Communication builds Trust and Understanding

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Trust Board paper E

Executive Summary

This patient story originated from a complaint and is about a family's poor experience following the patient's admission due to a diagnosis of gastric cancer and the subsequent required surgery within Leicester's Hospitals.

The family have met with staff from Leicester's Hospitals on a number of occasions and have also permitted their experience to be videoed to allow staff to hear their story at a number of forums.

Why Has This Patient Story Been Selected For Trust Board?

This story has been selected because the key theme in the patient and families experience was a lack of communication and involvement of the patient's family particularly when the patient was very unwell. This feedback is similar to identified areas for improvement across the Trust and therefore is a Trust priority for 2018-19 and will form part of the Trust Quality Commitment – We will actively involve patients and their families in decision making about their treatment and care.

Secondly as part of the complaints meeting with this family it was agreed that their experience would be used to assist in service development and improvement plans and has been shared in the Cancer, Haematology, Urology, Gastroenterology and Surgery Clinical Management Group to structure discussion and development plans.

What Are The Key Themes In The Patient Story And How Applicable Are They Across The Trust?

This family story will be shared via video link at Trust Board. There are a number of elements of this complaint but for the purposes of Trust Board specific areas will be focused upon. These are:

- Provision and access ensuring clear communication for this family with the medical team allowing them to be aware and involved in decision making about treatment and care.
- Ensure accuracy of discharge notes provided by junior medical staff.
- Improve nursing skills including communication between ICU nurses and base wards
- Safe discharge planning including tablets to take home.

What Are The Key Learning Points To Improve The Quality Of Patient Care/Experience, And How Will They Be Measured And Monitored In Future?

The issues raised in this video have been shared with staff and a number of actions taken in response to this feedback. The improvements following this patient's feedback are highlighted below:

- Dedicated TTO doctor in place at the Leicester General Hospital and now being phased in at the Leicester Royal Infirmary which will improve both discharge summary completion and accuracy

- Considering a business case for a band 7 pharmacist to assist in TTOs, this will improve accuracy of prescribing meds and also allow the junior doctors to focus more on the medical parts of the letter

- Case was discussed at Morbidity and Mortality and Division of Surgeons' meeting to raise the profile of the case

- The clinical area in which this experience occurred was experiencing extreme registered nurse vacancies at the time of this experience. Over the last five months the area has managed to recruit ten registered nurses and also a new Ward Sister and learning from this complainant has formed a key element in the new staff's orientation.

- Nursing practise has formed the basis of this new team's development and also how the team communicate with ICU staff and then patients and their families. Improvements in nursing practise are evident and for example cannula care is audited monthly now with a more in-depth audit every quarter with the last quarter's results showing 98% compliance.

- A comprehensive action plan following this feedback focused upon discharge planning and has included the development of a Discharge Guide and Resource File, discharge flowchart and link role development. Lastly all discharge drugs are now checked by two registered nurses to ensure accuracy.

The Clinical Management Group has discussed all the elements of the complaint at Senior Medical and Nursing Forums to ensure learning occurs across all clinical areas.

Conclusion

This patient story included a number of areas requiring improvement however it is mainly focused upon communication with the patient and their families. When reviewing the whole patient and family experience there is recognition by the family that the surgical intervention was excellent but the family were unable to build trust and understanding due to inadequate lines of communication.

The Clinical Management Group have been open to this feedback and have taken the time to share this feedback at many senior forums and identified clear improvements as a consequence.

For Reference

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

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Yes
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	Yes
Financially sustainable NHS organisation	Not applicable
Enabled by excellent IM&T	Not applicable

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

a. Organisational Risk Register	No
b. Board Assurance Framework	No

3. Related **Patient and Public Involvement** actions taken, or to be taken:
   This patient story is involving patients and their families in developing services and care.

4. Results of any **Equality Impact Assessment**, relating to this matter: N/A
5. Scheduled date for the **next paper** on this topic: TBC

6. Executive Summaries should not exceed **2 pages**. My paper does comply
7. Papers should not exceed **7 pages.** My paper does comply