

Community Engagement

BHRUT Patient Engagement project

Medical Receiving Unit (Acute medicine)

Patients' perspectives

July 2023



What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care in the London Borough of Havering. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Community Interest Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff, and by volunteers, both from professional health and social care backgrounds and lay people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your voice, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups, NHS Services and contractors, and the Local Authority to make sure their services really are designed to meet citizens' needs.

*'You make a living by what you get,
but you make a life by what you give.'*
Winston Churchill

Community engagement

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has a statutory duty to ascertain the views of health and social care services and to make them known to the commissioners and providers of those services so that they can be taken into account in the development, commissioning and delivery of services.

We do this in a variety of ways, such as surveys, interviews and focus groups.

We also participate, with other Healthwatch organisations across North East London, in the Community Insights System, which gathers views and comments on health and social care from people across the area. Intelligence gained from Community Insights is used directly in, or to inform, many of the surveys and other public engagement events that we carry out.

The results of our community engagement are shared with Havering Council, NHS North East London, NHS and other provider organisations and Healthwatch England.



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Introduction

Following the CQC inpatient visit findings, Barking Havering Redbridge Hospital Trust (BHRUT) are keen to improve the quality of care and patient experience across the hospital trust. In response to this BHRUT wanted an independent voice to speak to patients about their experiences of services provided by the trust and to explore patients' expectations of services and how these were met. BHRUT would use this to explore good practice and use the findings to improve areas where feedback showed changes need to be made.

There were six wards in total: Ash ward and Holly ward at King George Hospital, Goodmayes and Cornflower B ward, Ocean B ward, Sky B ward and the Medical Receiving Unit at Queen's Hospital, Romford.

Healthwatch Havering took the lead on two wards at Queen's Hospital: the Medical Receiving Unit (MRU) and Sky B ward.

This report reflects the findings from patients in the MRU, which is an intermediate service between the Emergency Department (A&E) and the ward to which a patient is admitted for longer-term treatment, which can take some time to arrange.

Research objectives

- To identify what is working well in each service area
- To identify what would improve patient experience
- Make recommendations based on feedback received from patients
- To explore patients' expectations of services and how these were met
- Provide a full report to BHRUT for each service area after a visit and telephone interviews.

Research approach

The research was carried out through:

- Face-to-face interviews conducted on the ward
- Telephone interviews (the aim was to conduct up to 10 interviews but, in the event, individuals' circumstances meant it proved impracticable to get that full number)

The differing nature of the wards and unit visited meant that there will not be a standard set of findings or recommendations; each ward and unit will have different requirements.

Methodology

The research was carried out in two steps:

- A questionnaire was devised, and questions were asked to patients on the ward, during the visit patients were asked if they would be happy to undertake a follow-up interview so we could explore their experience of the discharge pathway. The same questionnaire was used on each ward and the unit.
- A week later, individuals who had given permission were called, and exchanges over the phone were conversational and effective in obtaining high-quality feedback.

Summary of Demographics

The full demographic details of the respondents to this survey are set out in the Appendix. The principal details are summarised as follows:

<u>Age range</u>	<u>Respondents</u>
18-24	2
25-49	2
50-64	1
65-79	5
Declined to reply	3

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<u>Gender/identity</u>	<u>Respondents</u>
Man	7
Woman	4
Declined to reply	2

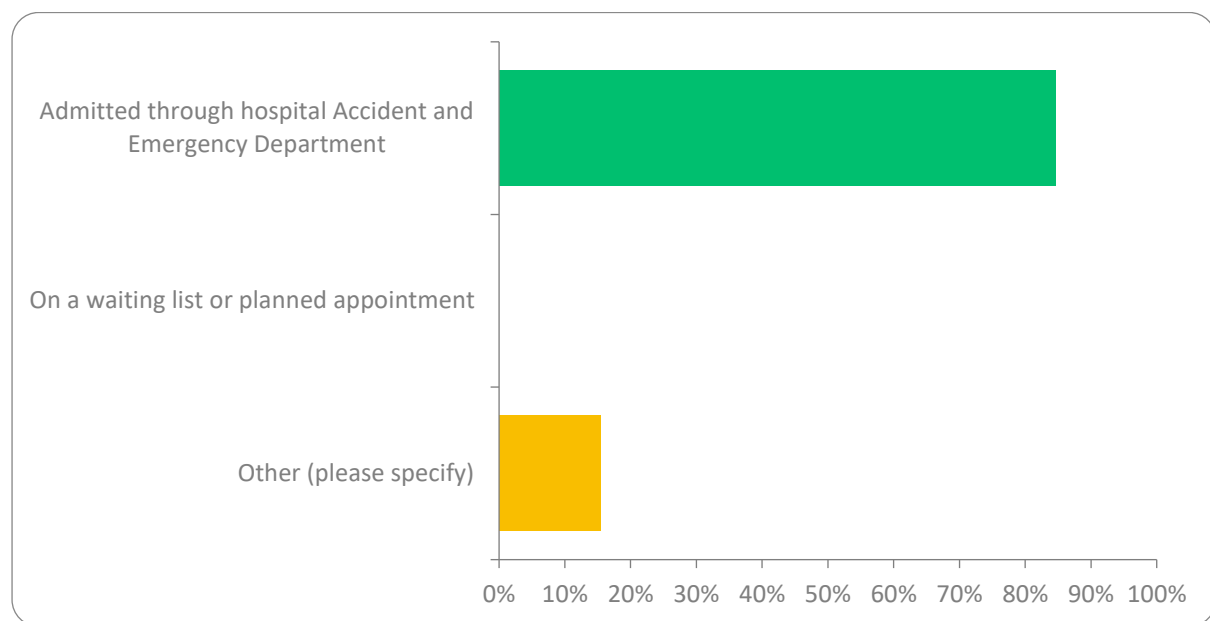
<u>Ethnicity</u>	<u>Respondents</u>
White British (etc)	9
Asian Indian	1
Asian other	1
Declined to reply	2

<u>Disabled</u>	<u>Respondents</u>
Yes	5
Prefer not to say	1
Declined to reply	7

Findings

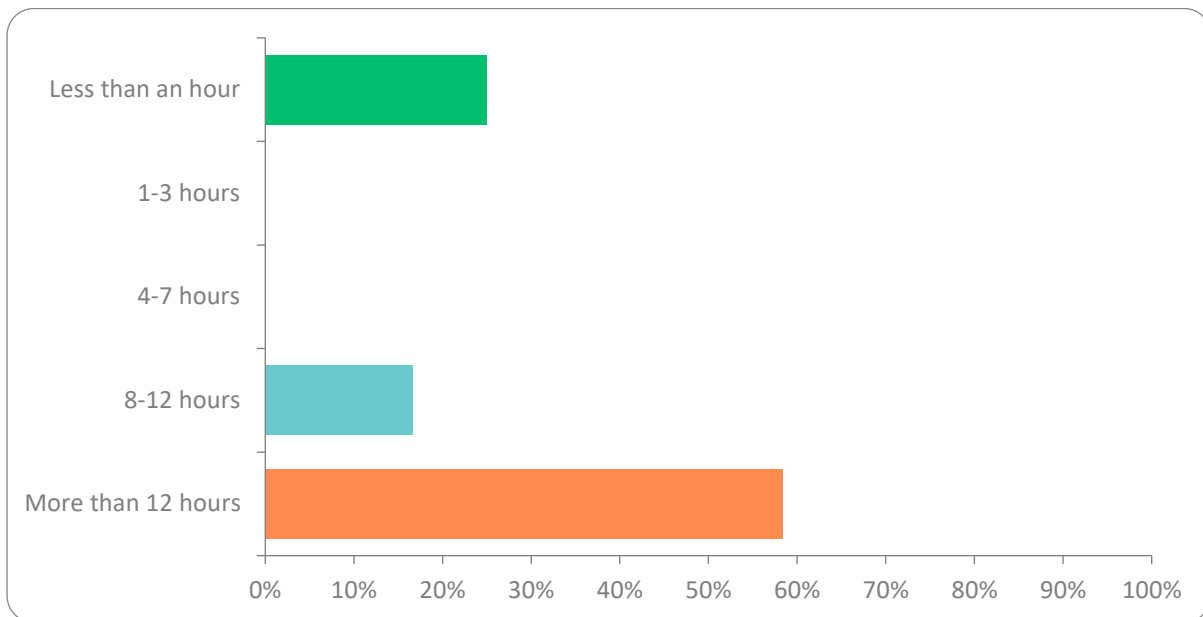
Healthwatch Representatives spoke to 13 patients during the visit.

Admission into hospital and ward



Given that the MRU is, in effect, a “halfway house” between the Emergency Department (A&E) and the appropriate in-patient ward, it was not surprising that all the patients we spoke to had been admitted following attendance at the A&E within the hospital. Most (85%) had visited A&E directly of their own accord but the remaining two (15%), had either been referred by their GP or brought into A&E by ambulance.

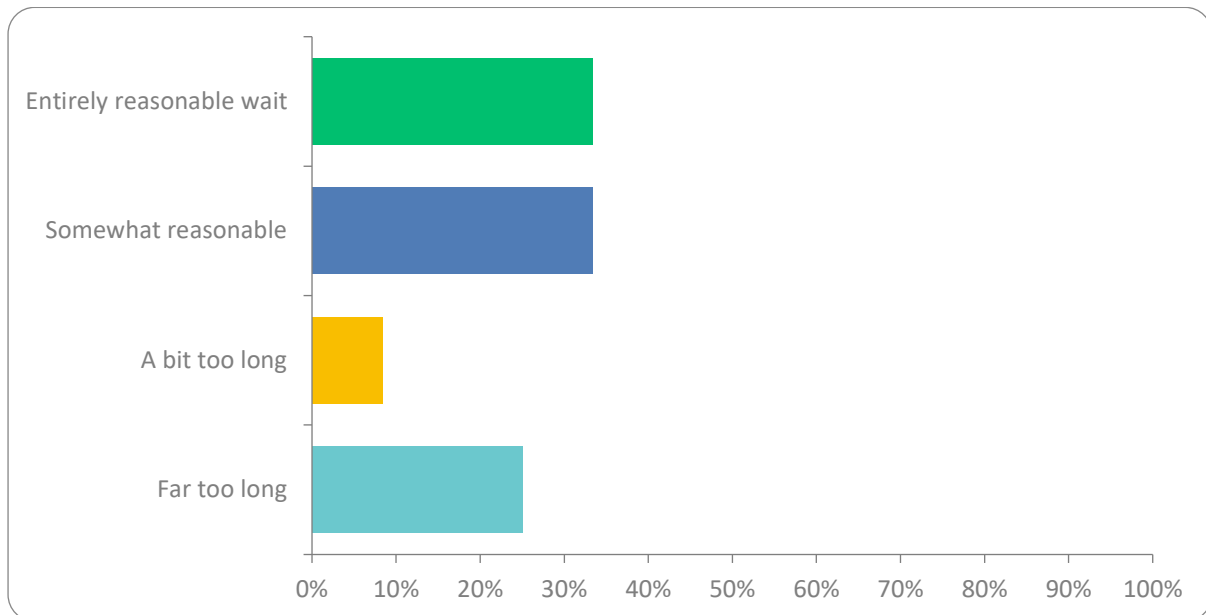
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We asked patients how long it had taken for them to receive a bed on the ward during the visit, measured from the time that the decision to admit them was made. They told us that their waits had varied from less than an hour (25%) to over 12 hours (58%), with 2 patients (17%) waiting between 8 and 12 hours.

The length of time that a patient must wait will vary according to demand and their individual circumstances, but by any measure, having to wait for over 12 hours before being placed in a unit such as the MRU is less than acceptable.

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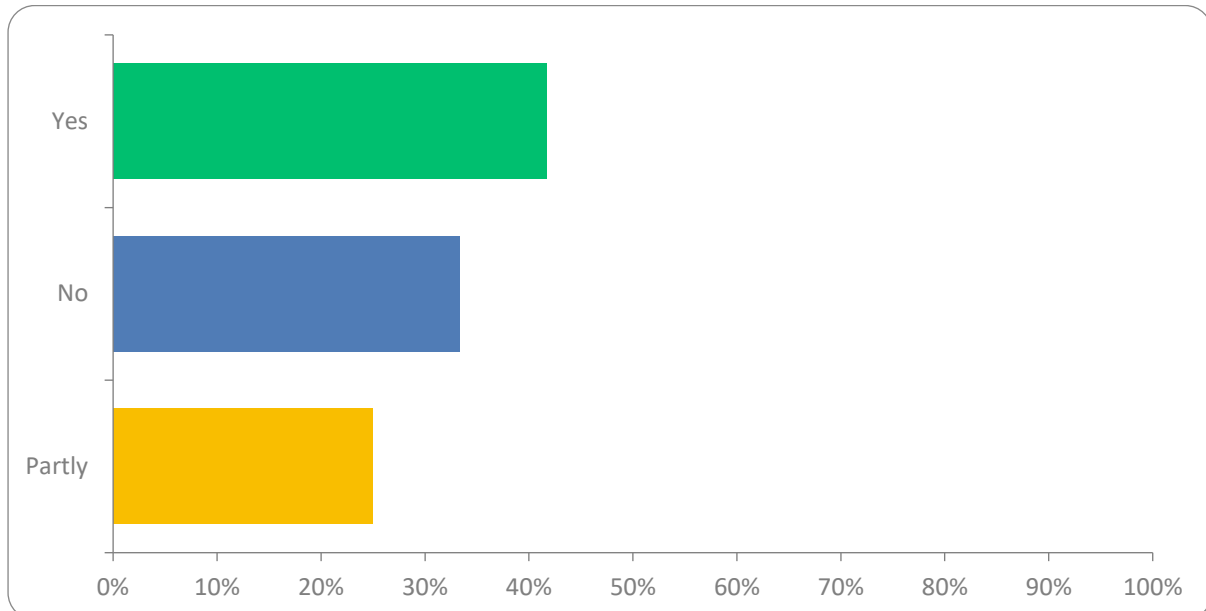


Most patients we spoke to considered that their wait was “reasonable” but 33% felt it was “too long”.

It should be noted that all the admissions to the MRU are, by definition, unplanned.

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The hospital environment



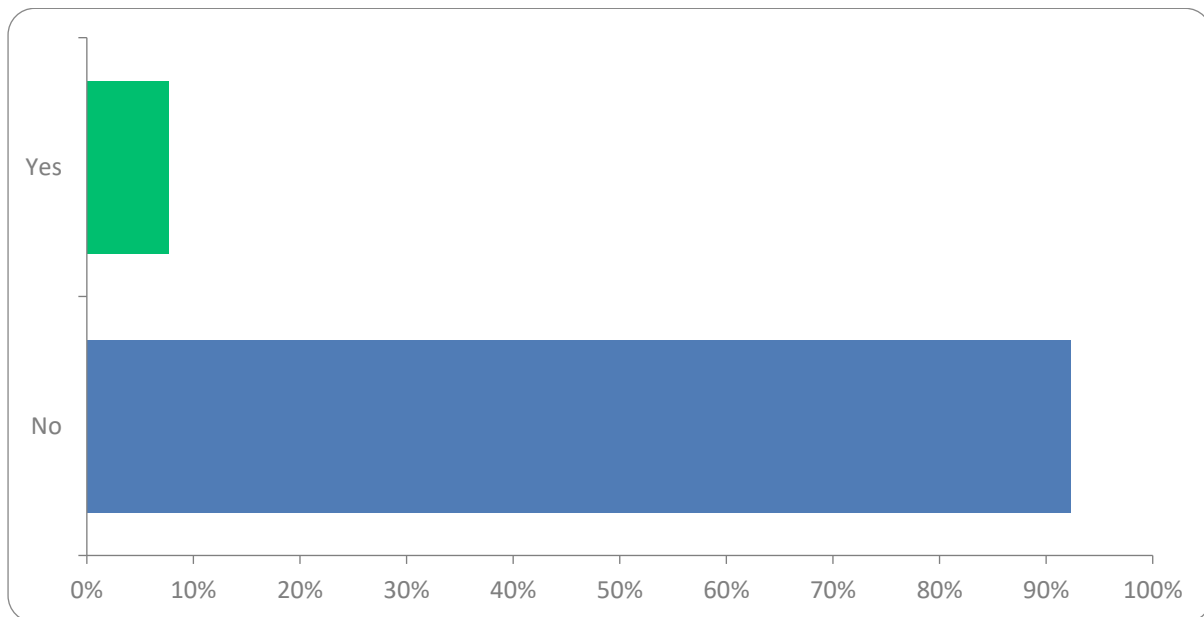
We asked patients how their sleep had been affected by being in hospital. Five (42%) told us that they had found their sleep disrupted while four (33%) had not been and 3 (25%) had found their sleep disrupted to some extent:

"Unfamiliar surroundings and therefore I could not sleep"

"The ward is too hot. There is no air. There is no window. There is no phone reception"

"Very noisy corridors"

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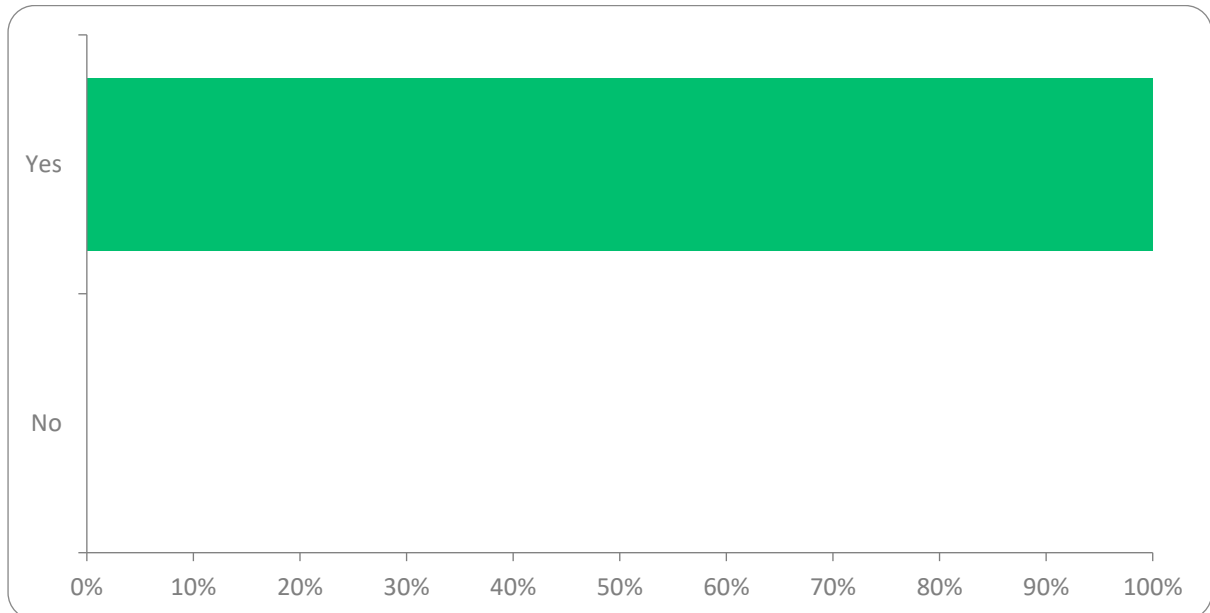


Of the respondents, only one (8%) reported that they had been moved during the night. This patient said that they were given no reason for the change:

"I was told just changing ward"

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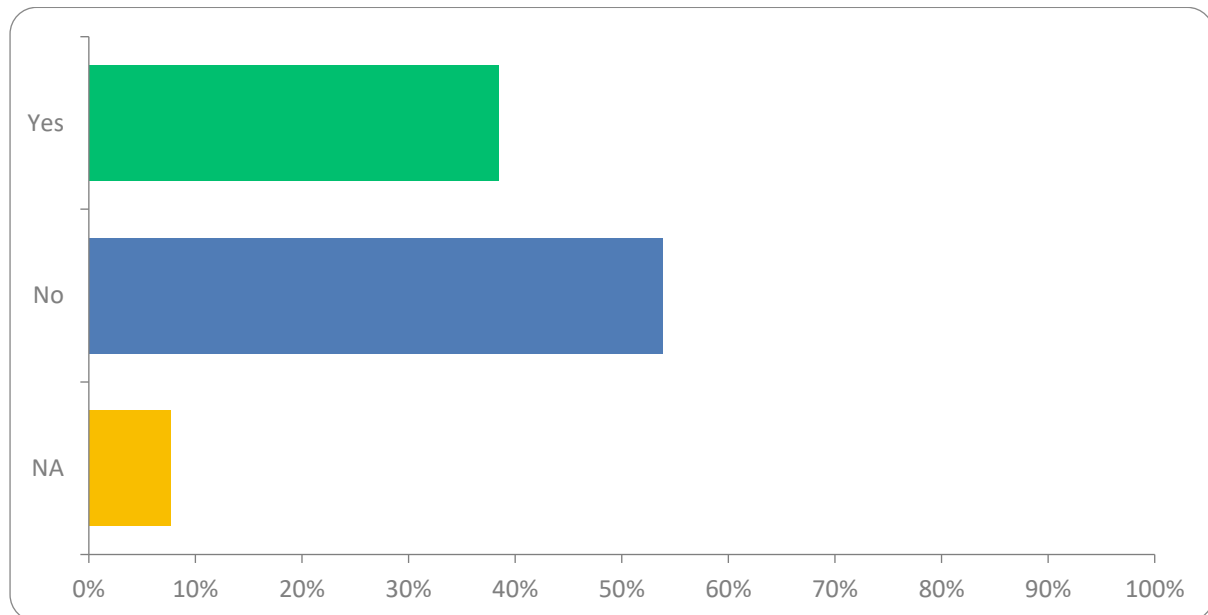
Hospital hygiene



All patients (100%) responded that the unit was clean during their stay. This shows that the unit is kept clean to a high standard, which enhances the patient experience during their stay.

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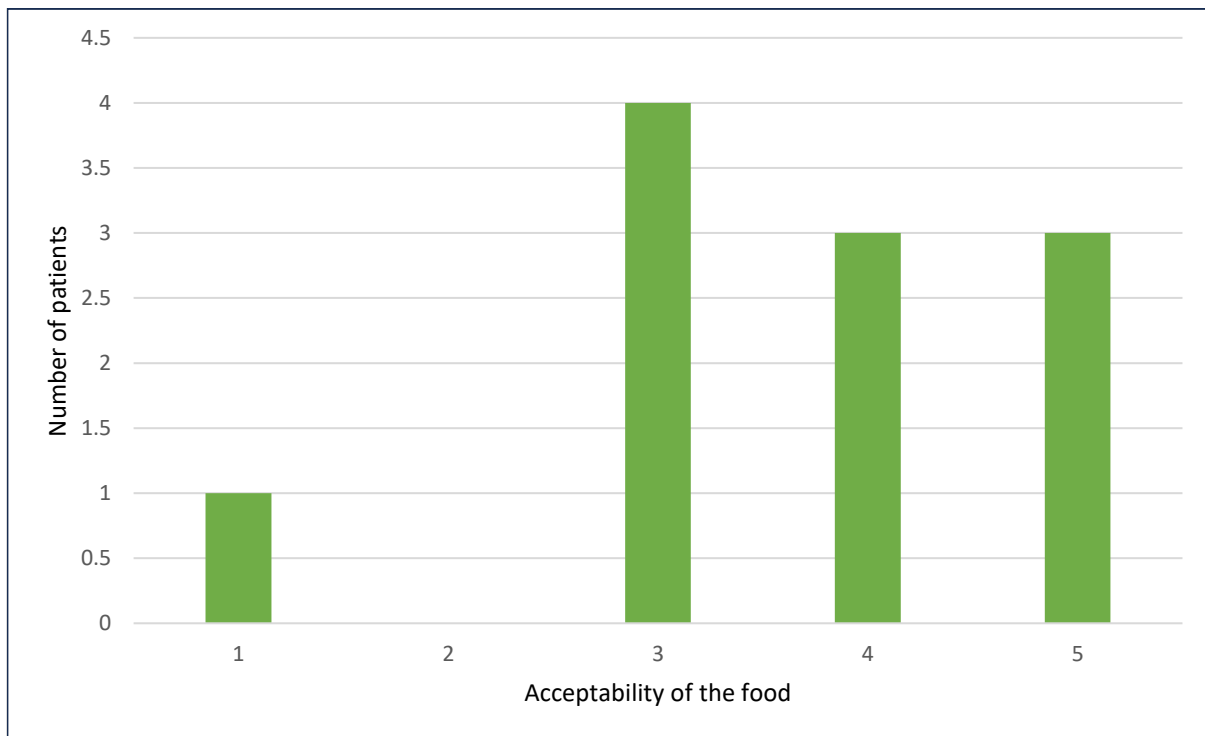
Food and Medicine



During the visit, 5 (38%) of the patients indicated that they were able to bring medication with them to the hospital and take it when they needed to. However, 7 (54%) told us that they were unable to take their own medication; one (8%) answered that this did not apply to them. According to research, many patients are unable to take the medication they took with them to the hospital; thus, it is important to ensure that everyone can continue their routine medical treatment as an inpatient (so far as doing that is not contra-indicated with the medications they need because of their treatment in the hospital).

Three patients declined to answer this question.

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Healthwatch representative asked the patients how they felt about the food provided by the hospital. Only one patient considered it very good; the rest rated it as 3 or higher (where the higher the number was, the less acceptable the food was). Their comments included:

"Love it. Have always liked hospital food"

"N/A only had a cold piece of toast"

"Used to spicier"

"Not eaten food as [I am] a vegetarian"

"Don't eat it. Only had cereal"

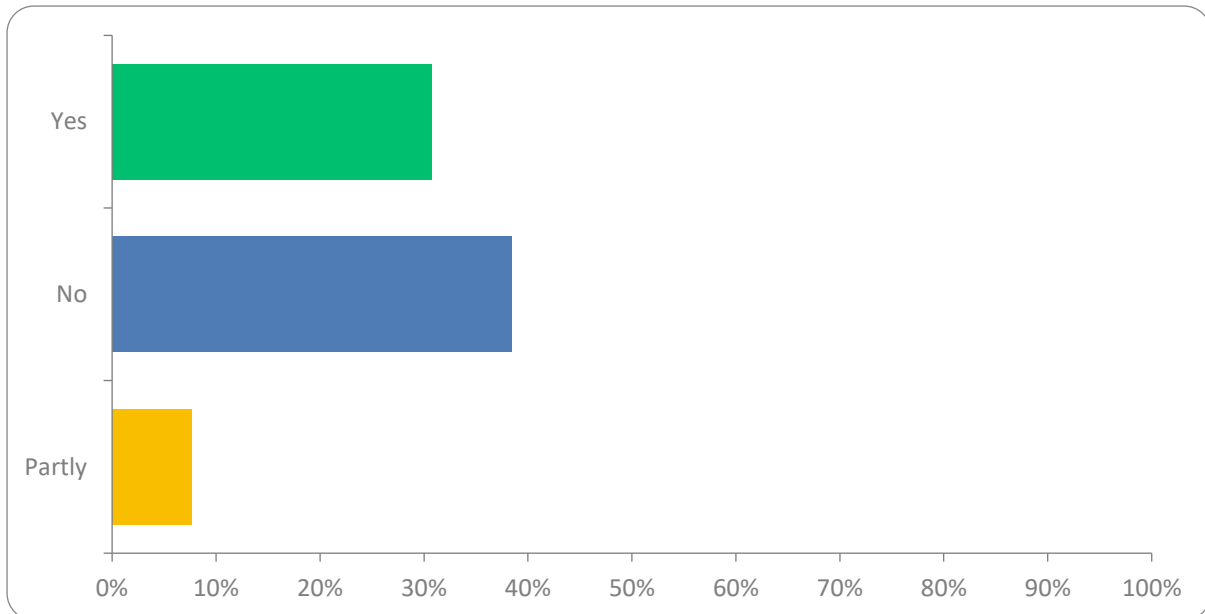
"Certain dislikes but it is fine"

"Choosing can be difficult"

"I eat because I am hungry"

"The food is OK"

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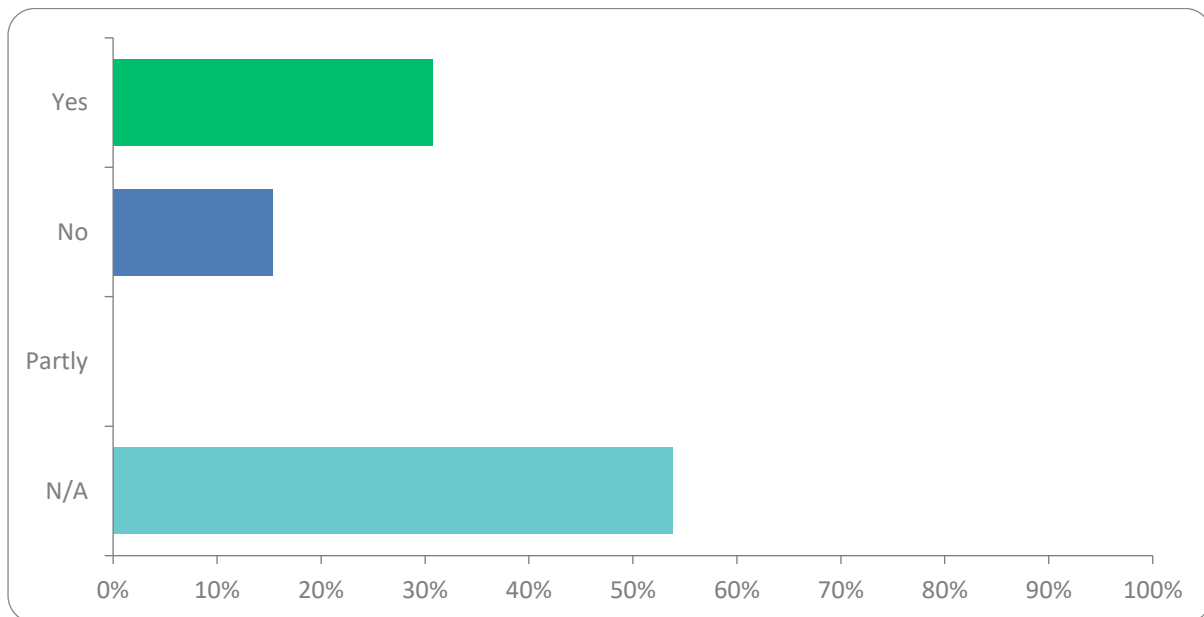
Bearing in mind that some people living in the Havering area have specific dietary requirements for religious reasons and others are vegetarian or vegan or have restricted diets for health reasons, it is important to ensure that those needs can be met.

The responses suggest that the dietary needs of only four patients (31%) were met to their satisfaction.

To guarantee that patients have a better experience eating hospital food, findings point to the need for more work to improve hospital meals.

Three patients declined to answer this question.

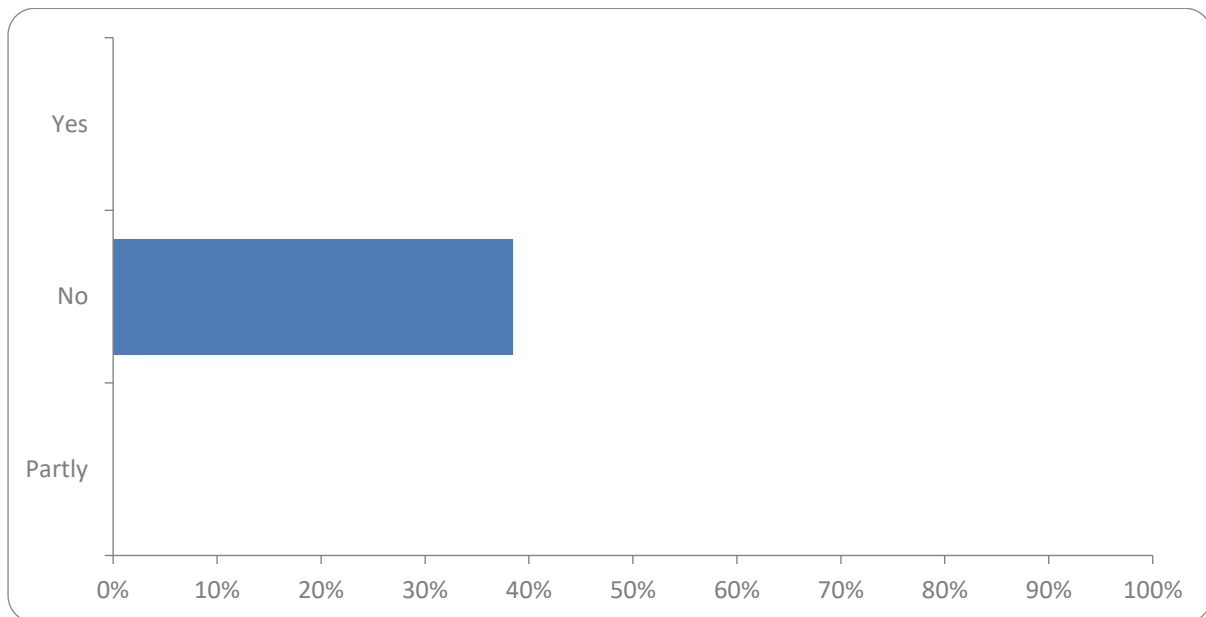
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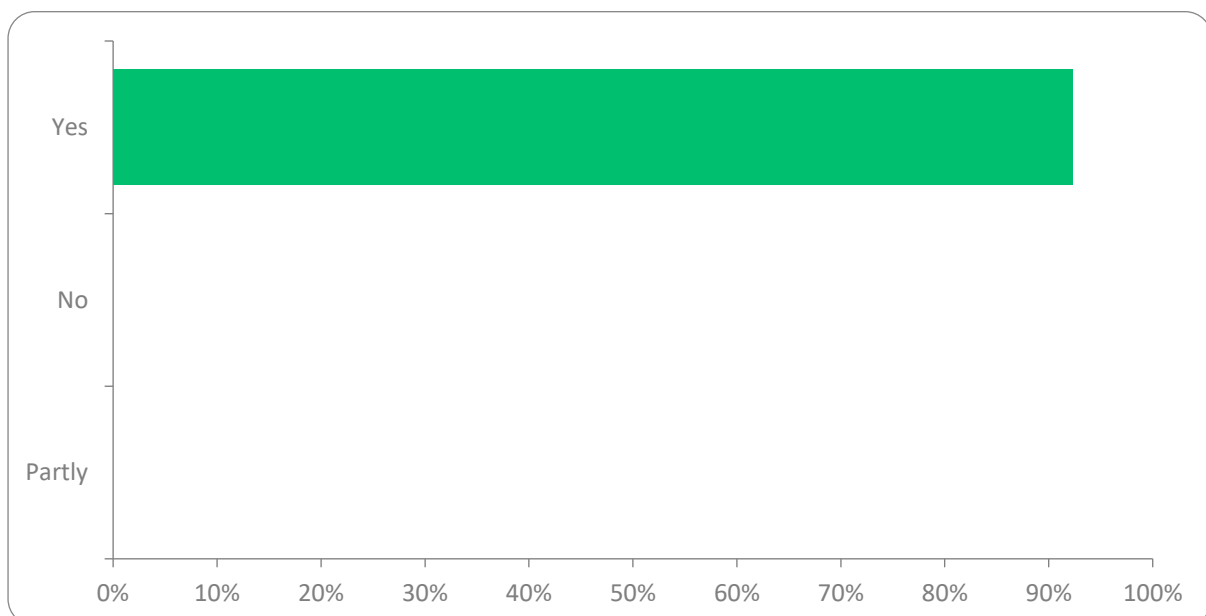
Four patients (33%) told us that hospital staff offered enough support for them to eat their meals if needed. Seven (54%) of the patients did not need any help as they were able to feed themselves.

Five (38%) patients told us they had not been offered assistance.

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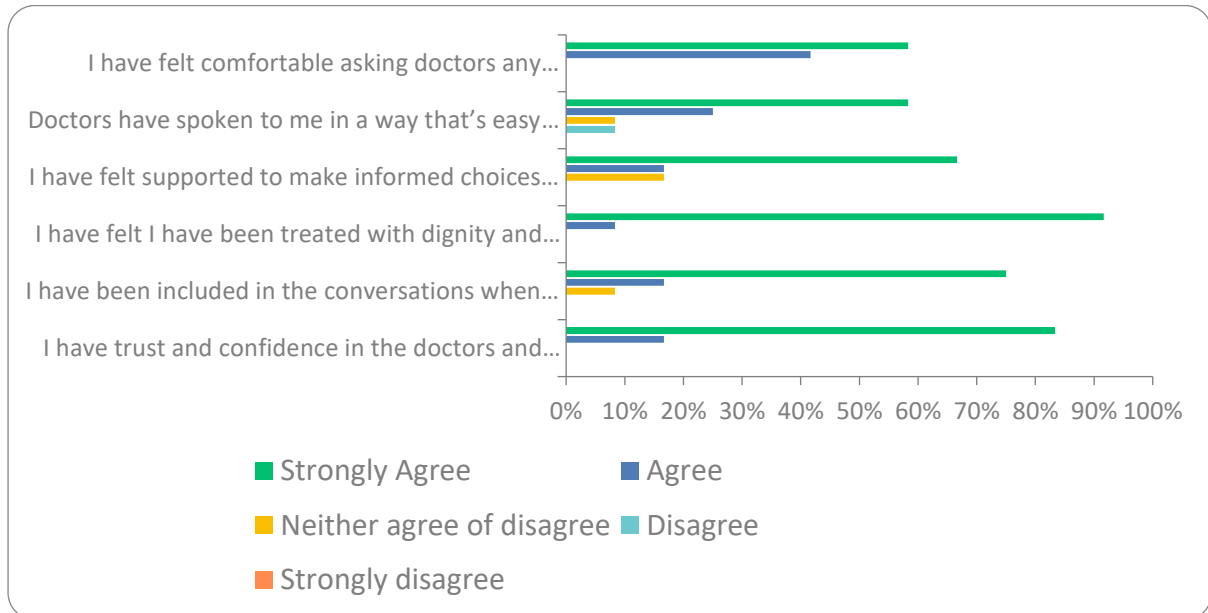
Five (38%) patients told us that they had not been able to eat other than during defined meal times.



Nearly all patients had been offered enough to drink – one declined to respond.

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Staff – Doctors and nurses



Most patients have great trust in their doctors. Nearly all of them – 92% – felt strongly that they were being treated with dignity and respect (and the rest did not disagree) and all told us that they had trust and confidence in the doctors. Only one patient reported feeling that they had not been spoken to in a way that they could easily understand. No one felt disrespected or ignored.

Patients told us:

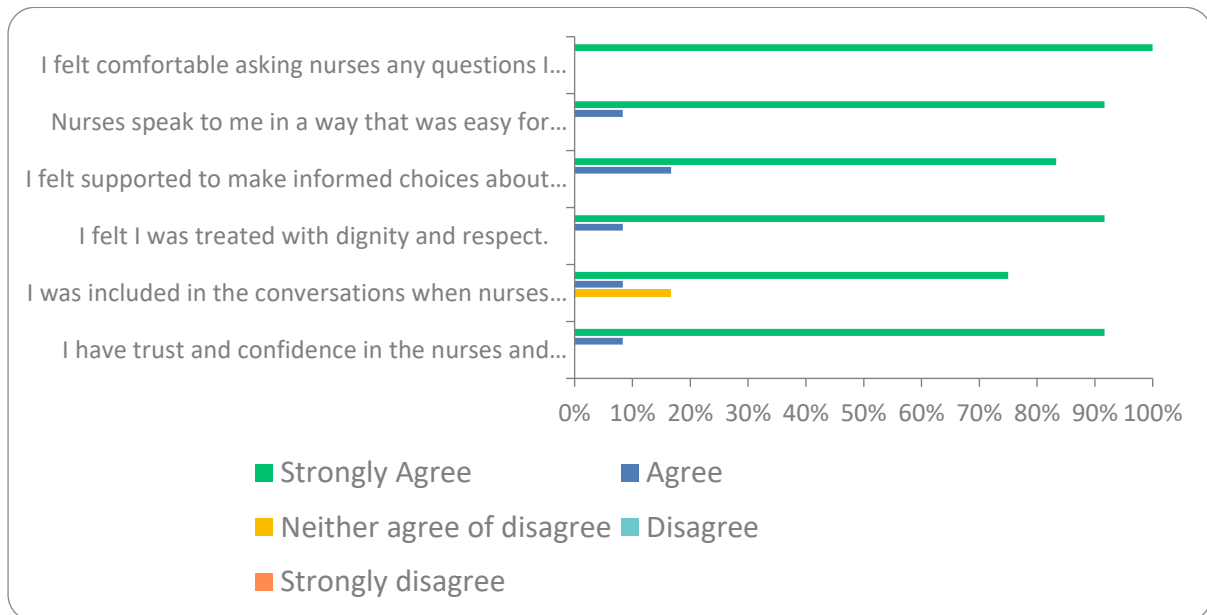
"Very good – understand what they are saying. I refused an MRI scan"

"Doctors have answered all questions to my satisfaction"

"Too much jargon"

"Some of the Doctors have been helpful re the above and some have not"

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All of the patients told us they felt comfortable asking nurses questions about their health, that nurses communicated well with them and that they felt treated with dignity and respect by the nursing staff. They said that nurses were:

"Very friendly - very good"

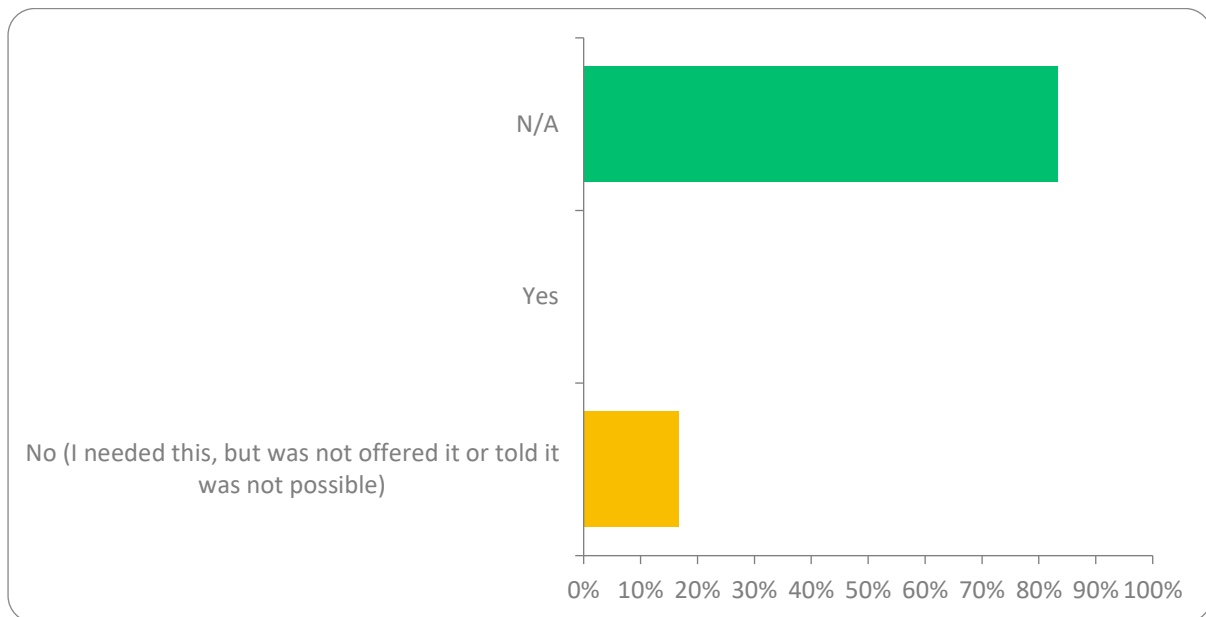
"Really good"

"Professional, responsive - always around. N.B. Nurse in A & E was initially unresponsive to request for medication. But came back and apologised"

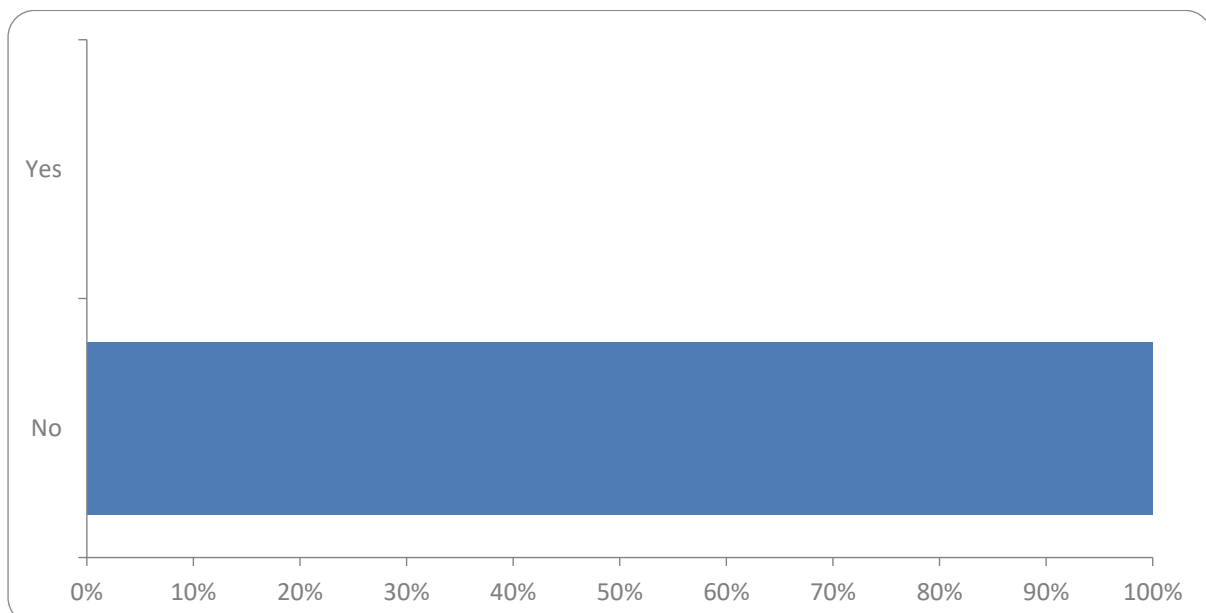
"100% fantastic"

"Really nice"

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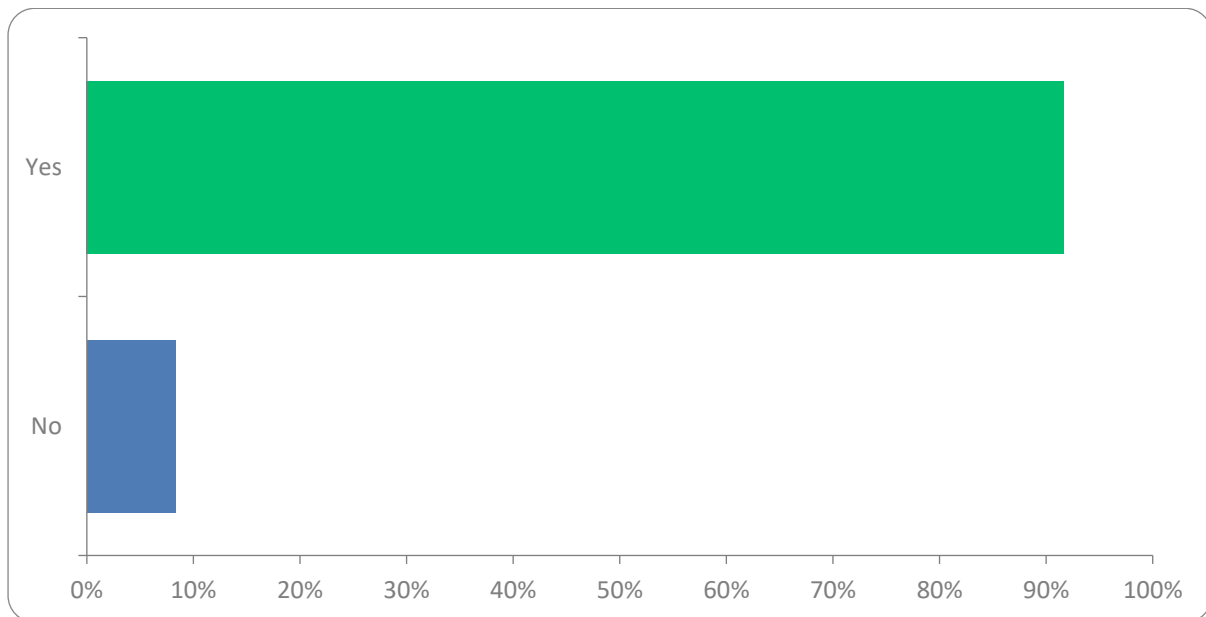


Only one patient told us that they needed, but had not been offered, an interpreter. They did not tell us why that was.



No patient told us that they had been given different information by different staff.

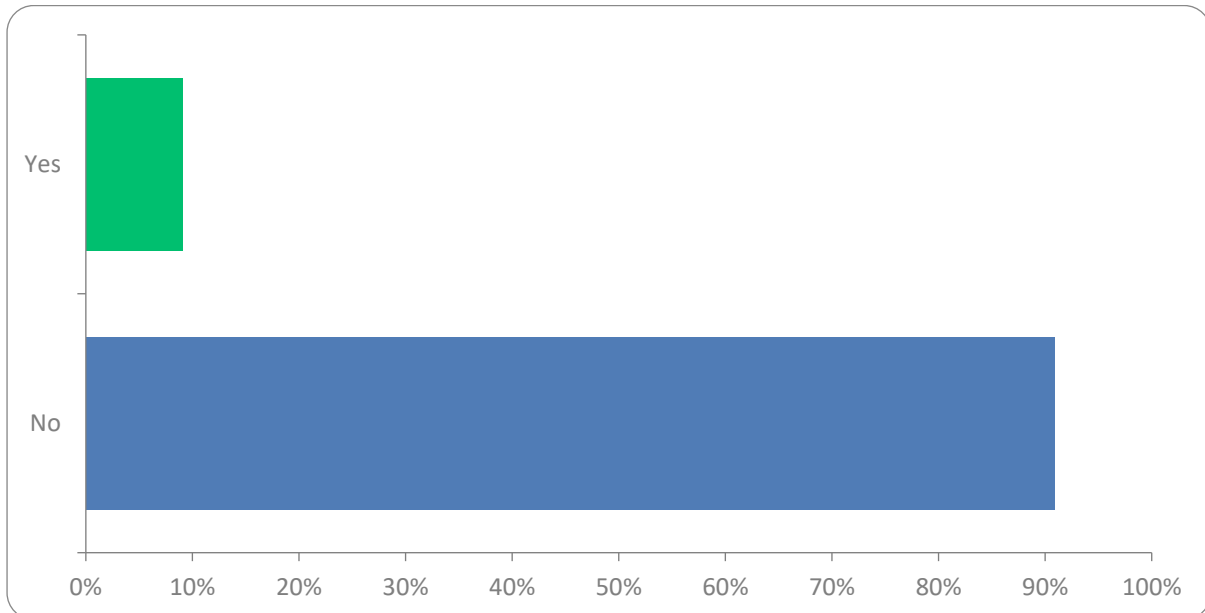
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Only one patient told us that they felt uncomfortable discussing their situation with staff – and that was because they were awaiting the arrival of a family member who would support them.

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Operations and Procedures



Only one respondent had needed an operation or procedure while in the hospital. That patient felt that their enquiries before the event had been answered well and that they had been told afterwards how the treatment had gone.

Overall impression of the stay in hospital

We asked our respondents whether they wished to add anything to what they had told us. Responses were positive and included:

"Very efficient"

"Lovely friendly. Someone to talk to"

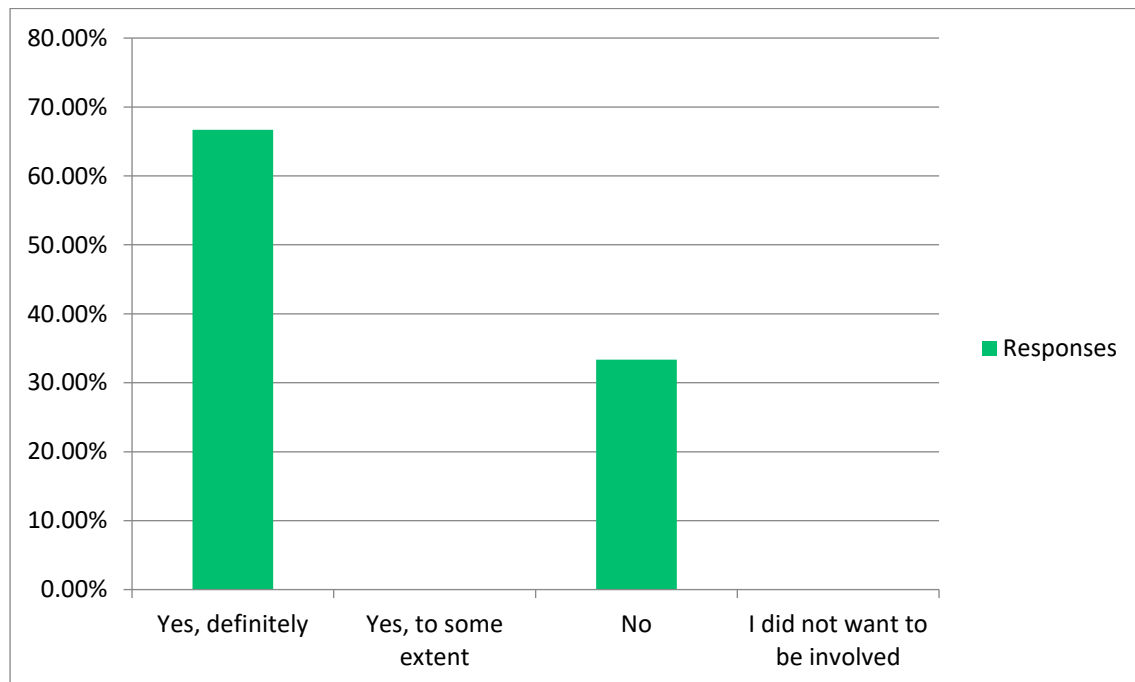
"Not been here long enough. Have been in overnight"

"Several times - all good"

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Discharge process and follow up

We were able to contact three (of the 13 patients we had spoken to in the hospital) after they had been discharged to ascertain what they felt now they were out of the hospital.

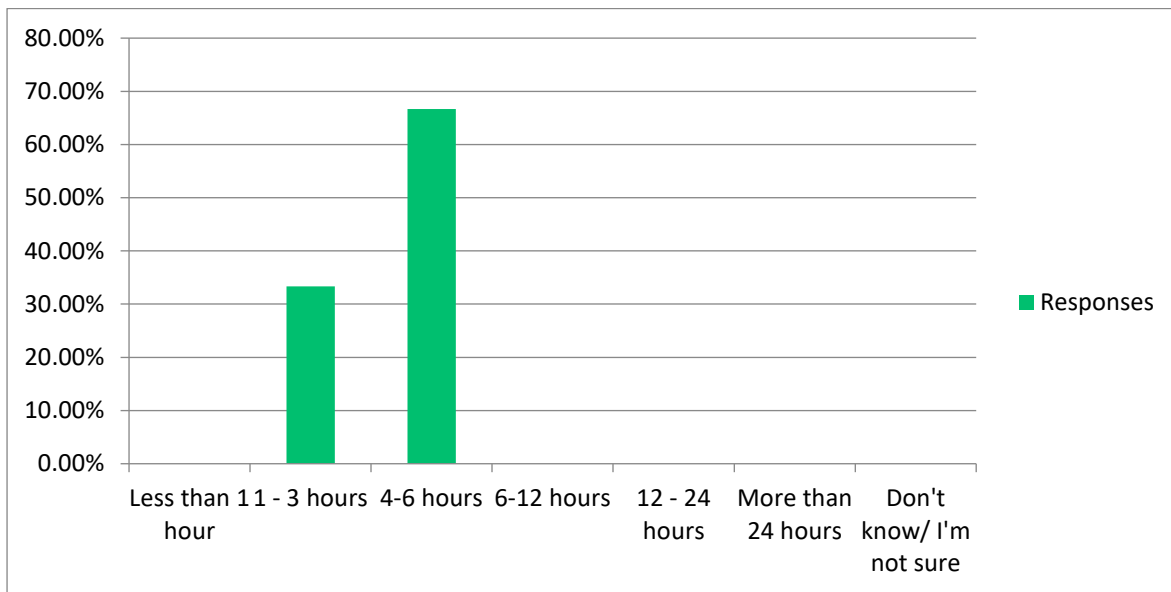


Of the three we spoke to, two felt that they had been involved in the decision to discharge them; one had not felt included. One told us:

“Doctors and Nurses spoke to me and family (when there) so I and they understood”

All three respondents told us that hospital staff discussed with them the need for additional equipment or changes that might be needed in their homes after they had left the hospital.

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No patient had had to wait more than six hours between being told they could go home and leaving the hospital, and one had left within three hours. All felt that they had been given enough notice that could leave.

Their experience of being provided with information about what to do once they had left the hospital was mixed:

- One told that they were given such information
- One told that they had not been given any information
- One told that they had not been given any information but that some would have been useful

"Information about possible cause of the problem experienced and reason for admission"

"Wife understood"

"Only advised to contact a GP if there was a further incident"

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Two patients left hospital without being prescribed medication. The one patient who was prescribed medication was given information about it by a health professional.

The three patients told us that, on leaving the hospital:

- One of them knew what would happen next with their care
- One was partly aware of what would happen next
- One was not told what would happen next.

All of them were told who to contact if they became worried about their condition or treatment after leaving the hospital. They also told us, however, that there was no discussion with staff about further health or social care needs: in one case, doing so was unnecessary but the other two would have liked such a discussion.

All three returned home after being discharged.

Although two patients did not consider they needed support from health or social care, the third would have found that useful.

One of the patients told us that:

“Because of the reasons for my admission I would have appreciated a discussion about the possible cause and the likelihood of a recurrence”

For two of the patients, the waiting time to discharge was entirely reasonable but one found it a bit too long.

All three patients told us that they felt treated with respect and dignity while they were in the hospital:

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"There is nothing else to tell. Am recovering now at home and the hospital was excellent and am very grateful"

"All staff were very polite"

And finally...

The patients told us:

"As regards whether hospital staff told me who to contact if I was worried about my condition or treatment – yes via a discharge letter"

"About support received – have been through this situation before. It was very reassuring I can still remain at home. Cannot fault the care I received. I'm lucky to have family involved. Family came and picked me up from the discharge lounge downstairs. It took a while to arrange but I know the state of the NHS and I am conscious of how busy staff are. Was prepared for this..."

"On the question of "did hospital staff discuss with me whether I may need further health or social care services after leaving hospital" – the answer is no but I would have liked them to"

Although not part of the survey now reported, in conversation with our representatives, several of the patients interviewed mentioned that it was nice to have someone to chat with while awaiting further treatment. Whilst recognising that this might be appropriate in every case, and acknowledging that volunteer

recruitment is not always easy, we do suggest that consideration be given to assigning volunteers to engage patients who are not receiving immediate treatment in conversation if they wish to chat with someone.

Recommendations

The purpose of this survey was primarily to ascertain patients' views about their experience while in the MRU and it is hoped that the report reflects that. There were, however, several points mentioned by patients where it would be helpful to change practice to secure an improved patient experience. The following recommendations are submitted for consideration.

- 1 That, whilst accepting that many factors may cause a delay in transferring a patient into or out of the MRU and that staff will be seeking to keep such delays to a minimum, consideration be given to making available volunteers to chat with patients while they wait as a means of reducing the boredom and anxiety that they may feel while waiting.
- 2 That consideration be given to alleviate the potential claustrophobic effects of a window-less environment, perhaps by arranging for the installation of air conditioning and distracting fixtures such as paintings (so far as compatible with clinical requirements).
- 3 That, so far as possible and providing there are no clinical contraindications to doing so, patients be permitted to continue to take pre-existing medications during their stay. Where for clinical reasons this is not

possible, the reasons should be clearly explained. Many patients are likely to become anxious or distressed if their daily medication regime is interrupted without explanation.

- 4 That, whilst accepting the essentially temporary nature of a patient's stay in the MRU, consideration be given to providing a range of snacks held in the unit rather than relying on the main catering arrangements so that patients can receive adequate food, meeting their dietary requirements.
- 5 That consideration be given to improving how information is given to patients about their post-hospital treatment (assuming further treatment is required). Our survey suggests that different patients have differing experiences of communication in this respect.

Acknowledgements

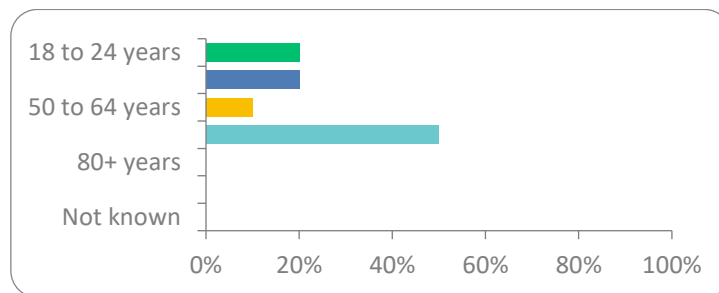
Healthwatch Havering would like to thank those patients who responded to our survey and the staff who facilitated the visit to the Unit for the first part of the survey.

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Appendix

Respondents' demographics

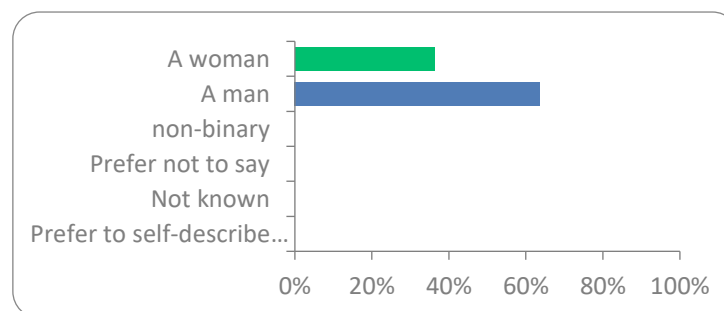
Age range



Respondents

18-24	2
25-49	2
50-64	1
65-79	5
Declined to reply	3

Gender/gender identity

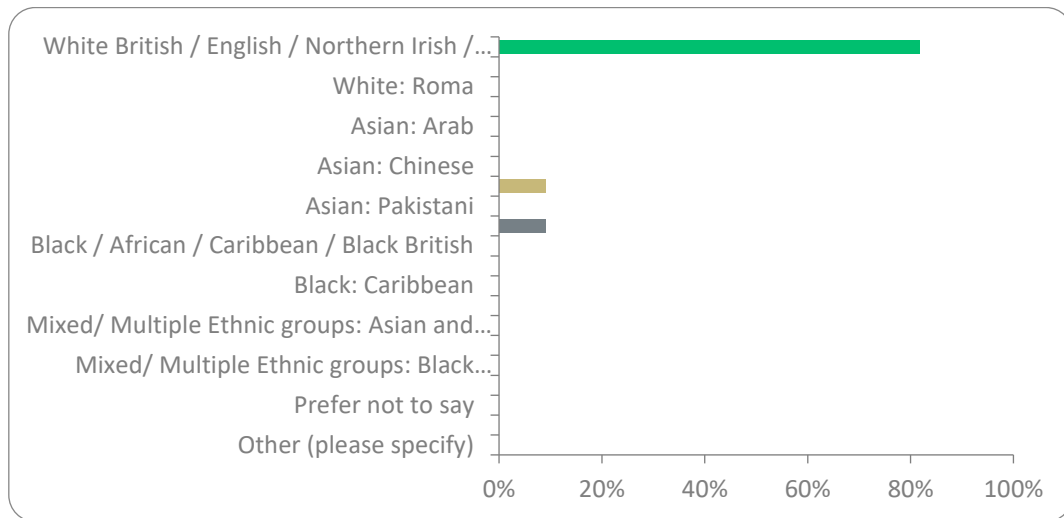


Respondents

Man	7
Woman	4
Declined to reply	3

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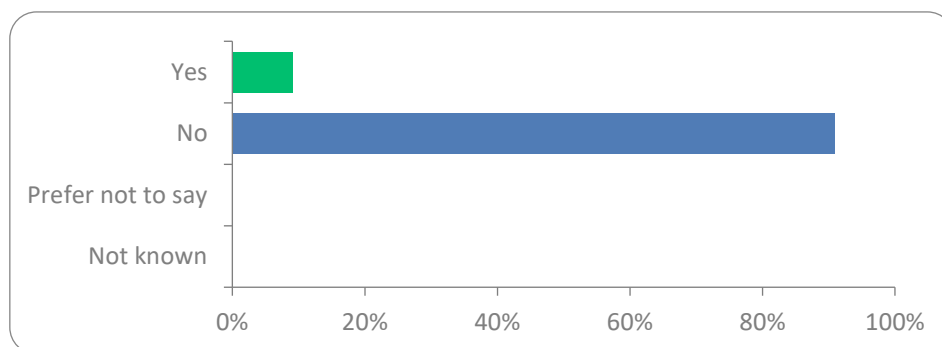
Ethnicity



Respondents

White British (etc)	9
Asian Indian	1
Asian other	1
Declined to reply	2

Are you a carer?

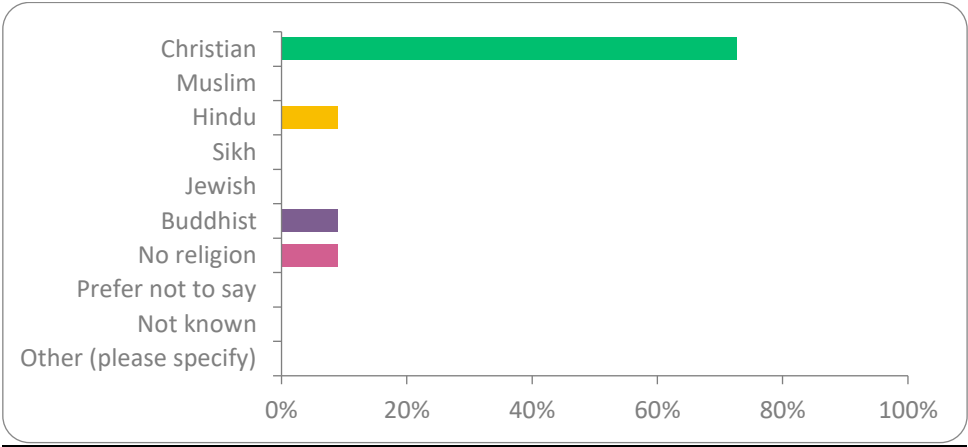


Respondents

Yes	1
No	10
Declined to reply	2

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Religious belief/faith

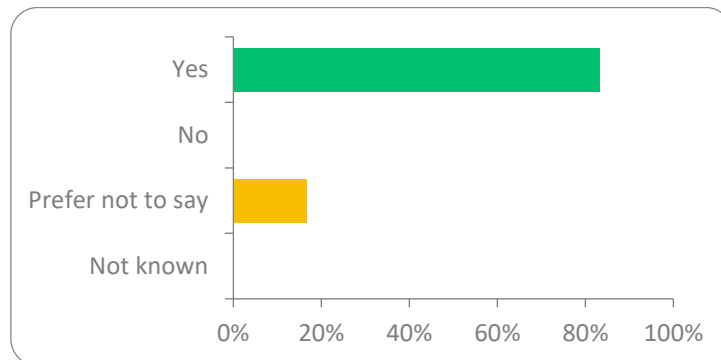


Respondents

Christian	8
Hindu	1
Buddhist	1
None	1
Yes	5
Declined to reply	2

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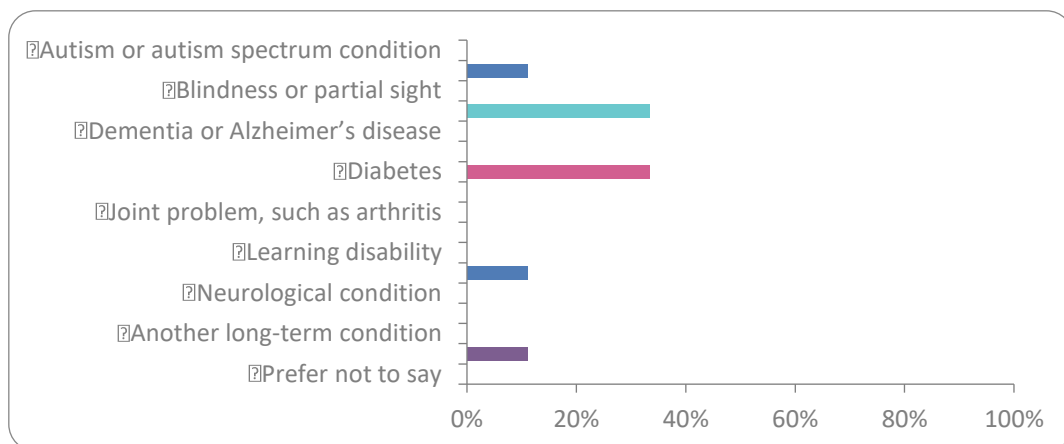
Do you have a disability?



Respondents

Prefer not to say	1
Declined to reply	7
Yes	5

Do you have a long-term condition?

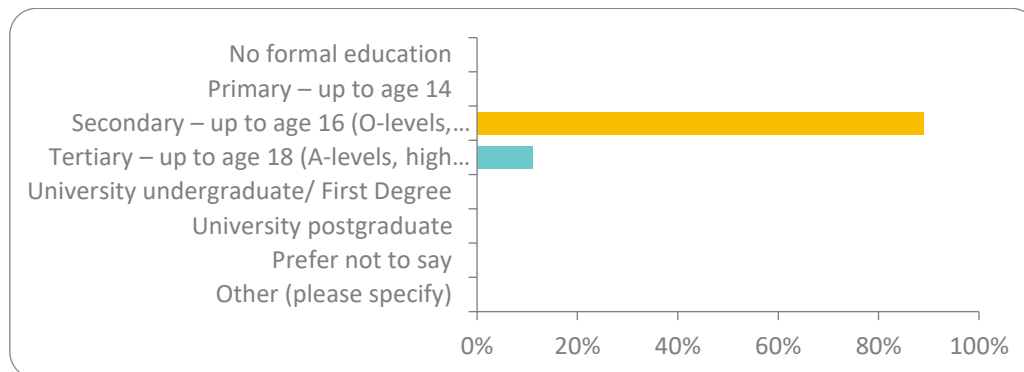


Respondents

Yes – breathing problem	1
Yes – Cancer in last 5 years	3
Yes – Diabetes	3
Yes – mental health	1
None	1
Declined to reply	4

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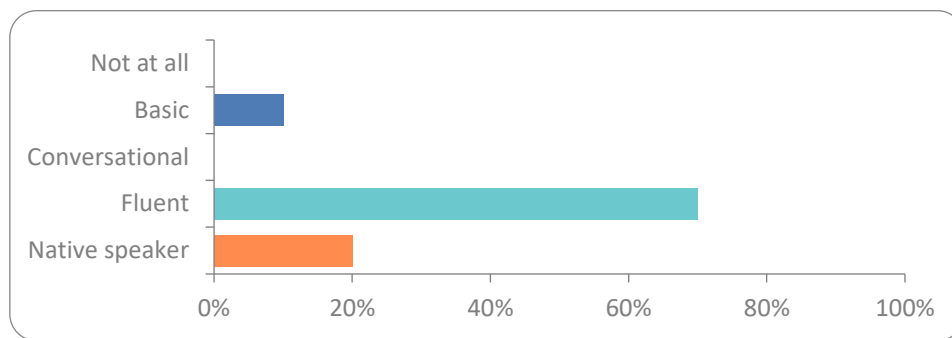
Education level



Respondents

Secondary (GCSE or equivalent)	8
Tertiary (To A Level or equivalent)	1
Declined to reply	5

Understanding of English



Respondents

Basic	1
Fluent	7
Native speaker	2
Declined to reply	3

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Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Healthwatch Havering Friends' Network

Join our Friends' Network for regular updates and other information about health and social care in Havering and North East London. It cost nothing to join and there is no ongoing commitment.

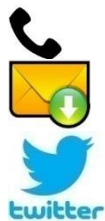
To find out more, visit our website at
<https://www.healthwatchhavering.co.uk/advice-and-information/2022-06-06/our-friends-network-archive>

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Healthwatch Havering is the operating name of
Havering Healthwatch C.I.C
A community interest company limited by guarantee
Registered in England and Wales
No. 08416383

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