Healthwatch Isle of Wight – Enter & View Report

Ward visited: MAAU
Date of observation 1: 2nd December 2013
Start time: 12.00 **Finish:** 13.45
Date of observation 2: 4th December 2013
Start time: 14.00 **Finish**: 15.30
Names of Enter & View panel members involved in the visits:
Susan Orchin, Niviera Piper, Maureen Wright, John Phillips (accompanied by Joshua Redford Healthwatch apprentice for note taking.)

About the Healthwatch Isle of Wight Enter & View function

Healthwatch is the independent consumer champion created to gather and represent the views of the public on health and social care. Healthwatch plays a role at both national and local level and makes sure that the views of the public and people who use services are taken into account.

'Enter and View' as laid down in the Healthwatch regulations of 2012, allows Authorised Representatives:

* To go into health and social care premises to see and hear for themselves how services are provided.

* To collect the views of service users (patients and residents) at the point of service delivery.

* To collect the views of carers and relatives of service users.

* To observe the nature and quality of services – observation involving all the senses.

* To collate evidence-based findings.

* To report findings and associated recommendations – good and bad – to providers, CQC, Local Authority and NHS commissioners and quality assurers, Healthwatch England and any other relevant partners.

* To develop insights and recommendations across multiple visits to inform strategic decision making at local and national levels.

Methodology

Healthwatch Isle of Wight are looking at inpatient experience at St Marys Hospital as one of their priority workplan areas. Visits to Colwell, MAAU and St Helens wards took place during the week of 2nd December 2013 through 8th December 2014 to find, highlight and share examples of good practice alongside providing evidence to contribute to the ongoing programme of development at IW NHS Trust. The visits were also designed to allow patients and their families voices to be heard.

St Marys was written to in advance explaining the project in full. The hospital was informed which week the visits would be taking place in, but not specific dates and times. Posters explaining about the visits were given to the hospital to put up to let staff, patient and visitors know what was happening and how to get in touch with us.

Number of Patients on ward at each visit	21 23	Were all beds full?	Not on first visit			
Total numbers spoken to:-	**Patients**	**18**	**Staff**	**8**	**Visitors**	**10**

Summary of staffing structure on the ward at the time of visits and whether it appeared to be adequate

During the first visit there were 4 registered nurses (including coordinator) plus 2 HCAs. The junior doctor compliment was 1 registrar, 2 FY2 and an FY1. There was 1 registered nurse off sick.

On the second visit there were the same as above plus an additional registered nurse.

Staff levels appeared to be sufficient, there was not a stressful or hurried atmosphere and the patients reported that staff came quickly when called.

Patient/Visitor feedback

Summary of comments/observations re: Communications
Patients reported that communication with staff was good. Staff used everyday language to explain procedures etc and patients reported that they were informed of what was going to happen with regard to discharges etc. Patients reported that bells were answered promptly. We saw staff helping new arrivals to settle in and asking if they needed anything or help in any way. There are concerns around communication with regard to new admissions and identity (See 4 below).
Summary of feedback re: Care
Most patients were happy with their care, with one patient being very impressed by early doctors round. The exceptions were:- 1. One patient was unhappy that the curtains were not pulled properly around the bed so that others could still see what was happening. 2. Another patient had requested an x-ray on a previous visit to be told it was unnecessary and sent home only to be sent back in two days later with pneumonia.

3. It was reported to us that a patient's urine bag was not changed for 3 days and was full of congealed blood. When they complained it was changed instantly. The patient was very happy with all the other care.
4. One patient was full of praise for how the staff had looked after them and then talked about an incident the previous day. They had been very surprised the previous day by the administering of a finger prick blood test and had screamed. When the nurse was asked what had been done, the nurse said that it was a test for blood sugars. The patient then asked what for and the nurse replied by saying it was for diabetes, at which point they told nurse that they did not have diabetes and it became obvious the test was for the patient in the next bed who had only just been admitted. The patient reporting this incident had been admitted on the previous Friday and our visit was on the Monday, so it seems likely this was a mistaken identity. They told us that when they had recovered from the shock they all had a good laugh about it.

Item 2 would seem to be a complaint with regard to Accident and Emergency and probably not with regard to MAAU.

Our visiting team on another ward was told about another incident which is attached as Appendix 1.

Summary of feedback re practical assistance/aids

The team saw one confused patient being helped to eat. One other patient had a walking aid. However when we saw this patient, they were sitting on the edge of their bed leaning on the walking aid almost asleep. The patient said that the person who had 'brought them back' had left them like that, they thought to go to the toilet, and wanted to get back into bed as they were very tired. The alarm bell was behind them on the bed but we are not sure if they could have twisted round to reach it.
After a few minutes a cleaner saw the patient and asked if they were OK.

Summary of feedback re: mealtimes

On our first visit everyone was happy – One patient said that the food was hot and tasted good and reported that there was a lot of choice. One patient said the meal was far too big but was a small eater anyway.
We observed that one patient seemed to be having difficulty opening an orange juice carton, they could not find the straw, so in the end a member of the panel helped to open it. We also saw another being helped to eat.
On the second visit one individual was unhappy with the salmon sandwich they had been given – saying it was 'not what they expected'. However another patient said that 'they are doing alright with the food, considering how small the budget is.'

Summary of feedback re: hydration

One patient had a drinking aid, which was out of reach. They were not distressed about this and were not thirsty. Most patients spoken with reported that they could have a cup of tea whenever they wanted and everyone seemed to have water jugs.

Summary of feedback re: discharge from hospital

One patient was unhappy believing that they had been discharged too soon on a previous occasion. (See above 2.). One individual had been told arrangements were being made for her to return home. Another patient was waiting for family to arrive to take them home. Everyone thought they had been informed as soon as possible about discharge.
One patient reported that another patient was 'going to Sevenacres'. We were not told how they knew.

Observations / questions for staff

Summary of communication

We feel that staff are using appropriate language with patients that is clear and they can understand. We only spoke to the Sister during the first visit with no other staff members talking to us but on the second visit staff were much more communicative and wanting to be helpful. Several members of staff wanted to know if we had found anything wrong, including the Sister.

Summary of personal hygiene support

Nurses and health care assistants help with personal hygiene. We noticed that there was not hand gel by each bed as seen in other wards. We were told there were 7 toilets for patient use and one of us saw the staff rest room with toilet. All beds have their own bag for personal rubbish.

Summary of support with practical assistance/aids

The ward has specialist cups, deep plates and cutlery for those that need aids to eat. They use yellow trays with red serviettes to serve those who need help to eat, so that those patients are easily identifiable. Bigger items would need to be ordered from department.
They have signs to help those with hearing loss.
The doctors and nurses make the decision regarding who needs specialist beakers or other aids based on their assessment on admission. This can be changed and is changed if ward staff see a different need. However, patients are not asked for their preference.

Summary of support at mealtimes/with drinking

We saw one person being helped to eat. Staff monitor eating and drinking and will keep a special record if there are concerns. Jugs are refilled three times a day and if too much left patient will be encouraged/helped to drink more. They sometimes add squash to water if patient does not like water. If food is left patient will be asked why.
It would seem that support is available and given where needed. Staff may need to be more aware of the need to place drinks within reach.

Summary of physical environment

Reception area
The staff were helpful and welcoming, particularly on our second visit. They were clearly very busy but seemed organised and there was a good atmosphere. It is however, a very crowded area with very little room and a lot of pamphlets, notices etc. Whilst we were there at one time there were two beds being manoeuvred in and out of the department in this small space. There was a notice with patient titles and surnames in reception area. We did not see any patient names elsewhere in the ward. We understand from staff that initials or forenames are not included because of data protection requirements. All the walls in the entrance seemed ‘busy’ with notices and leaflets which we found confusing.
Staff identification
The nursing staff all had their new yellow badges with their Christian names but most of the other staff such as house-keeping and admin are awaiting theirs. We found it difficult to read their role titles on the badges and did not know the uniform colours for various jobs, so could not readily identify who was who. We were told that a new board which will have pictures as well as names of staff is planned and should arrive shortly. There was a list of names and working roles on a board in the entrance. On our first visit we saw the consultant’s name being changed as it that staff member was no longer there.
Ward facilities
There were lots of bins with different coloured bags for different types of waste throughout the ward and patients are told what they are for as well as being shown their own waste bag on the side of their cupboard. The walls and floors were very clean - some we thought were new. Bathrooms were very clean although two were looking a little tired decoratively.
Summary of additional comments

We informed the Sister about two of the reported care incidents very briefly. These were items 3 & 4. The Sister felt that 3 could not have happened since urine bags would need to be changed frequently.
With regard to item 4 we were told that all patients are tested for diabetes upon admission for diagnostic purposes. We do not believe this was the case here, as the patient was very clear that it was intended for the new admission next to them and they had been on the ward 3 days all ready.

Conclusion

Generally the patients and families we spoke to were happy with the ward, there seemed to be sufficient staffing and some good processes in place to try and meet patient needs. There were some exceptions and things we noticed which we feel need attention.

This ward is very busy with lots of patient movements, working in a physical environment which is far from ideal. We know it is scheduled to be rebuilt in 2014. Many of the patients are not within view of the nurse's station which is cramped.

Our concerns are:

- How patients are identified and found by staff and visitors.
- Placement of drinks and alarms out of the reach of some patients.
- Showing respect for patients choices.
- The number of leaflets, forms, notices on walls and other items in and around the entrance.
- Identification of staff roles/positions for patients and visitors.

Recommendations

1. Staff to pay more attention to identifying patients in order to avoid mistakes in procedures and clinical processes.

   We understand the need for confidentiality on the ward but think that having formal names on beds would help in two ways:-
   - It would help avoid mistakes for procedures and drugs rounds
   - It would help everyone find and address patients by their names. (In particular, confused patients or those with dementia need to be addressed by their names).

   If names could be put on the end of the beds they could be removed when patients were discharged and the bed cleaned and they would stay with the patient wherever they went. There would be no more information there than at the ward entrance so this would not increase the risk of lost confidentiality. Nurses would still have to make their checks but we believe this would help avoid mishaps.

Response:
All patients have name printed and added to outside of folders at the end of bed.

14/1/14 MAU admission system being adjusted to make this an automatic function. Ongoing.

2. More attention to be paid to making sure patients have drinks and alarms within reach – especially those who are more frail or immobile.

Response:
All staff reminded of the importance to ensure bells and drinks within reach via email and newsletter.

Initially shared with staff 14/1/14 – Spot checks performed regularly by sister.

3. We would like patients to be asked on admission, which aids, particularly with regard to drinking and eating, they would prefer although recognising that some patients may need to have the decision taken for them.

Response:
Admission documentation amended with prompt to remind staff to ask if adds are needed.

Completed 2/2/14.

4. We would like to see the entrance walls and surfaces 'de-cluttered' with some of the notices leaflets – especially those for visitors – being place outside the ward if possible. (Would it be useful/possible to have little parcel of leaflets suitable for visitors ready to give to new visitors as they arrive rather than different boxes/piles around the nurses' station)

Response:
Entrance surfaces de-cluttered – there already is a leaflet rack outside the ward entrance which has been in place for several years. Minimal leaflets kept on reception desk to remind staff of friends and family survey and ward information.

Completed 14/1/14.

Spot checks carried out by sister.

5. We would like to see a chart showing staff clothing/colour in a clearly visible position so that patients and visitors know the role of staff they see. We understand that A&E has an excellent example of such a chart and wonder if could be rolled out across the hospital.

Response:
Posters in final draft stages at print room and should be available shortly.

Whilst the visits were taking place, Healthwatch isle of Wight received more feedback from the public about MAAU and so it has been agreed that a further visit will take place in the near future at a different time of day and week. However for clarity the findings of that visit will be reported separately.

MAAU Appendix 1

A relative of a patient who had been transferred to Colwell ward gave this account relating to patient experience whilst they were on MAAU.

The patient was on the ward for 8 hours before being seen by a doctor.

The patient is terminally ill and being cared for by the family at home. They described to us that they have a well maintained regime of medication which they administer at home. When the patient was seen by MAAU medical staff they decided to change the medication because as the patient was terminally ill, they considered that all they needed was to be kept comfortable. After a relative insisted the patient be kept on the same medication, they had to go home to get it as the hospital did not have what was required.

The reason for admitting the patient was because they had developed an infection which needed treatment by IV antibiotics. It would appear that this treatment could be provided at home as long as the active ingredient in the drip only needed to be administered once daily, but this patient needed it 4 times a day. The family had requested an admission for the hospice for the procedure, but were told that the Hospice do not have IV drips.

The patient had to spend 4 days in hospital occupying an acute bed when an admission could have been avoided if the community team had been able to make the 4 visits a day to the patient at home. Apart from the cost implication, the family felt that this would have prevented the distress the admission had so obviously caused the patient.