The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 16 January 2025

Agenda item		002/25		
Report Title		Patient Story – My Portacath Journey		
Executive Lead		Paula Gardner, Interim Chief Nursing Officer		
Report Author		Ruth Smith, Lead for Patient Experience		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF2, BAF3
Effective	√	Our people		
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance		
Well Led	√	Our partners		
Consultation Communication		Urgent & Emergency Care Patient Experience Group (18-12-2024) Practice Education Facilitator Meeting (23-01-2025)		
Executive summary:		The Board's attention is drawn to listening to the storyteller outline their experience through the digital story, and the actions being taken in response to the feedback being shared.		
Recommendations for the Board:		The Board is asked to: **Note** the actions being taken to increase awareness of portacath devices, and provide access and support from staff trained in their use.		
Appendices:		Appendix 1: Digital Story – My Portacath Journey		

1.0 Background

1.1 The person sharing their story has a condition where his body rejects phosphates, requiring weekly intravenous treatment. Over time canulation became more difficult and he had a portacath fitted to enable venous access. A portacath is a device that is placed under the skin on the chest, with a tube providing long term access to a vein.

1.2 During a series of emergency admissions, it became evident to the storyteller that the staff he encountered had limited awareness around portacath devices, with some staff asking him what the device was, and others wrongly assuming it was an implantable cardioverter defibrillator.

1.3 These events lead the storyteller to contact the Director of Nursing to share his experiences and explore measures that could be taken to increase awareness amongst staff, and establish a process for accessing a portacath in the event of an admission.

2.0 Actions

2.1 Following the experience being shared with the Trust, the subsequent actions have been taken:

- A Senior Practice Education Facilitator met with Marc to explore how they could work collaboratively to raise awareness of portacath devices
- An alert has been added to the system used in the Trust to flag to staff that Marc has a portacath in place
- Marc has been trained to access his own port for treatment
- A training pack has been developed for Practice Educator Facilitators to disseminate to staff to raise awareness
- Information on portacath devices has been incorporated in the Trust canulation and venepuncture workbook
- A Central Venous Access Devices group has been established to standardise the approach to training, accessing, and providing ongoing care for devices.
- Staff trained in accessing portacath devices are available from dedicated teams who can support across wards and departments between 07:30 and 20:00, and the ability to liaise with Critical Care Teams outside of these hours.

2.2 Further actions to be taken include:

- Rolling out training to Practice Educator Facilitators and Ward Managers to enable dissemination amongst wider teams.
- Identify a team to provide out of hours support.

Ruth Smith, Lead for Patient Experience, December 2024