National Spinal Injuries Centre

Stoke Mandeville Hospital, Aylesbury – Buckinghamshire Healthcare NHS Trust

SERVICE STANDARDS FEEDBACK – THE PATIENTS PERSPECTIVE

Overall Summary

The last Care Quality Commission (CQC) Inspection report, in June 2014, rated the overall service offered by the NSIC as "Good."

There are certainly many 'strengths' in the service provision, but there are also many 'weaknesses' that need to be considered to drive continuous improvement and provide better patient care and safety.

This report contains feedback based on first-hand personal experience and 'exit interviews' carried out in agreement with patients being discharged from the NSIC in January 2015.

It is not intended to be interpreted as a 'complaint' – but it is expected that the Trust will take this feedback seriously, investigate the specific matters raised and take action to address them.

Generally, the table below presents a 'snapshot' of the considered strengths and weaknesses of the service - in no particular order.

Strengths:

- Staff members at all levels
- Clinical diagnostics
- Physiotherapy sessions
- Occupational Therapy sessions
- Case Management
- Hydrotherapy pool
- Accessibility
- Porter services
- RVS Café

Weaknesses:

- Staff shortages, shift changes/handovers
- Staff language barriers and response times
- Condition of installations and equipment
- Medication and pharmacy issues
- Building services design and maintenance
- Cleaning services
- Consultancy delays and nature of dialogue
- Available activities and Wi-Fi
- Hospital food provided and served by Sodexo
- Patient Information Leaflets
- Commitment to corporate objectives

Introductory background

In the autumn of 2011, I was afflicted with a rare disease – a slow onset of transverse myelitis. This was eventually diagnosed as longitudinal extensive transverse myelitis (LETM) causing 'C2 complete tetraplegia' by the time I was admitted to NSIC.

After initial treatment at Addenbrookes Hospital in Cambridge, I was transferred to NSIC at Stoke Mandeville Hospital at the end of March 2012 and after extensive rehab, I was discharged on 21st November 2012, with a sensory level of 'T6 incomplete' with residual inflammatory issues up to C2.

I experienced care services on St Andrew's, St David's and St Joseph wards in NSIC.

Most recently, I was readmitted to NSIC for 3 weeks, from January 4th to January 23rd 2015. This was for the purpose of greater independence with bowel management and other rehabilitation benefits, such as improved transfers (including in and out of a car).

During my three week readmission on St Joseph ward, I was able to carry out 'exit interviews' with three other spinal injury patients. The views expressed had significant concurrence – and have enabled me to compile the foregoing feedback report. I was also encouraged to do so by my Consultant and former Physiotherapist.

Overall, I've had about **9 months NSIC experience as an in-patient**.

As with my first admission, it was common to hear extensive criticisms of NSIC (for all manner of reasons), but it seemed that few, if any, patients were prepared to either make a complaint or document their feedback. However, I believe it is **vital to provide constructive feedback**, in order to provide a focus of attention on **matters that need improving for the benefit of current and future patients**. The NSIC website, naturally, only portrays a very biased impression of the 'Good' service.

Staffing

Everyone, associated with this report, agreed that the individual members of staff were excellent – very caring and committed to what they were doing. One Nurse and HCA 'stood out' in their excellent care.

In spite of this, there were many issues, not least of which was the occasional problems of language barriers with nurses and health care assistants (HCAs) – recruited from other European countries.

No-one was averse to the diversity of staff members, but communication could sometimes become an issue, especially on a spinal unit where complex language is often used and is unfamiliar to east European staff. This also affected staff 'team' cohesion and operational effectiveness.

There were **two overriding causes of concern**, namely **staff shortages and shift changes/handovers**.

There was unanimous agreement that at 'peak' times, there were simply not enough staff on duty to cope. The staff/patient ratio was too small, with potentially all 16 patients to 4 staff (2 nurses and 2 HCAs), and this ratio was a 'given' throughout the day, **regardless of 'peak' demand**.

The **most obvious problem was the morning 'rush hour'** – but of course, for spinal patients, things take somewhat longer. So, from around 0700 – 1000hrs the ward is simply chaotic. It's a logistical nightmare

for so few staff, coupled with the fact that there is a 'shift' change right at the 'peak' of the morning rush, namely at 0800hrs!!

The wisdom of designing a shift change, at 0800hrs in the morning, **has to be seriously questioned**. Ideally, this shift change needs to occur either side of the 'peak' demand – and allowing for more staff availability from, say 0700hrs through to 1000hrs.

The 'emergency pull cords' are casually used for communication with staff during the morning procedures, such as bowel management, showering, dressing etc..., but it was not unusual to have to wait for **10-15 minutes** (occasionally even longer) for the appearance of a staff member for assistance. This was simply because of the 'sudden' level of demand – and one that the poor staff could not properly contend with! This also impacted on poor quality 'handovers' to overly pressured staff.

This needs to change – and fast!

Condition of installations and equipment

In this instance, perhaps a few pictures, as well as words to go with them:

This pressed stainless steel sink is located in a side-room on St David's ward.

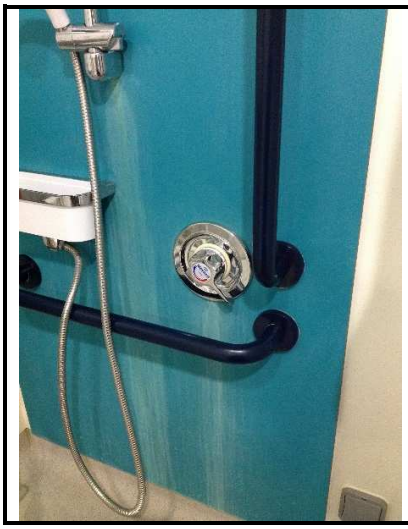
In June 2012, after running very hot water into a sink (just like it next door), I burned my knees which were, unknowingly, in contact with the underside of the sink base. This incident was formally documented.

To my surprise, not only are these same sinks insitu, but no improvement has been made to the thermal insulation beneath the sink! Or, alternatively control of water temperatures.

As can be seen, these sinks are not in good condition, but they need to either be properly insulated or TMV controls fitted to restrict water temperatures to 43^{o}C (as per HSE guidelines).

I regret to accuse the Trust of negligence and incompetence in dealing with this matter more robustly.

When I burned my knees (which are still being treated today due to skin damage) under the sink in 2012 it caused 'panic' on the ward and my injuries were photographed and documented. But after all this time, **nothing of note has been done to mitigate the health and safety risk**!!



This is a ‘typical’ shower installation in St Joseph’s ward.

Paneling to all the shower installations was in rather poor condition, albeit mainly due to carbonate staining.

Additionally, some of the thermostatic mixing valves (TMVs) were not very responsive, albeit they seemed to be delivering relatively ‘safe’ water temperatures.

This was a defective door handle and latch on one of the shower-room doors.

The same one is shown below, having been ‘repaired’.

However, on closer examination, the handle had not been re-fixed firmly – and in the ‘punishing’ environment in which this is used, it is unlikely to last more than a month or so.

This kind of SAA (satin anodised aluminium) fitting is not robust enough for this particular use and will constantly require maintenance and repair.

The decorative boxing that has been formed around the hand basin has fairly sharp corners and edges.

High level spinal patients, with no core stability could easily injure themselves on these protrusions, which are not at all suitable in this environment.

No care is taken in 'matching' the detachable arms with the correct shower chair.

This can be seen here, with one straight (or vertical) arm and one 'splayed' arm (it's not bent).

With core instability associated with high level spinal cord injury, it is essential to have handles that can be suitably tightened in place with the fixing screws provided. However, this cannot be done if the handle is not only incorrect for the chair, but is also corroded at the base.

It is hugely disconcerting to be sitting in a shower chair with ineffective or unstable arms.

There seems to be quite a lot of **redundant equipment** about, giving the ward a 'run down' feeling to it, such as this 'Rediffusion' control panel.

From my own experience in property maintenance, it would be quite normal to remove redundant fixtures and fittings in conjunction with internal decoration programmes.

The internal decorative condition is poor too, so dealing with both aspects in the near future would correct it.

Medication and pharmacy

St Joseph's ward hosts patients at the most advanced level of rehab prior to discharge. It also tends to host patients being readmitted to the NSIC for further rehab. The latter was applicable in my case, but others were shortly to be discharged.

The point is, that there is **quite a reasonable expectation that patients should be able to take control of their own self-medication** (if demonstrably competent to do so). In fact, it should be encouraged.

Several patients felt 'trapped' in an institutional environment, without the ability to go about their daily lives in a sensible manner.

In my own case, I had been successfully and competently managing my own self-medication for a period of over two years. But this was brought to a sudden halt within two days of being on St Joseph's ward.

This led to a dispute with pharmacy, as my lead consultant, Mr. Belci, had given support to my request to self-medicate.

This seemed a ridiculous situation, where a pharmacy procedure was 'trumping' the direct instruction of the consultant.

After lengthy discussion with PALS and the Lead Advanced Pharmacist, moves began to be made to implement a self-medication procedure. It's essential that this happens as soon as possible.

To add insult to injury, the primary reason given for not allowing self-medication on the ward was 'safety' of the patients. However, in my experience, I can formally document that I was given the **wrong medication on eight occasions during my three week admission**. How 'unsafe' is that! When this happened, the response was imply "whoops, sorry" and then to move on. Errors were probably not documented and Nurses, despite 'aprons' to try and prevent it, were regularly disturbed during the 'drug round.'

Building services and maintenance

Some maintenance aspects have already been mentioned above. However, inadequate attention to disability design should not occur in a specialist spinal injury centre.

The Building Regulations (Part M), make the assumption that all wheelchair users can transfer to a WC! But as evidenced by the patients at the NSIC, this is not the case.

Given that 'design' should be refined or optimised in a spinal unit, **why is it that the toilet cistern flush handle, is furthest away from a wheelchair positioned adjacent to the WC?**

It's sometimes small things that really matter!

The vinyl flooring is now in poor condition throughout St Joseph ward. If similarly aged material is still present in the other wards, it's a reasonable bet that they too will have broken down.

These pictures illustrate some of the issues, with failed jointing and surface staining.

What is rather surprising (even though understandable), is that the Trust is embarking on a very expensive 'facelift' for the foyer and reception area flooring and furnishings in NSIC, without first addressing the quality of the wards – putting patients first, rather than public image, should be a priority!!

One patient pointed out that he couldn't use the pedal-operated waste bins (domestic and clinical). Most wheelchair users couldn't with ease.

Consideration should be given to some alternative waste bins that have lids that can be lifted without the need of foot pedals!

Cleaning services

Whenever cleaning of the floors was carried out, floor-standing equipment was barely moved, if at all. Here we're talking about floor-standing bins, water coolers, cabinets, shower chairs etc… Staining to the floors makes the relatively poor cleaning services even worse.

The ward looked tired and worn – and that had, perhaps, an unfair bias on the judgement of the cleaning operations. The same applied to the kitchen fixtures and fittings, radiators, light fittings and other appliances.

It was notable, that the toilets remained particularly unclean over the weekends. No cleaning was done.

Consultancy

It was pointed out by a few patients that the consultancy 'Ward Rounds' were never on time – and up to two hours late. This was considered to be quite disruptive for that day's activity.

The three 'Ward Rounds' that I experienced during my readmission were all late, by up to an hour or so, but fortunately it didn't interfere with other activities.

One patient made a particular point about wanting the communication to be in 'laymen's' language and avoid any unnecessary technical terms and jargon.

On a matter more related to 'admissions' than consultancy is the need to try, **as far as reasonably practical, to ensure that the first consultancy ward round is carried out as close to the admission as possible**.

When I was admitted on 4th January (straight after the Christmas and New Year holiday), there was no planned objectives in the minds of the nursing/care staff. It was all very haphazard. Focus was not achieved until **four** days later, when an effective 'plan' was agreed with the Consultant and 'Named Nurse'. Essentially **four** days wasted.

In overall terms, there was plenty of praise for the professionalism of the consultancy clinicians.

Activities and Wi-Fi

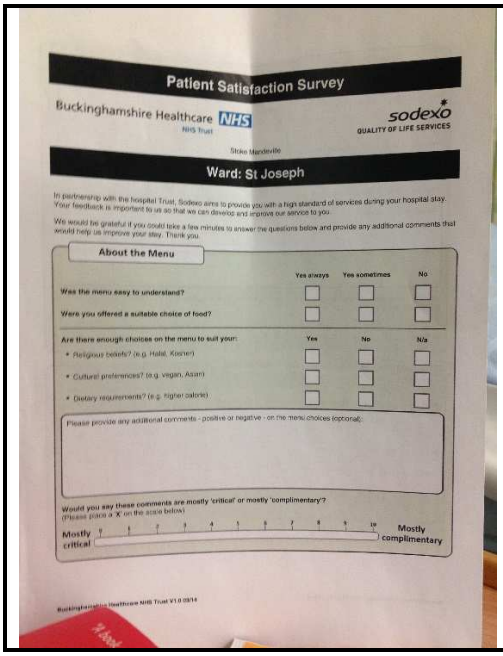
Even though each patient has 'Goal Planning' and a 'Weekly Programme Timetable' with, usually, several activities during the day. It was felt by some, that it would be good to have some other planned activities perhaps into the early evening? Irrespective, **it is essential to have a fully functioning and stable Wi-Fi facility**, the ones within the NSIC are diabolical to get a good signal.

It seems that not to have good Wi-Fi in a 'long-term' spinal rehab unit is rather behind-the-times!

Hospital food

Surprisingly, (it seemed to me) the hospital food came in for severe criticism, in every respect – quality, quantity, choice, temperature, goodness etc…

It's certainly true the menus haven't changed any time recently! In my three week readmission, the menus were the same as the ones during my first admission in 2012!


Patient Satisfaction Survey

Buckinghamshire Healthcare NHS

sodexo QUALITY OF LIFE SERVICES

Ward: St Joseph

About the Menu

Yes always | Yes sometimes | No

Was the menu easy to understand?

Were you offered a suitable choice of food?

Are there enough choices on the menu to suit you:

Yes | No | N/a

- Religious beliefs? (e.g. Halal, Kosher)
- Cultural preferences? (e.g. vegan, Asian)
- Dietary requirements? (e.g. higher calorie)

Please provide any additional comments - positive or negative - on the menu choices (optional):

Would you say these comments are mostly 'critical' or mostly 'complimentary'?

Mostly critical | Mostly complimentary

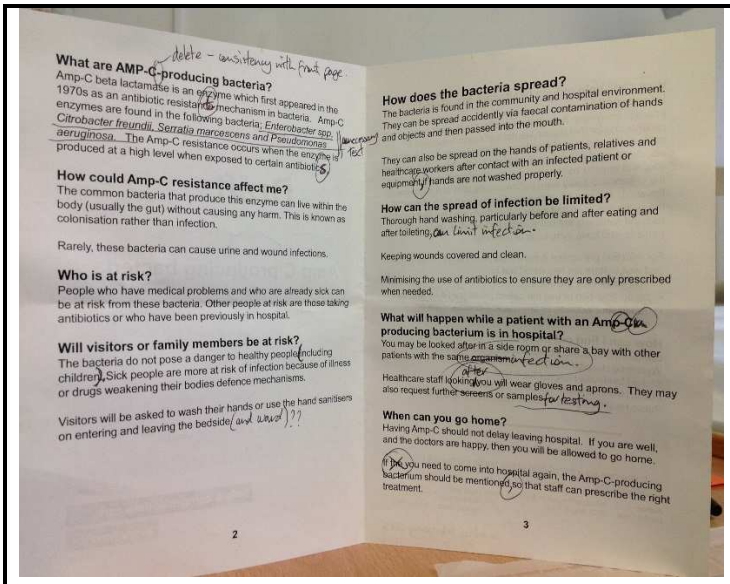
Whilst at St Joseph's ward during readmission, I was given a "Patient Satisfaction Survey" for feedback to Sodexo.

My hope, is that patients that thought the food was particularly poor, completed the survey for appropriate feedback purposes.

The one aspect that was very apparent, although not directly to do with food quality, was how slow the service was. Previously, there were two members of staff serving, but with a squeeze down to one, it seemed to take forever!

As we had good opportunity to feedback, I saw little point of documenting anything further in this respect.

Patient Information Leaflets



What are AMP-C-producing bacteria?
Amp-C beta lactamase is an enzyme which first appeared in the 1970s as an antibiotic resistant mechanism in bacteria. Amp-C enzymes are found in the following bacteria: *Enterobacter spp, Citrobacter freundii, Serratia marcescens and Pseudomonas aeruginosa*. The Amp-C resistance occurs when the enzyme is produced at a high level when exposed to certain antibiotics.

How could Amp-C resistance affect me?
The common bacteria that produce this enzyme can live within the body (usually the gut) without causing any harm. This is known as colonisation rather than infection.

Rarely, these bacteria can cause urine and wound infections.

Who is at risk?
People who have medical problems and who are already sick can be at risk from these bacteria. Other people at risk are those taking antibiotics or who have been previously in hospital.

Will visitors or family members be at risk?
The bacteria do not pose a danger to healthy people including children. Sick people are more at risk of infection because of illness or drugs weakening their bodies defence mechanisms.

Visitors will be asked to wash their hands or use the hand sanitisers on entering and leaving the bedside.

How does the bacteria spread?
The bacteria is found in the community and hospital environment. They can be spread accidently via faecal contamination of hands and objects and then passed into the mouth.

They can also be spread on the hands of patients, relatives and healthcare workers after contact with an infected patient or equipment if hands are not washed properly.

How can the spread of infection be limited?
Thorough hand washing, particularly before and after eating and after toileting.

Keeping wounds covered and clean.

Minimising the use of antibiotics to ensure they are only prescribed when needed.

What will happen while a patient with an Amp-C producing bacterium is in hospital?
You may be looked after in a side room or share a bay with other patients with the same organism.

Healthcare staff looking after you will wear gloves and aprons. They may also request further screens or samples for testing.

When can you go home?
Having Amp-C should not delay leaving hospital. If you are well, and the doctors are happy, then you will be allowed to go home.

If you need to come into hospital again, the Amp-C-producing bacterium should be mentioned so that staff can prescribe the right treatment.

2 3

Writing publically available leaflets is not easy, especially getting it into plain English.

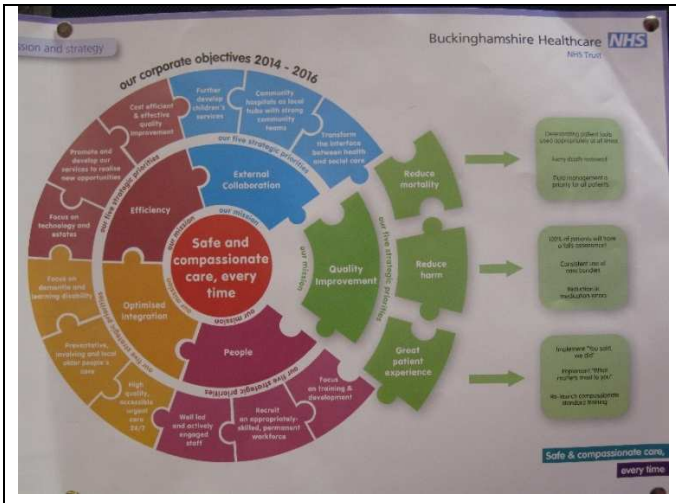
During my readmission, I was handed a 'DRAFT' leaflet titled:

"**Amp-C producing bacteria**"

This is hardly an endearing title for public or indeed 'patient' consumption. But the content was very poorly written and should have been better spell-checked and proofread before being given out as a draft for feedback.

What was also apparent, was that this leaflet contained advice that applied to all forms of infection control. So why a special leaflet on this one?, rather than a more general one on the vital importance of infection control with cleanliness and hand-washing etc…

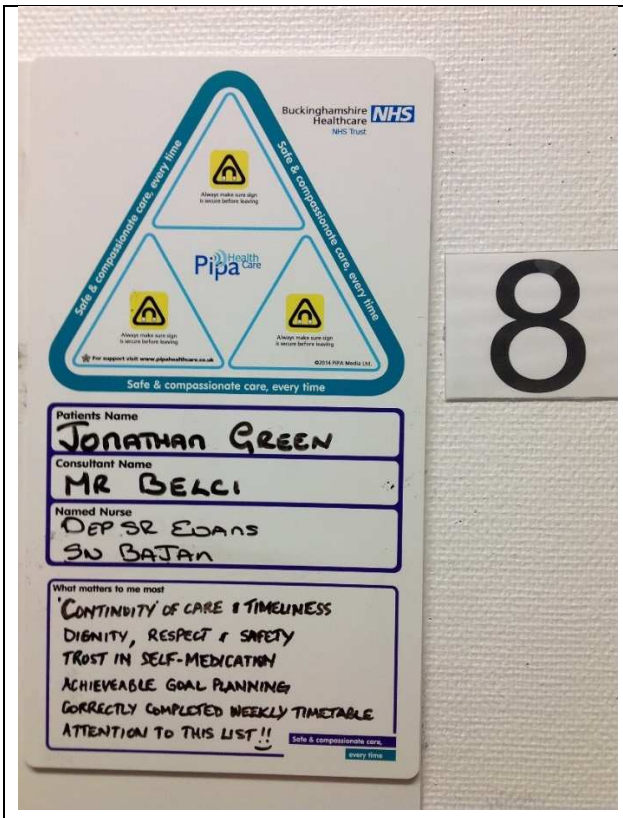
Commitment to Corporate Objectives



The diagram is a nicely produced 'jigsaw' of objectives – very imaginative.
But what actually happens on the ground (in the wards) is what counts.
Consider three examples from the diagram:

"100% of patients will have a falls assessment."
Unless this was just a 'paper' exercise, I know I didn't have one.

"Reduction in medication errors."
In my case, **eight errors in three weeks** is very poor – and possibly reflects the complexity of the "Long Stay Prescription Chart"…



"Implement "What matters most to you"."
Other than the one that I 'filled in' on my white-board (see photo), I did not see any others that were completed!
I assume it's not been implemented yet!

Even though I filled in this part of the white-board, it not only went mainly unnoticed, all of the items, apart from the second (dignity, respect and safety), went completely unheeded!

- Continuity and timeliness of care was completely random – mainly governed by whoever happened to be 'nearby'…
- There was no possibility of self-medicating! Even though this is offered at other NHS Trusts!
- There was no established 'goal planning' for the short time I was as in-patient.
- There were errors on all three time-tables that I was given (albeit rather minor mistakes – e.g. being allocated an inappropriate 'pilates' slot).

Summary Action Points:

- Ensure availability of correct staff/patient balance
- Devise effective shifts to contend with 'peak' demands
- Introduce clear 'handover' method (perhaps including patients) to ensure continuity of care
- Sufficient staffing to ensure 'emergency calls' are responded to within 2 minutes
- Re-examine the planned maintenance arrangements for all installations and equipment and balance the expenditure budget accordingly (prioritise wards, rather than 'public' spaces)
- Give back control and self-medication arrangements for suitably rehabbed patients
- Widely reconsider design arrangements 'through the eyes' of spinal patients, rather than simply use standardised plans (such as Part M of the Building Regulations)
- Introduce more thorough 'inspections' of cleaning services – especially following weekends
- Ensure that consultants use 'plain English' with patients during 'Ward Rounds' as far as possible
- Ensure that patient admissions are swiftly followed by goal planning at first 'Ward Round'
- Install a robust Wi-Fi service throughout NSIC and consider other activities for spinal patients
- Vary the food menu and improve the availability of fresh vegetables
- Only introduce 'Patient Information Leaflets' that are meaningful
- Abide by your own 'corporate objectives'… don't just produce pretty charts!
- Set meaningful performance targets for patients – but ensure they're 'smart' (specific, measureable, achievable, realistic and time-bound)