If Only… My Granddad

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Trust Board paper E

Executive Summary

Once every three months Trust Board hears directly from a patient and their family about their experience of care within Leicester's Hospitals. The vast majority of patient's feedback and therefore stories at the Board share extremely positive experiences but sometimes the level of care within Leicester's Hospitals does not reflect 'caring at its best' and when this happens it is important that these experiences are shared and lessons learnt.

This story centres upon the experiences of a gentleman and his daughter and granddaughter. This gentleman was admitted to Leicester's Hospitals in April 2018 and experienced poor aspects of care that require improvement. The family have worked in partnership with the Trust since these events allowing staff to hear their story and improve care. The story has also been instrumental in providing context for staff and framing Trust wide improvements.

Why Has This Patient Story Been Selected For Trust Board?

The main themes from this story reflect recurrent themes from feedback collected through surveys and Message to Matron cards from patients and their families and carers particularly from patients living with dementia.

This story has also been chosen because it is an excellent illustration of areas the Trust has identified as requiring improvement. This requirement has been identified through looking at national expectation and local results of national audits and to help staff contextualise the importance of these improvements this story has been and continues to be extremely helpful for all staff.

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

Mr Allen was a gentleman admitted from his residential home in April this year with possible delirium due to sepsis. On admission Mr Allen was severely frail (Rockwood score 7) and had a known diagnosis of dementia. Mr Allen lives in an excellent residential home where staff know him well and he has a good quality of life with family closely involved in his wellbeing.

Mr Allen's daughter and granddaughter will be attending Trust Board and will share with Trust Board members the experience of care for Mr Allen during his ten day experience in Leicester's Hospitals.

In consultation with Mr Allen's family there are three main elements of care that this story will focus upon:

- Nutritional provision
- Identification of an individual with a diagnosis of dementia
- Being outlied without family involvement

It is acknowledged that these three elements are intertwined but the family have specific concerns and therefore wished the three elements to be separate.

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

This patient story highlights the vulnerability of patients while in hospital and ensuring they are supported with the right level of nutritional support

Key Improvements and Learning Points:

Energy Dense Meals – Launched across the Trust in Autumn 2018

Following extensive consultation and piloting, five options have been added to the main menu. These options are smaller portion and energy dense; each meal contains at least 500kcal and 20g of protein. The new options have been devised for any patient that is generally not eating well and suffering with a poor appetite.

Finger Food Pilot

The second phase of a new Finger Food menu for patients with dementia concluded in November and the evaluation will be reviewed at the Dementia Strategy Action Group before launch across the Trust.

Mouth Care Matters

Mouth Care Matters is supported by Health Education England (HEE) and is a programme aimed at improving the oral health of hospitalised adult patients. There are certain groups of patients that will be more at risk of developing mouth related problem; dementia is included in one of these groups. This initiative is currently taking place across five wards led by the Dental Nurses in Orthodontics. In consultation with HEE the pilot will be evaluated in February 2019 and the plan is to include the recommendations as 'essential training' from April 2019 onwards.

Nutrition and Hydration Audit

Starting in November the Trust commenced the new Nutrition and Hydration Audit. The Nutrition and Hydration Assurance Committee are trying to establish how well the multidisciplinary teams provide and meet the nutrition and hydration needs of our patients within the Trust. This audit will help to establish a baseline and also determine the Nutrition and Hydration Strategy for the Trust going forward.

Part 1: will be undertaken by the Patient Partners - This will be an observational audit of a ward bay at the start of meal service and during a meal time service.

Part 2: will be undertaken by the Patient Partners - This will be a series of questions that the Patient Partner will randomly ask five separate patients anywhere within the ward they are observing.

Part 3: A clinical review undertaken by the Nursing Leads for the Nutrition and Hydration Assurance Committee - This will include a review of the patient's clinical notes and clinical observations.

Part 4: An assessment of staff knowledge led by the Nursing Leads of the Nutrition and Hydration Assurance Committee - This will be in the format of a questionnaire which will be given to the Matron, Ward Sister, and Deputy Sister. They will also be given randomly to one Registered Nurse, one Health Care Assistant and one Housekeeper on the ward.

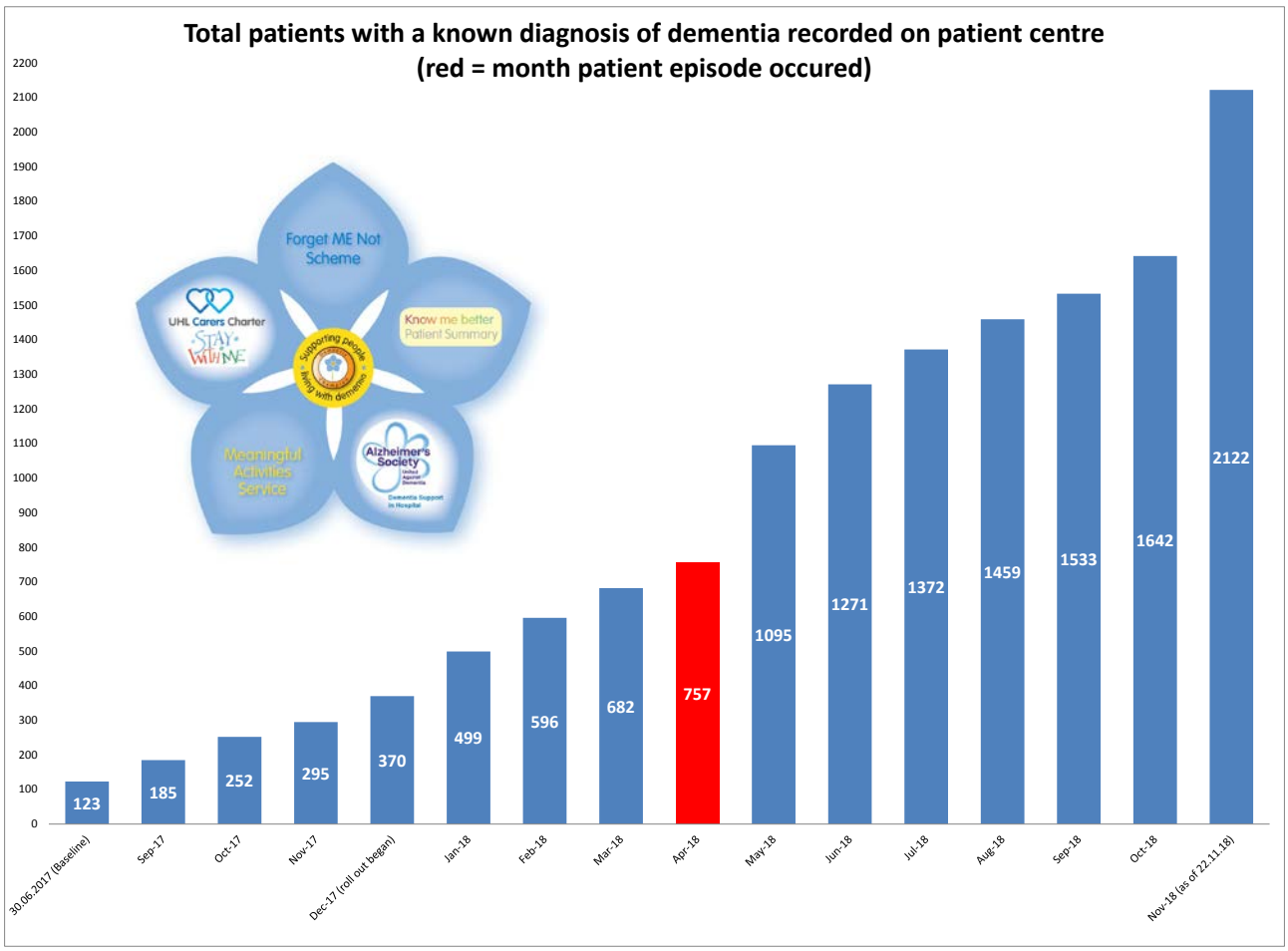
<u>This patient story highlights the importance of recognising that a patient has dementia and the additional support required</u>

Key Improvements and Learning Points:

<u>Forget ME Not Scheme - Rolled Out Across the Trust</u>

Following an extensive pilot it was agreed to roll out the 'Forget Me Not' Scheme across the Trust. The aim of the Forget ME Not scheme is not only to recognise patients with dementia but to ensure all staff respond to the person in a meaningful way.

The roll out began in December 2017 and the very positive results can be seen in the table below:



As a Trust we are now successfully identifying patients with a known diagnosis of dementia and therefore can provide the additional input this often vulnerable group need as highlighted in the 'Forget Me Not' flower. Additionally we can now monitor the care of this group of patients ensuring outcomes are triangulated with performance indicators.

<u>This patient story highlighted the negative consequences for patients with dementia and their family when they are moved wards when it is not in the patient's best interest without family involvement</u>

Key Improvements and Learning Points:

<u>Establishment and Launch of a New Outlying Adult Patients Policy – October 2018</u>

Following this patient experience of other feedback like this the trust has written a 'stand alone' outlying policy to provide clear structure for staff. This policy went 'live' in October 2018 and addresses the concerns raised in this patient story. From the beginning of November the application of this policy for patients with a known diagnosis of dementia is being monitored.

Conclusion

This story centres upon a poor experiences of care received by a family in April 2018 in Leicester's Hospitals. The story supports the family in sharing their experiences in an open and transparent manner. The Trust is eager to listen and learn and shape services/care in response to feedback from patients and their families. This story is an example of how the Trust has worked with this family and responded to concerns and how as a consequence the Trust is able to deliver 'caring at its best' to patients and their families.

Many of the improvements highlighted by this family will require a long term approach and the responses included to this family story illustrate immediate improvements and also long term structures to support organisational change.

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

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

a. Organisational Risk Register	Not applicable
b. Board Assurance Framework	Not applicable

3. Related **Patient and Public Involvement** actions taken, or to be taken: This is a Patient Story and reflects patient and public involvement and partnership working.

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

5. Scheduled date for the **next paper** on this topic: March 2019

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

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