healthwatch Portsmouth

‘WALK THROUGH’ OF THE EMERGENCY DEPARTMENT & ASSOCIATED AREAS: QUEEN ALEXANDRA HOSPITAL, PORTSMOUTH

EVALUATION REPORT

OBSERVATIONAL DATA COLLECTED BY HEALTHWATCH PORTSMOUTH TO ASSESS THE ‘FLOW’ OF PATIENTS AND THEIR EXPERIENCE FROM ADMISSION TO DISCHARGE

PUBLISHED MAY 2016

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AIMS AND OBJECTIVES

Healthwatch Portsmouth is an independent statutory body that gathers the views and experiences of local people, enabling them to have a chance to speak up about health and social care services in their area. We collect local evidence-based information through community engagement to ensure that the people who plan, commission and check services listen to the people who use those services.

As part of our response to local issues, we were invited to visit the Queen Alexandra (QA) Hospital to undertake a guided 'walk through' of the Emergency Department (ED) and associated wards following concerns raised in the local media about the 'flow' of patients through the hospital after admission into ED.

The aim of the activity was to see if there were observations we could make which might improve the flow and quality of care provided to patients during admission, treatment and discharge at the hospital via the urgent care pathway.

We recognise that the experience of the team during the visit was a 'snap-shot' of the hospital at that point in time. However, we hope the findings and recommendations within this report will inform the processes in place at the QA and the wider systematic review of urgent care pathway in the city.

Healthwatch Portsmouth would like to take this opportunity to thank the volunteers and all the hospital staff who gave up their time to plan and participate in the 'walk through' and feed into the drafting of this report.

METHODOLOGY

The Healthwatch Portsmouth 'visit' team comprised of 3 staff and 2 board members, who were met and shown around by different Portsmouth Hospitals Trust (PHT) staff members, observing the different areas and asking questions as the morning progressed.

We were informed there had been an 18% increase in admissions into ED during January & February compared to same time last year and that morning, there was a ten hour wait after triage to see a doctor (which was unrelated to junior doctor strike also taking place that day).

We started in the ED department, then moved to the Medical Assessment Unit (MAU), then on to the Ambulatory Unit, then wards D2 and D3 and finally the Discharge Lounge waiting area.

At the end of the activity, we collated the observations from all participating team members to ensure we captured all the key themes. Team members also made requests for more information on specific aspects of what they saw along with suggested ways for improving patient experience. These are summarised below.

FINDINGS & RECOMMENDATIONS

1. Location: Emergency Department (ED)

Observations:
The public walk-in / triage check-in area was well lit with ample seating. The system for checking in was well signposted but during the visit one of our team had to show 2 people how to use it. This raised queries as to whether this has been reviewed to see if it could be more straight forward to use and what systems do other hospitals use? The area around the check in machine was also quite narrow so has the potential to become congested at busier times.

Whilst there was a sign at the reception desk with a waiting time on it was unclear if this was for booking in or seeing a clinician after triage. It may be helpful to have a clear sign at the entrance giving approximate waiting times for minors, majors, GP access and perhaps even ambulatory if appropriate. This could prompt patients to consider going elsewhere if appropriate before even booking in.

It was also unclear if the threshold of what ED accept they will treat changes depending on how busy they are, and subsequently what is re-directed (ie to GPs, walk in centre) each day – is redirection increased at busier times? Is this applied consistently? Are different messages given out which could mean some patients return unnecessarily when they should go to other care provision available to them?

In the ambulance check in area, there seems to be a very clear system in place for ambulance staff to check patients in. However, due to the volume of patients arriving, there were patients queueing in the corridor. This appears to be the norm with staff pulled from their main working area to ensure patients waiting in the corridor are cared for. The concern here is the pressure this puts on staff to care for a larger number of patients which in turn has an impact on the care received. Patients in corridors also did not appear to have call buttons so if they do not have family/carers with them, getting the attention of staff is made more difficult. There is also the issue of the dignity and privacy of the patient which seems impossible to maintain in this setting.

If patients need to wait in ambulances, we understand they are made safe by ambulance crews and ED staff. Once on QA premises, it seems that patients become the responsibility of the QA even if waiting in an ambulance. Attending to patients in ambulance in turn takes ED staff away from duties in the department, questioning whether this is the best use of their time.

Once booked in by an ambulance crew, a patient is logged on to the IT system so if staff/visitors need to know where the patient is, even if they

are waiting in an ambulance, information is available to confirm their location.

During the wait in the ambulance, bottles & bed pans are used for toilet needs, which was not felt ideal. We were also not sure what the situation was with drinks/food for waiting patients – is this something provided for by QA staff?

Following up on the suggestion that a large ambulance is used to provide space for more patients to wait outside of ED, known as a 'Jumbulance', it was unclear if this was still in use. QA staff stated they no longer used this facility but Healthwatch Portsmouth had received other reports that it was still in use.

The target time for being seen in ED (up to 4 hours) seems to start the moment ambulance crews book in patients at ED on arrival, even though patients may still have to wait in an ambulance for a space in ED for some considerable time. It was therefore felt this practice did not support accurate or meaningful measurement of performance against the 4 hour target time. This has also highlighted whether or not triage/treatment could, in some circumstances, take place whilst someone is waiting in an ambulance so the patient is not waiting to then wait again once in an ED bed (as the team were not sure if this already happens).

The walk through also viewed the minor & major injury areas. The minors area was relatively empty but that may have been the time of day. Majors was very busy but felt calm considering the volume of patients being treated there.

With regards to increasing patient needs, feedback was that staff had seen an increase in patients with mental ill health and had to put in more resources to support these patients with these needs, relying on own resources rather than external or other support that had been available in the past.

In terms of co-ordinating responses to changing demand in ED, there seemed to be a position entitled 'Silver Command', which involves a nominated staff member taking oversight of wards and resources to respond accordingly. We were unsure however, if the responsibilities of this role have been communicated in detail to post holders and other PHT colleagues, possibly leading to inconsistent provision of this key position and different levels of expectations from other staff.

Use of porters as a great resource to help move patients around ED, to have tests and go to other wards, also impacts work of ED clinical staff as capacity of porters does not always seem to match the need for their help over a 24 hour period. When not, clinical staff then get involved in moving people to other wards etc, taking them away from treating patients.

Another area discussed was the new "Oceana" IT system being used by QA and the fact this doesn't seem to link to “System One” which is being used across the city by GPs and other agencies. In terms of timely access to medical records and the updating of patient needs, it would be helpful to understand why this stand-alone system was chosen and not one compatible with what is being used more widely across the city.

Recommendations / request for more information (ED):

1. Review the user-friendliness of the check-in technology to see if improvements can be made.
2. Make information clearer re expected waiting times and what they relate to.
3. Provide patients in corridors with call buttons to summon assistance if required.
4. Use a pool of Healthcare Assistants to support patients re toilet and refreshment needs, take basic observations, move to other departments (in absence of porters), provide reassurance re anxiety.
5. Confirm if ‘Jumbulance’ is used and in what circumstances.
6. Provide triage/treatment where appropriate in ambulances ahead of admission into ED.
7. Confirm specific role of ‘Silver Command’.
8. Confirm reasons for decision to implement stand-alone IT system rather than one that used by other health agencies in the city.

2. Location: Medical Assessment Unit (MAU)

Observations:

The MAU is used for a number of reasons to help reduce demand on ED. It seems to be used in the main for the following:

- GP referral for urgent care (by-passing ED). *The patients who are referred for urgent care are medical patients.*
- Patients needing tests or treatment without the need for attention in ED. *This is inaccurate, medical patients require tests as part of their on-going treatment, not as a bypass to the Emergency Department.*
- Patients waiting for admission into hospital. *These patients would be waiting for a medical admission.*
- Patients attending out-patient clinics such as TIA, alcohol misuse. *While the physical space for these clinics is housed by MAU, the service is not part of MAU.*

PLEASE NOTE: In response to feedback from PHT regarding the accuracy of the draft of this report, comments by PHT regarding each of the Healthwatch Portsmouth observations above are included in italics.

A new system of GPs referring directly into MAU (ie not using ED) had been brought in the week previous to our visit. It was too early to assess any benefits to ED but also if there had been a positive or negative knock-on effect to other wards where the flow might be increasing and more patients admitted because of faster movement through MAU.

It was felt that the MAU provides patients the opportunity to be seen by Consultants more frequently - more 'little and often' rather than in larger batches once or twice a day, which enables quicker referrals on for tests and other diagnostics.

If a patient arrives by ambulance (from their GP), it was confirmed that ambulance crews need to wait with their patient until a MAU bed is available, taking up ambulance crew time which was observed to possibly not be the best use of their time when demand for ambulances across the locality is high. This raised the question over whether there was another way patients could wait for admission into the MAU without the need to be 'looked after' by ambulance crews.

One query arose regarding the handling of calls into the unit as there had been experience of someone experiencing constant ringing with no reassurance of it being answered at any point. We recognise staff are busy and not always available to take calls – however, callers do need some mechanism to know their call is being 'handled' in some way, whether this is though a call waiting service or the option to leave a message for a call back, especially if the caller is anxious about receiving an update on a relative/friend.

With reference to capacity, we were informed that the MAU was currently over capacity, having 66 patients in situ when only funded for 58 – we were unsure why if there was capacity for an additional 8 patients, why these were not funded to help manage demand and relieve pressure on ED.

In terms of signage, the aspiration of ward staff to have more dementia friendly signage was welcomed by Healthwatch Portsmouth in seeking to guide and reassure patients with dementia in what might be an unsettling and anxious time whilst in the hospital.

<u>Recommendations / request for more information (MAU)</u>

1. Revisit to confirm if performance has improved since introduction of referral direct into MAU from GPs – confirm with ED and South Coast Ambulance Service (SCAS)
2. Use of a pool of Healthcare Assistants to support patients on arrival via ambulance to free ambulance crew up to attend another call.
3. Implement phone messaging / handling system for the public.
4. Confirm reasons why funding not available for 8 unfunded beds.
5. Make signage dementia friendly.

3. Location: Ambulatory Unit

Observations:
The Ambulatory Unit has been devised to take referrals from ED for those patients who are not too seriously ill and who can arrive there themselves. Patients are seen on an appointment basis via the established Consultant led service. The unit is open 8am-8pm, 7 days a week, and also operates clinics for treatments such as blood transfusions and abdomen drainage.

The unit currently sees over 30 patients on a typical day and is located in what was formerly the discharge lounge for the QA.

In terms of the environment, observations were that it had quite a cold clinical feel, with quite large open spaces and not much privacy. The question arose over whether the unit was too big (as we were unsure of future plans for the best use of the space). We were made aware that work is planned to improve the area but it is frustrating to note that given the size of the area, the staff are not able to see the full potential capacity of patients (potentially an extra 30-50) due to lack of skill set available in the current staff team. This led us to query whether the unit was in fact ready to open when it did, and what was the effect on the patient experience within the discharge lounge which had to move to smaller 'premises' to make way for this unit.

With the need for more skilled staff, we were unsure if the unit had made a positive impact on the flow through triage/ED and out of the QA.

Recommendations / request for more information (Ambulatory Unit)

1. What are the plans to upskill staff team to increase capacity of the unit to take more referrals?
2. What are the plans to improve the environment to make it more comfortable and warm for patients during their wait and treatment?

4. Location: D2/D3 Wards

Observations:
Admissions into D2 seem to generally arrive from ED/MAU with the intention that patients are staying for a short period of time before moving to D3 to undergo rehab and prepare to return home or be admitted to a longer term ward depending on their circumstances.

Staff seek to work with patients based on individual needs to support recovery and successful discharge. However, it seems the 'This is me' protocol of documenting a patient's specific needs, something that should follow the patient on their journey through the hospital, is not used consistently, missing an opportunity to provide suitable tailored care, which would improve the patient experience.

There did seem to be a challenge for staff to be able to split their time appropriately between pro-active quality care and more 'operational' or 'fire-fighting' duties such as moving patients on, arranging transport and implementing system changes. This was also seemingly impacted by the increase in patients with mental ill health and reduced support available from other services in supporting patients on the ward when mentally unwell - all impacting how staff are able to plan and reflect on patient progress to really focus on tailoring and providing person-centred care.

With regards to discharges, we were informed care assessments take place as required and funding is available for care packages but the issue centres on there not being the providers / placements to provide the care, meaning patients remain in hospital when they could be discharged to a more suitable location. It also seems that nursing homes are turning down referrals but it was unclear what these were for and whether support from local authority colleagues could overcome this. Another avenue could be re-ablement via the 'extra care' model or registered care (similar to the model One Housing has established with its local CCG in London - http://www.onehousing.co.uk/roseberry-mansions-reablement-service).

Feedback suggested a need for staff (including Social Workers) to know about whether any carers are involved in the life of the patient and awareness of the need to involve them, as appropriate, in care provision and discharge planning at the earliest point. We were unsure if staff were aware of the importance of this and about other support mechanisms, including the Carers Centre, in supporting carers through this process.

It was unclear how long the process of using D2 as the acute ward and D3 as a 'step down' ward had been in place but it seemed staff had been developing good working partnerships with other agencies to improve discharge opportunities for patients. This seemed to be in the early stages of producing some real joined up care which could potentially reduce the lengths of stays. However, this optimism was tapered by news about plans to change D2 to a maximum 72 hours stay unit, aiming to discharge 17 patients each day. We were uncertain of how much engagement there had been with staff and patients about this change, as it seemed little was known about exact plans, similar to when changes were made the week before regarding GPs being able to refer directly into MAU, which had already seemed to have had a knock-on effect of increasing referrals into D2 from ED. It seemed therefore that co-ordination of changes to the way the 'flow' works through QA are possibly not considered at a front-line level, with a potential need to better involve staff and patients to increase positive outcomes and reduce the negative impact of changes on sections of the 'flow' further up the pathway.

Recommendations / request for more information (D2/D3)

1. Consistent roll-out and use of the 'This is me' protocols.
2. Access support for patients with mental ill health.
3. Investigate barriers to discharge to nursing homes with local authority colleagues.

4. Explore other housing options for re-ablement with local authority colleagues and what works in other localities (including via www.housinglin.org.uk).
5. Improve awareness of the role of carers and carers support networks.
6. Greater engagement with patients and staff over potential changes and impact of these changes further up the pathway.

5. Location: Discharge Lounge

Observations:
This was the most disappointing area observed during the walk through. The staff were eager and keen to provide a great service but were hampered by the poor facilities for patients to wait comfortably before leaving the hospital, many of whom are still recovering in some way from treatment – the area was very small with poor natural light and little opportunity to respect patients' privacy / confidentiality. One patient, who had been settled during her stay in the hospital, was reduced to pacing up and down the corridor with her husband whilst waiting for transport home as she was so agitated. As the lounge is only open until 7.30 pm, but hospital transport runs until midnight, there had been occasions where staff have been required to work late or return patients to the ward before transport arrived.

We were informed there had been changes to the way hospital transport was arranged but we question whether this has been for the better when there now doesn't seem to be the flexibility for staff to re-prioritise patients based on their circumstances as would previously have been the case. Patients can be discharged from their ward in the morning, where they have been comfortable, but then are required to wait for many hours in an environment that is busy and crampt – which is not likely to leave them with a good parting view of the way they have been treated.

We also question the process followed to move the discharge lounge from the larger area (now occupied by the Ambulatory Unit). We understand the need to improve the flow generally through the hospital, but query the negative impact on patient experience through re-homing the discharge lounge in such a small and poor environment, further away from external doors to access the outside and ultimately to leave the building.

It seems there is a new area being arranged for better provision of this facility but it was unclear when or where this would be – which suggested there may have been little engagement with discharge lounge staff to help inform decisions around processes and design.

Despite this, it was recognised that arranging for medication to be ordered and provided by the discharging ward had reduced waiting times for discharge. However, there was seemingly still an expectation from some patients (and family members) that transport home was a right rather than

based on assessed need – something that might be useful to increase awareness of to help manage patient expectations at point of discharge.

Recommendations / request for more information (Discharge Lounge)

1. More control over transport arrangements by discharge lounge team.
2. Greater patient and staff engagement over proposed changes – to give opportunity to explore impact and what works and does not work on the ground.
3. Improve patients' understanding of access to patient transport and what they can expect if offered this service.

6. General observations

During the visit, there were general themes that seemed to apply to all areas of the pathway. These included:

1. The pathway which patients come through the QA are varied – it might be helpful to produce information to confirm what the main routes are.
2. We were unsure of what information is provided to patients regarding each area of the hospital. It might be helpful to produce literature to explain the function of individual wards / units to help patients understand the aims of each and how they raise a query over their care. A 'What to bring to hospital' leaflet may also benefit patients/visitors for future admissions.
3. Dementia friendly signage was highlighted in the MAU but one key improvement for all sections visited would be the use of this signage for all patients and visitors, to help orientate people and inform them about the services and service standards they can expect.
4. With regards to the displaying of information, there seemed to be many different charts and posters on walls but we were unsure how meaningful this information was to improve the patient experience of being in the QA. Has this information been reviewed by patient representatives or is it aimed at staff? The challenge might be that walls are not viewed as key places to gain information as when a patient is travelling from one location to another in hospital, they may only be concentrating on getting to their destination rather than picking up data on the way.

SUMMARY & CONCLUSION:

Healthwatch Portsmouth visited the QA Hospital to better understand the pathway through ED and related departments to see how the patient experience might be improved. As a snap-shot, the team has made a number of recommendations that may enhance the quality of care and improve the 'flow' through these areas.

Key themes centre on:

- The knock-on effect of one change in the pathway on others areas further up the 'flow' – that this is not always a positive one.
- The importance of patient and staff engagement in planning and implementing change.
- Information and communication with patients before, during and after their admission.
- The need to increase discharge options.
- The need to improve the environment which patients wait to leave the hospital.

This report was been shared with PHT ahead of being made available to the public and other stakeholders via the Healthwatch Portsmouth website and other media. The responses from PHT have been included in Appendix One to this report.

NEXT STEPS:

This report forms the basis for follow up work by Healthwatch Portsmouth into supporting commissioners, providers and the public to improve the urgent care pathway in the city, which will include a specific exercise in around 3 months' time to assess progress in the key areas observed, raised and highlighted from this 'walk through' activity.

APPENDIX ONE:

Below is a summary of response received from Portsmouth Hospitals Trust (PHT) further to Healthwatch Portsmouth sharing a copy of this evaluation report with PHT staff to confirm accuracy and responses for requests for more information on specific points raised:

HealthWatch Portsmouth – comments on draft evaluation report

Page	**Point**	**Paragraph**	**Comment** (additions/amendments in red, strike through remove as not accurate)
7	N/A	Recommendations/requests for more information	1. Review the user friendliness of the check- in to see if improvements can be made to the technology used. The technology used for checking- in is in place to maintain the patients' privacy. Prior to this method (similar to that used in Post Offices etc.) patients would form a queue close to the person in front of them who were often trying to explain about embarrassing / personal conditions. The method we currently have enables one person to be at the desk at a time affording them as much privacy as possible. The signs at the front door have been assessed and will be improved in an attempt to make the system smoother. 2. Make information clearer re expected waiting times and what they relate to. The Department is looking into purchasing a screen above the front door of the entrance to Minors. This will display the waiting time in Minors and Majors, also the times at Gosport Minor Injuries Unit. We are unable to display the time at St Marys Minor Injuries Unit. We would like to provide the telephone number to enable potential patients to call. This will help inform the patients and ensure a longer wait time does not come as a surprise – it may enable them to make an informed decision about where they go. 3. Provide patients in corridors with call buttons to summon help if required. We aim to move patients rapidly to negate the need for queuing patients in the corridor. We employ 2 technicians from the ambulance service to ensure that the people in the queue are observed. There is also a trained nurse overseeing these technicians. It is expected that the nurse or technician makes themselves visible to the patients and is available to provide assistance.

			4. Use a pool of Health Care Assistants to support patients re toilet and refreshment needs, take basic observations, move to other departments (in absence of porters) provide reassurance re anxiety. The Emergency Department is currently reviewing the workforce and we will be employing staff to track the passage of patients through the department. This will then release time for the Support Workers to care for patients needs and also to assist with essential nursing care. We will also be altering the way we work in the Emergency Department which will reduce the number of times a patient is moved. This will also help with on-going care of patients as it gives the nurses time to develop a rapport with their patient rather than moving from the queue into majors. 5. Confirm if "Jumbulance" is used and in what circumstances. I can confirm that the "Jumbulance" is no longer in use and will not be used in the future. 6. Provide triage/treatment where appropriate in ambulances ahead of admission into ED. Presently the nursing team do go out to the ambulances and carry out ECGs and observations. The ECGs are then read by one of the senior doctors in the Department. If the patient needs any treatments the patient will be brought in to the Department. If it is appropriate, that patient will then be given the next available space. 7. Confirm specific role of "Silver Command." The Department has an "Escalation Policy" and the role of Silver command is described in that document. It would be expected that each senior nurse responsible for taking charge of the Department would be aware of this. A communication will go out to the senior nurses advising them of this and it would be expected that this information would be passed on to the teams of nurses. 8. Confirm reasons for decision to implement standalone IT system rather than one that is used by other health agencies in the city. The decision to implement this system followed a period of consultation and discussion and robust tender process in line with NHS procurement and also visits to observe other Emergency Departments and the systems employed. It should be understood

			that the system was employed for the Emergency Department and works very well for this. We are continually updating and refining the system to fit the specific needs of the ED.
8	2	1. Observations *The MAU is used for a number of reasons to help reduce demand on ED. It seems to be used in the main for the following:* • *GP referral for urgent care (by-passing ED)* • *Patients needing tests or treatment without the need for attention in ED* • Patients waiting for admission into hospital • *Patients attending out-patient clinics such as TIA, alcohol misuse*	There are some points from the review in the Medical Assessment Unit which were inaccurate or required clarifying. The patients who are referred for urgent care are medical patients. This is inaccurate, medical patients require tests as part of their on-going treatment, not as a bypass to the Emergency Department. These patients would be waiting for a medical admission. While the physical space for these clinics is housed by MAU, the service is not part of MAU.
8	N/A	Recommendations/request for more information	2. Use of a pool of Healthcare Assistants to support patients on arrival via ambulance to free ambulance crew up to attend another call. Action: Additional HCSWs requested for late shifts to work with Take Teams and commence investigations for GP patients arriving in AMU 3. Implement phone messaging / handling system for the public. We will suggest this to the Senior Management team and plan to discuss with our Administration Team. 4. Confirm reasons why funding not available for 8 unfunded beds. As this area is utilised when there is a higher demand for additional beds, it is only staffed when the bed space is required. The resources for this flexibility are not within the departmental budget. 5. Make signage dementia friendly. We are currently working with Department of Medicine for Older People to look at ways to improve both dementia care and environment on AMU.

		3 "*It was felt that the MAU provides patients the opportunity to be seen by Consultants"*	This is due to patients arriving during the day rather than in larger batches once or twice a day, which enables quicker referrals on for tests.
9	N/A	Recommendations/requests for further information	1. What are the plans to up skill staff team to increase capacity of the unit to take more referrals? Staff will rotate to ensure exposure to skills required for the ambulatory area. In addition to this our Nurse Consultant and Senior Sisters are working together to establish competencies of staff working in ambulatory area. 2. What are the plans to improve the environment to make it more comfortable and warm for patients during their wait and treatment? We currently have building/redesign plans in draft format – we are awaiting funding approval and before work to go ahead.
9	3	Observations *Admissions into D2 seem to generally arrive from ED/MAU with the intention that patients are staying for a short period of time before moving to D3 to undergo rehab and prepare to return home or be admitted to a longer term ward depending on their circumstances.* *Staff seek to work with patients based on individual needs to support recovery and successful discharge. However, it seems the 'This is me' protocol of documenting a patient's specific needs, something that should follow the patient on their journey through the hospital, is not used consistently, missing an opportunity to provide suitable tailored care, which would improve the patient experience.* *It was unclear how long the*	There are some points from the review in the D2/D3 which were inaccurate or required clarifying. Patients are admitted to D2 from Ed & MAU - the patient would be either discharged from D2 or move to D3 if 'medically fit' for discharge (MFFD) or less acute. The 'This is me' documentation is only required for patients with a cognitive impairment and/or dementia. All patients have care plans which are individualised plans of care and cover activities of daily living.

		process of using D2 as the acute ward and D3 as a 'step down' ward had been in place *Plans to change D2 to a maximum 72 hours stay unit, aiming to discharge 17 patients each day. We were uncertain of how much engagement there had been with staff and patients about this change, as it seemed little was known about exact plans*	D3 has been a MFFD/Step down ward since August 2015. D2 is due to become a short stay ward, in response to recent data and intelligence regarding medical activity across the service. The move is anticipated to assist patient flow and aid better discharges for patients as there will be a dedicated pathway and process to follow. Little was known about the service, because at the time of the visit, the changes to D2 were in the infancy of planning. Our staff are kept up to date at all stages of planning to ensure they are involved in the change process.
10	N/A	Recommendations/requests for more information	1. Consistent roll-out and use of the 'This is me' protocols. As discussed above, the 'This is me' document is only used for patients with a specific cognitive need. 2. Access support for patients with mental ill health. Mental Health services can be difficult to access due to the criteria set by the service. As an organisation, we are working in partnership with Mental Health care provision to make improvements to access for all patients. 5. Improve awareness of the role of carers and carers support networks. We are working with the Patient Experience team to implement the Trust wide work streams supporting Carers. This includes utilising the carer support team that are based at the hospital.

11		Recommendations/requests for more information	1. More control over transport arrangements & 3. Improve patients understanding of access to patient transport and what they can expect if offered this service. The discharge lounge team is working with South Central Ambulance service; we have an ambulance liaison officer from SCAS is available on site Monday to Friday. Their role is to assist with patient concerns the discharge lounge team may have about specific patients that require priority in certain circumstances. 2. Greater patient and staff engagement over proposed changes. We are very pleased to say that the discharge lounge has since been relocated to a new unit, which offers a much more suitable environment for the care of our patients leaving hospital. At present work is underway in unison with patients, to further improve this area to ensure patient comfort, privacy & dignity, satisfaction and safety.
12	1	1	The pathway which patient come through the QA are varied – it might be helpful to produce information to confirm what the main routes are. It is acknowledged that the routes by which patient access the hospital are varied. They are also flexible, depending on the patient's needs and as such any information provided would need to reflect that. We will work with our patients and families to review the information currently provided on our website to establish any additional information that is required.
		2	We were unsure of what information is provided to patients regarding each area of the hospital. It might be helpful to produce literature to explain the function of individual wards/units to help patients understand the aims of each and how they raise a query over their care. A "What to bring into hospital" leaflet may also benefit patients/visitors for future admissions. The internet site provides core information on each department. Some individual wards/ units have their own introductory leaflet and we are working towards a standard template based on feedback from our patients and their families. There is information at ward level ("What to do if you're worried" leaflet), on the website (PALS) and PALS leaflets which encourage patients and their families to ask questions and raise a query or concern if necessary. "What to bring" information is available on the trust website under the "Your hospital stay" section. Elective patients are also provided with the leaflet

			with their letter advising of admission date.
		3	Dementia friendly signage was highlighted in the MAU but one key improvement for all sections visited would be the use of this signage for all patients and visitors, to help orientate people and inform then about the services and service standards they can expect. Currently, the Head of Nursing for our Medicine for Older Persons Department is working with MAU to look at how signage can be improved. These improvements will be added to the general improvement works that will be completed in MAU in the coming months.
		4	With regards to the displaying of information, there seemed to be many different charts and posters on walls but we were unsure how meaningful this information was to improve the patient experience of being in QA. Has this information been reviewed by patient representatives or is it aimed at staff? The challenge might be that walls are not viewed as key places to gain information as when a patient is travelling from one location to another in the hospital; they may be concentrating on getting to their destination rather than picking up data on the way. The ward information “dash boards” were designed in partnership with representatives of the local community last year. There is a mandated requirement for certain information to be publically available at ward/departmental level and we worked with patient representatives to ensure that we could make this as meaningful as possible. The information is also provided to provide families and other visitors with information about the wards which many have told us is useful.

For more information about Healthwatch Portsmouth, please contact the team at:

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- Post - c/o Learning Links, Unit 3, St Georges' Business Centre, St Georges' Square, Portsmouth PO1 3EY.