healthwatch Sandwell

Why Do Good People Allow Bad Things To Happen?

Report Into Care At Sandwell General Hospital

February 2016

Contents

DISCLAIMER

This report is based on the views and experiences of respondents. Due to the nature of this approach, we recognise that there may be differences between people's views and provider's intentions. Efforts have been made to ensure information is accurate or where necessary, reflect more than one view, whilst keeping to the brief.

Published by Healthwatch Sandwell, Walker Grange, Central Avenue, Tipton, DY4 9RY.

www.healthwatchsandwell.co.uk

Summary

Healthwatch Sandwell (HWS) carried out an investigation into patients' experience of care at Sandwell General Hospital (SGH), in particular potentially unacceptable incidents, during the latter half of 2015. This report contains findings from this investigation and recommendations for improvement.

The recommendations are:

- The Trust should consider why these issues have arisen, and what can be/has been done to prevent any repetition, even if improvements have already been made.
- The Trust should consider why the culture leading to these failures has existed among staff i.e. Why do good people allow bad things to happen?
- The Trust needs to consider patients' reluctance to complain, which patients sometimes attribute to fears of discrimination (which may be founded or not).
- The complaints process needs to be more explicit, clearly stating the steps involved, what can/will happen, and possible outcomes.

Our investigation found failures to provide appropriate nursing care, communications issues regarding patients and family, including end of life circumstances, and limitations in the complaints system.

This investigation was undertaken as a result of HWS being contacted by a number of patients and relatives, with issues relating to care on SGH wards. This included one particularly detailed case, which we successfully supported through the complaints process, detailing multiple unacceptable incidents.

Having established that unacceptable care incidents were occurring, our aim was to create a picture of the 'lived experience' for patients and their relatives and carers.

Therefore, it has considered the experience of the patient, but only where a description of the incident could also reasonably be considered to raise serious care issues. A two stage approach was taken, firstly to identify potential cases, and then to carry out in-depth interviews.

We have not sought to quantify the frequency of these experiences, and we recognise that the sample interviewed was small. However, we have established that these are not one-off incidents, and as we have focussed on incidents that would possibly be unacceptable at any level, we believe that it is not necessary to accurately determine frequency.

Recommendations

HWS recommend:

The Trust should consider why these issues have arisen, and what can be/has been done to prevent any repetition, even if improvements have already been made. HWS is aware that some improvements have been made recently, which may have improved care. However, we believe that it needs to be established if this has tackled the underlying cause or just a symptom. In either case, understanding how this situation has occurred is the only certain way of being able to take steps to prevent it happening again.

The Trust should consider why the culture leading to these failures has existed among staff i.e. why do good people allow bad things to happen? Where information is available, problems appear to be in particular wards, which suggests a cultural effect on staff's behaviour. We are also aware that there are examples of excellent care at SGH e.g. Children's Services, which was highly commended in a recent CQC report (2015), and which HWS concurred with. These cultural differences need to be understood, and best practices replicated.

The Trust needs to consider patients' reluctance to complain, which patients sometimes attribute to fears of discrimination (which may be founded or not). Complaints are essential to service organisations in order to know if they are getting it right. Complaints need to be welcomed and shown to be acted upon. Any reluctance from service users to complain due to lack of faith in the complaints system, not only deprives the organisation of valuable insight and feedback on how it is doing, it can also give the organisation a false view of the quality of service that it is delivering.

The complaints process needs to be more explicit, clearly stating the steps involved, what can/will happen, and possible outcomes. The SGH website does provide information on making complaints, but does not seem to explain the process following this or potential outcomes. Respondents were unaware of some of this information. Patients who complained were often unhappy with the response. They just wanted proper levels of care, and in some cases to prevent the same problems affecting others and confirmation that something had been done. They presumed this would happen, but it didn't, even when they persisted.

'Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients'

The Governments Mandate to NHS England for 2016-17

The Department of Health (December 2015)

'We need to embrace transparency and learning, unequivocally and everywhere, so as to build trust with the public and knowledge within the NHS. We need to embed compassion in every part of the NHS, placing patients' wellbeing at the centre of every decision we make. And we need to involve patients, their families and carers as much as possible in that process'.

Jane Cummings, Chief Nursing Officer for England and NHS England Chief Nurse

The Francis Report: One Year On (2014)

Comment

Given the findings and methodology used in this report, and our wider experience of SWBHT, we believe a comment is required to set them in context.

Although the issues highlighted are serious and raise concerns, we are aware that it is difficult to consider this information comparatively. i.e. similar research may not be available for other hospitals, so we do not know if the findings for SWBHT are outside of or the norm.

We believe it would be unfair to rate SWBHT on this investigation without similar research to compare to other hospitals. However, there are clearly issues in patient care and these do need to be addressed.

Findings

The following main themes were identified from this investigation:

- Failure to provide appropriate nursing care
- Communication with patients and family
- Communication: End of Life
- Limitations to complaints system

These themes are expanded below.

Failure to provide appropriate nursing care.

The experiences relating to this theme were varied and included, not receiving care, lack of access to medication, not being treated with dignity and a lack of care related to feeding.

Examples of experiences attributed to this theme:

Respondents described how they were left unattended for long periods of time and that requests for help (either practical care or access to medical care) were ignored. Ten respondents described how attention was given only after they had protested and how on one occasion, visitors had to intervene to help an elderly confused man whose family had returned home, as there was no accessible help. Another respondent described how their relative did not have access to water until a relative requested this

'Here we go again'

Issues were raised about access to medication: a respondent described how her father was very confused and she was concerned he wasn't getting his medication at the right time as the staff had suggested, 'that dad could manage his own medication'. He was confused and at times disorientated. The respondent felt that she had to persistently raise the issue of medication. She described the experience as here we go again.

A respondent described how his own drugs (Tramadol (controlled) and Oramorph) were 'lost' on admission and were not replaced. Another respondent described how her relative was receiving antibiotics via a cannula which was removed and not replaced. Her perception was that her relative was not receiving prescribed medication. She was not informed if medication was being given in other forms.

care did not seem to be given automatically

There were instances when patients were treated without dignity and many examples were given, which included, an elderly woman's dentures and glasses not being given to her and the relative later finding the dentures on the floor. Respondents described how their relatives were left in soiled clothes and bandages, causing distress for both. This instance was only addressed when it was brought to the attention of staff by visiting relatives. They described how care did not seem to be given automatically.

A relative described how she asked staff to feed her husband as he was unable to feed himself. The staff refused saying that he may choke, so she had to go into hospital every day to feed him. She was not advised to not do this. She never asked them to help again. She described how food and drink was put out of his reach on the bedside table.

She never asked them to help again

Another respondent, whose father was having chemotherapy and an operation to remove a cancerous tumour, described how he was being tube-fed, but the machine kept sounding an alarm. The staff didn't know why, until the Nutricare nurse came along and pointed out it was a gravity-feed and needed to be raised higher (it was flat). This caused considerable stress to patient and the family.

A daughter described how she would feed her mother, but one day she was prevented from entering the room while staff cleaned. When they left the room, they had left soiled pads and bedding in the room, and she believed it was unhygienic to eat in there. This relative believed that meal times were supposed to be protected and that cleaning should not occur while food is being served. She expressed concern about infection transmission and stated that there was supposed to be barrier nursing* when attending to patients, due to MRSA. Sometimes they would wear gloves, but not at all times.

[he] was left on the floor with staff passing him by for ten minutes

A visiting relative described that they saw a gentleman fall out of bed. They called a nurse, but the gentleman was left on the floor with staff passing him by for ten minutes.

*Barrier nursing is a set of stringent infection control techniques. The aim is to protect patients against infection, especially those with highly infectious diseases.

Communication with patients and family

Examples of experiences attributed to this theme:

Medication was discussed openly without apparent regard for confidentiality: a respondent described an incident involving a health care assistant and nurse openly discussing her medication in front of other patients. The nurse said, 'Oh that's alright, she only wants her morphine.' Patient was unhappy with this as it was said in front of another patient.

Three respondents described the aggressive manner in which they were spoken to:

A relative was questioning why the patient was in so much pain and wanted to complain about this. The relative asked a nurse involved for her name in order to pursue a complaint. The nurse threw her name badge at her saying, 'take it from that.'

'Your mother isn't the only one on the ward'

A physiotherapist was sent to show a patient how to use crutches. The patient described their approach as very aggressive, with the physiotherapist saying that the patient had already been shown how to use crutches at Manor Hospital. However, when the patient then asked the head nurse for his shoes (trainers) so that he could try to walk with the crutches, he was told, 'you have feet don't you?' It transpired that the trainers had been lost.

When a relative asked for help for her mother she was 'aggressively' told, 'Your mother isn't the only one on the ward'.

A patient who had had a severe stroke and was without speech was ignored and isolated. The relative described how no one communicated with her husband and that he was unable to let people know what he needed. The relative had to advocate for him, but could only do this during visiting times. She was very anxious about what happened to him when she wasn't there.

A patient… without speech was ignored and isolated

Two respondents described a lack of information about their relatives' care needs, both whilst in hospital and after discharge. A respondent was distressed that her husband was moved to City Hospital without consultation with her. She had also requested that he not be moved to City Hospital due to travel difficulties for her. Her husband had no verbal communication and was unable to give consent to any transfer. The relative was the key person and was not communicated with about this transfer or in deed the need to move.

A relative described how basic needs were met (washing, dressing and feeding at set times occurred), but no medical intervention. They were left totally unaware about what was happening, questioned why their relative was in hospital, but no one communicated with them. They received no diagnosis or prognosis.

Communication: End of life

A relative of a patient who was dying had to keep asking staff for information. She stated, 'They didn't tell me anything'.

This relative had assumed her husband was coming home, when in fact he was dying. She was never told this. She described how he was always lying on the same side, and when she asked them to move him, she was told they had 'only just done that'.

When he had a temperature, she asked for a fan to help cool him down. The nurse said she 'couldn't put a fan on him because we are not doing anything for him.'

'They didn't tell me anything'

This was the first time that the relative knew that her husband was coming to the end of his life. It does however question the quality of end of life care. This exacerbated a very stressful situation and appears to be very poor communication. One relative felt that she was put under pressure to sign a DNR form (Do Not Resuscitate) even though her mother was able to make that decision herself (capacity to consent). This was very distressing for the daughter, and raises questions about practices.

[She] felt that she was put under pressure to sign a Do Not Resuscitate form

These instances caused considerable distress to patients and their family members. A respondent stated, 'It's 'cause we're old they don't want to know'.

Limitations to complaints system

Examples of experiences attributed to this theme:

A respondent who had talked to a ward manager about issues with her relative's care noticed that afterwards, staff whom she had not met before knew her name. She felt this was due to having made a complaint and led to a feeling of being targeted. The same respondent gave an example of feeling targeted relating to rules regarding numbers allowed around the bed at visiting times. Before the complaint, these were relaxed, but afterwards were rigorously enforced. This experience caused further stress to the respondent, as she feared what might be happening to her relative when she wasn't there as a result of having raised concerns.

Respondents shared their experience of the Patient Advice and Liaison Service (PALS), which offers confidential advice, support and information on health-related matters and is a

point of contact for patients, their families and their carers. Experiences varied. One respondent spoke very highly but described some of the difficulties that PALs itself experienced with ward staff e.g. not returning calls etc.

'It's 'cause we're old they don't want to know'

Two respondents contacted PALS, but did not get a response. This left people feeling frustrated and they gave up pursuing their complaints.

One respondent stated that her mother didn't want her to make a complaint, 'just in case she got the bad end of the stick'

The investigation identified that there was suspicion around the complaints system which hindered people in reporting or pursing concerns. This is not only an issue for patients who can't complain, but also for the hospital as a result of losing this valuable insight.

…didn't want her to make a complaint, 'just in case she got the bad end of the stick'

Compliments

Although this report was addressing experiences of unsatisfactory patient care, examples of good and excellent care were given.

Three respondents described examples of good care that they had received at City Hospital and Queen Elizabeth Hospital: 'City were brilliant when he moved there. We were well informed. My dad had to go into the QE for major surgery and we have seen what good hospital care looks like. It was a marvellous experience way blown out of the window. Care on Ward 42 at City Hospital was good'.

They were fantastic when I had a seizure. They stayed with me, reassured me.

Another respondent stated that certain nurses took an interest in her mother, and even though she had dementia, they talked to her and encouraged her.

Three respondents described good experiences at SGH: 'I had fantastic treatment on AMU from [Named staff]. They were fantastic when I had a seizure. They stayed with me, reassured me. They were comforting, explaining to me what was happening and they gave me pain relief'.

> '[Named staff] on Newton would make me hot drinks and stay with me when I couldn't sleep'.

Finally, one respondent believed that her care improved once her parents rang the hospital after she had rung them at 10pm. Care did seem to get better for a while, including nurses asking her if she needed anything.

Rationale and Aim

As a result of the background to this investigation, our aim was:

To identify if people have recently experienced care at Sandwell General Hospital that could be considered unacceptable, in particular on Lyndon 5 (but not limited to), and to understand and describe the patient experience.

Where instances have occurred, to ask about experiences of making or considering making complaints.

Background

During 2015, HWS was contacted by the relative of a patient who was unhappy with their care at Sandwell General Hospital. The issues they raised also suggested possible cultural issues at the hospital relating to care. The relative wanted to complain, so due to the systemic nature of the issues, HWS agreed to support the complaint. This led HWS to carrying out further research. This involved reviewing previously gathered intelligence, which showed that between May 2015 – August 2015, there were 49 recorded experiences. Our Experience Gatherers were asked to look for any more potential cases during their work. HWS had previously carried out an Enter and View visit at the hospital, which although had found no issues, had been the result of previous concerns raised.

As well as the issues relating to the above, HWS's existing evidence suggested that very few people would complain, or if they did, would not see it through. This was also a view, and of concern to the Healthwatch Sandwell Board.

Notice of this investigation being carried out was provided in our Healthwatch Activity Reports 7 and 8, dated June and September 2015 respectively (Available on our website). http://www.healthwatchsandwell.co.uk/activity-update-0

The CQC inspection report (March 2015) reported that urgent and emergency services, medical care, and surgery required improvement and outpatients and diagnostic imaging was inadequate.

In medical care it was noted that some people's care plans were not effective in providing guidance to staff as to how to safely provide the care and treatment to meet their assessed needs. This investigation confirmed that some staff were not aware of patients' assessed need.

The CQC inspection report (March 2015) summarised that the trust had systems in place, including internal and national audit, to monitor patient safety. However, some practices were creating risk to patient safety. These included doctors not reporting incidents and staff not properly following some procedures, such as for medicines storage and for infection control. The report noted that in surgery, infection control measures were largely ignored by medical staff, and in outpatients and diagnostic imaging the Inspectors saw practices that could compromise the safety, privacy and dignity of patients.

SGH provided us with Family and Friends Test results (see Appendix 1). Recommendation levels appear high (significantly over 90% for most wards, apart from one at 66%). Response rates do vary significantly.

Methodology

Approach

From the background and purpose, the need identified was to understand experiences relating to care that should not be happening. Therefore, an in-depth understanding of experiences was needed. The method chosen was to identify patients who reported experiencing potentially unacceptable care, and to carry out in-depth and predominantly open interviews to capture the full lived-experience of what they had gone through.

Methods used to identify the individual patients (or relatives and carers) are detailed below. Therefore, although this study is not aiming to describe or present a statistical picture of what is happening (as these are events that should not happen), the data is available for the reader to draw their own conclusions regarding the frequency of incidents.

Identification of patients' stories

An analysis of data collated at HWS identified 49 patients who had spoken to HWS about concerns relating to their experience at SGH, either through HWS's experience gathering in the community, or through them directly contacting HWS's office, between May and August 2015. Of these, fifteen had agreed to be contacted for further information. They were contacted to take part and twelve agreed to participate.

Three HWS support officers visited SGH and spent a day on the whole of floor 5 (Lyndon, Priory, Newton) in August 2015 talking to patients and relatives. They used a pre-set questionnaire which collated qualitative and quantitative data. They spoke to 33 people, 21 of whom reported negative experiences in relation to care and agreed to being contacted at a later date.

In total 33 from both of the above sources agreed to be contacted. This was followed up with eleven people agreeing to be interviewed. Five respondents were from the day spent at the hospital and six from other contact with HWS.
Reasons given by those not wanting to take part included, wanting to put the whole experience behind them.

We recognise that this study is based on an approach that would be considered interpretivist within the realm of social sciences. However, the above details, regarding the sourcing of stories, are provided to allow the reader who may be more used to quantitative and positivist based research, to understand the validity of what may appear, to the untrained eye, to be a small sample size. We do, however, feel able to comment that the number of stories identified in relation to the efforts undertaken, specifically with regards to the survey carried out on the hospital ward, does show a worrying level of occurrence. We recognise the limitations of identifying most of these sources from one visit, but we think it is fair to presume that this was not a one-off. We would add further, that this approach is consistent with the Francis report, and Robert Francis' (Inquiry Chairman) comment in his covering letter:

'It should be patients – not numbers - which counted. That remains my view'.

Questions and interviews

A set of semi structured questions were developed and were trialled with one of the respondents. These results were taken into account, and two officers visited the remaining people. The interviewers asked respondents to describe their experiences at SGH, if they had complained and any barriers to complaining. These interviews were recorded and analysed into key themes.

All interviews were recorded and stored in accordance with the Data Protection Act (1998).

Note: Patients were frequently unable to remember the names of wards, or may never have been aware of the name. They simply knew that they were in the hospital and how to get around. We recognise that not providing names of wards where incidents occurred may cause difficulties for those responding to this report. However, we believe that not being able to provide a ward name should not prevent the evidence being used. The patient experience is paramount, and to ignore this on a technicality would be to repeat the lessons of the past.

Acknowledgements

Healthwatch Sandwell would like to thank all respondents for sharing their experiences.

About Healthwatch Sandwell

HWS is an independent consumer champion that gathers and represents the public's views on health and social care services in Sandwell. It ensures that the views of the public and people who use the services are taken into account by those who commission and provide services.

Healthwatch Sandwell's activities include:

Experience Gathering. HWS staff meet with the public at various locations including community events, supermarkets, bingo halls, high street etc. They provide information about Healthwatch and ask if people would, 'describe their last experience of health or social care services'.

Enter and View. These are visits to health and social care premises, involving staff and volunteers to look at the quality of services from the patients' perspective.

Information and Communication. HWS provides information and means for people to contact through various means including: telephone, website, email, public meetings, networking with community groups, Twitter, Facebook.

As part of HWS's statutory functions, it is our responsibility to make:

> '…reports and recommendations about how local care services could or ought to be improved.'
>
> (1 Section 221 (2) of the Local Government and Public Involvement in Health Act - 2007)

References

Care Quality Commission (2015). Sandwell and West Birmingham Hospitals NHS Trust. Sandwell General Hospital Quality Report

Care Quality Commission (2015). Sandwell and West Birmingham Hospitals NHS Trust. Children, Young People and Families Services

Department of Health (2015) The Governments Mandate to NHS England for 2016-17

Francis, R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office

The Francis Report: One Year On (2014), https://www.england.nhs.uk/2014/02/06/the-francis-report/

Appendix 1: Family and Friends Test Results

	Friends and Family Test Results - April 2015 to January 2016 (Quarterly Average)											
	QTR 1			QTR 2			QTR 3			QRT4 (Jan16)		
Wards/Areas	Response Rate	Would Recommend	Would Not Recommend	Response Rate	Would Recommend	Would Not Recommend	Response Rate	Would Recommend	Would Not Recommend	Response Rate	Would Recommend	Would Not Recommend
New ton 4	100%	98%	1%	81%	100%	0%	68%	100%	0%	100%	100%	0%
Priory 5	15%	86%	2%	36%	82%	9%	54%	81%	14%	99%	100%	0%
Priory 4	69%	94%	2%	37%	99%	0%	40%	98%	2%	45%	100%	0%
SAU - Sandw ell	19%	96%	3%	8%	97%	3%	7%	94%	2%	37%	100%	0%
Lyndon 5	49%	94%	3%	43%	96%	2%	0%	0%	0%	1%	100%	0%
AMU B - Sandw ell	59%	94%	2%	39%	97%	1%	8%	94%	4%	0%	100%	0%
New ton 3	32%	94%	3%	11%	98%	2%	47%	94%	0%	83%	98%	0%
AMU A - Sandw ell	11%	81%	1%	5%	89%	0%	29%	97%	2%	23%	98%	1%
New ton 5	31%	96%	4%	15%	93%	7%	13%	100%	0%	67%	96%	3%
Critical Care - Sandw ell	100%	92%	0%	100%	94%	0%	98%	96%	0%	70%	95%	0%
Lyndon Ground	16%	90%	0%	26%	92%	4%	17%	90%	5%	21%	95%	3%
Lyndon 3	48%	98%	0%	44%	96%	0%	40%	99%	0%	41%	93%	4%
Lyndon 1	28%	77%	1%	33%	96%	2%	26%	94%	2%	22%	89%	8%
Priory 2	67%	98%	1%	35%	92%	1%	29%	94%	4%	5%	83%	0%
Lyndon 4	29%	97%	1%	6%	29%	0%	16%	81%	2%	10%	66%	22%
Priory Ground	33%	33%	0%	56%	100%	0%	47%	67%	0%	n/a	n/a	n/a
Lyndon 2	58%	94%	3%	36%	94%	2%	18%	87%	4%	n/a	n/a	n/a
New ton 2	24%	93%	1%	9%	85%	1%	n/a	n/a	n/a	n/a	n/a	n/a

Source: Sandwell and West Birmingham Hospital Trust

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses.

It was created in 2013 to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving care or treatment across the NHS.

NHS England and NHS Choices websites (2016)