Paper ref:	TB (09/19) 001

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Improvements made from Patient stories at Trust Board		
Sponsoring Executive	Paula Gardner, Chief Nurse		
Report Author	Paula Gardner, Chief Nurse		
Meeting	Trust Board	**Date**	5th September 2019

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

The Trust Board is committed to learning from actual patient experience. Every month we have patient or relative attend the Board meeting where we actively listen to the real experiences of them. The story enables the board to learn how problems in care provision affect and impact upon patients and their families.

This enables the Trust as a whole to maintain a focus on continually improving patient safety and experience.

As we are now in our 6th month we felt it pertinent to review all of the stories from April to August to reflect on the story and to understand what improvement we have made and lessons learnt.

The board is asked to

1. **Reflect** on the five patient stories,
2. **Note** improvement made and lessons learnt,
3. **Review** patient story format for future boards.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan		Public Health Plan		People Plan & Education Plan	
Quality Plan		Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

At previous Boards

4. Recommendation(s)

The Trust Board is asked to:

a.	**REFLECT** on the five patient stories
b.	**NOTE** improvement made and lessons learnt
c.	**REVIEW** patient story format for future boards

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register							
Board Assurance Framework							
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 5th September 2019

Improvements made from Patient stories at Board

1. Introduction or background

1.1 The Trust Board is committed to learning from actual patient experience. Every month we have patient or relative attend the Board meeting where we actively listen to the real experiences of them. The story enables the board to learn how problems in care provision affect and impact upon patients and their families.

1.2 This enables the Trust as a whole to maintain a focus on continually improving patient safety and experience.

1.3 As we are now in our 6th month we felt it pertinent to review all of the stories from April to August to reflect on the story and to understand what improvement we have made and lessons learnt.

2. Patient Story April 2019

2.1 The daughter of a patient who is coming to tell her story about her mother who was admitted over Christmas 2018 to Sandwell Hospital. The story starts in ED where she was on a trolley for some length of time transferred to AMU where upon an attempt at catheterisation was unsuccessful and caused major distress to her mom. Her mom was them moved to OPAU (Older person's assessment unit) where the staff were very kind and were making plans for discharge. There was an issue on the ward with regards to a distressed patient and how this patient affected other patients and relatives in this area. Unfortunately the patient deteriorated and passed away whilst on OPAU.

2.2 **What improvements were made** - In respect of the patient story and the issues that were experienced we have since taken the following steps to ensure improvement.

All patients with a cognitive impairment with distressed behaviours are seen by the DDD team who support the team in devising the appropriate care plan for the patient. This may involve the use of distraction therapy for example use of the seal.

If the patient requires one to one nursing this care is delivered by a member of the substantive nursing team rather than a bank nurse to enable consistency of care and the rights skills to be utilised.

Patients that display aggressive or inappropriate behaviour that is deliberate and not due to any medical consequences are advised by a senior nurse that this is not acceptable and steps are taken if it continues towards safe discharge of the patient, and or notification to the police of any criminal behaviour.

We are also introducing a piece of work across all of the elderly care wards surrounding frailty and end of life. We have an action plan in progress which includes recognition of frailty and stratification of frailty utilising a frailty stratification tool (Rockwood)

Education for the team and nursing competencies surrounding the above to enable a skilled competent work force.

End of life is an arm of this work and every step is being taken to ensure that patients at the end of their life are accommodated in a side room if possible and if not in a quiet area of the ward and not in the vicinity of patients displaying distressed behaviours

3. Patient Story May 2019

3.1 This lady was on one of our wards where she had suffered a delirium and the granddaughter described her grandmother as not being herself at all. To assist with patients who are distressed from a delirium or a cognitive impairment we as a Trust have purchased a robotic seal that works on artificial intelligence to help the distressed patient.

3.2 The story for the May board was a video of a patient with our new robotic PARO seal which highlights the impact of the seal on a patient who had a severe hyperactive delirium.

3.3 **Background of PARO SEAL**

There are 3000 PARO seals worldwide the vast majority are in Japan where they have been used to befriend earthquake victims.

PARO is a robot seal modelled unashamedly on a baby harp seal both in terms of looks and the plaintive cry that it makes. Its Japanese creator Takanori Shibata chose it because people are unlikely to have unhelpful memories of real seals.

PARO has some artificial intelligence it has the ability to learn and remember its own name and it can learn the behaviour that results in a pleasing stroking response and repeat it.

3.4 **What improvements were made** - Sandwell and West Birmingham hospitals have purchased 4 seals. As stated above the Video demonstrates the reaction of the patient on D16 that resulted in her face lighting up and smiling which she had not done for 3 weeks the patients granddaughter was very impressed with her nans reaction. The seals will be used to reduce anxiety in patients with cognitive impairment and or delirium and who can become very distressed.

4. Patient Story June 2019

4.1 A 63 year old gentleman had undergone hernia repair in February 2018. Since February he had repeated admissions due to a wound infection. On the 22nd April 2018 the patient underwent a small bowel resection and evacuation of abscesses due to infection. He then developed a fistula to the wound and then went on to have further surgery on the 2nd May which was a laparotomy and end ileostomy and a mucus fistula of distal ileum as the anastomosis had broken down. This meant the patient spent a number of admissions in ITU due to complex emergency surgery. The patient was left with short bowel syndrome and he then developed a high active stoma which meant he was unable to absorb nutrients adequately therefore he ended up with replacement nutrition via total parental nutrition (TPN) Due to long term TPN the patient required a referral to the intestinal failure unit at the Queen Elizabeth Hospital. The patient's daughter and wife had care and communication issues with regards to the patient on Priory 2. The daughter made contact with the Chief Executive and from this the Chief Nurse met with the family and the ward to listen to the families concerns. This led to improved communication, and although the patient has died, the family are very happy with the care he received on Priory 2

4.2 **What improvements were made** - Following the patient story being presented at Trust Board in June Priory 2 have made the following changes:

Sister Dudley meets with all the long stay patients and their families on a weekly basis. Sr Dudley following these discussions arranges meetings with the patients consultant.

Regular staff engagement events have been organised with the matron to promote a positive culture.

The Practice Development Nurses have undertaken sessions on professional standards that have evaluated well and which we will look to roll out across surgery.

The Directorate are still committed to progressing an enhanced recovery pathway for complex colorectal patients to promote independence.

The Matron and GDoN are working with the level 1 lead to develop competencies and confidence in the management of level 1 patients.

Over the last 5 months Priory 2 has received no formal complaints relating to nursing care.

5. Patient Story July 2019

5.1 A 7 week old baby girl was referred to Lyndon Ground ward at Sandwell Hospital with high temperature and general lethargy and poor feeding. Aubree was seen immediately and bloods were taken and whilst there was no confirmation of an infection at the time Aubree was treated with anti virals and antibiotics. Mother and father were present throughout the full examination.

Whilst there has been no working diagnosis to date despite 3 lumbar punctures and many more bloods taken, the baby had improved. The mother and father state that the care had been exemplary however there could have been better communication especially during the immediate phase when she was being treated as an emergency. Plus there have been conversations with the parents stating when blood results would be back. Unfortunately the parents themselves felt they had to chase the staff for the results.

5.2 **What improvements were made** - there is a new Group Director of Nursing in post in paediatrics. The Ward Managers attend the morning Paediatric handover to improve communication. The ward managers are cascading information with regards to the learning from incidents, complaints and patient stories. The GDoN has arranged some away events that enable staff to be engaged in identifying solutions for improvement.

Further work on ensuring that Nurses accompany Doctors when seeing their patients will be undertaken in the next month.

A communication board at the bedside will be in place to support relatives and carers and is based on the model of 'Nursery' parent's feedback especially if parents are not on the ward.

6. Patient Story August 2019

6.1 This is a story about a 16 year old boy who talked about having allergies since a small baby. He spoke about the care from the paediatric team especially Dr Makwana. He entered into a de-sensitization programme that has subsequently changed his life.

6.2 **What improvements were made** - He talked about how he is now able to eat various foods which he was not able to eat over the last 15 years. The experience he has encountered especially in relation to the medical staff has led to him wanting to become a paediatrician and seeing Dr Makwana as a role model.

7. Conclusion

7.1 Board members value hearing stories from patients, relatives and carers. Whilst an individual story is not representative of all patients' experiences each story is valid and brings a human dimension to what we do. Collectively stories can help build a picture of what it's like to be a patient at Sandwell and West Birmingham.

7.2 Going forward do we need to consider stories which are theme related such as linked to our promises e.g. keep you informed and explain what is happening and make time to listen? Also using different formats other than patients and /or relatives presenting use written or filmed stories. At a previous Board the agenda focused on a theme of paediatrics therefore should we consider aligning other stories to the Board agenda such as frailty or safeguarding to give two examples.

8. Recommendations

8.1 The Trust Board is asked to:

a. **Reflect** on the five patient stories,
b. **Note** improvement made and lessons learnt,
c. **Review** patient story format for future boards.

Paula Gardner
Chief Nurse

August 2019