Agenda Item No.3

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC)

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
Libby McManus, Chief Nurse	Decision		High	Med	Low
	Discussion	X		X	
	Information	X			
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
Edmund Tabay, Deputy Chief Nurse	Strategic				
	Operational	X			
	Governance		**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				
CQC Domain: (safe, caring, effective, responsive, well-led)	Effective Responsive Safe Caring				

Meeting Date: 27th August 2019
Report Title: Revisiting the Patient Story

PURPOSE:

To update the Board on actions taken following the staff member's account of the care the patient received whilst in the Emergency Department.

SUMMARY:

- A Sister in the Emergency Department shared her account and experience of the care the patient received whilst in the Emergency Department. This was in relation to a patient who stayed in the department for a prolonged period of time whilst waiting for a bed in a specialist facility. Sister Crawford explained the impact of such experience to the patient, the family members and staff working in the department.

FINANCIAL IMPLICATIONS / EFFICIENCY SAVINGS / QUALITY IMPROVEMENT:

RISK ASSESSMENT (CROSS-REFERENCE WITH RISK REGISTER WHERE APPROPRIATE):

Strategic / External	Operational/ Organisational	Financial	Clinical	Legal/ Regulatory	Reputational / Patient Experience
X			X		X

RECOMMENDATIONS:

The Trust Board is requested to note the actions taken following the story.

REPORT TO THE TRUST BOARD ON A PATIENT EXPERIENCE

1. Introduction

Leanne Crawford, Sister in the Emergency Department kindly agreed to speak at the Trust Board to share her experience and account of the care the patient received whilst in the Emergency Department. This was in relation to a patient who stayed in the department for a prolonged period of time whilst waiting for a bed in a specialist facility. Sister Crawford explained the impact of such experience to the patient, the family members and staff working in the department.

The reason for the delay in transfer was multifactorial which is influenced mainly by our system partners, however, there are there are elements of their experiences that we can improve on.

2. Update of actions taken/to be taken following the story

- Sister Crawford received a thank you letter from the Chairman and Chief Executive Officer for being open and honest about her account.
- A letter is being sent to the patient and/or family members informing them that their experiences were shared to the Hospital Board and what action has already been taken
- The damaged seating facility (sofa) in the mental health room has been replaced. The League of Friends has indicated their support to supply additional sofa if needed.
- A meeting is being arranged with system partners to discuss mitigations when similar incidents happen.
- Robust escalation process has been put in place to support staff dealing with similar incidents.

Edmund Tabay, Deputy Chief Nurse
22nd August 2019