Board Call Recordings (to support Go Listen paper)

Agenda Item: 14
Reference: 10B.132

Trust Board Meeting: 20 December 2010

Summary	This paper contains an example of recent service use to stimulate Board discussion about users' experience of our services. The example provided is an example of a third party call from a member of staff at a care home for an elderly patient. This paper should be considered in conjunction with listening to the recordings previously provided. The Board should consider the user and patient experience of this example of service use.
Issues to be considered by the Board	The Board should consider: • The user experience; and • The current improvements being made to our handling of calls from staff in residential homes.
Action required by the Board	The Board is asked to: • Note the Clinical Director / Chief Nurse's actions; • Receive this report and note its contents; and • Use this example of service contact to stimulate broader discussion about users' experience of our services.
Accountable Executive Director	Helen Young, Executive Clinical Director / Chief Nurse
Author of Paper	David Foord, Associate Director of Clinical Governance
Date prepared	10 December 2010

1. Purpose

As part of the wider activities of the Board to engage with and become better informed of the quality issues associated with our services this paper is provided as an example of recent service provision. The example provided in this paper and the associated call recordings should be used to stimulate broader discussion by the Board about patient and user experience of our services. The Call Review Tool found in Appendix 1 of this paper can be used by the Board to consider patient experience issues.

2. Background

We have an open, systematic and thorough approach to identifying, responding to, investigating and learning from adverse incidents. Incidents can be related to patients who use our services; or those who use our services on behalf of a patient, e.g. parents or care-givers. On rare occasions we identify serious incidents relating to contact with our services. At the time of identifying these incidents it is initially unknown whether the contact with our services was significant in the final patient outcome. The purpose of our investigation is to ensure that we take prompt appropriate action to mitigate any relevant risk; follow a structured proportionate process; identify root causes; and apply learning and actions across systems, processes and services to minimise the risk of recurrence. We also ensure that we have appropriate contact with the patient and / or their family in relation to our investigation and findings.

3. Example of patient service contact

3.1 Incident Summary

A call was made to our core 0845 46 47 service call at 18.42 on Thursday 25 November 2010. The caller was a carer seeking advice for a 95 year old female patient who was resident in a care home. The caller described the patient as having deteriorated and 'going hot and cold'. She had been seen by a doctor earlier that day at the home. The Health Advisor (HA1) assessed the patient's symptoms and reached a 'Priority 3' outcome (non-urgent call for nurse call-back). The call record was placed into the queue at 18.49 for nurse assessment. The caller was advised that the service was busy and to expect a call back within four hours. The service experienced high demand resulting in long call-back queues that evening and over night and a call-back wasn't made until 06.52 on Friday 26 November 2010. A Nurse Advisor (NA1) called the care home and was informed that the patient had passed away over night. This was escalated for investigation as a serious incident the same day. Due to the recent nature of this particular case, the full investigation findings are not available at the time of writing this paper; however, a full investigation is currently under way and will be undertaken in line with our procedures for serious incidents.

3.2 Chronology of Incident

GP home visit to patient 25/11/2010 (some time in the morning)

From information provided by the care home we have identified that the patient was seen by a GP in the morning of her death at the care home and had been prescribed antibiotics for a chest infection, but no further action was advised by the GP at that time.

HA1: 25/11/2010 18.42 (Inbound 0845 46 47, core service call)
First contact with our core 0845 46 47 service was an inbound call for advice about a 95 year old female care home resident. The patient was described by the caller as 'going hot and cold' and was reported to have deteriorated since being seen earlier that day by a GP. HA1 assessed the patient initially using the 'safety question' then the 'generally unwell 12 years and over' protocol in our clinical decision-support system, reaching a 'Priority 3' (P3) outcome. The call was then placed into the queue at 18.49 for a nurse to call back. HA1 advised the caller that there should be a call back within four hours. HA1 gave instructions as to what the caller should do if the patient's condition worsened whilst waiting for the nurse to call. The wait for call-back for non-urgent calls was very long at the time of the call and the high proportion of urgent and less urgent calls (P1s and P2s) increased the wait for the P3 calls to be responded to by nurses.

Care Home Information 25/11/2010 19.20 (details reported by care home)
At 19.20 on Thursday 25 November the staff at the care home checked the patient and found her collapsed with no pulse. A 999 call was made and resuscitation was attempted, which was unsuccessful. The ambulance crew advised care home staff that they would notify NHS Direct of the patient's death, but we have not had any subsequent contact from them.

NA1: 26/11/2010 06.52 (Outbound call)
NA1 made an outbound call back to the care home and was advised by the member of care home staff who answered the call that the patient had died at approximately 19.40 the previous evening (about 50 minutes after the end of the call with HA1). A doctor had attended the care home having been called after the call to us at 18.42 and had left at approximately 21.00.

3.3 Action and Learning

Initial findings of our investigation have not found any issues with the clinical decision support system (CSPT/CAS) for this call to the service. The Clinical Director / Chief Nurse will ensure that full learning and any actions necessary will be identified by the Peer Review Panel who will convene to review the findings of the investigation as part of our serious incident process.

Our policy to support staff in the assessment of calls from care homes states that where the caller is a non-registered health professional, e.g. care assistant, the call should be treated as any other where the intermediary is a lay person. In this case the call was processed as per this policy. The staff involved in this incident have been offered support and access to our staff counselling service, as involvement in any incident such as this can be difficult to deal with.

This call is illustrative of calls we receive from carers who are not registered health professionals in residential homes. Whilst we have an effective policy and procedures both to support calls of this type and more broadly to support calls from third parties we will use this incident as an opportunity to review and where appropriate improve these. Following this incident we have further alerted front-line staff to the risks associated with these calls.

3.4 Patient Outcome

The patient died between 18.50 and 19.20 on Thursday 25 November 2010 (within 50 minutes of the end of the call to us). Care home staff have advised us that the cause of death has been registered as “old age”. It is not possible to say at this stage whether this could have been prevented by more prompt action until further information is received and our full investigation process completed; however, this it is unlikely, due to the age and frailty of the patient and how soon she died following contact with us. The family are aware that a call was made to us and they have met with the GP and report to be satisfied that we acted appropriately. The care home manager is aware of the investigation we are conducting.

4. Action

The Clinical Director / Chief Nurse will:

- Complete her full investigation into this incident and update the CEO and Chair of the Clinical Governance Committee of the outcome;
- Consider the potential for learning from this incident; and
- Consider the risks relating to calls from care home staff and take appropriate action to mitigate this risk.

The Board is asked to:

- Note the Clinical Director / Chief Nurse’s actions;
- Receive this report and note its contents; and
- Use this example of service contact to stimulate broader discussion about users’ experience of our services.

Appendix 1. Call Review Tool

Factor 1: Patient Safety		Rating
1.1	Greets the caller using agreed salutation for service being provided	
1.2	Clearly explains the process to the caller	
1.3	Deals with 3rd party and intermediary calls appropriately.	
1.4	Rapidly establishes call control and focuses caller to presenting need	
Note		
Factor 2: Call Closure		Rating
2.1	Advises patient of anticipated call back time in accordance with operational status	
2.2	Gives clear worsening instructions at call closure	
Note		
Factor 3: Documentation		Rating
3.1	Correct demographics collected	
3.2	Documents demographic accurately	
3.3	Correct data protection process followed to verify record	
3.4	Consent is gained for information sharing, or there is evidence of critical reasoning if consent not sought	
3.5	Uses only approved abbreviations and annotations throughout	
3.6	Bypasses or exits early from the CSPT protocols	
3.7	Documents accurately reason for bypassing/exit early	
Note		
Factor 4: Policy and Guidance		Rating
4.1	Adheres to policy, procedure and guidance relevant to call handling	
4.2	Works within scope of role and responsibility	
4.3	Where issues arise during a call, escalates appropriately	
4.4	Demonstrates an awareness of own practice issues	
Note		
Factor 5: Rapport		Evidence
5.1	Communicates effectively [includes use of English]	
5.2	Mirrors (matches) tone and pace of caller	
5.3	Reflects callers language appropriately	
5.4	Treats caller as an individual	

5.5	Gains co-operation of caller by keeping them informed	
5.6	Shows interest in caller	
5.7	Validates or educates caller on their actions where appropriate	
5.8	Reassures caller	
5.9	Uses humour appropriately	
Note		
Factor 6: Questioning		Evidence
6.1	Personalises questions to caller / person being called about	
6.2	Adapts language used in question to aid callers understanding without changing meaning / context of question	
6.3	Uses tone / pitch of voice effectively to deliver questions in a spontaneous fashion	
Note		
Factor 7: Approach		Evidence
7.1	Positive and confident attitude and language.	
7.2	Demonstrate willingness to help and a ‘can-do’ attitude	
7.3	Polite and courteous	
7.4	Demonstrate sensitivity and a non-judgemental approach to the caller’s need	
7.5	Be Honest	
Note		
Factor 8: Active listening		Evidence
8.1	Reflect back and confirm understanding of the caller’s response	
8.2	Use verbal nods appropriately	
8.3	Allow the caller time to respond	
8.4	Picks up / responds to non-verbal cues	
Note		
Factor 9: Call control		Evidence
9.1	Use the conversation cycle to control the call	
9.2	Identifies key elements of caller's symptoms to focus the call	
9.3	Gives a good explanation of the assessment process	
9.4	Appropriate adaptation of speed for the callers needs	
9.5	Positively manage the caller’s expectations	
Note		