The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	25th July 2011
Title:	Report of the Ombudsman *Care and Compassion?* Draft RWHT action plan response
Executive Summary:	The above report serves as a significant reminder to Trust's like RWHT of the poor experiences that patients and families continue to suffer. In addition to the poor experience, the way in which their concerns are handled adds to their levels of dissatisfaction resulting in referral to the Ombudsman. This report provides a gap analysis and action plan actions extracted from the issues identified in the *Care and Compassion?* report. The overall assessed risk is amber.
Action Requested:	The board review the recommendations and actions identified to implement learning and an improved patient experience.
Report of:	Director of Nursing & Midwifery
Author: **Contact Details:**	Zena Young, Divisional Head of Nursing, Division 2 Tel: ext 6449 Email: zena.young@nhs.net
Resource Implications:	Nil identified.
Public or Private: **(with reasons if private)**	Public
References: **(eg from/to other committees)**	
Appendices/ **References/** **Background Reading**	www.ombudsman.org.uk
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details	
1	In February 2011, the Health Service Ombudsman for England released a report, 'Care and Compassion?', regarding the results of 10 investigations into NHS care of older people. The report can be accessed at www.ombudsman.org.uk The purpose of the report is to raise the potential for issues throughout the NHS so that lessons may be learned to prevent other patients and families experiencing healthcare as cited in the 10 investigations.
2	The draft action plan is attached which takes account of the report findings and provides a level of assurance for this organisation. The action plan indicates a RAYG scoring, based on the level of perceived risk **before** the further actions are taken, the urgency of the required action and the existence of any controls or mitigation. In summary, there are ten sections with the following risk profile: **One red risk – discharge planning arrangements.** **Four amber risks** **Three Yellow risks** **One green risk** And one further risk yet to be quantified and catergorised. The overall assessed risk is **AMBER.**
3	Monitoring progress with this action plan will be undertaken at the Quality & Safety Committee. A finalised action plan will be presented to this committee at the next available date. .

Report of the Ombudsman *Care and Compassion?*

<u>Draft</u> RWH action plan response – July 2011.

No	Issues arising	Current Assurance / Concern	Further actions to be taken	Lead for further action	Timescale	Evidence/Monitoring	RR
1	**Poor communication with carers/relatives in A/E department – long waits in waiting room separate from patient, excluded from clinical assessment and therefore unable to advocate / provide information of importance to condition, poor / untimely information to those waiting.**	Restricted space results in some difficulty in allowing relatives present in minors area during patient consultation. Refurbishment of department including waiting room agreed on Capital Plan 2011/12. Department team participated in regional Dementia away day June 2011 and identified this issue for addressing. 'Do not resuscitate' documentation introduced to be consistent with Trust Resuscitation Policy CP11. A/E complaints themes consistent with issues identified in C&C document. Feedback to individuals involved in complaint.	LIA event planned to discuss issue with all grades of staff. Scoping actions required to implement a more Dementia friendly department. Proposed increase in size of minors clinical areas to facilitate relative accompanying patient. Receptionist responsibility of alerting nursing staff to the presence of a waiting relative and improved processes for keeping patients and relatives informed of wait times. End of Life Care – training to commence for Doctors and Nurses.	Directorate Management Team	July 2011 April 2012 July 2011 December 2011	Monitoring via Directorate Governance forum.	A
2	**General care issues relating to:** **poor pain**	March 2011CQC responsive review of Essential Standards: Outcomes 4, 6, 13, 16 & 17 require improvements.	Action plan required to address findings & recommendations.	DDNM	DateTBC	Report and monitoring via Quality & Safety Committee	A

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	management; **call bells left out of reach;** **toileting needs not addressed;** **personal hygiene not attended to;** **lack of concern/ sympathy by staff.**	'Patent Experience Trackers' to ascertain real-time feed back implemented on adult in-patient wards from April 2011 – show generally positive results. Senior sister & matron clinical rounds, availability and contact sign posted on all in-patient wards. 'Comfort rounds' instigated in most in-patient areas. D22 Dementia ward using 'About Me' personalised care plans. Complaints themes consistent with issues identified in C&C document. Directorate actions. Feedback to individuals involved in complaint.	Implement quarterly report to Divisions. Update of relative information boards. Review and refresh of 'Essence of Care' benchmarks for best practice Implement personalised care plans across in-patient areas.	Patient Experience Lead Matrons Matron - Gastroenterology Divisional Heads of Nursing	August 2011 September 2011 Datetbc December 2012	Monthly report to Trust Board. Complaints trends analysis monitored and discussed at Directorate and Divisional levels and at quarterly performance review.	
3	**Ineffective management of personal belongings**	Policy for the management of patients property - OP18. Property checklist included in transfer documentation – audit of documentation shows good practice, however a number of complaints and claims for lost property were received during	Policy due for review. - Requires inclusion of care of soiled items and actions to be taken if no known NOK.	Director of Finance.	August 2011	Policy Committee receives completed.	Y

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		the last 12 months. Judy data pls Care of soiled items includes use of soluble bags.					
4	**Nutritional care needs not identified / met.**	March 2011CQC compliance review of Essential Standards of dignity & nutrition for older people: Essential standards outcomes 1 & 5 were both met, with a minor concern relating to meeting nutritional needs.	Separate action plan devised to address CQC findings & recommendations, which incorporates recommendations from the 'Still Hungry to be Heard' document.	DDNM	October 2011	Report and monitoring via Quality & Safety Committee	Y
		CQUIN 2011/12 – 90% of in-patients should have MUST nutritional assessment score calculated and care plan in place for high risk patients.	On-going monitoring of MUST completion. Further work to audit care plan development.	Divisional Heads of Nursing	By Q4 2011/12	MUST scoring compliance reported monthly through Divisions to DN&M and COO and to Trust Board. Results show an improving trend and above 90% compliance (as of June 2011).	
		Dementia outreach receives referrals from across in-patient areas. Piloting personalised care plans for patients with dementia in Elderly Care and Trauma Wards.	Implement Productive Ward Meals Module in A/E – to include consideration of swallow assessments, soft diet options, over bed tables, modified cutlery and crockery.	Senior Matron - A/E	DATE tbc		
		LiNK audit 2010 identifies partial implementation of the Protected Mealtime policy.	Full implementation of the Protected Mealtime policy across in-patient wards.	Matron – Gastroenterology & Divisional Medical Directors	DATE tbc.	Progress reported bi-monthly to Productives Group	

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5	**Poor wound management.**	Improved reporting has resulted in an increased rate of DATIX recorded tissue damage. Action plans devised for specific wards. CQUIN 2011/12 – Improve TV assessment to at least 90%, and care plan in place for 90%, and 10% total decrease in numbers reported (all grades). RCA's undertaken for grades 3 and 4 pressure damage.	Revision of CP13 - Pressure Ulcer Prevention and Management policy in process, to align with community approach. Implementation of Rapid Improvement Event for reduction in HAPU's grades 3 and 4 in high risk areas.	DDNM Divisional Heads of Nursing	August 2011 Date TBC	Policy Committee receives completed. Progress reported monthly to Pressure Ulcer Prevention Group (?correct title). RCA's received by this group and by Divisional & Directorate governance forums.	A
6	**Repeated falls in 'high risk' patients.**	Rate of falls in adult in-patients during 2010/12 was 5.62/1000 OBD's, a slight increase from xxxx in 2009/10. Judy data pls. CQUIN 2011/12 – reduction in falls in adult in-patients. Acute target of 5.4/1000 OBD's. RCA's undertaken for falls resulting in serious injuries. Safety briefings and/or electronic nursing handover implemented on most in-patient wards. Dementia care bundle implemented on Ward D22.	Revision of Falls Prevention CP42 and Bed Rail Use CP46 policies in process, to align with community approach. Implementation of Rapid Improvement Event for Falls Reduction in high risk areas.	DDNM Divisional Heads of Nursing	August 2011 September 2011	Policy Committee receives completed. Progress reported monthly to Falls Prevention Group. RCA's received by this group and by Divisional & Directorate governance forums.	A
7	**Discharge planning**	Discharge from Hospital policy	Check list format to be reviewed	Capacity	August 2011	Policy Committee receives	R

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	/ arrangements – poor information to patient and GP regarding medications on discharge; communications regarding discharge arrangements.	CP04 over due for review (September 2010). Compliance with check list completion low (July 2011). Medicines reconciliation occurs on discharge summary letter. CQUIN 2011/12 – Medicines reconciliation baseline reporting. Concerns relating to discharge raised in complaints, incidents, safeguarding referrals, feedback from other services. Discharge coordinator roles for stroke, orthopaedic, rehabilitation. Electronic discharge letters in use in A/E. Hard copy of discharge letter to nursing/ care home in addition to GP.	as part of policy review. e-discharge documentation rollout. Further modification to document to improve medicines reconciliation. Separate action plan devised to ensure 'Improving Safe & Effective Discharge'. Workforce review of nursing & midwifery	Team Manager K. Cantrill DDNM Deputy Director of N&M	 Date tbc October 2011 September 2011	completed. Progress reported monthly at project Steering Group. Report and monitoring via Quality & Safety Committee Progress reported monthly to Steering Group as a sub-group of Senior Nurse Strategic group.	
8	**Management / care and attention to patients with dementia.**	National and local dementia strategy being implemented. Dementia friendly environment created – one ward (D22) and one area of EAU.	Further consideration by Dementia steering group & Care of Elderly directorate required.	TBC		Progress monitored via Dementia Steering Group and Directorate Governance forum.	G

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		Outreach team recruited & referral criteria devised. Care bundle approach - independent evaluation in progress. Numerous compliments from relatives regarding D22. Any complaints – Judy??					
9	**Inappropriate/ injudicious use of antipsychotics.**	Protocols in use for delirium. Dementia strategy and outreach service with personalised care plans. Medicines review on ward rounds.	Further consideration by Dementia steering group & care of Elderly directorate required.	TBC			TBC
10	**Complaints handling – formal/informal/oral /written complaints management varied.**	Complaints & PALS teams. Complaints policy OP08 & process. Complaints response/ handling sign-off at Divisional Management level prior to submission to CEO. Quarterly trends and themes analysis at Directorate and Divisional level shows complaints themes consistent with issues identified in C&C document. Directorate	Revision of Policy OP08 in progress. Policy re-launch & awareness training. Review of complex complaints over 1 month for consistency in approach. Review of model for PALS.	DDNM	September 2011 October 2011 August 2011 September 2011	Quarterly complaints	Y

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		actions. Feedback to individuals involved in complaint. Complaints referred to PHSO Q4 2011 - No new. 4 Complaints upheld by PHSO 2011 - most relate to 2009. Patient bed-side folders include information on how to complain and details of PALS service.	Increase/improve information available at entrance of wards.		August 2011	reports to Trust Board	