Patient Experience Story-Excellent Care Tainted by Hitches

Author: Sister Sharon Fowlkes Sponsor: Carole Ribbins, Acting Chief Nurse Date: Thursday 2 July 2015

Context **Trust Board Paper E**

Each month the Trust Board is presented with a 'patient story'. We ensure the Board is exposed to both positive and negative stories. The purpose of this is twofold:

- to ensure that feedback from patients, family and carers frames decision making at this senior level
- Trust Board gains assurance through many ways including board stories that feedback from patients leads service developments and redesign.

Prior to the presentation extensive engagement with clinical staff takes place to ensure the scenario is investigated in detail both from the staff's perspective and the patient's perspective.

At Trust Board the patient's feelings and perception of the situation and consequences of this are presented. The clinical teams are then supported in the understanding that even if other patients perceptions are different or the staffs perception of the situation is different changes still need to occur to ensure staff are equipped to deal with all patient's needs.

Patient Story

To describe for Trust Board the experience of a patient when attending for planned surgery on Kinmonth ward and how services have been changed in response to this experience.

Friends and Family Test - Kinmonth ward results are displayed as a percentage for May 2015.

% of patients who would recommend the ward		Neither likely nor unlikely, don't know	**% of patients who would not recommend the ward**	
94%			**0%**	
Extremely likely	Likely		Unlikely	Extremely Unlikely
12	4	1	0	0

This patient story identifies the excellent care and support received throughout this patient's admission. However two incidents occurred that tainted this otherwise excellent experience of care.

Firstly, a pressure relieving mattress was not made available on admission despite being arranged in Pre-Assessment two weeks earlier. The fast action of the ward staff ensured a mattress was sought quickly but unfortunately when delivered the item was faulty and not the type of mattress that was expected. The ward staff effectively explained and provided reassurance to how pressure area care would be managed until another mattress arrived the next day.

The second issue occurred when the ambulance booked for transport home never arrived. Despite the best efforts of the Kinmonth team to assist in an effective discharge process the patient had to secure their own transport several hours later in a taxi which was not conducive to the surgery and their disabilities.

Response to Feedback

This patients experience has been shared with the Kinmonth team and through the internal surgical training module. Sharing patient's experiences of care powerfully motivates clinical staff to challenge and instigate changes towards delivering 'Caring at its Best'.

1. Investigation shows that the mattress had been requested from Pre- Assessment clinic but recorded in the diary on Kinmonth ward as required on a different date. Improvements have made in the following areas:

- Review of the process of ordering pressure relieving mattresses from Pre-Assessment clinic.
- Increased staff awareness around ensuring the correct date and patient details are recorded in the planned admissions diary.
- Improved education regarding types of pressure relieving mattresses for staff on the ward and access of this information.
- Increased staff awareness re ordering of mattresses and cancelling mattresses.

2. With collaboration with Arriva Transport services investigation shows, an ambulance had been requested but their system shows that the patient had not been made ready for transfer. Therefore miscommunication has been identified. To ensure safe and effective management in transferring patients, improvements have been made by:

- Increased education for staff around effective communication and documentation when booking ambulances through Arriva Transport Solutions. Clearer records of when patients are made ready for transfer to ease follow up after two hours if the ambulance has not arrived.
- Providing Arriva Transport Solutions with feedback if delays or failures occur is actively encouraged
- Increased staff awareness to escalate to Arriva Transport Solutions and/or the duty manager regarding ambulance transport problems
- Reviewed the internal processes and put in a Trust wide training programme in relation to appropriate and timely booking of ambulances.

Conclusion

To continue to offer a service of excellence based on the needs of patients with on-going appraisal of patient feedback, raises the importance of effective communication and documentation and supports collaborative effective partnerships.

The Trust Board is asked to:

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