Mid staffordshire scandal explained

Wilful neglect can be explained as an offence related to performance. Aftermath Mid Staffordshire scandal it was related to dereliction of duty, besieged and a sequence of petrifying blunders in healthcare sector (Alghrani et al. 2011). In the Mid Staffs public inspection many disagreements took place for and opposed to the foisting of a judicial duty of candour on health professionals, scrutinizing the probability of claims that such a duty would result in a greater secrecy amongst them and might lead to protected professional practice. At an organisational level there was a very sad climate of fright in staff as they had to face impassive attitudes and chicanery. Investigation of disagreement for imposing an individual duty, foreground the pre-existing moral obligation on healthcare professionals to apprise the patients who have encountered harm, has not yet been adequately immersed throughout the National Health Service (NHS) by the professional rules of conduct, and there is a requirement to initiate consistent and legalized reporting in order to slash any clinical errors (Kemp 2014). This essay will draw a light on the reviews of critics who believe that introduction of such reforms might deter clinicians to speak about malpractice from their co workers.

The Mid Staffordshire scandal concerned about the mortality and the standard of care provided to the patients resulted in an inspection by the Healthcare Commission (HCC) which had issued a critical report in March 2009. . This inquiry was made by the Rt Hon Andy Burnham Health Secretary of State. At Mid Staffs the amalgamation of turning an already grappling hospital into a foundation trust and immoderately doing savings in an extremely hasty manner, while pressing on to achieving those targets led to

catastrophic consequences for many patients. These set of investigations gave rise to worldwide public concern and loss of credence of people in the NHS Foundation trust, its services and management (Francis 2010). Making a ten million pound profit out of the budget in a year was the grounds of calamity. The Board was aware of hitches in the emergency department but their main focus was on promoting the trust cogently (INQUIRY & Wood 2013).

The Francis report narrates a series of outraging and awful consecutive shortcomings in the Healthcare system of Britain that left many patients abandoned, humiliated and screaming in pain routinely. The main reason behind the scene was that the trust mainly focused on trimming the costs and fulfilling the government goals. Absolutely there was no quality care given to the patients, their hygiene, meals and its timing. The patients remain drenched with their own urine and excrement for a substantial period of time. Basic grades of hygiene were ignored and often the patient relatives would take their sheets home and washed themselves. Many families were enforced to remove already used dressings from public areas and also to clean toilets all by themselves for the fear of catching infections. There was substantiation regarding high incidence of falls suffered by patients which was unobserved by staff which even led to serious patient injuries. On the whole the patients were neglected in a routine and fatal consequences were seen (Alghrani et al. 2011).

The Healthcare advisor, Don Berwick was commissioned to review patient safety in the NHS after the Francis report into Mid Staffordshire scandal. He pointed out that there was a need to learn how to improve health services so

that quality improvement becomes a practice, discipline and based on knowledge in its own right and giving opportunity to people to practice it. Another lacking area was no particular description made about number of nurses, healthcare assistants by healthcare organisations who are responsible for ensuring professional, experienced and qualified staff. He recommended for uncomplicated supervisory and regulatory systems that motivates responsibility. These thoughtful responses are helpful in facing the arising challenges of the contemporary health system and will enable to deliver high quality, safe and effective care to all patients. Professor Berwick absolutely recognised that whilst it was obligatory to move away from blame culture, there remained purview for prosecution of reckless neglect. Provided that clear guidelines for prosecution policy are being mentioned to all organizations it should become clear to all practitioners that offences should be executed thoughtfully as criminal prosecution applies to rare serious cases. Taking these factors into consideration it is inadequately lucid that the imposition of duty on individual risk intensifying existing fears, or that any actual risk is so great that it precludes the need for measures to be taken to mark an existing culture in which revelation of information is not yet a professional norm (Masterson 2013).

The Health Department of Britain considered many recommendations regarding the criminal misdeed of intentional neglect to be applied on individual persons and organisations. After the disaster of Stafford hospital many reform proposals were made in England and Wales regarding those nurses who deliberately abandon patients should be sent behind the bars for up to five years. It was clearly stated that the misdemeanour should

distinctly state maltreatment rather than authentic delusion or mishap(Keogh 2014) .

All NHS trusts and foundation trusts are responsible for provision of hospital services and should review standards, governance and performance. The proposed duty of healthcare provider or registered professional (doctor, nurse or other health professional) should be to bespeak that wherever suspicion of harm caused to the patient arises which can result in serious injury or death, he or she (or a relative) should be informed of the incident and provided with full revelation and support. In practical terms, it is the duty of registered professional to report their employer who would then bear the responsibility of notifying the patient or relative. Predominantly, it is advocated that the observation of the duty by the healthcare provider and practitioners should not be considered as evidence by itself or an admission of criminal or civil liability. In other words reporting of a fallacy is not automatically evidence or an expression of liability and indicates that the purpose of duty is to stimulate a culture of openness and not to facilitate prosecution and trial. Undeniably, the framework is accurately targeted at bringing about change in viewpoint to provision of information to patients (Kemp 2014).

A similar act of misconduct was observed in Stoke Mandeville and Tunbridge wells hospitals in UK. There was an epidemic of C difficile as there was no attention paid to cleanliness. The chasing of waiting times and monetary objectives over safety and quality care delivery was the cause of neglect. Doctors and nurses were criticised for not segregating the patients (INQUIRY & Wood 2013).

In the year 2013 a patient from England died because of diabetic ketoacidosis but was inaccurately diagnosed with depression in a call made to out of hours GP helpline. The GP Bala Kovalli petitioned liable to manslaughter and got a custodial sentence for two and a half years. He even made an appeal against the duration of sentence but was refused and gradually was terminated from the medical council (Edwards 2014).

The cynosure of bustle is that the duty may engender a fear of speaking out because an individual often worries that he or she may face a criminal trial for gross negligence manslaughter or an offence of causing serious distress by breaching of a fundamental standard (Alghrani et al. 2011). In a recent review eight trials and three convictions in England and Wales between 2006 and 2012 compared with twenty three trials and eight convictions in preceding seven years. The risk of execution was low for gross negligence manslaughter and is a factor of which mostly the health professionals are aware of. Certainly the health professionals may be too concerned about proposed new offences including causing harm or death by breaching fundamental standards. However, the removal of blame culture within healthcare and criminal prosecution should not be erratic (Hawkes 2013).

Whistleblowing is event recognised by authoritative reviewers as an important measure for patient safety. A whistleblower is a person who raises concern regarding misconduct, malpractice and unethical behaviour. In a highly critical 6 th Report the House of Commons Health Committee stated that NHS remains largely contradictory of Whistleblowing, with staff members being afraid of ramifications of delivering unsafe care into light on official channels. It is highly recommended that the Department of Health

should bring new reforms and proposals on how to improve the situation (Bolsin et al. 2011).

Since April 2013 a group was constituted called Quality Surveillance which gathered all the representatives, commissioners and the healthcare regulators contributing their knowledge regarding the standards of care provided across the system encouraging the culture of cooperation and openness (Department of Health 2013b).

Whether the enforcement of criminal laws on healthcare provider and the fear which it creates will cause any change in the behaviour of professional is yet to be seen. On the other hand in Denmark provision of mercy for reporting events might be a more effective approach (Reeve 2013).

While concluding, the corollary of Mid Staffs, these visionary views indicate that formalised reporting of flaws is paramount in reducing gaffe within the health system. However, there is no clear corroboration that error reporting is sufficiently embedded as a norm throughout the NHS. The probability that an individual duty of candour will lead to trepidation of reporting cannot be discounted (Holmes 2013). The foremost thing is to understand the needs of patients and viewing from their perspective and ignoring the system interests. It is a professional responsibility to stand up to realities in delivering care to patients from an excellent to relatively poor care. In certain circumstances when the board is unable to meet the standards of accreditation it is their responsibility to justify themselves. While analysing the riposte to inquiry’s suggestions critically it is seen to reinforce the culture of solicitous care. In future the experiences learned from Mid Staffordshire

will enable the conveyance of safe and effective care to patients of all hospitals and especially if things go wrong lessons should be learned quickly with due liability (Department of Health 2013a).

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