be with their loved one at the end of their life. This can benefit the patient, as they can be surrounded by people that they are familiar and comfortable with.

Communication continues to be a top theme for improvement within the Trust and this story highlights the consequences when this is not undertaken in a meaningful way.

What are the key themes in the patient story and how applicable are they across the Trust?

The gentleman was admitted to the Emergency Department in January 2019. He had a stroke in 2015, which had left him wheelchair bound and he had faced many health challenges following this. On this attendance he was admitted to the emergency room, but the family were not given an understanding of how ill he was.

The relatives contacted the emergency room by telephone on the night before he died and the telephone was given to the patient, who then updated the relative on his condition. The relative was not given any kind of update by the member of staff.

This gentleman, who was an active member of his church, was cared for at home by formal carers, but also by a network of family and friends. On the morning of his death, they were making plans for how they were going to improve the care that they were giving him, when he was discharged home.

The gentleman died in the emergency room without his family having the opportunity to be present, which they feel would have given him and them comfort in his last few moments. The relative details how this lack of opportunity will never be available to them again and it has negatively affected the gentleman's children, mother and wider family and friends.

There are a number of learning points from this patients and families experience that are transferable across the Trust to reinforce the importance of this element of practice for all disciplines and specialties.

Quality Improvements in response to this Patient Feedback

The multi professional team within the Emergency Department have responded to this patient feedback by initiating a number of quality improvement strategies to improve the communication with relatives of patients who have a life limiting illness, to help them understand the potential outcomes. These quality Improvements are part of a long term improvement project in the department that will be closely monitored to ensure delivery.

Examples of the main Improvements already initiated:

- The Emergency Department has reflected upon their processes and have learnt the importance of recognising when a patient may be at risk of dying. They have developed the 'Butterfly Project' to compliment with work already being done across the Trust to recognise and take account of clinical frailty. The project's aim is to facilitate staff in recognising patients in the Emergency Department whose recovery is uncertain and to initiate having respectful and honest conversations with patients and their relatives about treatment planning.
- 90% of staff surveyed are aware of the project and 80 junior doctors and Advanced Care Practitioners have now had specific training on initiating these conversations. Work has also been undertaken to upskill staff on the RESPECT document, due to be launched in January 2020.
- Documentation of treatment escalation plans has improved from 37% to 44% and communication of uncertain recovery has improved from 44% to 51%. This project requires an incremental culture change in the way clinicians approach assessing and treating patients at the end of life and such widespread behavioural changes take time. The department fully anticipates that it will continue to improve as the tipping point is reached to ensure that such conversations are normal practice.

For Reference:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	Not applicable
Safely and timely discharge	Not applicable
Improved Cancer pathways	Not applicable
Streamlined emergency care	Yes
Better care pathways	Yes
Ward accreditation	Not applicable

2. Supporting priorities:

People strategy implementation	Yes
Estate investment and reconfiguration	Not applicable
e-Hospital	Not applicable
More embedded research	Not applicable
Better corporate services	Not applicable
Quality strategy development	Yes

3. Equality Impact Assessment and Patient and Public Involvement considerations:

This is a Patient Story and reflects patient and public involvement and partnership working.

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?	N/A	
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register	N/A	
New Risk identified in paper: What ***type*** and ***description***?	N/A	
None	x	

5. Scheduled date for the **next paper** on this topic: March 2020

6. Executive Summaries should not exceed **5 sides** My paper does comply