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'Care and compassion': why does it go wrong?

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This editorial is in response to *Care and Compassion*, the latest report published by the Parliamentary and Health Service Ombudsman (2011). The report identifies and discusses ten separate investigations following complaints regarding the care of older people within the NHS. Each account provides a unique story of the experiences faced by older people and their families during a period of ill health. Ann Abraham, Health Service Ombudsman for England, highlights that prior to this, each of the individuals referred to in the report led full, worthwhile lives, valued by themselves, their families and friends. Each case paints a disturbing picture of the consequences when things go wrong in the management and delivery of health care for older people whilst in hospital, during discharge and following discharge into the community. Unfortunately nine of the ten patients within the report died during the events outlined. It is essential that health-care staff learn from such incidents to improve service and care provided to individuals.

Throughout each of the ten cases outlined in the report, key themes emerge including communication, dignity and documentation. However, each theme has been previously identified within various policy documents aimed at improving care for older people; these include the National Service Framework for Older People (Department of Health (DH), 2001); the Stroke Strategy (DH, 2008a); The Dementia Strategy (2009) and Essence of Care (DH, 2010). The Ombudsman's report highlights examples where there were problems with communication and the sharing of information between health-care staff, patients and their families.

One such example is the case of Mrs Y where adequate information was not made available to the patient's GP to ensure appropriate care following discharge from hospital to home. Another example is the case of Mrs H who was partially sighted, deaf and communicated through British sign language; the Ombudsman found that information and care were not provided to meet her linguistic and cultural needs. Communication and information giving is highlighted as an important aspect of care (DH, 2008b). The DH (2008b) report outlined that all individuals with a long-term condition should have a personalized care plan which should be developed in agreement with the patient. In the cases presented by the Ombudsman's report, there is

evidence to suggest that this was not the case or indeed, if a care plan had been developed and agreed upon, it was not effectively implemented. The National Service Framework for Older People (DH, 2001) called for high quality integrated health and social care services for older people, a notion which is further developed in both the Stroke Strategy (DH, 2007) and the National Dementia Strategy (DH, 2009). Both strategies clearly articulated the importance of patients and their carers receiving 'good-quality' information throughout their journey of care.

The case of Mr L explores the lack of communication and inadequate documentation between health-care staff, the patient and their family. During his stay in hospital, Mr L received doses of medication which were considered to be higher than required, compromising his ability to make decisions about his care. Despite the fact it was acknowledged that the prescribed dose should have been amended, this was not documented appropriately.

The consequences of this breakdown of communication within the health-care team resulted in compromising Mr L's capacity to engage with them in any decision making. The Mental Capacity Act (2005) was introduced to ensure that those who lack capacity permanently or temporarily are treated fairly and that their wishes and values are respected. The Mental Capacity Act (2005) has been law for several years and other policy initiatives have been introduced which emphasize the need for information sharing and person-centred care (DH, 2001; DH, 2007; DH, 2009). However, the evidence suggests that in the case of Mr L, this was not applied.

Several cases described within the report demonstrate that health-care staff failed to maintain and respect patients' dignity. In 2001, the DH challenged every NHS organization and council with social service responsibilities to identify champions for older people, providing a tool kit to support champions (DH, 2001). The aim was for all older people coming into contact with health and social care services to be treated with respect, and regarded as partners in their care. However, more recently the Council and Care report (Passingham, 2010) identified that more support is still needed:

'Older people and their families have been extremely worried about the support (or lack of

it) available to their older relatives or friends who are starting to find it difficult to manage their finances or are struggling to make decisions about their care and support by themselves.’ (Passingham, 2010: 3)

Despite such emphasis on dignity, problems still persist. This is evidence of this in the case of Patient H, who whilst in hospital, was left in unfamiliar clothes held together with paper clips and had laundry bags, containing clothes belonging to another patient left with him. Additionally, the care of Mr R is identified whose symptom of pain was not managed effectively, resulting in distress and an undignified death. There is evidence that the patient assessment which should have informed his care plan, was not used appropriately and resulted in the patients care being described as ‘below an acceptable standard’.

The DH (2001) demonstrated the importance of high quality end of life care, recommending that health-care services should ensure patients’ preferences are recognized and that individualized care is provided. The DH also identified that patients and their families should receive appropriate information regarding symptom management including pain control (DH, 2001; DH 2008a). The theme of documentation or ineffective record keeping is apparent throughout each case in the report. However, it has only been a year since the publication of the NHS Care Record Guarantee (NHS, 2010), which aimed to ensure high quality care delivery.

Each of the ten cases outlined in the report are disturbing and have clearly resulted in distress amongst both the patients and their families. On reading this shameful report, it is difficult to comprehend how situations like this are possible in a developed country. The report raises many questions; what are the explanations for this lack of care? How can we improve the health service provided for our ageing population to deliver the effective care that is deserved?

Unfortunately these problems are not new and as identified above, there have been numerous policy initiatives developed in an attempt to prevent such failings in care. If such policies exist, why is the delivery of care lacking? Arguably it may be that additional resources are required to help reduce the risk of such events reoccurring. However, it appears that part of the problem may be the attitudes of some health-care staff and their understanding of their roles.

Perhaps the investigation of such incidents requires attention. Currently each complaint within the NHS

is examined in isolation, whereas health professionals deliver care in complex environments where there is a need to prioritize care. Complaints need to be placed in the context in which they occurred to identify the real causes of the problems and to allow for the identification of realistic resolutions. This is more important now, as life expectancies increase, than ever before considering there are 1.7 million more people over the age of 65 than there were 25 years ago (Parliamentary and Health Service Ombudsman, 2011). Ultimately this will lead to an ever increasing demand on health-care services. Therefore, the need to build an efficient service that recognizes and responds to changes in service demand without compromising standards is essential.

These cases either identify that current systems for providing safe care are inadequate, or that the systems or protocols were not followed appropriately. The context in which the care is delivered could be the key to such failings. Audit is one tool which can be used to monitor documentation and evaluate standards of care. Through analysis of audit data, health-care providers can identify potential risk factors which may

impact negatively on care, such as staff shortages or an inappropriate skill mix when clinical areas are busy.

The Ombudsman’s report should be taken seriously by all health-care providers and lessons must be learnt. It is essential that staff are educated in relation to effective communication and documentation skills and that all health-care areas ensure these mistakes are not repeated. Nurses, as the largest group of health providers, must reflect on the cases in this report and care for all patients as individuals with the philosophy ‘do unto others as you would have done unto you’.

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