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Patient flow in an acute hospital: learning from system failures

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IN A NUTSHELL

The shocking story of Mr X's experience in the Royal Cornwall Hospital, and the response by senior staff to questions about it, show how patients can come to harm when they do not fit neatly into a one-size-fits-all policy designed to facilitate patient flow. Patients living with frailty or co-morbidity or who develop a wound infection may be particularly at risk.

Six system failures can be identified from this case:

1. The failure of staff to recognise Mr X's post-operation deterioration and respond accordingly. He was not monitored during the weekend immediately after his operation and his need for pain relief was not met.

2. The failure of Trust Board members to enquire into what went wrong and what lessons have been learned.

3. The failure of the policy to cover the need to monitor post-operation patients at weekends and offer steps to take if monitoring reveals grounds for concern.

4. The failure of the policy, which is highly prescriptive, to allow for unforeseen circumstances to do with individual patients (as opposed to a 'surge' in patient numbers), when the onus will fall on staff to show initiative and resourcefulness.

5. The failure of the policy to highlight shortages of the staff it calls for, such as therapy professionals, who have a major part to play in facilitating patient flow.

6. Crucially, the failure of the policy to relate to 'clinical pathways', which detail the steps in a course of treatment for a patient. In a minority of cases, typically of people living with frailty or co-morbidities or in whom wound infection develops (Mr X seems to be an example), it becomes necessary to lengthen the patient's clinical pathway and consequently to defer discharge.

The hospital's patient flow policy clearly needs to be rethought. Clinicians and former patients should be fully involved in this process.

Mr X's treatment

Mr X was admitted to the Royal Cornwall Hospital (Treliske) one Friday in 2023 for an operation on his colon. By his account, which the Chief Nursing Officer has not disputed, 'the operation went well and the Surgical ward were excellent', but he was moved to another ward which he described as 'horrendous'. He reported: 'They had no pain relief that was prescribed for me by the anaesthetist, only paracetamol. I had severe diarrhoea [for] two days'. He evidently was not visited by a clinician and his condition was not monitored. On Monday different staff provided him with pain relief, but by then he was dehydrated and had to be put on a drip.

The following day, Tuesday, it was found that one of his wounds had become infected: he was given antibiotics and at 8pm he was sent home. On Thursday he was readmitted to the hospital, where the site of his operation was treated again: it needed to be 'opened up and cleaned out'.

Mr X posted a description of his experience on the 'participation platform' on the Care Quality Commission's website, where it could be seen by the public:[1] however, since the RCHT Board meeting described below access to it has been denied.

The hospital's patient flow policy

The latest version of the Royal Cornwall Hospital's patient flow policy has recently been published.[2] It is dated August 2023.

System failures

1. The failure of staff to recognise Mr X's post-operation deterioration and respond accordingly. He was not monitored during the weekend immediately after his operation and his need for pain relief was not met.

We can see that on the weekend after his initial operation, Mr X needed monitoring of his medical condition to check how he was recovering, and therapeutic care to help him recover from the trauma that he had experienced. Neither of these was provided for him. Instead he appears to have been simply 'parked' in a space that happened to be available.

2. The failure of Trust Board members to inquire into what went wrong and what lessons have been learned.

(1) At a meeting in public of the RCH Trust Board, details of Mr X's experience were not read out despite having been tabled as part of a question from the

public. So they were not heard by Board members and they are not recorded in the published minutes.[3]

(2) The Board was told by the Chief Nursing Officer (CNO), as we see and hear from the video recording of the meeting:[4] 'The patient always remains under the care of the operating consultant'. The consultant involved was not present at the meeting. This statement by the CNO does not appear in the published minutes of the meeting.

(3) The CNO said: 'It almost looked like Mr X had been transferred from a surgical ward to a medical ward but … the transfer was actually between two surgical wards which is really really interesting but gives no more information.' She also said there were 'things that didn't happen as we would expect', but gave no details. Again, no Board member commented.

(4) The CNO said too that patients 'will always get a named nurse so everyone is very very clear who is responsible for the care on that day', but she did not say whether there actually were named nurses responsible for Mr X's care at all hours during his weekend stay. Once again, no Board member commented.

(5) Nor did the CNO offer any answer to the question: 'What steps has RCHT taken to ensure that no-one else has the same experience as this patient?' Yet again, no Board member commented.

As we see, the tenor of the hospital's response to questions about Mr X's experience was very much defensive rather than illuminating. Very little information was volunteered, and Board members did not follow up answers or challenge them. The CQC's withdrawal of access to Mr X's story after questions were raised about it suggests that the CQC endorses the staff's defensive behaviour.

3. The failure of the policy to note the need to monitor post-operation patients at weekends and offer steps to take if monitoring reveals grounds for concern.

The hospital's patient flow policy is designed, it says, to 'create a regular and uninterrupted flow of patients across the Trust from admission through to discharge in a consistent way' (p.28). This makes no provision for people in Mr X's situation, whose operation is not entirely successful and who will inevitably find themselves obstructing the 'flow'. The hospital's reaction, intended or not, was to ignore him until his need for further treatment was inescapable.

4. The failure of the policy, which is highly prescriptive, to cope with unforeseen circumstances to do with individual patients (as opposed to a 'surge' in patient numbers), when the onus will fall on staff to show initiative and resourcefulness.

A prescriptive approach may well be appropriate to a hierarchical organization structured by links of accountability, and where one day's work is very much like another's, but it is not well suited to an organization where, on a day-to-day basis, demands change, new challenges are posed, there is continual learning, and staff working directly with patients may see old problems with fresh eyes and come up with original ideas for solving them.

Moreover, the hospital's patient flow policy does not incorporate any means of systematically evaluating the policy or even 'flagging up' awkward cases like that of Mr X. Its authors have set out as targets the steps that every member of staff must take: it is implicitly assumed that if everyone fulfils their allotted task everything will go according to plan. This simply does not work out in practice, as the need for clinical pathways tailored to individual patients demonstrates (see 5 & 6 below).

5. The failure of the policy to highlight shortages of the staff it calls for, such as therapy professionals, who have a major part to play in facilitating patient flow.

The patient flow policy stipulates that each ward will have a Morning Ward Round which is to include (among others) the Ward Consultant, Junior Doctors and Senior Nurse (all required) and Therapy Professionals *where available* (italics added). Evidently there are too few therapy professionals in post at the present time, but the policy ignores the issue that this presents: it does not, for example, say that incidences of their non-availability should be recorded.

The fact that it is regarded as acceptable to do without therapy professionals is significant. After an operation a patient requires not only monitoring of their medical condition but also therapeutic help, in the form of assistance with recovering their normal physical and psychological state and counteracting hospital-associated deconditioning (HAD).[5]These are necessary elements of a patient's post-operation 'journey', i.e. the clinical pathway[6] that they take through the hospital: someone may no longer meet medical 'criteria to reside' but at the same time not be fit to move elsewhere.[7] So it must be a matter of

concern that the presence of therapy professionals in ward rounds that will decide whether a patient is fit to be discharged is not regarded as essential.

And in the case of Mr X, therapy professionals might have warned against ‘Give him antibiotics and send him home’ as a prescription for him on the Tuesday evening after his operation. More generally, the opportunity was missed to make the case for establishing the role of therapy professionals in preparing patients for discharge.

6. Crucially, the failure of the policy to relate to ‘clinical pathways’, which detail the steps in a course of treatment for a patient. In a minority of cases, typically of people living with frailty or co-morbidities or in whom wound infection develops (Mr X seems to be an example), it becomes necessary to lengthen the patient’s clinical pathway and consequently to defer discharge. The term ‘clinical pathway’ nowhere appears in the patient flow policy document. Instead it uses ‘management-speak’: we read of four phases in a patient’s journey: ‘site management’, ‘presentation at a front door’, ‘care and treatment on ward’, and ‘discharge planning’. This classification is crude to the point of being unhelpful. For example, it does not distinguish between any of the steps along the clinical pathway.

Conclusion

The hospital’s patient flow policy clearly needs to be rethought. Clinicians and people with experience of being a patient should be fully involved in this process.

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References

[1] Care Quality Commission, CQC's participation platform, July 2023
https://cqc.citizenlab.co/en-GB/ideas/

[2] Royal Cornwall Hospitals NHS Trust, *Patient Flow Policy V4.0*, August 2023
https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/ChiefOperatingOfficer/PatientAccess/PatientFlowPolicy.pdf

[3] Royal Cornwall Hospitals NHS Trust, Meeting of the … Trust Board in public, *Minutes of the previous Board meeting held on 4 May 2023* p.27/30
https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/ChiefExecutive/TrustBoard/Minutes/2324/202307/AgendaPackBoardInPublicJuly2023.pdf

[4] Royal Cornwall Hospital, Board Meeting in Public 4 May 2023: VIDEO
https://www.youtube.com/watch?v=1ZaJu2W-oJk

[5] Sarah Hanson *et al*, *Evidence Briefing: Hospital-associated deconditioning*, June 2019
https://ueaeprints.uea.ac.uk/id/eprint/71832/1/Evidence_Briefing_HADS_Approved_FINAL_version.pdf

[6] Thomas Rotter *et al*, 'Clinical pathways as a quality strategy', in *Improving healthcare quality in Europe: characteristics, effectiveness and implementation of different strategies*, World Health Organization: Regional Office for Europe European Observatory on Health Systems and Policies, 1 October 2019
https://www.who.int/europe/publications/i/item/9789289051750

[7] Peter Levin, 'Medically fit for discharge' does not mean 'fit to go somewhere else', *BJGP Life*, 22 December 2022
https://spr4cornwall.net/wp-content/uploads/%E2%80%98Medically-fit-for-discharge-does-not-mean-%E2%80%98fit-to-go-somewhere-else-%E2%80%93-BJGP-Life.pdf