**GUIDANCE FOR PATIENT STORIES**

Patient stories are important to us as a Trust. Whilst an individual story is not representative of all patient experiences, each story is valid and brings a human dimension to what we do. Collectively, stories can help to build a picture of what it is like to be a patient receiving care, and how we can improve. Our aim is to use themes arising from patient stories to help us to identify priorities, and to make improvements for our patients. The patient story for the monthly Board meeting will be chosen from the directorate QOFP meetings, so please consider the following when choosing your story:

**Why have you chosen this story?** Stories should include an opportunity as to how we can learn, both as a directorate and a Trust. This does not mean that the story has to be an example of a negative patient experience – sometimes it might be a positive experience that a patient has had because you have changed something and you want to demonstrate the benefit of that change, or it might be something that you would like to change and you are presenting the story to show why. The story should reflect an important area on which you are focusing as a directorate, or on which we are focusing as a Trust. Occasionally, it might be appropriate to bring a staff / colleague story instead, if there is a strong link to improving the patient experience.

**Choosing a patient story.** In choosing a patient story, the mostimportant consideration is the story that the patient is telling. Some patients will be very willing to come and talk to Trust Board; others may be happy to be recorded (either on video or via a voice recording); others may prefer for their story to be presented via a letter or for one of the team involved to present the story on their behalf.

**Can we use groups of patients rather than one patient?** This may be appropriate in some instances but generally there is much more power in an individual patient story, although you might also want to include the experience of the patient’s family or carers.

**How should it be presented?** The story should be presented on the template attached. If you choose to give a presentation instead, the questions on the attached template should guide the content of that presentation. Please try to keep your story brief in the first instance

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| Directorate: Neighbourhoods | Date of QOFP Meeting: 17 May 2023 |
| Why have you chosen this story?  This is good example of the use of the **OPMH high dependency beds** in order to assess and stabilise a patient with dementia thus preventing an admission into Pyrland ward 2.  It also demonstrates close joint working between IDS and the care home provider. The situation has led to establishing a trusting and enhanced relationship between the home and IDS. | |
| Patient story (brief description of what happened)  Female patient with a diagnosis of dementia was assessed and supported by IDS in her home in the community. She is a fiercely independent lady. She was referred to IDS due to her non engagement with her carers in her own home and concern that she required placement but would be unlikely to agree to go anywhere. She has previous respite in a Specialist residential home however she absconded and refused to return.  Whilst open to IDS she had a 24 hour care package however she was locking her carers out of the house and reluctant to allow IDS staff in. No medication could be trialled at home as she would refuse to take this. Due to her absconding from previous respite and her fluctuating capacity several OPMH nursing homes had declined her for potential respite/placement. Family had power of attorney for finances but not health and wellbeing.  The OPMH High dependency beds at Immacolata House had just gone live. IDS completed an assessment recommending this lady was considered for one of these beds. This environment has high levels of staffing experienced with managing challenging behaviours associated with dementia. The lady was accepted by the home manager and working with the social worker and the lady’s son a transfer date was agreed. Her son took her into the home and she slept well the first night. DOL’s was applied for due to her fluctuating capacity.  The following morning she became very agitated and unsettled kicking the front door in and trying to abscond from the homes garden by climbing over raised flower beds as a means of escape. She was disorientated and recognised she was somewhere unfamiliar.  IDS were called and visited due to her acute escalated behaviour as the home were concerned they may not be able to continue with her stay and that she may need a MHAA and possible detention to hospital. IDS worked very closely with the home to prescribe medication and support them whilst the lady stabilised. Triggers to her wanting to leave were identified. Meaningful activity and engagement plans were developed with the patient and staff in the home. The lady was discussed daily in the morning OPMH bed call and IDS visited her every day. The home was also aware they could call IDS anytime between 8am and 8pm should they need support. It was explained to the home that IDS would support them to manage the lady but also there was a clear plan what the home should do outside of IDS working hours if the lady’s behaviours worsened or if her behaviour became risky to other residents.  IDS visited daily and titrated her medication. She began to calm which enabled the staff in the home to engage her in some meaningful activity which helped occupy her and reduce her risk of seeking to leave. Over a period of time the staff have really got to know this lady well and know how to respond when things are going so well for her.  This lady has settled and is now at a point where she can transfer into an OPMH nursing bed within the main part of the home. Staff have identified her enjoyment of gardening and when she transfers this will be into a room on the ground floor to enable this activity to continue. | |
| What three things did you learn from this patient’s story?  1. The importance of timely response and intensive input by IDS to support care homes when patients behaviours have escalated and where homes are struggling to manage.  2. The reassurance and confidence that a clear and transparent management plan can provide care home staff to enable then to manage and de-escalate challenging situations with IDS jointly working this.  3. The relationship between IDS and the home has significantly developed enabling positive risk management with IDS support. This will also help going forward as the home does seek advice or informally discuss other cases with IDS so may prevent a situation getting to the same level of acuity | |
| What actions have already been taken as a result of this story?  1.Effective working relationships continue to be maintained between the care home and IDS  2. The lady is awaiting a ground floor room within the home and then will become a permanent resident where staff already have a good knowledge of her personal needs, preferences and daily routine.  3. At the weekly PDF meeting we identified this to be a success story of these beds. | |
| What further actions (if any) are required?  1. To continue to join the daily pathway bed calls to enable prompt IDS input as required. | |
| Do you think that the patient involved (or their family) would be willing to tell their story to the Board, either in person or in some other way? If yes, please advise who the patient experience team should contact to extend the invite and any known adaptations required.  Patient is unable to due to her fluctuating capacity. | |