Further Information from ABMU Health Board in Response to Commissioner's Request for Further Information

Recommendation 1-Stronger Leadership

Authority of Ward Sisters/Charge Nurses to select staff

As detailed in section 1.6 of our action plan, we intend that our Heads of Nursing will audit the role of Ward Sisters and Charge Nurses in the recruitment Process. The intention is that this will identify barriers to involvement. If it is identified that Ward Sisters and Charge Nurses are not involved then Heads of Nursing will implement a mechanism to ensure that they are fully involved in recruiting nursing staff. This review will be completed and appropriate measures put in place by December 2011.

Evaluation of training and monitoring of its effectiveness in practice

Within sections 1.2, 1.3, 1.4, 1.5, 1.7, 1.8, 1.9, 1.11, and 1.13 of our action plan, there are very detailed descriptions relating to the evaluation of training and monitoring the effectiveness of this training in practice. This includes evaluation and monitoring the effectiveness of our Pathfinder Project, Empowering Ward Sister/Charge Nurse Development Programme and developing leadership skills of other ward staff including nurses, therapists and healthcare support workers. As stated, we have put specific actions in place to provide additional training and development to address continence and dementia issues.

The strategic role of the Board and senior managers in empowering ward leaders

The ABMU Health Board Response to the Older Persons Commissioner Report was signed off by the Executive Team, The Executive Board and the ABMU Health Board. This affirms the commitment of the Board and senior managers to ensuring that Older People within ABMU Hospitals are treated with dignity and respect. In addition to receiving performance information and accounts of patient experience including patient stories, the Board and senior managers within ABMU are engaged in a programme of walkrounds to visit ward areas and discuss issues at first hand with ward leaders. ABMU Health Board is committed to a zero tolerance approach to the compromise of patient dignity and respect and has taken all appropriate measures to empower ward leaders.

The benefits of using 'virtual patient persona' in an acute hospital setting

Communication to front line staff of policy and strategic intent is known to be challenging as clinical staff may not perceive the relevance of this to patient care and their daily working practices. Patient Personae have been used in other health economies, notably in Jonkoping District in Sweden to achieve service improvement. 'Esther' is a persona that clinicians in Jönköping invented to help them improve patient flow and coordination for seniors in six of the county's municipalities. Care for the elderly is a critical issue in Sweden, a country that has the world's oldest

population (18% are aged 65 or over). ‘Esther’ is an 88-year-old Swedish woman who continues to live alone in the community but has a chronic condition and occasional acute needs. Beginning in late 1998 Jönköping clinicians and leaders came together to map Esther's movements through the complex network of care settings and providers. In addition, interviews were conducted with patients like Esther and clinicians who provide care for her across the system. This exercise provided a starting point for identifying and working on improvements in the way patients flow through the care system. Much work was done to align capacity with demand and to strength coordination and communication among providers. Examples of changes made included a redesigned intake and transfer process across the continuum of care, open access scheduling, team-based telephone consultation, integrated documentation and communication processes and an explicit strategy to educate patients in self-management skills. The Esther project yielded impressive improvements over a three- to five-year period, including an overall reduction in hospital admissions by over 20% (9,300 to 7,300) and a redeployment of resources to the community, a reduction in hospital days for heart failure by 30% (from 3,500 days per year to 2,500) and a reduction by more than 30 days of wait times for referral appointments with specialists such as neurologists.

The development of Esther inspired improvements throughout primary and secondary care including ; reduction in hospital admissions ; reduction in number of days within hospital for chronic heart failure ; cultural changes ; concentration on what patients value rather than what clinicians value ; and a transformation for Jonkoping to become the highest quality, lowest cost base service in Sweden.

ABMU Health Board aims to develop a patient persona ‘Margaret’ that can be used to explain and make real our corporate objectives.. The intent is that giving clinicians and support staff a realistic image and persona of a service user will make ‘Margaret’s’ experiences more real and will drive improvement. Margaret’s patient stories as she moves through a complex system of care will be powerful in improving responsiveness to her needs

The aim of developing ‘Margaret’ will be to improve patient safety and service quality within health and social care. By presenting ‘Margaret’ to frontline clinicians the aim is to change behaviours in keeping with the Welsh Government’s agenda of providing care closer to home using a person centred approach with case management. ‘Margaret’ is at the centre of our care system and is used to demonstrate that health and social services value innovations, and staff are empowered to challenge the system to improve care for her. By posing the question ‘how does this service work for Margaret’ it is postulated that there will be ; reduction in avoidable mortality ; reduction in avoidable harm ; improved communication ; reduction in variation ; reduced failure demand and institutional demand ; and through the above, reduce costs.

In developing ‘Margaret’, there are a set of overarching principles, namely :

- ‘Margaret’ should be safe from harm arising from the healthcare system
- Our system of care should be designed to meet the most common of Margaret’s needs, but have the capacity to respond to Margaret’s individual choices and preferences;

- Margaret should be given the necessary information and the opportunity to exercise the degree of control she chooses over health care decisions that affects her;
- Margaret should have unfettered access to her own medical information and to clinical knowledge;
- Margaret should receive care based on the best available scientific knowledge;
- Our healthcare system should make information available to Margaret and her family that allows them to make informed decisions when selecting a health plan, hospital or clinical practice, or choosing among alternative treatments;
- Our healthcare system should anticipate Margaret’s needs, rather than simply reacting to events;
- Our healthcare system should not waste resources or Margaret’s time;
- Our clinicians and mangers should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care;
- Margaret should receive care whenever she needs it and in many forms, not just face-to-face.

Arising from these principles are a number of pledges that the healthcare system will make to ‘Margaret’, her family and carers, namely :

- ‘Margaret’ believes that when she comes into contact with health services, she is entering a place of safety and she, her family and carers have a right to believe that she will receive the best possible care.
- Health services will put robust standards and safety processes in place to reduce risk to ‘Margaret’ to the lowest possible level.
- Margaret’s health should not be adversely affected by falling, acquiring an infection or pressure sore or having wrong medication when in our care
- Margaret should feel confident that she will not be harmed, or receive suboptimal care, and know that should her condition deteriorate, she is in the best place for prompt and effective treatment.
- It is unacceptable that Margaret might suffer avoidable death or avoidable harm when cared for by our health services.
- By continuous pursuit of perfection, all staff will act to deliver World Class care, service quality and patient experience to ‘Margaret’ by 2015

The virtual patient persona can be used through a ‘patient story’ approach to illustrate how patients move through the system. Virtual patient methodology has already been applied as teaching tools to enhance healthcare student's knowledge base, assessment, and counselling skills when interacting with patients in various situations. There is evidence to demonstrate that this approach can improve overall knowledge and communication skills.

The appropriateness of the use of the term 'modern geriatric ward'

The professional body of the Medical Staff caring for Older People is the British Geriatrics Society. They have debated over many years whether to change this title and have generally decided not to, reflecting the desire to take pride in their vocation and to demonstrate that care of frail older people is the core focus of their work. There are a myriad of different terms for hospital departments with responsibility for older people including 'geriatric medicine', reflecting the lack of consensus on terminology. In other areas, such Medical Staff are termed 'Care of the Elderly' Physicians. There is no intent to use the term 'geriatric' in a way that would be considered pejorative by Older People.

In developing new service models for Older People, ABMU considers one of the tasks as reinventing the "modern geriatric ward" in our hospitals. Physicians involved in care of Older People consider that it is desirable to examine service models where older people are cared for in hospital within specialist care of the elderly wards. These wards would have both general expertise and commitment to looking after frail older people and through in-reach of community teams, would have significant knowledge and have developed understanding of the needs of individual older people with chronic conditions.

Timescales for implementing changes

These are set out in our Action Plan

<u>Recommendation 2-Dementia Care</u>

How advice will be given in specific cases since ABMU is currently reviewing the interface between the Consultant Nurse and Advanced Practitioner roles.
ABMU has a significant number of Medical, Therapy and Nursing Staff with skills as 'Advanced Practitioners' in Dementia care. In addition, two Consultant Medical staff have National reputations in academic research in Dementia. Specific teaching in Dementia is delivered in collaboration with Swansea University by Nurses and Therapists with expertise in Dementia. The availability of this level of expertise within ABMU provides assurance that specialist advice is available and that it would not be beneficial to develop a Nurse Consultant role at this time until the review is concluded. However, ABMU will consider evidence from other Health Boards where developing a Consultant Nurse role in Dementia care has led to improved outcomes for patients with Dementia.

Whether dementia awareness training will be given to all staff who may work with older people, how often and whether or not it will be mandatory

Within our action plan, points 2.1 and 2.4 detail ABMU's commitment to determining the need for dementia awareness training and delivering this where appropriate.

Whether or not this is mandatory for individuals and frequency of training will be determined from training needs analysis and appraisal. Since ABMU HB employs over 17,000 staff, the majority of whom work with Older People, we consider it appropriate to await receipt of the training needs analysis before answering this question in detail.

The meaning of paragraph 2 on page 11 of ABMU's response particularly the last sentence ('increased appropriate use of community Do Not Attempt Resuscitation orders')

For every person there comes a time when death is inevitable. Although Cardiopulmonary Resuscitation (CPR) can be attempted on any person prior to death; it may not be in everyone's best interests to do so. To enable patients to die with dignity, it is essential to identify patients for whom cardiopulmonary arrest represents a natural end to their illness and for whom CPR is inappropriate. It is also essential to identify those patients who do not want CPR to be attempted and who can competently refuse it.

Where no explicit advance decision has been made about the appropriateness or otherwise of attempting resuscitation prior to a patient suffering cardiac or respiratory arrest, and the express wishes of the patient are unknown and cannot be ascertained, health professionals will make all reasonable efforts to attempt to revive the patient. Anyone attempting CPR in such circumstances would be supported by their senior medical and nursing colleagues.

A "do not attempt resuscitate" or "DNAR" is a legal order written either in the hospital or on a legal form to respect the wishes of a patient to not undergo cardio pulmonary resuscitation or advanced cardiac life support (als) if their heart were to stop or they were to stop breathing. This instruction is usually written following discussions between the patient , patients advocate and the general practitioner or hospital consultant and allows the medical teams taking care of them to respect their wishes. The Consultant or GP looking after the patient is responsible for making, recording and disseminating the DNAR decision. In their absence the most Senior Doctor responsible for the patient can make the decision. In this event the decision should be communicated to the Consultant or GP at the earliest opportunity so that they can endorse the decision in the appropriate section of the form.

Whenever possible, this decision would be agreed with the whole healthcare team. If there is genuine doubt or disagreement about whether CPR would be clinically appropriate, a further senior clinical opinion would be sought.

Where a patient's care is shared (e.g. between a consultant and a GP) there is a shared responsibility for making a decision about CPR attempts and discussing the issue with other members of the healthcare team, the patient or with those close to patients who lack capacity. One of these decision making professionals takes charge of ensuring that the decision is made properly, is recorded and is conveyed to all those who need to know it. If there is genuine doubt or disagreement whether CPR would be clinically appropriate, a further senior clinical opinion is sought.

Neither patient nor those close to them, can demand treatment that is clinically inappropriate. If the patient or those close to the patient do not accept this decision, despite careful and sensitive explanation by an experienced senior clinician, a second opinion is offered.

Clinicians responsible for making a CPR decision must discuss this decision with any other health professionals involved in the patient's care. Teamwork and good communication are of paramount importance.

Although the term "do not attempt resuscitation" suggests that care is being withheld, research shows that only about 5% of patients who require ALS outside the hospital and only 15% of patients who require ALS within hospital survive . Older people who are living in nursing homes, have multiple medical problems, or who have advanced cancer are much less likely to survive. For Older People who are at the end of their lives, it may not be in their best interests to either admit them as an emergency to hospital or to affect aggressive resuscitation attempts whilst in hospital. Where CPR may be successful in restarting the patient's heart and maintaining breathing for a sustained period, the benefits of prolonging life must be weighed against the potential burdens to the patient. This decision must be based on the patients known or likely wishes and discussion with the patient (or if the patient lacks mental capacity, those close to the patient) about whether CPR should be attempted will be an essential part of the decision-making process.

When a patient is in the final stages of an incurable illness and death is expected within a few days CPR is unlikely to be clinically successful. In some cases it may prolong or increase suffering and subject the patient to an undignified and traumatic death. In these circumstances most patients want a natural death without unnecessary interventions. Earlier discussions with patients about their general care and treatment aims may address this issue. For example in the context of palliative care, where patients are known to have an incurable illness, discussion and explanation of the realities of attempting CPR may occur in advance of the last few days of life. The All Wales Care Pathway for the Last Days of Life provides a comprehensive template of appropriate evidence based multidisciplinary care for the last days of life and is currently being implemented throughout Wales.

DNAR orders can only be made with the consent of the individual patient or their family or others acting on their behalf if the patient lacks decision making capacity.

Decision making capacity refers to the ability that individuals possess to make decisions or to take actions that influence their life. In a legal context it refers to a persons ability to do something, including making a decision, which may have legal consequences for the person or for other people. Patients over 16 years of age are presumed to have capacity to make decisions for themselves unless there is evidence to the contrary. A person must be assumed to have capacity to make a decision unless the reverse is proven. Under the Mental Capacity Act (2005) clinicians are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR has been made.

Where an adult patient lacks capacity to make a decision about their resuscitation status, this decision remains the responsibility of the Consultant/GP caring for the patient unless: the patient has previously nominated an individual as their Lasting Power of Attorney (LPA) with authority to make end of life decisions in which case the decision can be made by the LPA as if they were the patient, or the patient has a valid and applicable advance decision in which case this must be followed. Advance decisions relating to end of life decisions must be made in writing.

A DNAR does not affect any treatment other than that which would require intubation or cpr. Patients within hospital who are DNAR will continue to get chemotherapy, antibiotics, dialysis, or any other appropriate treatments. It is the intention to provide appropriate end of life care within the community through implementation of an end of life pathway and palliative care support within the community, but a patient with a Community DNAR order will still need to be admitted to hospital for symptom control or other necessary treatment . Healthcare professionals have an important role in helping patients to participate in making appropriate plans for their future care in a sensitive but realistic manner, making clear whether or not attempted CPR could be successful. Ensuring that discussion takes place about CPR and a decision is made in advance, where possible, is preferable to making decisions in a crisis when there may be insufficient time to gather and consider all the relevant information relating to the patients wishes and clinical condition.

For many patients, the risk of cardio respiratory arrest is very low and no clinical decision is required in advance of such an event, unless raised by the patient or with those close to patients that lack capacity. If there is a risk of cardiac or respiratory arrest it is good practice to make decisions about CPR in advance whenever possible. Decision making will include a full clinical assessment of the chances of a successful outcome.

Decisions on DNAR are always made on current clinical information and on an Individual basis. Blanket policies that deny attempts at resuscitation to groups of patients, such as those over a certain age or who are cared for in a hospice or nursing home are unethical and unlawful under the provisions of the Human Rights Act. The key issue that must be considered is not the decision maker’s view of the patient’s disability or level of recovery that can reasonably be expected following CPR but an objective assessment of what is in the best interests of the patient, taking account of all relevant factors, particularly the patient’s own views.

Timescales for implementing changes

These are detailed within our Action Plan.

Recommendation 3 : Continence needs

Your concerns that ABMU has not demonstrated in its response a zero tolerance approach to unacceptable practice

The intent of the detailed Action Plan is to absolutely demonstrate that ABMU Health Board will not tolerate unacceptable practice in continence care. In addition to explicitly signifying this within policy, Unified Assessment, SAFE rounding and the actions set out in the plan, ABMU will provide patients with appropriate expectations over meeting their continence needs whilst in our hospitals. The Executive Team is clear in its expectation that patients toileting needs will be met in a timely manner, that should patients be found to have waited an unacceptable time in soiled bed linen the matter will be treated as a POVA issue and that continence assessment and management will be given appropriate priority. In addition to a detailed Action Plan within Section 3, ABMU HB has indicated that ward staffing levels must ensure that patients continence needs are met. The annual Fundamentals of Care Audits and monthly nursing metrics reported to the Quality and Safety Committee fully implemented across all Wards in the Health Board ensure strict performance management processes and reinforced accountabilities in this area of care.

Recommendation 4 : Address the limitation of 'dignity pegs' which will not prevent the overhearing of personal information at the bedside

The purpose and function of 'dignity pegs is not to prevent the overhearing of personal information at the bedside but to ensure physical dignity of patients. This ensures that when patients are in a state of undress that staff do not enter curtained off cubicles. The other actions to be taken to prevent the overhearing of personal information at the bedside are detailed within our Action Plan.

Persuade you that the default position will be that all conversations involving personal information (medical and non-medical) will be held in private

The actions to be taken to ensure that conversations involving personal information are not overheard are detailed within our action plan. This has significant challenge, particularly in situations where patients cannot be moved from their beds to be taken to a private room or where suitable rooms do not already exist on our wards. ABMU Health Board is committed to ensuring Patients right to confidentiality.

Address the ways in which ABMU will put 'much more focus on the rights of patients' (p19 of response)

These are both explicitly detailed and implicit throughout our Action Plan. In particular, ABMUHB will develop an 'Expectations Booklet' to be given to patients on

admission to wards that details their rights when being cared for. The intention is that this will clearly demonstrate to patients, families, carers and staff the rights and responsibilities that they have when in our hospitals. This will empower patients to challenge staff if they consider that their dignity is not being respected.

Recommendation 5 : Hospital Discharge

Whether the response was approved by Bridgend County Borough Council, Neath Port Talbot County Borough Council and the City and County of Swansea Council

The original response was subject to wide consultation with stakeholders including Bridgend County Borough Council, Neath Port Talbot County Borough Council and the City and County of Swansea Council. Although comments received from Local Authorities were used in the compilation of the response, the original response was not formally approved by the three Local Authorities and that there was some disagreement over the wording within the response. However, the Action Plan accompanying this letter has been formally approved by Bridgend County Borough Council, Neath Port Talbot County Borough Council and the City and County of Swansea Council. This is evidenced by the signatories to the letter.

Your concerns that the response demonstrates an insufficient sense of urgency in resolving the problems in discharging older people in an effective and timely manner.

It is clearly in the best interests of patient care, service quality and resource utilisation to ensure that older people are discharged from hospital in an effective and timely manner. The action plan jointly prepared in response to recommendation 5 by ABMU Health Board Bridgend County Borough Council, Neath Port Talbot County Borough Council and the City and County of Swansea Council demonstrates the importance which all agencies place on resolving such issues urgently. There are specific actions around increased focus on discharge from the Executive Team and other Senior Managers. Weekly multi professional complex and simple discharge meetings are held on each site, and the focus has changed to ensure that each Ward Sister and Charge Nurse attends the meeting with a clear understanding of the individual patient issues, thus clear accountability has been reinforced and demonstrable benefits regarding effective discharge planning have already been evidenced. The importance of improved partnership working between all agencies is emphasised and there are a number of other actions that will ensure that delays in discharging older people are urgently resolved.

Timescales for implementing changes

These are detailed within our Action Plan.

Recommendation 8 : Ward environment

What will be done to collaborate with patients, their families and carers in relation to changes to existing wards (not just 'new builds') other than quarterly patient surveys.

Within point 8.2 of the attached plan, there are actions to involve the Arts in Health Group, to use information from patient stories, questionnaires and continuous patient engagement to involve patients, their families and carers in making changes to existing wards. There is a specific action point to involve the Disability Reference Group in new builds and refurbishment.

Whether changes will be considered in relation to all wards, not just wards usually associated with older people

With the exception of Paediatric wards specifically designed for children and reserved for their exclusive use, all of the wards within ABMU hospitals are used for the care of older people. Although there are specific design features of wards used to care for patients with dementia, high dependence or intensive care wards and other specialist wards, ABMU will collaborate with older people, their families and carers in making changes to all wards and not just those designed specifically for the care of older people. The Transforming Care Project has already resulted in simple but effective changes to the Ward environments.

Timescales for implementing changes

These are detailed within our Action Plan.

Recommendation 12 : Knowledge and Skills

Which staff will be required to undergo mandatory training and in which areas

Within our action plan, points 12.1 and 12.2 detail ABMU's commitment to determining the need for education training and delivering this where appropriate to ensure that all our staff working with older people have appropriate levels of knowledge and skill. Whether or not this is mandatory for individuals and frequency of training will be determined from training needs analysis and appraisal. Since ABMU HB employs over 17,000 staff, the majority of whom work with Older People, we consider it appropriate to await receipt of the training needs analysis before answering this question in detail. However, there will be programmes of mandatory training for all ward staff including Medical, Nursing, Therapy and Health Care Support Worker staff.

How staff will be released from clinical duties to attend mandatory training

General Managers within ABMU Health Board have a responsibility to ensure that appropriate staffing levels are maintained on wards whilst facilitating staff to be released from clinical duties to attend training including that which is considered

through appraisal to be mandatory. There is a balance to be struck between continuously maintaining appropriate staffing levels to deliver high quality care and releasing staff to attend training. Mandatory training is closely monitored through the nursing metrics and the Heads of Nursing report compliance through to the Nursing and Midwifery Board monthly. Compliance has improved and increasingly more flexible methods of delivery are implemented including tailored training for specific areas. The Executive Team and Board will provide scrutiny to ensure that an appropriate balance is maintained.

Timescales for implementing changes

These are detailed within our Action Plan.