
Healthwatch Richmond

**West Middlesex University Hospital
Compassionate Care Project**

**Dates of Visits: October - November
2014**

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Project Group: Batcho Notay, Jan Marriott, Julie Risley,
Louise Smith, Perin Hughes, Rasha Hussein, Sandra Hempel,
Maureen Chatterley.

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Introduction

In May 2014 Healthwatch Richmond were approached by West Middlesex University Hospital and invited to undertake a project in the spirit of the Compassionate Care Audit conducted by Richmond LINK between 2010 and 2011. The previous audit saw around 50 people engaged via in-depth interviews.

Aim of project

The aim of this project was to gain a better understanding of current patient experiences at the hospital. We expanded on the previous audit by shortening the interviews and gathering more qualitative data from a wider audience to gain a broader impression of patient satisfaction at the hospital. The project was not designed to draw firm conclusions and make recommendations on all aspects of the hospital services, but to gather data to inform a more focused second phase of the project.

The project was carried out between 27th October and 12th November 2014. Healthwatch agreed with West Middlesex that the project should begin and end before the CQC visit which took place on 24th November 2014. The findings of our project are presented in this report.

It was agreed that the project was to be conducted in two phases. Phase one involved a very broad general survey of inpatient departments at the hospital. This is the phase detailed in this report.

These findings will be used to inform phase two; a more focussed survey in collaboration with Healthwatch Hounslow in 2015. The boroughs of Hounslow and Richmond make up a significant percentage of the patient base at West Middlesex Hospital, therefore it was agreed that it would be beneficial for both Healthwatch to be involved in this work where possible.

What we did

To gain a better understanding of existing data on patient experience at the hospital, Healthwatch Richmond analysed comments on the Healthwatch Infobank, the Friends and Family test and revisited the previous CQC report on the hospital. This analysis demonstrated the need for this project to take place. Having reviewed these sources of information, we found that we had very little current information on patient experience at the hospital. This project was therefore designed to gain a better understanding of what it is like to be a patient at West Middlesex University Hospital.

To develop the questions for this project, we reviewed the questions and observational audit from the previous Compassionate Care Audit. The 2010/11 Compassionate Care Audit gathered quantitative data from around 50 patients and volunteers. Those who participated in the review told us that the questionnaires took a long time to fill in.

In order to be able to speak to more patients we simplified, generalised and broadened the scope of the questions. We also altered the questions to gain qualitative rather than quantitative answers. For this reason it is not possible to provide a direct comparison between the results of the two reports, and any comparison made will be of limited value as the data collected in this report was not designed to be compared to the previous audit.

Methods

Healthwatch Richmond and West Middlesex University Hospital worked in collaboration and consulted Healthwatch Hounslow to plan the visits and design the questions. It was agreed that each visit would be undertaken, where possible, by two trained volunteer 'Authorised Representatives for the purpose of Enter and View'. Enter and View Representatives undergo a thorough recruitment process including completing an application, references and interviews, relevant training and DBS checks.

We reviewed the questions and observational audit from the previous study, simplified them to allow for more qualitative, subjective and experience lead responses. The questions were reduced and simplified to reflect the broader themes and prompt conversations whilst retaining a broad scope.

The six wards we visited were:

Ward	Type of Ward	Admission Pathway
Lampton	Care of the Elderly and Heart Failure	Mainly emergency with a some patients being admitted from clinics
Crane	Care of the Elderly - Dementia Speciality	Emergency pathway
Richmond	Surgical - all specialties	Mainly planned but also some emergency patients
Syon 2	Orthopaedic	Elective and emergency patient s
Osterley 1	General Medicine and Gastroenterology	Emergency patients
Marble Hill 1	Medical specialties	Emergency Patients admitted from Assessment Medical Unit

Each ward was visited a total of three times over the three week period; once in the morning, once in the afternoon and once in the early evening. The visits were conducted for 2 hours. Hospital staff were notified of the project before it began and volunteers were given an induction to the hospital, infection control and the wards. Each volunteer wore Healthwatch Richmond identification at all times throughout their visit.

During the project, the volunteers introduced themselves to the staff, conducted an observational audit (Appendix 2) and semi-structured interviews with patients. These interviews were patient led, but were broadly guided by a pre-agreed questionnaire (Appendix 1). At the beginning of each visit the volunteers asked staff if there were any patients which, for medical reasons, would not be appropriate to interview.

Due to the patient-led nature of the interviews, the need to end interviews to allow hospital activity to take place uninterrupted, and as the subject group were acutely unwell, it was not practical or appropriate to ask every patient every question. The response rate differed between the various wards, with Crane (dementia speciality ward) having a higher proportion of incomplete or absent answers.

Feedback was provided to West Middlesex throughout the data collection phase in order to inform the hospital before their CQC inspection.

Limitations

The research was not designed and nor does it claim to provide a representative view of patient experience at West Middlesex University Hospital.

The research aims were to:

- Conduct broad semi-structured conversations with patients
- Collect a range of patient experiences and not to generalise experience
- Identify and report where patients have concerns
- Identify from these experiences areas for future research.

The research has gathered data from patients across six of the hospital wards. Individual experiences will inevitably be different, based on their needs and expectations of care at the hospital.

The response rate was quite variable due to the environment and the natural variability of the sample. For example Crane ward had a high number of patients who did not provide a response to some questions. This could be because a greater proportion of patients had dementia or were very elderly, making completing interviews with patients more challenging. In addition, the patient-led nature of the methodology allowed patients to focus on the issues that were more important to them and not respond to questions that were less important. This further reduced the response rate.

The survey was designed to collect qualitative data on subjective patient experience across a broad spectrum of inpatient hospital services and aspects of care. It was not practical to collect quantitative data at the same time.

Due to the timeframe we had for the study, we were limited to visiting a selection of the wards. We were provided with two randomly selected wards from each discipline: care of the elderly, surgical and medical. Whilst there were no other criteria for selection of the wards, it was agreed that excluding wards such as the stroke ward would be appropriate because of the likely level of patient engagement with our questions.

While every attempt has been made to provide a sense of scale to the issues raised by patients throughout this report, the methodology does not allow for these to be robustly quantified. Whilst the data was placed into positive and negative categories to aid analysis, these categories are very subjective because some of the comments were ambiguous in their sentiment. The data has therefore been presented with proportions of patients spoken to, rather than percentages of the answers received. This key difference in the data meant that we are not able to directly compare the findings of this project and the previous compassionate care audit.

The findings presented identify positive and negative aspects of patient experience and raise important issues to consider and examine in greater depth for Phase 2 of the project.

Analysis

The qualitative data analysis of the patient interviews was carried out with an approach based on:

1. Reviewing the volunteer reports from patient interviews to describe the responses and assign themes
2. Assigning data according to the themes
3. Assigning the overall sentiment of comments (positive, neutral, negative, no data) per ward
4. Preparing a descriptive summary for each question or theme
5. Reviewing the results

During the analysis, data was considered in terms of frequency, specificity, emotion and extensiveness under each question. On the same basis emerging themes that cut across the questions were identified where patient comments highlighted a collective position.

Responses were grouped by question, by ward and by emerging theme. This enabled the themes to be split by wards for comparison across the hospital. The questions lent themselves to thematic groups.

A total of 116 patients were interviewed, and 34 volunteer observational audits were completed. The numbers of patients interviewed per ward can be seen in the table below.

	Lampton	Crane	Richmond	Syon 2	Osterley 1	Marble Hill 1	TOTAL
Total number of patients spoken to per ward	13	14	19	24	18	28	116

The report has broadly been structured by the questions asked, with the exception of question 2 *“What were the positive aspects of your care and treatment or what needs improving?”* as all the answers to this related to other questions and emerging themes.

Overall Care and Treatment

Care and Treatment was a broad and common theme that ran throughout the data on each ward. Patients were asked to describe their overall care and treatment on the ward.

Overall, over half of patients who responded rated the care and treatment at the hospital positively, but there was substantial diversity among the wards.

Crane, Lampton, Richmond and Syon 2 received positive responses from over half of patients surveyed. Patients described their experiences with expressions such as *“staff have been lovely”, “top notch on care and treatment”, “I’ve been looked after well”* and *“could not have better caring staff”*.

Osterley 1 received more mixed responses. Some felt treatment was *“excellent. Good nurses who are very helpful... quick to respond”*, whereas others felt that *“the nurses aren’t around to help”* and *“Sometimes the nurses don’t answer”*.

Marble Hill received the most mixed responses, with several patients responding positively *“everyone is nice... it is nice to be looked after”*. However a quarter of patients asked responded negatively, with comments such as *“not one of the team has asked about my care and they don’t listen if I try to talk”, “staff are caring but have no time to be kind”, “some care is good, some bad. One day it was awful all day”* and *“the feeling of isolation on the ward needs improvement”*.

Emerging themes

Meeting Patient Needs

On each ward that we visited some patients told us that they had not received help or care when they had asked for it. The importance of this to individual patients, and that it was experienced across the hospital as a whole, makes this a significant issue for West Middlesex Hospital to address.

Some of the comments expressed by patients also refer to sections later in the report, for example there were a number of comments relating specifically to patients' dignity which were drawn from the section on 'Respect, Privacy and Dignity'.

Managing patients' continence

Problems with managing patients' continence were noted on half the wards, with incidents observed by our volunteers where patients were not cleaned after episodes of incontinence, and patients being left waiting to use or while using the bedpan.

On **Marble Hill 1** our volunteers observed several instances where patients clearly needed assistance due to a continence issue; *"a patient was walking round the ward just wearing a gown with the back open and what appeared to be soggy incontinence pants drooping"*. On another visit there was a patient wandering around who had *"wet themselves - staff were needed to clear up the mess, which took a while"*. We also received comments from patients about treatment of their continence on **Marble Hill 1**: *"I wasn't seen for 4.5hrs. I had a fever and was told to sit and hold the drip in one hand. I was very uncomfortable and just wanted to go home - being there was like being in a prison. I was left sitting in my own waste and no one came"*.

On **Syon 2**, we received a number of comments from patients who told us that they have been made to wait to use the bedpan or visit the toilet during their stay and that staff are *"unable to respond quickly to commode call - sometimes 20 minutes"*, leading to problems where *"...by the time they get to me and I get to the toilet its often too late, so they have to clean up after me"*. One patient told us that: *"Once I was left after using the bed pan when the nurse went to get some wipes. The nurse didn't come back and I had to wipe myself"* [it was noted that the patient's condition would have made this difficult and possibly unsafe].

On **Richmond** it was observed by our volunteers that *"One patient was calling out - needed help because they had been left sitting on a bedpan. Eventually the HCA came after another patient alerted them"*.

Patients not receiving help or care when they ask for it

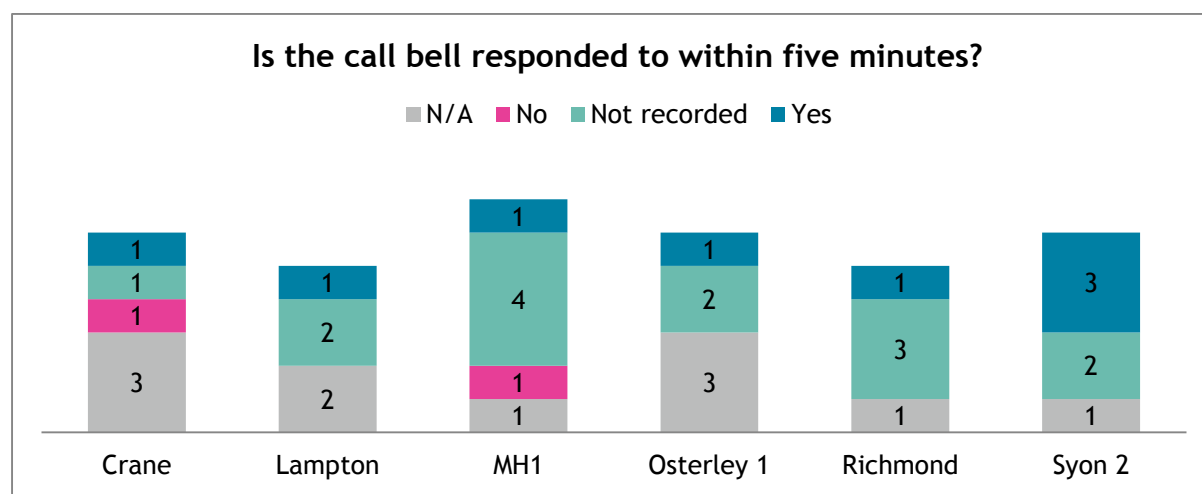
On **Marble Hill 1**, **Osterley 1** and **Syon 2** volunteers received comments where patients were concerned about not receiving help or care when they ask for it.

Several comments from these wards suggested that nurses say they'll do something for a patient, then do not; *"They say they'll get it then get as far as the door and forget"*, *"they often forget if you have asked a question and go off and do other things"*, *"staff go*

off to do something when you ask but then get distracted and forget”, “the nurses seem to be taught to forget things”.

Additionally, patients on **Marble Hill 1** and **Osterley 1**, expressed difficulties in getting staff attention: *“when they’re busy they ignore you. It can take up to 10mins for them to come when you press the call bell”, “I’ve sometimes have to wait a long time when I’ve asked for something” and “staff are a little slow if you ask for something”.* One patient told us that *“in a minute” is always the response to anything”.*

On **Syon 2** one patient commented that *“catering staff brought me a drink and then refused to help sit me up. They were quite rude and said ‘I’m not a nurse’. They left and no nursing staff appeared”.*



Waiting for care and attention to medical needs

On all the wards we collected comments from patients who felt that they had been left waiting for care and treatment.

On **Crane** several patients felt that they *“spend time waiting for care”.* However, one patient said *“you don’t have to wait for anything”.*

On **Lampton** and **Richmond** comments made ranged from *“you have to wait a long time but then they are very busy”* to *“I’m a bit fed up with waiting around for something to be done”.* On **Richmond** one patient was concerned because her *“appointment was at 12:00 and she was still waiting at 3:45. No news - nobody keeping her up to date. Nurses walking backwards & forwards and she thought staff had forgotten her. Her family & children were calling for news and patient had none. This was stressing the family and in turn patient was getting even more stressed because their family were stressed.”*

On **Syon 2**, one patient commented that *“staff are offhand and make you wait for things to be done.”*

On **Marble Hill 1** concerns were raised about the level of attentiveness to patients’ needs from staff, even when issues are raised. One patient commented, *“No checks made when visitors are there. Friend noticed the antibiotic drip was empty and there was a long line of blood in patient’s arm. Took over an hour to do anything about this”.* Another patient

told us that *“needs are not always met. E.g. told he should not sit out for longer than 2 hours but this never happens. Can be left all morning until evening”*.

Finally, on **Syon 2** and **Osterley 1** volunteers received comments from patients saying that *“I have not cleaned my teeth since entering hospital”* and *“I have been showered by my daughter but the nurses haven’t asked me if I need a shower or anything”*.

Noise

On five of the wards noise was highlighted as an issue for one or two patients per ward as impacting on their experience, particularly overnight.

- **Syon 2** patients commented that it’s *“very noisy day and night”*.
- **Osterley 1** patients commented that *“in the ward there is no peace, which is very draining”*
- **Richmond** patients commented that it is *“difficult to sleep at night because of noise”*.
- **Marble Hill 1** - one volunteer commented that in the beds close to the nurses’ station and bins, it was difficult to hear the patient because of the noise of bins banging when they closed, and another patient commented that *“I’m happy with everything apart from the noise at night”*.
- **Crane**- one patient commented that *“some of the nurses are very loud”*.

Lampton, in contrast, received a positive comment highlighting that *“it’s nice and quiet here”*.

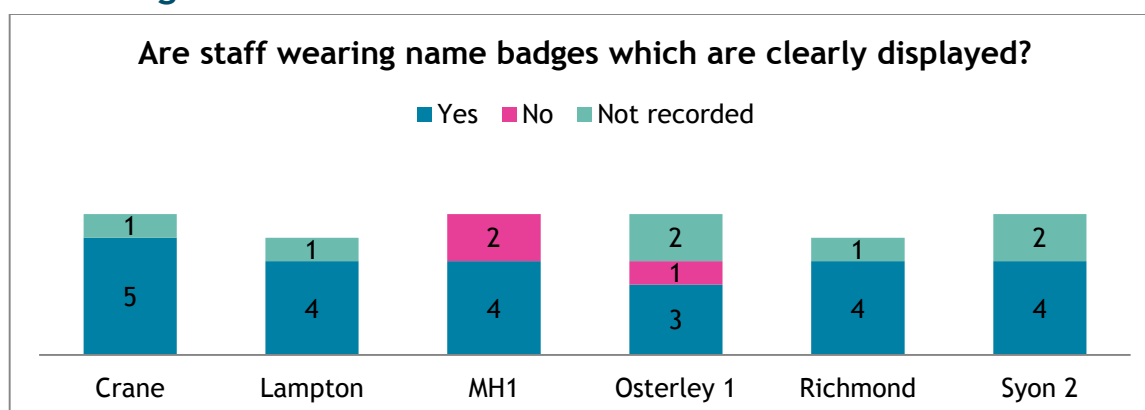
Hazards

On several wards our volunteers observed some hazards.

- **Marble Hill 1** *“The door to the room marked ‘Treatment Room’, which in fact was a store room for items that included sharps, was propped open with a bin.”* This was noted along with a comment on patients with dementia left wandering around the ward. On a separate occasion it was observed that *“Doors are left propped open with bins, one of which was clinical waste!”*
- **Osterley 1** it was observed that *“There was a lot of equipment around the ward - left in corridors etc”*.
- However one of the volunteers who visited **Richmond** twice, commented that *“Last time I visited, doors were left open. It’s good to see that this had been noted after I mentioned it”*.
- Another volunteer commented that **Crane** also had some hazards around the ward, for example they observed that *“there were fans on the floor”*, which could cause a fall.
- On **Lampton** one patient felt that it was *“frustrating. Not very tidy. The aisles are blocked by things that are a trip hazard.”*

Syon 2 was the only ward where there was nothing of this nature reported.

Name Badges



Volunteers noted that most staff - but by no means all - were wearing name badges. However, volunteers queried the readability of these badges.

- On **Crane**, “Some staff were wearing badges and some - I think mainly the care assistants - were not. Other staff were wearing badges but these were not clearly visible. But this is a moot point, given that you have to be very close up to be able to read the badges ” and “The name badges for staff were not easily read, and it is difficult to tell who is what kind of staff member.”
- On **Osterley 1**, “Nursing staff all appeared to be wearing clearly displayed name badges. However, those badges are far too small to be read, other than very close up”, and “staff all wore name badges but some had them tucked into their pockets so they would not get in the way when they were helping patients.”
- On **Marble Hill 1** it was noted that not all staff were wearing badges. Of those who were it was observed that they were turned inwards so they were not readable.
- Finally, on **Lampton**, we observed that “Two physios were not wearing any visible name badges”.

Volunteers also found it challenging distinguishing between staff members; “There was a range of different styles and colours of uniform, which is more confusing than enlightening for patients and relatives”.

Uniform recognition was a problem on **Osterley 1** “one can’t always recognise just who nursing staff are. So introduction by staff to each patient they meet becomes more important at this point of contact for treatment. If the patient understands this then they can be confident they are in good hands”.

Additionally there were not always clear guides to staff uniforms provided, “making distinguishing between different staff very difficult.” On both **Marble Hill 1** and **Crane** volunteers commented that “It was useful to see some job titles [Eg. OT/Doctor] embroidered onto uniform”.

Our volunteers noted that uniforms with embroidered titles, for example ‘Doctor’, made staff identification much easier. Volunteers also commented that identification badges on lanyards tended to be placed in a pocket to keep them out of the way when treating patients and were therefore not visible.

Communication

Communication was a common theme that ran throughout the data on each ward. Patients were asked to describe the overall communication between themselves and the clinical teams.

The answers patients gave can be broadly categorised into three sub-themes; overall communication, language - patients specified that language was a barrier to effective communication, and personalised communication where patients' comments related to whether the staff used patients' names and whether patients' conditions were considered when communicating with them. These themes were drawn from a diverse mix of comments from patients, highlighting that all these aspects are integral to patient experience and compassionate care.

Three fifths of communication between patients and the clinical teams was rated positively by those asked and a fifth rated communication negatively.

Overall communication

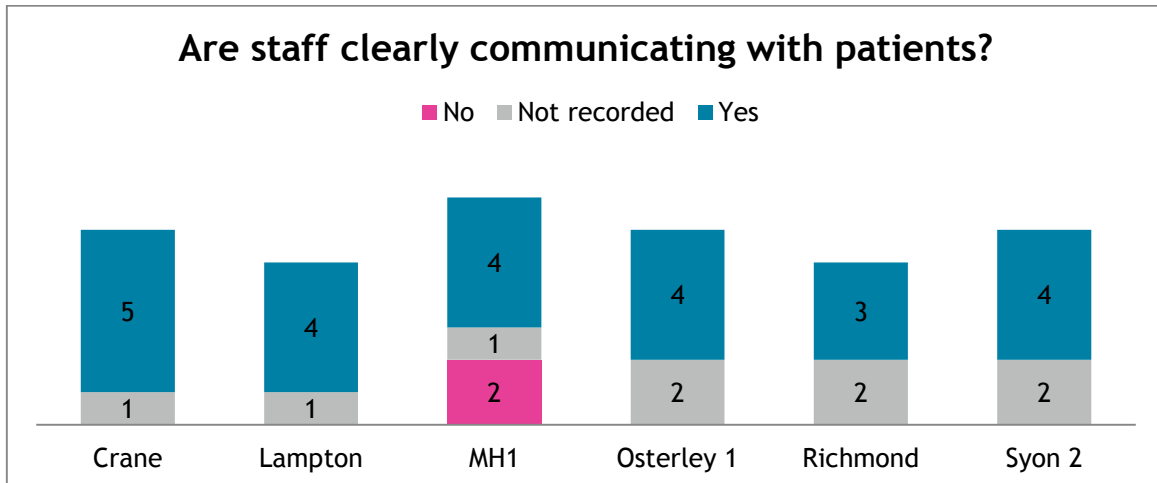
Some wards received very positive comments on communication between the staff and patients.

- On **Richmond**, over half of patients made positive comments about the communication between staff and patients; *"communication good every step of the way", "the staff make sure that the patients understand what's happening" and "always informed of treatment and progress. Staff are wonderful, always ready to listen and talk to you"*.
- On **Syon 2**, half of the comments were categorised as 'Good': *"very good, no problems at all", "they're very encouraging"*.
- On **Lampton** patients were very positive stating that the care was 'Good' with just under half of comments reflecting this *"I have a laugh and a joke and try to be positive and have a positive relationship. They're generally good humoured"*.
- **Crane** had mixed perceptions, with some patients feeling uneasy *"they're often chatting between themselves and you often wonder if they're talking about you"* but most of the patients expressed feeling positive and commented that *"they listen"*.
- On **Osterley 1**, there were no negative comments made about the communication between the staff and patients, comments made were *"generally fine", "I've been given good explanations" and "overall good communication"*.

However, there were several comments from patients on some of the wards highlighting that communication was *"Poor"* or *"communication between staff and patients is non-existent"*.

- **Marble Hill 1** - a third of the comments were 'Poor'. One patient told us that *"I ask to speak to the nurses but I'm ignored. They say the nurses are always on the phone or somewhere else"* and another patient told us that the nurses don't listen when they try and talk.
- **Richmond** - one patient said *"The night staff were rude and did not want to know"*.

- **Lampton** a sixth of patients rated communication negatively, with comments such as “I’m just waiting to hear what they plan to do”.
- **Syon 2** a sixth of patients rated communication negatively, with comments such as “I’m in pain. The doctor always says he will get something stronger but nothing happens”.



During our observational audit we looked at the overall communication between staff and patients as we saw it during our visits. It was clear from our observations that, for all the wards, patients appeared to understand the staff.

In two wards, our volunteers noted:

- On **Richmond** “the staff nurse spoke to patient not just to nurse. There was a relatives room for private discussions. Communication was good between staff and patients.”
- On **Syon 2** we observed that “On one occasion a nurse was observed giving a patient feedback about their discharge and engaging in conversation with them.”

However, on **Marble Hill 1**, two volunteers did not observe staff communicating clearly with patients. Observer comments highlight that communication between staff and patients was not always clear; “‘partial’ for staff clearly communicating and patients understanding staff” and “Routine communications with patients poor only 1 out of 5 addressed the patient by name”. We also observed an incident where one volunteer “heard one member of staff barking at a patient ‘do you want painkillers or not?’”.

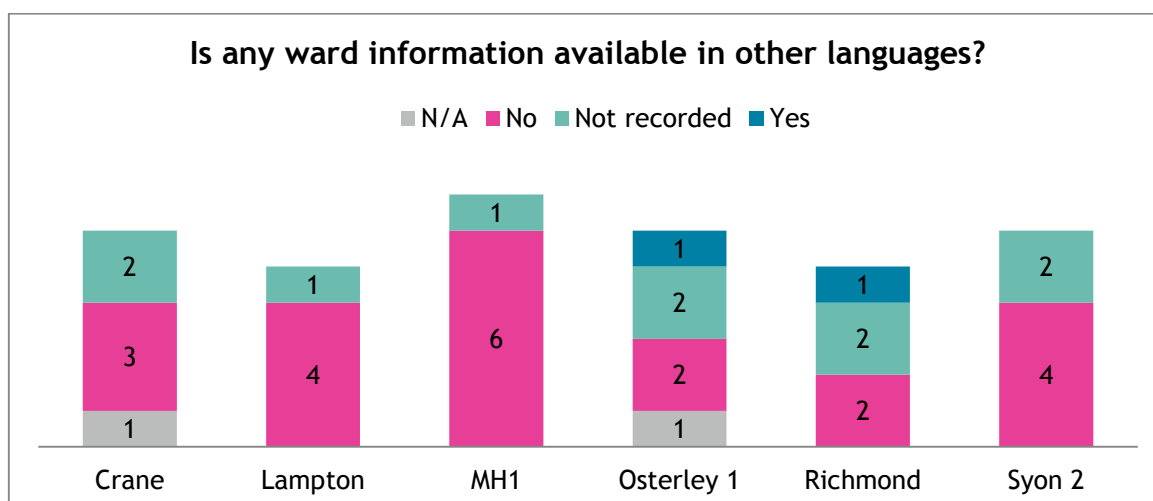
Language

Staff language skills were observed to be a barrier to communication on **Marble Hill 1**, **Osterley 1**, **Richmond** and **Crane**.

- On **Marble Hill 1**, patients observed: *“the cleaning staff cannot understand or speak English”*. One patient also found it difficult to understand the male nurse. One of our volunteers noted that he found it difficult to speak in full sentences, although the words were fairly clear.
- On **Osterley 1**, *“I sometimes have problems understanding some members of staff whose English is not so good”*.
- On **Richmond**, *“The accents of some nurses are a bit difficult to understand”*.
- On **Crane**, during our observational audit, we noticed a *“...lack of understandable English by the catering staff on their round for patient selection [of meals]”*.

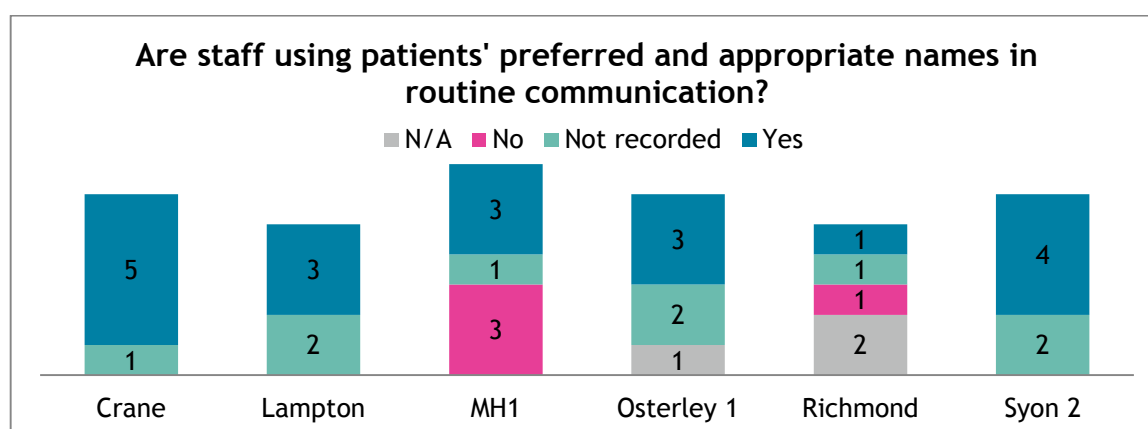
Patient language skills were also barriers to communication, but issues here were dealt with in a more positive way;

- During our observations on **Lampton**, volunteers commented that the *“Staff nurse said they assessed the needs of each patient and found a solution. She and other staff knew several words in one commonly used Asian language, and they also had picture cards. At the very least she said that they ensured that patient was able to communicate key issues such as pain, toilet, thirsty, etc.”*
- Additionally, on **Osterley 1** *“Staff seemed aware of the importance of good communication and to make efforts to address the needs of each individual. For example, for a Spanish lady who spoke no English, staff had found a Spanish-speaking member of staff from another department to translate, while a relative came in at least twice a day to interpret for a second patient with no English.”*



We did not observe any ward information provided in other languages on most of the wards visited.

Personalised Communication

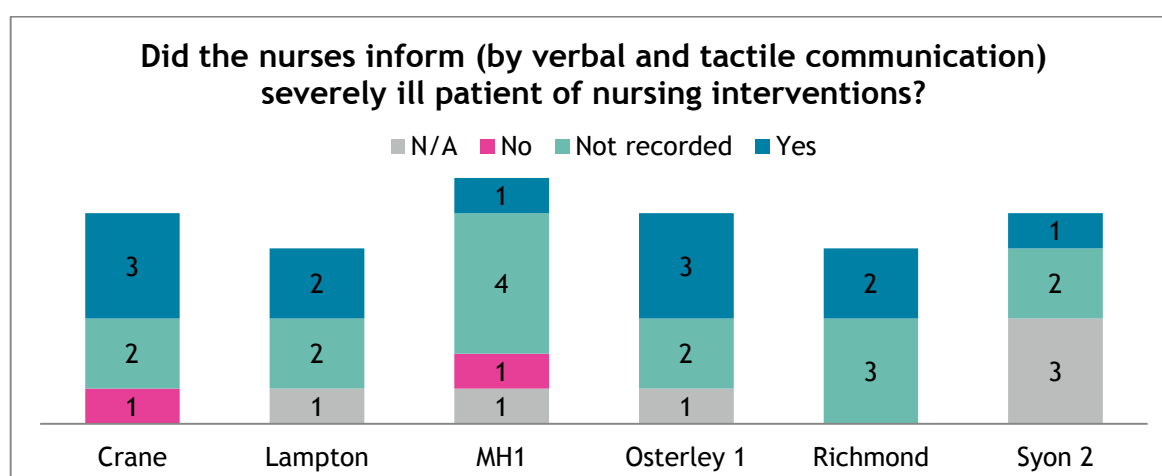


On **Marble Hill 1** three volunteers, and on **Richmond** one volunteer did not observe staff using patients' names in communication, whereas on **Syon 2** and **Crane**, the majority of volunteers observed patients' names being used routinely.

Feedback on the other wards was mixed as to the use of patients' names in routine communication. Our volunteers noted that in a number of cases the patient's name was not displayed above their bed making the use of names more challenging.

On **Lampton**, the daughter of a patient with communication problems expressed dissatisfaction with the way the younger staff approached the patient, saying they came up too quickly and spoke too soon for the patient to realise that they were there and to understand, so failed to communicate as a result. The daughter queried the lack of training in these matters and asked *"isn't it a nurse's responsibility to know the patients' specific needs?"*

Quite a few patients across the wards were relying on more family members to gain information, or were relying on the communication between family members and staff to hear about their care. On **Osterley 1** one patient said *"my daughter is with me. She probes so I don't know if I'd know as much if she wasn't here"*



Where we were able to assess whether nurses communicated with severely ill patients the responses were generally positive. Only on **Crane** and **Marble Hill 1** did one volunteer observe that staff did not communicate with severely ill patients.

Teamwork

Patients were asked whether they thought that the clinical teams worked well in caring for them. Answers were rated on whether they broadly say 'Yes' or 'No'. This is presented in the table below.

Overall, three quarters of patients asked said that the staff worked well ('Yes') in caring for them. There were high rates of no response for this question, which could be because patients felt unable to answer this question adequately.

Coordination and communication between departments was a problem identified across several wards.

- On **Osterley 1** patients commented on the *"poor coordination between occupational therapy, equipment services and social services"*, *"they all work separately"*
- On **Lampton** patients also commented that *"they don't seem to communicate well between departments"*.
- On **Syon 2** there were several negative comments by patients which centred on a feeling that there was a *"lack of communication between departments"*. This was the highest negative response about teamwork received. However, a third of patients asked responded positively to the question.

Despite the perceived poor coordination between services in the hospital, patients broadly rated the clinical teams positively in their ability to work together in caring for patients.

- On **Osterley 1**, comments like *"seem to work together well"* were common.
- On **Lampton** we received comments such as *"they are good at working together"*.
- On **Crane** we were told that *"they really care about the treatment they're giving"*.
- On **Richmond** patients said *"Teamwork is good"*.

Marble Hill 1 comments were also more mixed. Teamwork was rated by just under half of the patients as positive, however several patients rated it negatively. Comments ranged from *"they all seem to know what each other is doing"* to *"no teamwork"*, *"sort of"* and *"no"*.

Care and Treatment Plan

Patients were asked the question *“Have you been involved in your care and treatment plan?”*

Whilst some of the patients responded negatively to the question, their overall response demonstrated that they did in fact know what the next phase of their treatment plan was. For example one patient commented *“I don’t really have a treatment plan - I’m waiting to have an endoscopy”*, another said *“I’m waiting to hear about that. I’m having tests”*. Where patients demonstrated awareness of the next phase of their care this was considered to be evidence that they were aware of their planned care.

Most patients across the wards felt that they had, to some extent, been involved with their care and treatment. In **Osterley 1** and **Richmond** patients were generally very positive about their involvement in their care; *“yes they’ve been very good about that”*, *“no worries about this”*, and *“involved every step of the way”*.

On **Syon 2** the responses were also generally positive, with just under half of patients stating that they *“had been advised well”* or *“they try to keep me informed”*. A small number of patients interviewed on this ward felt that *“staff are too busy to keep me informed of my care”*.

On **Crane** responses were generally positive with patients stating that they had been involved to an extent in their care. However there were a number of patients who commented that *“I don’t really have a treatment plan”* and *“not really”*.

Equally, on **Lampton** patients were generally positive about their involvement, however this ward also had a high number of patients feeling uncertain about their care and treatment, with around a quarter of patients saying that they were *“waiting to hear”*.

On **Marble Hill 1** a few patients told us *“I’m not sure what had been planned or why I’ve been in hospital so long”*, *“feel uninvolved”*, *“I have not been informed /involved in care or treatment plan”*. However, several other patients made comments on their involvement, stating that *“they tell you what they’re going to do”* and *“yes, they involve you in everything”*.

Discharge Plan

Patients were asked, *'Have you been informed of your care and discharge plan?'* The data suggests that there is uncertainty over discharge across the wards visited. Poor communication between the hospital and patients about discharge can leave patients very worried. Patients want reassurance in good time before they are discharged, of what will happen when they go home and of what arrangements have been made.

A few of the patients asked responded positively, however the majority of comments across the wards focused on the uncertainty patients felt around discharge. We recognise that there are other services involved in the discharge process and the comments we received may also relate to other NHS and Social Care services.

Discharge Communication

Osterley 1 patients felt informed of their discharge plan and they were the most certain across all the wards; *"Yes everything well explained"*, *"I hope to go home soon but not better yet"* and *"I think a discharge plan is being discussed"*.

On **Syon 2** a few patients had been informed of their discharge, however there were several patients who were more uncertain; *"They don't know yet"*, *"I think they're sending me for more tests"*. Additionally, one of the volunteers observed a discharge taking place that was worrying and confusing to the patient:

"The Patient was approached by staff whilst being interviewed and informed that they were going home - transport arrived to take them before they had been properly told. Staff then came over and informed patient about being discharged. This was the first they had been formally told about going home. They were worried about not having the right support at home and were concerned that the hospital was sending them home to an empty house to fend for themselves. The nurse informed the patient that their family had been told and that they had organised care. Whilst being informed of this discharge, Transport came to take them home. Patient was not ready to go and was rushed into packing up. Nurses were very good and helped, but it was rushed."

Another patient on **Syon 2** said:

"I may be going home today, but I'm not sure. They've not come and told me. I'm worried about how I'm going to manage at home because I'm not sure they will have organised anything for me. I'm not happy about going home and I don't feel ready to go yet."

Many patients on **Lampton** said *"I'm waiting for results of tests"* or *"no discharge information"* and *"nothing's been decided yet"*.

On **Crane**, one patient felt uncertain in their plan for discharge *"Not until today - I was told over the weekend 'maybe Monday', and I wasn't seen by a doctor this morning. But I've just had some blood taken for more tests so I'm not sure if I'm going home or not."* Another patient said *"I have to use the bedpan and I'm not allowed to use the toilet, how am I supposed to go home? They're expecting me to go home soon"*, whereas another had faith that *"they won't let you go home until you are 'right'"*.

On **Richmond**, there was also a lot of uncertainty over discharge with patients saying *“I may go home tomorrow, I will be told today” “hoping to be discharged today” and “discharge process lets things down. Doctor did blood tests at 9:30 and these were OK so ready for discharge at 10:30am. It’s now 2:15 and I’m still waiting for medication”*.

Discharge communication on **Marble Hill 1** was concerning; several patients had not been given any communication about their discharge: *“no discharge information”, “No discharge plan, just asked if she felt better then told she could go home”, “no such thing as a discharge plan. Patients just told they can go home” and “I’m awaiting discharge, no information or communication”*.

During our observations on **Marble Hill 1**, one volunteer

“witnessed one incident that I was not happy with. A nurse was organising the discharge of a patient. She spoke to them in a loud, brusque voice and ticked them off for not doing as they were told as she was trying to get them out of bed. She then began to have a dispute with someone I took to be either a porter or a member of the patient transport staff about something that had gone wrong with the arrangements. The staff member she was speaking to responded quietly but again she was loud and aggressive. She then said: “Oh well, we’ll just have to cancel the discharge then” and marched off, with no apology or explanation to the patient or any acknowledgement their presence at all”.

Post Discharge

Some patients expressed concern because they had had previous poor experience of discharge home.

Osterley 1: a patient said *“it’s the day you leave that you start worrying”*.

Marble Hill 1: a patient expressed that they were *“afraid after last time”* to be discharged.

Syon 2: one patient said

“A couple of months ago I was discharged from the hospital and sent home and there was no one there. My daughters were away and I wasn’t sent any help for days, no one checked up on me. I got help eventually when my daughters got back, but by then it was too late. After that discharge I couldn’t get upstairs and didn’t have a bed downstairs - I spent two nights sleeping in a chair”.

Another patient on **Syon 2** said:

“I may be going home today, but I’m not sure. They’ve not come and told me. I’m worried about how I’m going to manage at home because I’m not sure they will have organised anything for me. I’m not happy about going home and I don’t feel ready to go yet.”

Respect, Privacy, Dignity

Patients were asked how they felt they had been treated in terms of respect, privacy and dignity. Answers were graded on whether they were broadly positive, negative or mixed. This is presented in the table below.

Overall, most patients who answered this question were positive about their care with a small proportion were negative.

Generally on all the wards, patients responded that they felt well treated. Our volunteers observed throughout our project that curtains were used effectively and appropriately and provided adequate cover for patients to maintain dignity.

Patients told us;

Richmond *“caring staff maintain dignity, privacy and have respect for you”.*

Crane *“yes, which is difficult to do with an old lady”*

Osterley 1 *“They are always very discreet”*

Syon 2 *“Always treated with courtesy and politeness”*

Lampton *“they’re very respectful”*

Marble Hill 1 *“respect dignity privacy at all times”.*

However, on **Marble Hill 1**, patients made some strong comments regarding their treatment. Whilst just under half of patients asked felt they were well treated, *“Staff have been polite”*, there were several patients who felt poorly treated. This ward received the highest number of negative responses across all the wards for this question. Additionally, these comments were strongly negative, relating to the way patients had been treated on this ward; *“I’ve been treated very badly. I was very unwell, very upset and left with a drip for hours. I was very dirty”* and *“I have been treated rudely and with contempt since I made a complaint”*. Several other comments have been drawn out to the broader theme ‘Meeting Patient Needs’ detailed at the beginning of this report.

On **Crane**, one of our volunteers witnessed that *“The staff (from porters to nurses) were very respectful of a deceased patient and very considerate of other patients. Porters were very professional “I’ve come to collect for downstairs” - all the curtains were drawn around the other patients and, if asked, they explained why this was happening. 10/10 for sensitivity.”*

Individual Needs

Patients were asked whether they felt that their individual needs had been met.

Overall, four fifths of patients who were asked responded positively to this question and a fifth responded negatively. However, out of the 116 patients interviewed, only 56 answered this question. The low amount of feedback collected for this question, may partly be because the answers were broadly covered by the answer to the previous question on respect, privacy and dignity. However, volunteer feedback suggested that this question was difficult for patients to understand, and also difficult to explain. It may therefore mean that this question was not asked by volunteers, or it was not judged to be appropriate, as it had been answered already.

All six wards had predominantly positive responses with many patients agreeing to the question on whether their individual needs had been met.

Richmond *"Yes, all needs have been given the best of care"*

Crane *"Yes, I'm very happy", "yes, I get the same care as everyone else"*

Osterley 1 *"My needs have all been met"*

Syon 2 *"Very satisfied in here"*

Lampton *"Yes, fine"*

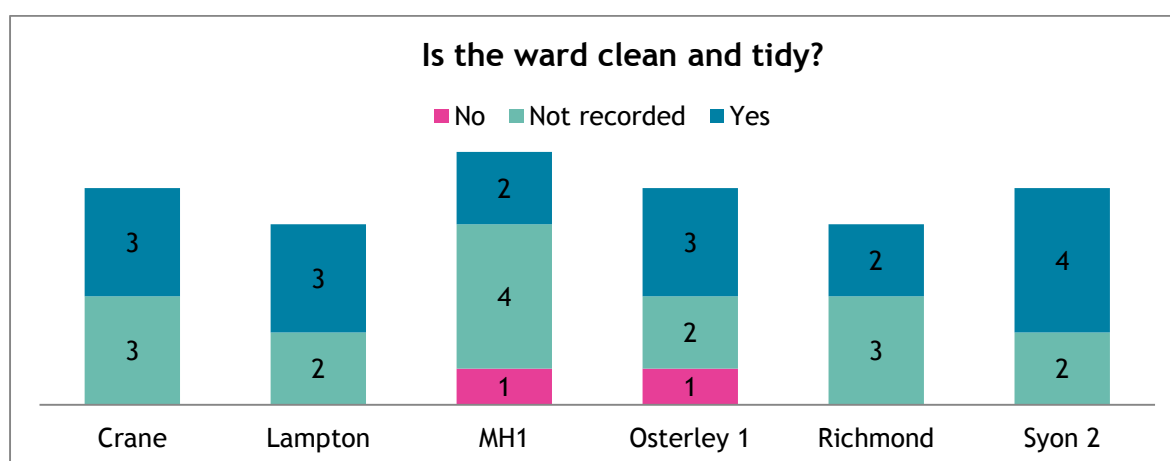
Marble Hill 1 *"Yes, I'm happy about that".*

Cleanliness

Patients were asked to describe the overall tidiness and cleanliness of their ward. The answers were rated on whether they were positive or negative. This is presented in the table below.

Ward Cleanliness

Overall the cleanliness across the hospital was positively rated by patients on the wards, with comments such as *“nice and clean”*, *“always cleaning”* and *“ward clean and tidy”*. Very few negative comments were received. Overall four fifths of patients who responded rated the cleanliness positively, several patients rated it as ‘Fine’ and there were a few negative comments regarding the cleanliness of the wards.



Overall, patients were able to respond with positive descriptions of the overall tidiness and cleanliness of the wards. This was also supported with our volunteers’ observations, as pictured in the above graph, of the cleanliness of the wards. There were two exceptions; on **Osterley 1** and **Marble Hill 1**, one volunteer on each ward observed it as unclean and untidy.

On **Lampton**, **Syon 2** and **Osterley 1** we observed that the wards were *“clean and tidy”* *“clear and uncluttered”* and *“Corridors and bays clear and uncluttered.”* This broadly supported the patients’ views of the wards; most of the patients on **Osterley 1** rated the cleanliness positively and most of the patients who responded on **Syon 2** were positive about the cleanliness.

On **Crane** most of the patients rated the ward cleanliness positively: patients commented *“they keep it very clean”*, *“always cleaning”* and some volunteers commented that *“the ward was overall very clean and tidy”*. However volunteers observed during a couple of visits that the ward was cluttered, with trolleys everywhere, and concerns were noted on the way that mealtimes were cleared away *“The cupboard/sideboard in each bay was filled with plates, cutlery and rubbish from the time we arrived (1pm) until 1:30 when the side was cleared.”* Nonetheless they rated it positively overall for cleanliness.

On **Richmond** our volunteers observed that there was *“Equipment cluttering corridor”*. However, all patients who responded rated the cleanliness of the ward positively, stating that *“it’s always clean and tidy around bed and floors”* and *“always cleaning”*.

Most patients who responded on **Marble Hill 1** rated the ward positively for its cleanliness, however patients stated that it was “*variable*”. This was supported by our observations where on one occasion the volunteer observed the ward to be unclean and untidy overall.

One of our volunteers rated **Osterley 1** as unclean and untidy overall, stating that “*there was urine left in bedpans in the toilets. Patients mentioned that they had been there all day. There was a lot of equipment around the ward - left in corridors.*” However other volunteer comments said that the “*ward was clean, tidy and appeared very well run*”.

Toilets

The cleanliness of the toilets was raised as a negative issue on **Osterley 1** with several comments such as “*there are bedpans un-emptied in the toilets*”, “*the bathroom has used bedpans in there on the floor that seem to have been left for a long time*”, “*there's sometimes a problem with the bathrooms but that's the fault of the patient who's been in there before you, not the staff. They can't have someone standing outside every bathroom, cleaning after every patient.*” This problem was also observed by one of our volunteers; “*there was urine left in bedpans in the toilets*”.

On **Marble Hill 1** from the patients who mentioned them, comments about the toilets were “*Not great. Have to use bedpan because of condition, nowhere to put them and I found them lined up in the toilet*”, “*variable - the toilets sometimes have paper on the floor*”, “*on transfer to Marble Hill 1, I was physically sick at the state of the bathroom and the filthy state of my side room*” and “*not cleaned bedpans properly*”.

On **Lampton** reception to the toilets was mixed. Some patients commented that there were “*reasonably clean toilets*”, whereas another commented “*Last week a couple of bedpans were left on the floor of the bathroom by another patient*”.

There were no problems with the toilets on **Syon 2**, one patient commented that the “*Ward is always clean and tidy likewise the toilet*”.

The cleanliness of the toilets was not mentioned in patient or volunteer comments on **Richmond** or **Crane** wards.

It is important to note that the overall question asked was about ward cleanliness, patients who raised the issue about toilet cleanliness often did so as it is clear that the toilets were unpleasant. Where patients didn't mention this issue it is possible that this was an issue which did not affect them.

Food

Overall there was a very mixed reception to the food. Patients were asked “*what is the food like?*” Over two fifths of patients who responded rated the food negatively, and under two fifths of patients rated the food positively.

Issues with the food surrounded the quality, temperature, support, choice and the catering staff. These are summarised below.

Quality

The quality of the food was highlighted on all the wards, and had a very mixed reception.

On **Osterley 1**, most of patients who responded rated the food negatively and said that “*it’s disgusting; everything is pureed and tasteless, and the vegetables seem to be either overcooked or undercooked, they can’t get it right*”, “*Food is atrocious, it goes straight through. I have my own food*”, but another patient also said “*I have to have a special food, which is ok*”.

On **Marble Hill 1** the majority of patients asked rated the food negatively, with a couple of patients rating it positively and a few rating it as ‘Fine’. Patients commented that “*I don’t recognise what I’m eating most of the time*”. The response rate to this question however was very low on this ward.

On **Syon 2**, several patients rated the food negatively with comments such as, “*All the food is cooked to a puree and is inedible*”. Whilst there were a high number of negative comments received, more patients rated the food positively with comments such as “*lovely food*”.

There was more positive feedback on **Lampton**, where most patients rated the food positively and a few rated it as fine, with comments such as “*I can always find something I like*” and “*the food is nice*”.

On **Crane** the majority of patients rated the food positively with comments such as “*it’s ok, I can’t really say any more*”.

On **Richmond**, most patients rated the food as ‘Fine’ or ‘Good’, with the majority of comments as “*Food is good*”.

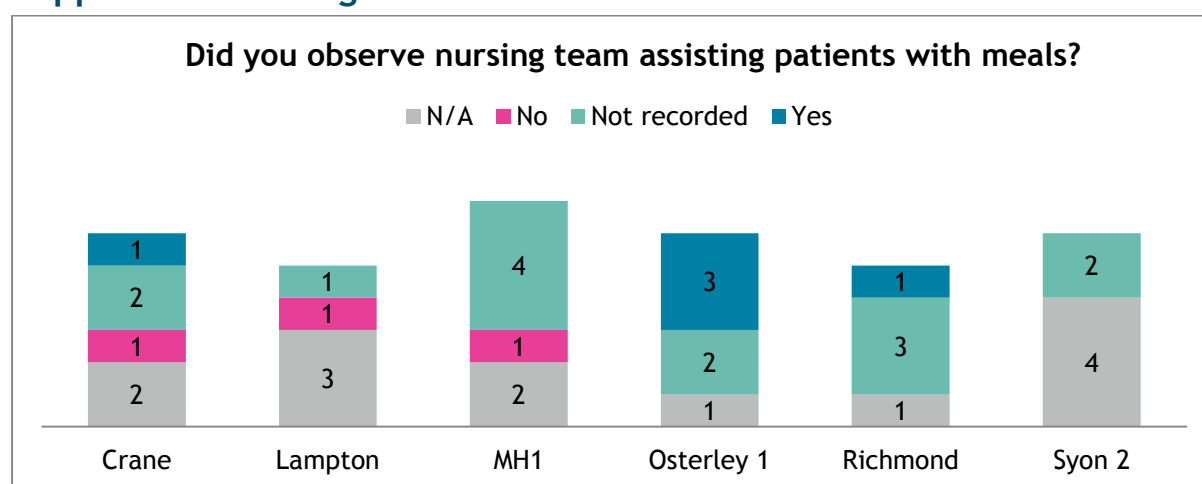
Temperature

The temperature of the food on serving was highlighted as a problem on half of the wards.

- **Syon 2**, a patient commented that they had a “*crème caramel served frozen and inedible*”
- **Richmond** patients commented, “*Food is sometimes cold*” and “*Sometimes warm rather than hot.*”
- **Marble Hill 1**, patients commented that “*Some things aren’t properly cooked. Temperatures vary, it depends how long it has been kept before serving*”, “*I’ve had chicken which was still frozen*” and “*the food arrives cold*”.

Not all patients’ experiences on these wards were negative; some mentioned that the food they received was “*nice and hot*” or “*served hot*”.

Support with eating meals



Patients had a variety of problems in receiving support around mealtimes.

On **Syon 2** and **Marble Hill 1** a few patients said they had problems reaching their food “*I cannot always reach my drinks and I often spill them*”, “*cannot always reach the hospital food*”. Another patient on **Marble Hill 1** said that they “*have no teeth and were often given unsuitable food*”.

On **Lampton**, one patient’s daughter said that she was never encouraged to stay at meal times to help the patient. The patient was blind and suffered a multitude of other problems, including dementia. At one afternoon visit the daughter noticed the patient’s dentures were still in the bedside locker, so assumed the patient hadn’t eaten lunch, and queried if anybody had cut up patient’s food as the patient was unable to see to do this and needed encouragement to eat.

Where we were in a position to observe, on several wards we did not see patients being helped with their food by staff. **Osterley 1** was viewed most positively, with 3 out of 6 observations recognising that patients were being helped with their food.

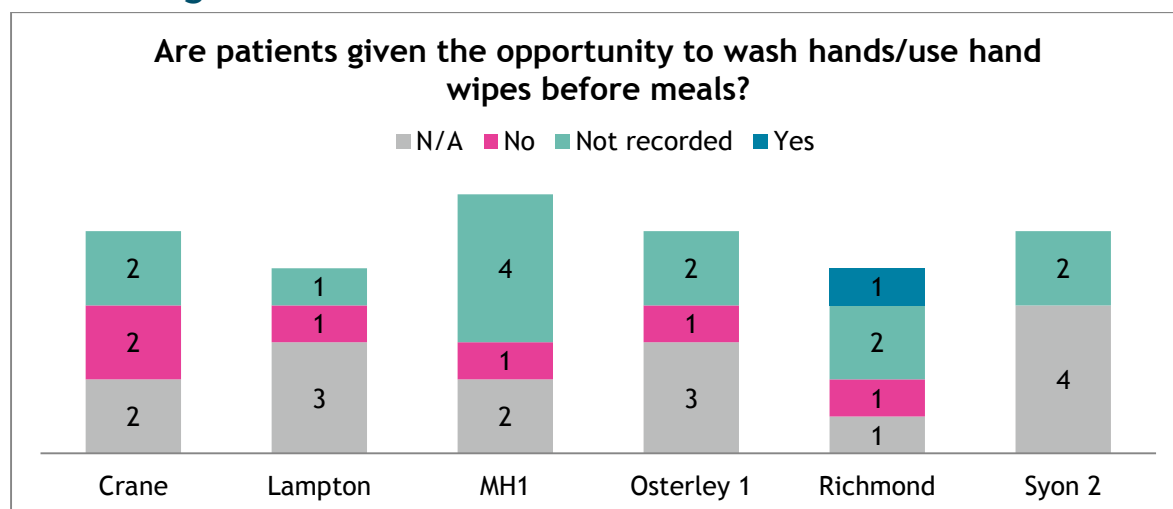
On at least one visit to **Richmond** and **Crane**, the volunteers saw patients being helped with their food by staff.

Choice/Ability to Choose

The choice of food available received mixed comments across all wards, patients experienced problems in both amount of choice available, and receiving the option that they had chosen. In some cases, there were problems with the ethnic food available.

- **Syon 2**- some patients commented that “the choice is fine” whereas others said “*it’s not the kind of food I would like. I’d like a mix of food*”.
- **Osterley 1**- a few patients commented that they were “*not offered choice or preference.*” Additionally one patient said that their “*ethnic diet was not catered for*”.
- **Lampton** patients were more positive, “*you get to pick what you want and you get what you picked*”, however others said that “*I was asked what I wanted and then told I couldn’t have it*”.
- **Crane** patients had mixed perceptions “*choice of food is a problem*” but also “*choice is ok*”.
- **Richmond** patients commented that they “*would like more time to choose*” and “*I would like more variety*”
- Some **Marble Hill 1** patients commented that they were “*Often given things I haven’t ordered*” and others said that “*I like some of the food. Some I don’t like but there is a choice*”.

Hand washing



On five wards we observed at least once that patients were not offered the opportunity to wash their hands. We did not always attend at mealtimes and so were not able to observe this on every occasion.

Richmond was the only ward where patients were observed to have had the opportunity to wash their hands.

Catering Staff

Quite a few patients raised concerns about the attitudes of some catering staff on half of the wards, particularly in reference to catering staff refusing patients' requests.

On **Syon 2** one patient commented that *"catering staff brought me a drink and then refused to help sit me up. They were quite rude and said 'I'm not a nurse'. They left and no nursing staff appeared"*.

On **Marble Hill 1**, a patient said that

"Sometimes the food is not enough and I have asked for some more [e.g. fruit] from the catering staff but they said no. I asked for a sandwich one evening because I was still hungry - one staff member said, "no, the sandwiches weren't delivered". When my daughter asked the nurse for sandwich, nurse said that there were always sandwiches available - the catering staff member had been lying."

Another patient who was given an ethnic diet said that

"Indian food is OK but I asked if I could have anything other than Indian food. The staff member said they would change my preferences when they brought the food around, but I was given Indian food again. Staff member was in too much of a rush to give different food."

On **Lampton**, one patient had problems getting the catering staff to give them something hot to drink

"Due to my condition I find it difficult to swallow things, and need a hot drink to wash down the food. The catering staff refuse to give me tea- I find it difficult to drink water as it doesn't wash the food down. I've been told to drink water - they don't listen to me, I choke on food regularly."

There was also a problem relating to communication with the catering staff, comments included *"the communication is really poor and unclear. Quite often not told what you are going to be getting"*, *"the dinner ladies can't often pronounce things"*, *"they never ask you if you want something like orange juice to drink"*. This was particularly clear on **Osterley 1** where one patient commented and our volunteer also noted:

"A catering staff member came to ask what the patient's preference was for supper. The catering staff member's English was appalling and they spoke from the end of the bed. They were very difficult to understand."

Next Steps

The aim of the study was to build a foundation of rich patient experience on which to base a second phase of the project. This section of the report looks at the potential areas for future investigation, as well as providing some recommendations for the hospital based on the findings in this report.

The findings of the previous Compassionate Care Audit, published in 2011, are broadly aligned to the findings of this report. The previous report picked up that overall care and treatment was viewed positively by patients and that the wards were clean. It also identified that areas for improvement were communication between staff, discharge information and the hospital meeting patients' needs, particularly regarding mealtimes, toilet needs and levels of noise at night.

Phase 2

Patient needs not being met

Following discussions with West Mid, it was agreed that an area for future investigation includes patients' needs not being met, particularly where staff forget about patient care.

The problems highlighted were regarding patients being left waiting for a long period of time for their call bell to be answered, particularly regarding times when they need the toilet. It is not acceptable for patients to have to wait for 20 minutes to be taken to use the toilet. There were also occasions where patients asked for help with eating and drinking and were refused, with no indication of receiving any help.

Future research to focus on patients being able to get the help they need to manage their conditions in hospital.

Discharge

Following discussions with West Mid, it was agreed that discharge and communication with patients around discharge should be an area for future investigation.

Patients should, where possible, be kept informed of plans for their discharge. It is understandable that discharge plans change, however it is important to ensure that patients are kept informed of this to manage their expectations.

It is clear that patients are concerned about what happens to them when they leave the hospital. In some cases patients had no care after they left hospital, in other cases patients were uninformed of the care that had been arranged.

The hospital have agreed that this is an area of concern for further investigation.

Mealtimes

Healthwatch have suggested an area to further investigate is *why* there is so much inconsistency across the hospital with food and mealtimes.

Marble Hill

Marble Hill 1 consistently performed poorly throughout our visits, particularly regarding staff attitudes, communication towards patients and how attentive staff are to patient

needs. The Hospital is aware of issues at Marble Hill 1 highlighted throughout the report and is resolving these, however this ward may also be an area for future research.

Recommendations

WMUH have agreed to bring together the volunteers and hospital staff members to a round-table action planning session. This will primarily be aimed at discussing the recommendations below. They will produce an action plan for addressing these points and we will hold them to account on these actions.

Communication

Communication between patients and staff needs improving regarding information about care. There were a number of instances across the wards where patients felt uninformed about their care and treatment and had been left wondering what was happening.

The Hospital have agreed to review the provision for information in other languages. We recognise that it is not necessary or feasible to provide leaflets in all languages, however we recommended that the hospital make it clear to patients and visitors that there is a translation service available to those who may need it. A poster in multiple languages providing this information on each ward, and possibly in patient bedside information, for example, might be a low cost solution to this concern. The hospital have agreed to consider this.

Additionally, we recommended that the hospital should review the language skills of staff who regularly communicate with patients, particularly the catering staff, as it is clear that patients have problems understanding some staff.

Cleanliness

We recommended that the hospital look at providing patients with the opportunity to wash their hands before meals and addressing the cleanliness of toilets, particularly on Osterley 1.

Noise

We recommended that steps should be taken to try and reduce the amount of noise impacting on patients in the wards, particularly at night. One possible solution may be that the hospital considers replacing the lids of the bins to soft-close, which would help to manage this. However we appreciate that a hospital is not a quiet place.

Staff Identification

We recognised that staff members were not easily identifiable to patients who had been admitted; boards identifying uniforms were at the entrance to the ward - an area not necessarily ever seen by a bed bound patient. These boards were also not available on every ward. The hospital acknowledged this and we suggested providing a sheet on staff identification in the patient's bedside information, as well as ensuring every ward has a board on staff uniforms. Our volunteers noted that uniforms were broadly difficult to distinguish between and that uniforms with embroidered titles, for example 'Doctor', made staff identification much easier. Volunteers also commented that identification badges on lanyards tended to be placed in a pocket to keep them out of the way when

treating patients and were therefore not visible. We recommend that the trust reviews the way that staff are visually identified.

Acknowledgements

We would like to thank West Middlesex University Hospital NHS Trust for their cooperation, assistance in conducting the research and the positive way they have engaged with the results. We would also like to thank the volunteers who have supported this project, designing, conducting and reviewing the research.

Appendices

Appendix 1: Interview Audit

Healthwatch Richmond & Department of Nursing Ward Based Compassionate Care Project - Oct 2014

PATIENT STANDARD INTERVIEWS

DATE & TIME COMPLETED:.....

Auditor's name/ organisation.....

WARD:.....

BAY/ BED NUMBER.....

I am [*state your name*] from Richmond Healthwatch working in partnership with the Trust to speak with you about your experience of care and treatment during your stay here. Would it be OK if I ask you some questions about your experience of the hospital?

Please tick if patient agrees to this survey ☐

If you have already responded to this survey would you like to answer the questions again? - tick above if patient agrees to be surveyed again.

How would you describe your overall care and treatment on the ward?
What were the positive aspects of your care and treatment or what needs improving?
How would you describe the overall communication between yourself and the clinical teams e.g. doctors, nurses, physiotherapy etc? Positive and negative experiences
Do you feel that the clinical teams e.g. doctors, nurses, physiotherapy etc have worked well together in caring for you?
Have you been involved in your care and treatment plan?

Have you been kept informed of your treatment and discharge plan? If so, how often?
How have you been treated in terms of respect, privacy and dignity?
Have your individual needs been met? If not, why?
How would you describe the overall tidiness and cleanliness of the ward?
What was the food like?

OTHER COMMENTS - *Do you have any additional comments about your care? These comments are very helpful to us as we work to improve the quality of care we provide to patients.*

Appendix 2: Observational Audit

Healthwatch Richmond & Department of Nursing Ward Based Compassionate Care Project - Oct 2014

OBSERVATIONAL AUDIT

DATE COMPLETED:..... WARD:.....

TIME COMPLETED.....

Auditor's name/ organisation.....

Please Note: The observational audit must be completed at least 2 times per visit.

AREA OF PRACTICE TO BE AUDITED	EVIDENCE PRESENT		
	YES	NO	N/A
Communication			
Are staff wearing name badges which are clearly displayed?			
Are nursing staff seeking consent from the patients prior to undertaking care?			
Are the doctors introducing themselves to patients prior to undertaking care?			
Are staff using patients' preferred and appropriate names in routine communication?			
Is any ward information available for those with language difficulties or disabilities?			
Are staff clearly communicating with the patients?			
Do the patients understand the staff?			
Were the patient bedside information boards updated?			
Assisting the Patient			
Is a patient's self care equipment within easy reach i.e. locker, table, jug and glass, call-bell?			
Is the call bell responded to within 5 minutes?			
Did you observe any ad-hoc nursing rounds to check if patient's are comfortable? (intentional rounding)			
Did you observe the nursing team assisting patients when required with meals, i.e. help to sit up, help with cutting food, help with eating, offering patients more food?			

Appendix 3: Observational Data Overview

