St George's Healthcare NHS Trust

BrendonCare

JOINT RESPONSE to HEALTHWATCH WANDSWORTH REPORT

We would like to thank Healthwatch Wandsworth, Enter and View team, for reviewing our service on 15th May 2018. Receiving feedback from the patients that we support is important to us and the visit has enabled us to review the service in relation to the whole report, and also provided an opportunity to respond to specific recommendations made. These shall be addressed in order that they appear in the report;

CARE

Staff should be reminded of the need to protect patients' privacy and dignity, especially at busy times such as the early morning.

Respecting the privacy and dignity of our patients is very important to us at any time of the day. All staff receive training regarding dignity in care because we consider a person centred approach is essential in achieving positive care outcomes for patients. We also have dignity champions within the home therefore we were disappointed to hear that we had not reached a standard that we all expect and have taken measures to address with all staff who work at the home. We will also be monitoring this quality standard more frequently and requesting further feedback from patients during their stay to ensure

More attention should be paid to giving medication at appropriate times and, in preparation for discharge, encouraging patients to take their own medication where possible.

All patients have their medications reviewed during their stay by the General Practitioner and Registered Nurses. Medications are also reviewed at the weekly Multidisciplinary team meetings. We use an electronic medication administration system which enables the Nurses to manage medications at time intervals prescribed and reviewed by the GP. It also has a built in time window when medications should be given and will provide an alert should there be a breach for any reason..

In hospitals and generally, medications are prescribed at certain times e.g. 08:00 (breakfast), 13:00 (Lunch), 18:00 (Tea), 22:00 (Night) however there are also some medications prescribed which are more time specific for the management of symptoms related to a patients health condition. We can adjust times to meet patient's specific needs and the GP will undertake this. We can also monitor the times medications are actually administered in relation to symptoms for patients where this is required and make further adjustments. As part of the patients stay we will continue to undertake reviews but further involve patients especially where there have been new medications introduced or changes made to existing medications.

For all patients an initial medication assessment is undertaken to determine any support that may be needed following a stay in hospital. Some patients may require full support with nurses administering all medications whilst for some patients they are able to continue taking all or some medications. This can change as patients health and wellbeing improve therefore we review medications during their stay in preparation for discharge home.

We reviewed how often the medication assessments were undertaken and found that there were inconsistencies when the assessments were completed. We have made improvements to the admission process to ensure all patients have their assessments completed and choices recorded in their medication plan.

Clearer information about the GP's availability and role could be made available to patients.

We are happy to review our patient information leaflet which describes the Intermediate Care service in order to provide clear details concerning the availability of the GP and their role within the service.

More care should be given to meeting the needs of patients with special dietary requirements.

All patients' dietary needs are clinically assessed prior to admission and this continues until discharge. All patients have a nutrition care plan which outlines dietary need including personal preferences and choices. In addition all patients are assessed by a dietician who is part of the contracted multidisciplinary team and attends a weekly review meeting with the therapists, nurses, General Practitioner and Hospital Consultant.

The catering team are informed of any dietary preferences and specific needs. All nursing, care and therapy staff attend daily 'handover' of information where any special dietary needs are highlighted and discussed where applicable.

We have reviewed these processes and procedures in light of the issues raised in the report particularly the quality of information recorded and how this is communicated and exchanged. We did find that we are not always consistent in conveying information with patients and are in the process of streamlining how information is recorded and monitoring the quality of information received.

Staff should be mindful of patients who are largely confined to their rooms by their physical condition or state of mind. They may need information about activities and encouragement to come out and participate.

We consider socialisation and engaging in activities an important part of a patients rehabilitation towards recovery and home. To support this we provide a full and varied programme of activities, predominantly small and larger groups, and actively encourage patients, and their family and friends, to join in. In addition all patients have their individual bedroom with TV and also en-suite and they can choose to rest or spend some quiet time with family and friends if they wish.

We do recognise that some patients are at various stages of rehabilitation and on occasions a few patients may need to receive therapy and or care and treatment in their room for a period of time. Whilst we endeavour to involve all patients in meaningful activity we have reviewed how we can improve assessing and reviewing patient choices regarding activity and will be implementing a new individual plan for these residents. We will also ensure that all patients have an individual copy of the weekly programme of activities.

The home should discuss with commissioners the need for a laundry service for patients as an alternative to relying on relatives to provide this.

We have reviewed the joint policy regarding laundry services. The vast majority of patients rehabilitation stay is on average four weeks with a rapid turnover of admissions and discharges seven days a week, fifty two weeks a year. Understandably, laundry management on our size and scale becomes quite complex logistically, not least, labelling clothing, managing clothing inventories where items may have been exchanged with items from the patients home and also repatriating items upon discharge. Therefore we operate on a policy similar to the NHS hospitals where patient's families support any

laundry requirements. If there are any difficulties or hardship then this can be discussed with the Home Manager on an individual basis as highlighted in the report.

We see the absence of any nearby shopping facilities for simple items patients need as a problem. Consideration should be given to how this could be addressed.

We do stock a small selection of toiletries, e.g. soap, toothpaste toothbrushes, shampoos, shaving foam, combs etc for sale in the home. Unfortunately we are unable to accommodate a shop within the service. However we do recognise that this service could be more improved upon and we are currently working with the 'Friends of RGH' volunteers to the setting up of a mobile shop. This should provide greater access and potentially choice. There are also local shops which patient's family and friends can access within a 10 – 15 minute walk from the home and also accessible via the G1 bus route.

We do have newspapers and magazines delivered to the home for long term residents however this service is reliant upon accounts being set up to ensure payment. We can facilitate this for patients during their short stay rehabilitation however the agreement will be between the patient and the newsagent which will be on a weekly arrangement, with one week's payment in advance. Brendoncare accept no liability for this service.

We do have copies of the daily Metro and Evening Standard available for all residents in the Open Lounge.

REHABILITATION

It might be possible to do more during a patient's stay to reinforce awareness of the risk of falls and the various interlocking strategies for avoiding them. Greater prominence should be given to the need to identify and implement individual falls prevention strategies.

Falls is one of many reasons for patients to be referred to an Intermediate Care Bed for rehabilitation. Patients who are at falls risk are identified early in the assessment and receive targeted therapy and designed to improve their balance and strength. Referrals are made to other services during their admission following assessment with the aim of improving mobility and decreasing the falls risk, ie, podiatry, orthotics and opticians.

The patient management plan ensures that the whole team is aware of individual falls risk and strategies which could minimise the risk. However, we agree that we could do more formal education on falls awareness. We run a daily exercise group and we intend to use this group as an opportunity to deliver Stay Steady talks.

We do provide a selection of patient leaflets on falls and other health matters and these are located on the wall outside the gym.

We would like to see goals broken down into their constituent steps, expressed in plain English and for a copy to be given to patients.

Goal setting is completed with patients and the component steps of each goal is routinely discussed with the patient.

We will offer the patient a copy of their goals, although we know that whilst some patients would like a copy of their goals, some patients will decline. For those patients who would like a copy of their goals, we will ensure that the goals are written in clear English with no abbreviations and are easily understood.

Documentation of therapy goal-setting and monitoring should be reviewed and monitored for adherence.

The weekly goal setting meeting is used to discuss and review patient goals. During this meeting, documentation will be monitored to ensure that adherence to the process is maintained.

The Therapy Operational meeting is held approximately every two weeks and this examines documentation and compliance.

INFORMATION FOR PATIENTS AND THEIR FAMILIES

In any redesign of information material for patients and their families, more prominence could usefully be given to providing clear advice on who to contact with any queries and concerns.

As part of the review of our patient information literature, we will ensure that patients have clear guidance on whom to contact should they have any queries or concerns

DISCHARGE

To reduce confusion and anxiety, the unit should identify more clearly when patients enter a "preparation for discharge" stage and, for example, mark this with use of a discharge leaflet for patients and relatives.

We recognise that some patients, family and friends will have anxieties and concerns regarding their discharge from the Intermediate Care beds.

The Therapy Team have produced a Discharge Information leaflet which is designed to answer some of the most commonly asked questions but we are not always consistent in providing this in a timely fashion.

Our intention is to provide this leaflet with an estimated discharge date within 2 weeks of admission. We will review this after a period of time to ensure that this course of action is effectively reducing anxieties and concerns.