Learning from Experience – Q1 & Q2 2008/09

Hampshire Partnership NHS
NHS Trust

PATIENT ADVICE & LIAISON SERVICE (PALS) AND COMPLAINTS

PALS and Complaints were told...	It is recommended...
When I transferred to a different unit my belongings went missing. There did not seem to be a robust system in place to record service users' belongings.	A full inventory of service users' property should be taken when they are admitted and should be updated if the service user goes on leave or is transferred to another area.
When my mother fell in hospital and broke her hip, there was no spare wheelchair or other necessary equipment available for her use.	Ward stocks should be reviewed to ensure that appropriate equipment is available for patient use wherever possible. Robust systems should be in place to loan equipment if necessary.
When I was admitted to hospital my room and bed were unclean and smelt.	All bed areas should be cleaned and repairs carried out before new admissions.
When I completed a questionnaire used to psychologically assess me, I completed it with the help of other service users on the ward as I did not realise this would affect the results.	Psychologists undertaking a structured assessment and questionnaires with service users should record in their notes whether the questionnaire was completed by the patient on their own or in the Psychologist's presence. They should ensure that service users understand the questionnaires should be filled in by themselves only.
When my wife was discharged her discharge summary stated she was to take 5mg of her medication. I had previously been told she would need 10mg which was in fact the correct dosage.	Discharge summaries should be checked for accuracy by another nurse. A system should also be introduced to ensure that the person administering medication at home, either patient or carer, fully understands the correct dosage and time of administration.
I was not made aware when my relative had a fall which resulted in an injury. Staff also failed to inform a doctor about the fall.	Staff should be aware of the need to always inform the identified relative when patients have a fall. Staff should also ensure that a doctor is informed if a fall occurs and it is suspected that an injury has been sustained.

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If you have any comments or queries about this poster, please contact PALS and Complaints on **023 8047 5265** or email **pals@hantspt.nhs.uk**

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PATIENT ADVICE AND LIAISON SERVICE (PALS)

The following are recommendations the PALS Team are making as a result of referrals made in the first half of 2007/08.

No service user should be allocated a Care Coordinator who does not know they have been allocated. A member of staff should always understand a role is theirs before it is handed to them.

Trust staff should always maintain a professional approach at all times in their dealings with service users and their relatives. This includes responding to their email communications in a timely and polite manner, at the very least to acknowledge receipt.

When an in-patient's named nurse is known to be on long term leave, a temporary replacement should be identified to ensure continuity and to address any concerns which may arise

When service users have been waiting a certain period of time for a specific service to which they have been referred, which is operating a waiting list, they should be entitled to receive a periodic update as to where they are on that list and how long they may still have to wait. It should be then be explained to the S/U, at the outset, that there is likely to be a long wait, but that they will hear, at pre-determined times, where they are on the list.

Trust Staff should avoid advising service users and their carers that a particular, named, clinician would be the best person to treat them.

Information given to inpatients about what they may do (e.g. go home for a weekend's leave) must be able to be followed through, or sound reasons provided for not following through.

In line with Trust policy, all staff should always give their full name when communicating with service users or relatives.

Service users themselves, and their close relatives, may well have a good idea of what is wrong with them and when their mental health is deteriorating. They should be listened to. If their views are not shared, good reasons for the difference of opinion should be offered, and if appropriate, information should be given on how to challenge the opinion.

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Careful thought should be given to decisions about what is offered to service users and/or their carers. Once something has been offered, learning subsequently that it is not after all going to be provided is likely to cause distress or anger

Trust staff should not delay in sharing information that service users are waiting for