SANDWELL AND WEST BIRMINGHAM NHS TRUST

Trust Board Story : March 8th 2023

Patient/Family Story:

Summary of the Story :-

Peter McKernan was a 76 year old man admitted to City hospital via his GP in July 2020. Peter had dementia and an aortic aneurism; he was diabetic with high calcium and was in remission following kidney cancer. He was able to walk with assistance. Peter was a proud man able use a commode only rarely using a pad as a precaution. He was able to carry out small tasks, such as making tea. The purpose of the 24 hour admission was only to rule out a stroke. The agreement with family was Peter would stay no longer than 24 hours. Peter's stay extended to four days, after which he did not get out of bed once home and Peter died one month later.

Peter's wife Sheila wrote to the Trust in August 2022. She did not want to make a complaint, only to highlight what happened during Peter's admission. The Chief Nurse met with the family and the adult safeguarding lead to discuss the issues raised and take away the learning and share this across the Trust

Peter arrived at City Hospital via booked ambulance with a GP plan made to take Peter straight to the appropriate ward. Staff were not aware of the admission arrangements. Peter waited in the ED, then AMU and was transferred to the correct ward over 24 hours later.

With Covid restrictions in place, Sheila was allowed to visit only to support during mealtimes. She was asked to leave immediately after, even when food was late and Peter had not eaten. Sheila described issues regarding Peter's dignity. For example on one occasion she arrived to find Peter with his bottom half entirely exposed to the ward except only for a pad. On discharge he was dressed in a hospital gown, open at the back. Sheila explained that Peter was not taken to the toilet/commode; he was only put in a pad. He wasn't shaved and didn't appear to have been washed during his stay.

Two days into Peter's admission Sheila arrived to find Peter unresponsive; his drip should have been administered on arrival had not been by this point. On raising this, Peter became more alert within 30 minutes. Sheila had no assurance that diabetic medication was administered or that Peter was fed when she was not there. Food brought from home to encourage his eating was left in the bag it was brought in. Sheila noticed water jugs remained undisturbed and Peter went on to develop oral thrush.

Sheila described poor communication between staff and inconsistent, incorrect or non-existent communication regarding food medication and test results. Family explained to

staff Peter had a blanket which calmed him and helped him to sleep. This blanket was left out of Peter's reach.

Staff did explain that Peter's calcium levels concerned them. Family explained that Peter's (SWB) consultant was monitoring those, was happy with them and results were available to SWB staff. Family however were not listened to or advised of any test results. The scan for which the 24 admission was for arranged on the Friday was finally performed on the Sunday.

Peter was discharged on Monday, yet there were difficulties with his medication, which was eventually sent to the home via taxi.

What are the key lessons / themes to emerge from this story?

Sheila had no reassurance or faith in the care provided. As a patient with dementia, Fundamentals such as medication, feeding, assistance with hygiene and communication where not evident to her. A proud man able to mobilise and remain physically functional could not do so following discharge. She grew increasingly upset and frustrated at the lack of communication and not being listened to about what would help Peter. She saw little dignity and support afforded to her husband of 54 years.

Sheila and family had knowledge and expertise in how to care for Peter to share with staff and this was not accepted. Peter's intended 24 admission was elongated to 4 days, during which his physical deterioration was evident to his family. Sheila was Peter's voice and his advocate. When discussions about Peter going to rehabilitation ward were raised, physiotherapy staff advised Sheila to *"fight to get him home or he'll not come home alive."*

Peter had a large and highly supportive family and staff were reluctant to discharge Peter home, citing post-discharge support as the issue. Although Covid restrictions were in place, Shelia could have helped and supported staff to care for her husband.

Key Actions implemented since this story was shared with us by the family

1. Dementia lead nurse commenced February 2023
2. Johns campaign being relaunched
3. About me documentation being reviewed
4. Fundamentals of Care Trust Priority of Communication – Plan in place trust wide plus several projects
5. Carers partnership agreement being scoped
6. Visiting policy reviewed and improved to a better position to Pre Covid ensuring families are able to help and support their loved one 24/7 if requested
7. Partnership work with Black country Healthcare to improve our care pathways