



Enter and View Visit Report Sheet

The visit report will aim to:

- Focus on patient/service user benefit
- Concentrate on key issues
- Be clear and concise
- Be balanced.

Date of visit: 26th August

Service/premises visit: Littleton Ward, Cannock Hospital

Authorised Representatives who undertook the visit:

Mrs Brenda Constable , Mr Cyril Burton, Mrs Isabel Ford

Reason for the visit: letter received from LINK participant asking the LINK to take forward issues regarding step up /step down facilities

REPORT TITLE

1. Report Overview

Littleton ward is a PCT commissioned, GP run, 27 bedded intermediate care ward based in Cannock hospital. The majority of patients 80% who are admitted to the ward are via GP's from home and are step up patients with only 20% being admitted as step down patients from other wards. Step up patients are admitted from home, or A&E through a referral to the bed manager, these are patients who are deemed to have needs that do not require admission to an acute ward but who require further assessment or rehabilitation for a short period. Step down patients will be referred by their consultant who will confirm that they are medically stable and fit to be admitted to the ward. Medical cover on the ward is managed by GP's who provide cover for 2 hours a day and attend a ward meeting once a week. Harmonie Badger GP's provide cover on the ward from 6.30 pm to 9.00 am. Immediate observations suggested that some reconfiguration of the first two bays was required as these appeared very dark and dreary lacking in natural light. This is acknowledged by the ward staff who try to make a maximum stay of only 2 days for patients in those bays.

The ward on the day of the visit appeared to be well staffed and efficiently run. All beds were occupied and patients were up washed and dressed and mostly sitting by their beds. The enter and view team were informed by staff that since the appointment of a new sister on the ward, standards of care had improved considerably and this is partly due to a reduction in the number of people who have dementia and are therefore inappropriate admissions. Staff were pleasant friendly and enthusiastic and were supported by equally enthusiastic health support workers and Age UK volunteers which patients valued. Patients are admitted to the ward with a number of different conditions. Some patients are diagnosed with dementia or confusion; some are admitted for palliative care and some for rehabilitation. It is therefore a diverse mix of patients with a range of dependency and needs from full nursing care to rehabilitation to build skills and confidence to enable people to return home. Care

planning for patients starts from the point of admission and this will include any rehabilitative programme provided by the therapy team. Carers are seen as integral to the care of the patient and are involved in the whole journey of admission to discharge. The average length of stay is 27 days with a readmission rate of 9.8% . Beds are kept open for 72 hours for patients where there is concern on either side of their ability to cope at home. Delayed discharges were put down to lack of resources such as care packages from social care and health and equipment but the relationship with the social care and health's Rehabilitation team was described as good.

The conclusion reached by the enter and view team was that this was a well run ward which was busy but calm and one in which patients spoke positively of their experience of care and treatment on the ward. Staff and volunteers appeared to work well together and were friendly and approachable towards patients. The main issues identified by the team related to lack of stimulation for patients and the boredom of sitting for long periods of time alone. Although there was a programme of activities available through the Occupational and Physiotherapy service, which patients could access, these did not appear to be on a daily basis and on the day of the visit no activities were taking place. The garden outside the ward was poorly maintained which did not encourage patients who were mobile to use it when the weather was nice. Although there is a day room this did not appear to be used by patients but by staff for meetings etc. No activities were observed so it was difficult to know whether patients use this for socialising or for group meals. The team observed that meals appeared to be eaten next to beds rather than in the day room and it was felt that this was an opportunity missed to increase the psychological well being of patients and for patients to socialise assisting recovery and potentially discharge.

2. Reason for the visit

The visit was planned in response to an approach from a LINK participant to look at step up / step down facilities in Mid Staffordshire, how they work in relation to easing the pressure on acute beds, improving the experience of patients on acute wards who may no longer need acute care but who need to have further care or support to facilitate their discharge. Littleton ward is the step up / step down ward and therefore is central to the effectiveness of the intermediate care service and the flow of patients who need this type of service. This visit is therefore the first element of the service that the LINK are interested in looking at. This may be followed up with further work looking at the community elements of the service.

3. Approach used

A meeting was held with Claire Mckirdy in July and the visit was identified at this meeting. Following this a written brief for the visit was produced and shared with the trust. The enter and view team were provided with the ward operational policy and procedures and a report from the ward on the philosophy and day to day running of the ward.

The visit was undertaken by 3 LINK participants 2 of whom are experienced in enter and view and one who acted on this occasion as observer.

The visit was conducted using observation, talking to staff, talking to visitors and patients, looking at and analysing written information. Feedback on the visit was given immediately to ward managers and a de-brief session was carried out to collate information received and agree content of the report.

4. Observations/findings.

Environment.

This is a 27 bed step up /step down ward with 5 side rooms and 7 2/4 bed bays. There are distinct bays for male/female and these meet the single sex compliance regulations. At the time of the visit there were 23 female patients and 4 males. The unit is nurse led with GP oversight. GP cover is provided from 8.30- 6.30 and out of hours cover provided by Harmoni Badger out of hours service between 6.30 and 9.00 am . Physically the ward was clean and tidy though rather cluttered with a lack of storage space for equipment. Two of the bays were dark and dreary and lacking in natural light . The wall of a new theatre unit was almost up against both windows cutting out lots of light. Local college art department students had visited and suggested a mural on the window but the team were informed that there had been very little communication since then. Both staff and patients complained about the atmosphere on the ward but this is currently being addressed by the bed manager in the

allocation of the beds. It was suggested by a member of the enter and view team, a psychologist by background that consideration should be given to installing false outdoor lighting on the walls to give the appearance of natural daylight. She felt that this might lift the depressing feel of the bays. There was a clear separation between male and female bays with adequate toilets and showers available which appeared clean and tidy.

Staffing.

Staffing on the ward is made up of a mixture of PCT and Trust staff and includes the range of roles from Matron to Health Care Support Workers. Also on the ward were a number of Age UK voluntary workers who carry out a number of functions and are there to assist patients with a number of tasks and are seen as an integral part of the team. All volunteers have been trained in assisting patients to eat. Discussions with staff and patients indicated that the friendliness, helpfulness and cheerfulness were valued by all. The enter and view team did consider whether this role could be expanded to spending more time talking with patients, reading, playing games etc in order to reduce some of the isolation and boredom. There is also a therapy team who cover the ward. This team carry out assessment of the patient's capability of coping with day to day living and devise a plan to meet needs assessed.

The ward has a comprehensive training programme most of which is mandatory including dementia and dying matters. There is protected learning for staff to prevent accidents and there is a special prevention of falls programme in place, which has resulted in a 30% reduction in falls in a 12 month period. It was stated by staff that nursing care for patients had "greatly improved" with the arrival of a new sister and attendance at training days had also improved. Staff also expressed their views that at one time there seemed to be a lot of patients with dementia being admitted to the ward, this has reduced considerably which gives more time to care for patients who can benefit from the ethos of the ward. Staff generally came over as enthusiastic, friendly and approachable.

Some concern was expressed by the team who were due to meet with the staff nurse that she was working from 8am to 8 pm and although she was entitled to a 2 hour break and they had arranged to meet her after a 1 hour break, the staff nurse reported that she had not actually had the break because there was no one to hand over keys to. The team felt some concern about effectiveness and patient safety in these circumstances and feel this should be addressed. The team were also concerned about the lack of facilities for staff to have lunch and breaks with inadequate seating and lack of cafe facilities.

Patient Pathways

Admission and discharge to the unit is managed by a Non Clinical Transitional Unit Manager (bed manager) She is responsible for bed occupancy and has a supervisory role, monitoring working practices and the staff appraisal process. She is based on the ward but will when necessary go out into the community to assess patient's suitability for admission. The bed manager liaises closely with the crisis team and with the local authority enablement team. Patients may be admitted to the ward as an emergency but normally there is a waiting list of 2 to 3 weeks. Patients come into the hospital via a number of routes; home, other hospitals, people taken ill whilst on holiday in the area. An assessment and care plan, including a potential discharge date is carried out from the point of admission and is usually in place within 72 hours, this includes the patient's carer, relative or friend. At this assessment a patient's nutritional needs are assessed and a care pathway put in place to meet these. There was evidence of food and drink being available throughout the day and of patients being both encouraged and assisted to take adequate nutrition. Mealtimes are protected but relatives are able to come in to help patients eat. Patients that were observed at lunchtime were eating by their beds. Although the ward literature states that a day room is available for this purpose there was no evidence on this visit that it was used for this purpose. There are good facilities on site such as kitchen, gym and hydrotherapy pool and a place to carry out activities such as pottery, gardening etc. The therapy team carry out home visits to assess a person's ability to cope in their own home and assess the need for equipment.

Discharge is planned using the Trusts Transfer of Care Policy. This is in conjunction with the patient, their relative, the multidisciplinary team including the social work department. Delays to discharge were put down to lack of service from social care but this assertion was not tested as to its validity and is therefore the view of the staff on the ward. Readmission rates are generally low but a bed can be kept open if there are concerns about a patient's ability to cope at home.

Patient and Carer /Relative Feedback

Both patient and carer feedback was generally very positive and this was in line with the patient satisfaction survey carried out between April 2010 and March 2011. There was overall praise for ; staff, food, care and thought to dignity issues with some very minor exceptions. The biggest issue raised by patients and carers is the lack of activity for long periods of the day, the lack of stimulation, of opportunity to socialise and the general boredom of being in hospital, especially for patients in for several weeks. One patient spoken to said that “ the staff are friendly and helpful but at times the bell took a long time to answer” she stated that “although a card was available for the TV accessibility for a frail elderly patient was too difficult. She felt that “more mental and physical stimulation was needed”. Although the team were given a copy of the activities programme they did not observe any activities being carried out and therefore cannot comment on how these are received or engaged in by patients. The ward literature states that a day ward has been freed up for activity and communal meals; again there was no evidence of this being used by patients, though it was used by staff as a meeting room.

5. Conclusions

The overall conclusions formed by the Enter and View team were that this was a valued resource offering the opportunity for patients not requiring acute care to receive recuperative and rehabilitative service in a non acute but safe setting. Although aspects of the ward environment are not ideal, the team felt that the service offered on the ward was generally of a good standard and good quality with positive feedback being received by both staff and patient’s/carers. The written documentation provided and the observations made certainly indicated that this is a well run and managed ward with adequate staffing levels and training to offer a quality service. The only concern noted was the working hours of a staff nurse and the lack of breaks which could affect patient care. The period the visit took place was between 10.30 am and 5 pm and in that time there were no major areas relating to patient care observed.

The service offered is mainly a step up service with 80% of admissions being in this category. This seems to be a valuable resource to both GP’s and the community intermediate care team but is perhaps less effective in facilitating discharge from acute wards in Stafford hospital where patients may be medically but not physically fit for discharge. It would be helpful to know how the 80-20 split impacts upon discharge from acute medical wards and whether there are knock on effects on delayed discharges from these wards. Delayed discharges were generally attributed to social care and health and it would be useful to see if the evidence supports this assertion.

The main issues raised were not about staffing or patient care, but with lack of activity, stimulation and opportunity for socialisation. Given the importance of mental well being on the recovery process, this is something the ward manager might want to look at.

6. Recommendations

- 1.To improve the problem of clutter in the ward giving more room for moving around in safety.
- 2.To look again at solutions to improve the first 2 bays which are depressing for patients and staff.
3. To look at ways to ensure that staff working long shifts have adequate breaks to ensure that they can operate effectively at all times
- 4.To find ways of reducing the boredom for patients through better use of resources to improve opportunities for patient’s to become involved in more stimulating activity. Considering the further use of volunteers, chaplaincy might be worth exploring to address this.
5. To improve the garden area outside the ward so that mobile patients can make use of it for activities or just fresh air.
6. Consider further work to look at impact of the 80-20 split on patients on acute wards and assess further the working relationship between all aspect of intermediate care to ensure maximum effectiveness in use of resources is achieved.