Investigation Report

Investigation of a complaint against the Belfast Health and Social Care Trust

NIPSO Reference: 16347

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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SUMMARY

This complaint is about the care and treatment provided to the complainant's mother (the patient) on three separate admissions to the Royal Victoria Hospital. The patient had a history of severe chronic obstructive pulmonary disease; congested cardiac failure, mitral and aortic valve replacement and atrial fibrillation.

The complainant raised concerns about; decisions to discharge her mother, the communication with the family and a General Practitioner regarding discharge, the provision of discharge medications, the focus of her mother's care and treatment, and the management of pain relief during her final admission. She also complained about communication with the family on all three admissions.

The investigation of the complaint identified that the decision to discharge the patient following the first admission was reasonable, however the communication with the patient's family and her General Practitioner could have been better, and prior planning would have ensured the patient would not have left hospital without her discharge medications and prevent the subsequent confusion as to how these were to be obtained.

In relation to the patient's second admission, the investigation established that specific aspects of the care and treatment provided and the communication was reasonable. However, there was a failure to complete a pre-MUST assessment, to make a referral to the dietician and to restart the patient's care package on discharge. However, in relation to this admission, the patient's observation charts have been lost by the Trust and I could not conclude that she was medically fit for discharge.

In relation to the patient's final admission I concluded that the patient's pain was appropriately managed and communication with the family was appropriate.

I recommended that the Trust apologise to the complainant for the injustice resulting from the failures identified in the report, and that it provide assurance that the issues in relation to the discharge of patients have now been addressed.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust) in relation to the care and treatment provided to the complainant's late mother (the patient). The complaint focused on her mother's medication, treatment and discharges as well as communication with the patient's family. Her complaint involved three separate admissions of her mother to the Royal Victoria Hospital (RVH) in 2014:

    - 30 January 2014 to 1 February 2014;
    - 6 March 2014 to 11 March 2014; and
    - 12 March 2014 to 14 March 2014.

Background

2. The patient had a history of severe Chronic Obstructive Pulmonary Disease[1] (Non- industrial) ("COPD"), congested cardiac failure[2], mitral and aortic valve[3] replacement and atrial fibrillation.[4] The patient was admitted on 30 January 2014 to Ward 7B via the Emergency Department (ED) following the Community Respiratory Nurse's concerns regarding shortness of breath and hypoxia[5]. The patient was subsequently discharged on 1 February 2014. The patient was admitted on 6 March 2014 via ED to Ward 7A with exacerbation of COPD and high International Normalised Ratio[6] ("INR") and discharged on 11 March 2014. On 12 March 2014, she was admitted to ward 7B via ED with increasing shortness of breath and unfortunately passed away on 14 March 2014.

Issues of complaint

3. The issues of complaint which I accepted for investigation were:

[1] An umbrella term used to describe progressive lung diseases including emphysema, chronic bronchitis, and refractory (non-reversible) asthma
[2] A chronic progressive condition that affects the pumping power of heart muscles.
[3] Two valves located on the left side of the heart.
[4] A heart condition that causes an irregular and often abnormally fast heart rate.
[5] A condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level.
[6] A system established by the World Health Organisation and the International Committee on Thrombosis and Haemostasis for reporting the results of blood coagulation (clothing) tests. Abbreviated as INR.

Issue 1: Whether the care and treatment provided to the patient during her admissions to the RVH in 2014 was appropriate in relation to medication, treatment, discharge and communication with the patient's family?

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the investigating officer obtained from the Trust all the relevant documentation together with the Trust's comments on the issues raised by the complainant. At this point I would highlight that my investigation has been severely hampered as a result of the Trust's loss of observation charts for the patient dated 8 March to 11 March 2014. In relation to this loss of medical records the Trust stated that an extensive search was conducted of the ward and records of other patients who were inpatients at that time but the missing records were not found. The Trust explained that an incident form was completed after the event.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

- **A Consultant Nurse for Older People (N IPA)** – Senior nurse with eighteen years nursing and managerial experience across both primary and secondary care with Diplomas in Adult Nursing, Asthma and Chronic Pulmonary Disease (COPD)
- **An Acute Medicine Physician (A IPA)** – MBiochem(Oxon), BMBCh(Oxon), MMedSci(Clin Ed), FRCP(Edin). Part-time consultant physician in Acute Internal Medicine. Regularly sees and treats acutely unwell adult patients; and
- **A Consultant Respiratory Physician, MBBS MD FRCP (R IPA)** – Consultant in respiratory and internal medicine at a large university teaching hospital since 2004.

6. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPA has provided me with 'advice'. However how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

7. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

The general standards are the Ombudsman's Principles[7]:

- The Principles of Good Administration

8. The specific standards are those which applied at the time the events occurred and which governed the exercise of the professional judgement and administrative functions of the Trust staff whose actions are the subject of this complaint.

The specific standards relevant to this complaint are:

- National Institute for Clinical Excellence (NICE) (2004) CG12 Chronic Obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care (2004 NICE COPD guideline);
- National Institute for Clinical Excellence (NICE) (2010) CG12: Chronic obstructive pulmonary disease (2010 NICE COPD guideline);
- National Institute for Clinical Excellence (NICE) (2014) CG187: Acute Heart Failure: diagnosis and management (2014 NICE Guideline);
- Department of Health, 'Ready to go?', 2010, Planning the discharge and the transfer of patients from hospital and intermediate care' (Department of Health discharge guidelines);
- Nursing and Midwifery Code 2008 'The code. Standards of conduct,

[7] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

performance and ethics for nurses and midwifes' (NMC Code 2008);

- Nursing and Midwifery Code 2009 ' Standards for medicines management' (NMC Code 2009);
- Belfast Health and Social Trust 2011, 'Policy for supply of discharge medications from wards when the pharmacy is closed' (Medications on discharge policy);
- British Association for Parenteral and Enteral Nutrition (BAPEN) 2003 Guide to the MUST Screening tool for adults (MUST guidance); and
- National Institute for Clinical Excellence (NICE) Guidelines 2015 NG31: Care of dying adults in the last days of life (NICE 2015 guidelines on care of dying adults).

9. I have not included all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

10. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and reasonableness of the findings and recommendations.

INVESTIGATION

Issue One:

Whether the care and treatment provided to the patient during her admissions to the RVH in 2014 was appropriate in relation to medication, treatment, discharge and communication with the patient's family?

11. The complainant raised twelve specific concerns regarding care and treatment during her mother's admissions (including issues relating to communication). For ease of reference, I will consider each of these under the relevant hospital admission and will therefore use the following headings:

    - 30 January 2014 to 1 February 2014 admission
    - 6 March 2014 to 11 March 2014 admission
    - 12 March 2014 to 14 March 2014 admission

30 January 2014 to 1 February 2014 admission

Detail of complaint

12. The complainant said that she was informed of the patient's discharge over the telephone on 1 February 2014. The complainant also stated that the discharge report sent to the GP was not accurate; it stated that '*daughter reluctant to accept her* [the patient] *home'.* The complainant felt her mother was not fit for discharge and the doctor did not provide sufficient explanation to the complainant to allow her to understand the reason for discharge.

13. The complainant also explained that her mother was discharged without medication. The complainant and her family believed that the patient's medication was to follow in a taxi later that evening; however a family member had to go to the RVH and collect the patient's medication more than 24 hours later. The complainant said that this led to a delay in steroids and antibiotics being administered to her mother.

Evidence considered

Legislation/Policies/Guidance

14. I considered the NMC Code 2008, particularly sections 8 and 12:
    - *'You must listen to the people in your care and respond to their concerns and preferences'*
    - *'You must share with people, in a way they can understand, the information they want or need to know about their health'*

15. Furthermore, I considered Department of Health discharge guidelines which outlines a 10 step plan for discharge:
    - *(1) Start planning for discharge or transfer before or on admission.*
    - *(2) Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.*
    - *(3) Develop a clinical management plan for every patient within 24 hours of admission.*

- *(4) Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.*
- *(5) Set an expected date of discharge or transfer within 24-48 hours of admission, and discuss with the patient and carer.*
- *(6) Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.*
- *(7) Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.*
- *(8) Plan discharges and transfers to take place over seven days to delivery continuity of care for the patient.*
- *(9) Use a discharge checklist 24-48 hours prior to transfer.*
- *(10) Make decisions to discharge and transfer patients each day.'*

16. In addition, I considered section 2(11) of the NMC Code 2009 specifically in relation to medications on discharge:
    - "*Patients are discharged with a supply of medicinal products as agreed locally*".

17. I considered the Medications on discharge policy. The introduction to the policy states the following:
    - *'The Hospital Pharmacy must dispense all medication required on discharge however in exceptional and/or unforeseen circumstance when all pharmacy departments are closed, and once all other options are exhausted a registered nurse/midwife may supply medication for a patient to facilitate discharge.'*

18. Section 17 provides guidance on the provision of medication on discharge and communicating plans with patients:
    - *'It should be made clear to patients how and where to obtain further supplies e.g. to return to the hospital at a specified time. The nurse/midwife is responsible for arranging this and ensuring the patient*

does not miss any doses. If a prescription needs to be sent to the pharmacy when it is next open the nurse/midwife should ensure that the doctor has written it'.

19. I also considered section 42 of the NMC 2008 Code which states:
'You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been'.

Trust's response to investigation enquiries

Decision to discharge and communication of discharge

20. The Trust explained that '*It is standard good practice to inform relatives as early as possible when discharge has been confirmed to ensure that they have ample time to prepare for their loved one to return from hospital. The patient's daughter would have been telephoned to inform her that the doctors had decided to discharge her mother. The patient would have been advised during the ward round that she was to be discharged home'.*

21. The Trust also explained that '*The patient was admitted on 30 January 2014 and discharged on 1 February 2014.* [The Consultant Physician] *(who was at that time a Medical Registrar), documented that the patient's daughter was not keen for home unless a blood gas analysis was performed.* [The Consultant Physician] *then asked for a blood gas to be carried out.* [The Consultant Physician] *reviewed the blood gas and considered the result to be satisfactory for the patient who was at the end stage COPD.* [The Consultant Physician]*, when speaking to the patient's daughter, did emphasise that her mother was medically fit and keeping her in hospital would put a lady of her frailty at risk'.*

Medication on discharge

22. The Trust explained that on 1 February 2014 '*The patient was discharged at 19:30, the deputy sister has documented that the patient's family were asked to phone the ward the following morning to ensure the medication was on the ward for collection by them. The Trust cannot comment on what time the patient's family contacted the ward as agreed or when they collected the*

medication'. The Trust further stated that in 2014 the '…*pharmacy had no extended hours of opening; since 2014 there has been significant investment in Pharmacy to ensure that patients receive their medication in a timely manner prior to discharge.'*

23. In addition, the Trust stated that '*It is documented that the patient was prescribed her warfarin to take at 8pm, this medication was a preadmission existing tablet that she would have had at home. She had received her steroids and antibiotics for that day.'*

Clinical Records

24. As part of the investigation, I reviewed the patient's relevant clinical records. This included entries from The patient's clinical records:
    - Entry from 1 February 2014, by Medical registrar:
      "*Spoke with daughter not keen for home unless ABG[8] has been documented. Daughter also not happy for discharge due to the confusion and concern regarding low 02[9] sats. Explained medically fit for discharge and delaying discharge could place her mother at risk of hospital acquired infection. Daughter would prefer for her not to go home until confusion aspect addressed".*

25. I also reviewed records from The patient's Nursing Assessment and Plan of Care booklet dated:
    1 February 2014, 19:30:
    '*Family took pt* [patient] *home – medication to follow tomorrow, family aware to ring the ward Sunday 2/2/14 to arrange medication to be collected. Warfarin 2mg prescribed for tonight, pt's daughter made aware of same by myself*'. [Ward Sister]

26. I reviewed the patient's discharge letter from the Consultant in Acute medicine to her General Practitioner (GP) which stated:

[8] Arterial Blood Gas
[9] Oxygen

'…ACE inhibitor was withheld as her blood pressure was low… and plans were made for discharge. I note subsequent discussions with the registrar on call. The lady's daughter had been reluctant to accept her home.'

Independent Professional Advice

Decision to discharge and communication of discharge

27. The A IPA was asked whether the patient was medically fit for discharge on 1 February 2014. The A IPA advised that *'There are no objective observations in the notes to suggest that she is not fit for discharge.'* The A IPA further advised that *'there was clear evidence that the patient did not want to be in hospital* "*Fed up and doesn't want to be here"- (30th Jan 2014). Her saturations had improved from a documented 80% on room air prior to admission to 93% and therefore the direction of travel was positive.'*

28. The A IPA was asked whether further tests or examinations should have been performed prior to discharge. The A IPA advised '*It might be expected for an attempt to have been made to categorise the degree of her confusion using a 30 point Mental Test Score… but with skeleton staff on a Saturday morning, this is not practicable and keeping her in until the Monday for this to be done is certainly not in her best interests due to the risks of deconditioning[10] and infection.'*

29. I asked the N IPA who was responsible for communicating a patient's discharge. The N IPA advised that discharge should take a '*whole team approach*' and is the responsibility of medical staff to communicate when a patient is '*medically fit'* for discharge and nursing staff will communicate when a patient is '*functionally fit'* for discharge. The N IPA advised that *'… discharge should not be an isolated event but rather an ongoing process that starts from*

[10] Deconditioning is a complex process of physiological change following a period of inactivity, bedrest or sedentary lifestyle. It results in functional losses in such areas as mental status, degree of continence and ability to accomplish activities of daily living.

admission and only ends on discharge from hospital (Department of Health 2010 'Ready to go?').'

30. The N IPA advised that the patient was advised of her expected date of discharge on 31 January 2014 as recorded in the daily evaluations. The N IPA listed the following relevant entries:
    - *'"?home tomorrow"* (query home tomorrow?) at an unknown time between 11.25 and 13.20
    - *"Keen for home"* is documented at 18.30 on 31 January 2014
    - 21.00 31 January 2014 *"I have also told (The patient's daughter) that I will arrange for her to speak to one of the medical staff tomorrow before her mother goes home.'*

31. In addition the N IPA advised that '*the Consultant told the patient's daughter on the morning of 01.02.2014 that she was medically fit for discharge but the patient's daughter wanted her oxygen levels checking. This was completed, reviewed and documented by a junior doctor (FY1) at 12.15. After this a more senior doctor (Registrar) relayed this to the family. I do not know what time this was.'*

32. I asked the N IPA whether the telephone communication of the patient's discharge to her family was appropriate. The N IPA advised that '*The patient's family were informed over the telephone. There is no standard for how discharge plans are communicated, only that they should be communicated. Communication regarding discharge was thus in line with national standards.'*

33. I asked the A IPA to comment on the communication to the family on this admission. The A IPA advised that '…*communication was adequate…and clinical decision was correct'.* The A IPA advised that the patient's family were concerned that the patient appeared to be suffering from confusion. The A IPA advised that it is not *'…unusual for confusion to be caused by an elderly person being outside their normal environment and upon discharge (to their normal environment) this settles.*' The A IPA further advised that '…*it should have been communicated to the family that doctors were aware of their concerns about*

confusion but felt it may settle when discharged'. The A IPA concluded that the '*The decision was correct, even if communication to the family was not all it could have been… It is not appropriate to keep someone in hospital until 'the confusion settles in these circumstances'.*

34. The A IPA was asked whether the discharge report to the patient's GP was accurate and in line with the applicable guidelines. The A IPA advised '*…it could have perhaps have mentioned family concerns about confusion and to monitor this to ensure it settled, however what is stated, from the notes, is correct.'*

Medication on discharge

35. I asked the N IPA to describe the procedures for providing medication to patients on discharge. The N IPA advised that medical staff are '…*responsible for completing an accurate discharge letter, which includes the list of discharge medications that the patient should take and any that have been stopped or changed during the patient's stay.'*

36. The N IPA advised that nursing staff should '…*check discharge medicines against the patient's prescription and medicines Kardex. They also discuss medicines with the patient (if not already completed by pharmacist) and return the patient's own medicines to them if appropriate.'* The N IPA advised that '…*Trusts must ensure processes are in place to appropriately facilitate the effective, timely and safe discharge of patients from hospital, this includes the provision of medication*.' The N IPA referred to the Trust's policy on the supply of medications on discharge, and advised that: '*… if followed correctly, the policy ensures that all patients are discharged with medications that they require on discharge.'*

37. I asked the N IPA whether the actions taken by the Ward Sister regarding the patient's medication on discharge were in accordance with discharge policies. The N IPA advised '*The patient was discharged without her medications. Her family were asked to contact the ward the next day (Sunday 02.02.2014) to see if they were ready for collection.'* The IPA advised that this procedure

"…*increases the risk of missed medications, especially if the patient has no means of collecting them. This situation should have been avoided, because nursing staff knew on Friday 31.1.2014 that the patient's expected date of discharge was Saturday 1.02.2014. Knowing that this was the case, the patient's TTO (to take out medications) should have been arranged prior to Pharmacy closing at 1pm on Saturday. This is in line with national guidance: Nursing and Midwifery Council (2009) 'Standards for medicines management', page 22 "Patients are discharged with a supply of medicinal products".'*

38. The N IPA further advised that "*Asking the patient's family to collect TTO's the next day is also outside of local policy: BHSCT 2011 'Policy for the supply of discharge medications from wards when the pharmacy is closed' section 8.1 "The majority of discharge prescriptions must be dispensed by the hospital pharmacy department or the pharmacy extended hours service'. In summary, the actions taken by the Ward Sister with regards to discharge were in line with national standards; the exception to this was the discharge without TTO's…'*

39. The N IPA concluded that the patient's discharge was not in line with local policy on medication provisions on discharge. The N IPA advised that '*This is because staff should have been proactive in sourcing the patient's take home medications…. Staff knew she was being discharged on 1.02.2014 the day prior and could therefore have organised her medications before 1pm on a Saturday.'* The A IPA was asked as to what effect the delay in receiving medication would have had on the patient. The A IPA concluded that '*Delaying the antibiotics could be expected to have an unquantifiable negative impact- by which I mean the length of illness might reasonably be expected to have been slightly prolonged.'*

40. The N IPA was also asked to comment on the adequacy of record keeping with regards to this discharge. The N IPA advised that '*Record keeping relating to discharge plans is unstructured as discharge is randomly referred to within the daily nursing evaluations rather than on the discharge checklist. The discharge checklist is blank. Accordingly, record keeping was not in line with national standards: NMC (2008)…'*

Responses to draft report

The complainant's response

41. The complainant provided a detailed response to the draft report. I have included key elements of the response below. The complainant stated that 'I*t has been with a heavy heart and strong belief that there were failings in my mother's care. My aim and hope is that these can be acknowledge, addressed in order to prevent the reoccurrence with any patient or carer experiencing what my mother and I did.'*

42. The complainant explained that on 1 February, she had a conversation with the doctor as she was worried about her mother and did not think she was fit for discharge. The complainant stated that *'…he [the doctor] did not say, this is why your mother was admitted, we've done this and this is why I believe she is fit for home.'* The complainant felt that this could have been explained more clearly and that better communication would have allowed her to understand why her mother was fit for discharge. The complainant explained that she felt that she had tried to relay her concerns to the medical team but did not feel that her concerns were being listened to and that she found this to be very distressing; *'Outside I didn't know what to do or who to turn to I was genuinely concerned about my mother and despite explaining this to the doctor, I felt that I had been so let down. As her main carer at home my mother was my responsibility and I was in charge of her care.'*

43. The complainant accepted our findings regarding the patient's take home medication.

The Trust's response

44. The Trust accepted all findings and recommendations within the report.

Analysis and Findings

Decision to discharge and communication of discharge

45. Having considered the relevant clinical records, I accept the A IPA's advice that the decision to discharge the patient was '*correct*' and that keeping her in hospital for further monitoring would not have been *'…in her best interests due to the risks of deconditioning and infection'*. I consider the Trust's decision to discharge the patient was appropriate. Therefore I do not uphold this element of the complaint.

46. In relation to the communication of discharge, I note that the patient's discharge was discussed with both the patient and the complainant on 31 January 2014 and again via telephone with the complainant on 1 February 2014. I reviewed the complainant's response where she explained that she felt '*let down'* and she felt that the doctor should have provided a more detailed explanation as to why the patient was fit for discharge. On review of the relevant guidance, I note the N IPA's advice that '*there is no standard for how discharge plans are communicated, only that they should be communicated*' and that communication of the patient's discharge to her family via telephone was '*in line with national standards'*. Therefore while overall the communication regarding discharge was *'adequate'* I note it did not address the family's concerns regarding the patient's confusion. As noted previously, the patient's confusion was not a reason to delay discharge and this could have been explained to the patient's family. I note the A IPA's advice that communication with the family was not '*all it could have been'* and that '… *the family should have been told to monitor the patient's confusion and bring her back if it deteriorated'.*

47. The complainant also complained that the discharge letter was not accurate as it stated that she did not want her mother to return home. I have reviewed the discharge letter and the relevant medical records. I acknowledge that the discharge letter does not detail the complainant's concerns as to why she did not want her mother to be discharged i.e. concerns regarding confusion or her mother's oxygen levels. Therefore, I accept the A IPA's advice that the letter could have *'…mentioned family concerns about confusion and to monitor to*

ensure it settled.' I have examined the medical records and these detail that medical staff addressed the complainant's concerns and these were documented. I also note the A IPA's advice that letter to the GP was in line with the applicable guidelines and '…*what is stated, from the notes, is correct'*. Whilst I note the A IPA's advice, I consider the letter could have more accurately reflected the complainant's concerns that confusion and her mother's oxygen levels were the reason she did not want her mother to return home at that time.

48. I consider that the communication with the complainant could have been better regarding her mother's confusion and the letter to her mother's GP could have more accurately reflected the reason the patient did not want her mother to return home. I consider the lack of clarity in the discharge letter and failure to explain to the patient's family about her confusion amounts to a failure and is not in accordance with the Principles of Good Administration; namely *'Being customer focused'.* I consider that this amounts to maladministration on the part of the Trust. I am satisfied that this caused the patient's family to suffer the injustice of uncertainty as they were not provided with reassurance regarding her confusion. I also consider that this caused the complainant to suffer the injustice of frustration, as her concerns were not accurately recorded in the discharge letter.

Medications on discharge

49. The complainant said that her mother was discharged without her medication. The family believed medication was to follow in a taxi but a family member had to go to the hospital on 2 February 2016 to collect the patient's medication. I note the N IPA stated that '*Trusts must ensure processes are in place to appropriately facilitate the effective, timely and safe discharge of patients from hospital, this includes the provision of medication.'* In addition, the N IPA referred to the Trust's policy on the supply of medication on discharge and concluded that '… *if followed correctly, the policy ensures that all patients are discharged with the medications that they require on discharge.'*

50. I acknowledge the Trust's response which explained that the Ward Sister had communicated with the complainant and stated that *'the deputy sister documented that the patient's family were asked to phone the ward the following morning to ensure the medication was on the ward for collection by them.'* I also note that the Trust stated that '*The patient was prescribed her warfarin to take at 8pm, this medication was a preadmission existing tablet that she would have had at home. She had received her steroids and antibiotics for that day'.*

51. I accept the N IPA's advice that '*this situation should have been avoided, because nursing staff knew on Friday 31.1.2014 that the patient's expected date of discharge was Saturday 1.02.2014. Knowing that this was the case, the patient's TTO (to take out medications) should have been arranged prior to Pharmacy closing at 1pm on Saturday.'* The medical records indicate that the patient's family were '*aware'* that they had to return to the RVH the next day to collect the medication. I have no reason to doubt that the complainant and her family believed that medication was to follow in a taxi on that same day. However, in this instance I prefer to rely on the contemporaneous record which documents the plan for medication and that the family were to contact the ward. However, I do not consider this is the pertinent issue as the confusion over how the medication was to be obtained would have been avoided if the Trust had followed its medications on discharge policy. Following its own policy would have insured that the patient's TTO medications would have been available prior to discharge. Therefore I consider the lack of prior planning in relation to The patient's TTO medications resulted in her being discharged without these medication and this amounts to a failure on the patient's care and treatment.

52. I note the family returned to the hospital the next day to collect the medication for the patient and therefore there was a delay in the patient in receiving her medication by 24 hours at most. I accept the A IPA's advice that a delay in receiving medication could be expected to have had an '*unquantifiable negative impact'* on the patient's health and '*the length of the illness might reasonably be expected to have been slightly prolonged'.* As a result, I consider that the patient suffered the injustice of the loss of opportunity to receive her medication

in a timely manner. I am unable to determine the impact that this would have had on the patient; I note that the patient did not return to hospital until the 7 February 2014. However, I am satisfied that this failing caused the patient and her family to suffer the injustice of frustration and uncertainty. This is because they had to organise to collect her medication the following day and they did not know if the failure to receive the medication had any impact on the patient.

53. I also considered and accept the N IPA's comments relating to the '*unstructured'* discharge notes and the fact that the discharge checklist was not completed. I consider that the relevant nursing staff failed to adhere to the professional standards set out in: NMC code 2008. I also note the Department of Health discharge guidelines which state that a discharge checklist should be used 24-48 hours prior to transfer. It would be my expectation that the Trust remind relevant nursing staff of the importance of completing a discharge checklist.

6 March to 11 March 2014 admission

Detail of complaint

54. The complainant complained about the patient's care, treatment, discharge and communication in relation to this admission.

Care and treatment

I. The complainant said that there was too much focus on INR during the admission from 6 to 11 March 2014. She believes that her mother's heart failure and end stage COPD should have been taken into consideration to determine appropriate care and treatment.

II. A second x-ray was not carried out on the patient during her admission of 6 to 11 March 2014. The complainant believes it should have been, as her breathing had deteriorated.

III. The patient was not weighed during her admission from 6 to 11 March 2014 to monitor fluid input and output. The complainant was concerned about build-up of fluid in her mother's legs.

IV. The complainant had requested a respiratory consultant attend her mother during her admission from 6 to 11 March 2014. She believes her request was not actioned. She complained that the patient was only seen by a respiratory nurse and was not seen by a consultant.

Discharge

V. The complainant complained that the patient should not have been discharged on 11 March 2014. She had been reliant on oxygen until the evening before discharge. The complainant believes that her mother should have been monitored for a further 24 hours before discharge.

VI. The complainant complained that there was no assessment prior to discharge on 11 March 2014, due to progression of her illness. The patient had to climb stairs at home. She believes there was no consideration of the impact this would have on her condition.

VII. The complainant stated that the patient's discharge on 11 March 2014 was not properly planned as her community service carers were not informed of her discharge.

Communication

VIII. The complainant complained that as her mother's main carer, there should have been more communication with her to determine what was typical in relation to her mother's existing conditions.

Evidence considered

Legislation/Policies/Guidance

55. I considered Department of Health discharge guidelines which provide operating principles for effective patient discharges:

'1. Discharge and transfer planning starts early to anticipate problems, put appropriate support in place and agree an expected discharge date.

3. The care planning process is co-ordinated effectively.

5. The Multidisciplinary team (MDT) works collaboratively to plan care, agree who is responsible for specific actions and make decisions on the process and timing of discharges and transfers.

7. Patients and carers are involved at all stages of discharge planning, given good information and helped to make care planning decisions and choices.'

56. I considered the MUST[11] guidance which provides a five step process for identifying subjects who may be at nutritional risk and who may benefit from appropriate nutritional intervention:

- *'**Steps 1 and 2**- Gather nutritional measurements (height, weight, BMI, recent unplanned weight loss). If it is not possible to obtain height and weight, use alternative measurements.*
- ***Step 3**- Consider the effect of acute disease.*
- ***Step 4**- Determine the overall risk score or category of malnutrition. If neither BMI nor weight loss can be established, assess overall risk subjectively using 'Other criteria'*
- ***Step 5**- Using the management guidelines and /or local policy, form an appropriate care plan.'*

Clinical records

57. As part of the investigation, I considered the patient's pre MUST assessment from the Nursing plan of care:

7 March 2014:

Does the patient have:-

1. A history of recent weight loss? (No is ticked)

2. Altered/decreased appetite for 7 days or more? (No is ticked)

3. A risk of under nutrition due to current illness? E.g. difficult eating/drinking (No is ticked)

4. A need for assistance with feeding? (No is ticked)

58. I reviewed the patient's clinical records from 10 *March 2014 which record:*

[11] The 'Malnutrition Universal Screening Tool' ('MUST') was developed by the Malnutrition Advisory Group, a standing committee of BAPEN

'Continued weight loss on Fortisip, may need addition of Calogen. Please weight & refer to dietician'.

Trust response to investigation enquiries

Care and treatment

59. In relation to the focus on INR, the Trust explained that *'The patient was advised by her GP to attend the Emergency Department on the 6 March 2014, regarding her high INR, with increased shortness of breath with a history of 'end-stage' COPD. Dr [*Consultant Physician*] then reviewed the patient the following day on 7 March 2014 at 09:10 hours. He felt that the primary diagnosis was a high INR and that the patient's severe COPD was at its baseline based on his assessment and her history. She was monitored closely during her stay and her respiratory rate, oxygen saturations, blood pressure and heart rate remained stable during the admission indicating that there was no clinical evidence of deterioration in her breathing from her already significantly impaired baseline. Her blood markers of infection were also checked and did not show any sign of developing infection prior to discharge.'*

60. In relation to the X-ray, the Trust explained that *'There was no clinical reason to repeat a second x-ray.* [The Consultant Physician]*, had assessed the patient clinically and felt she was at her baseline. The patient's target oxygen saturations were 88% which she maintained, and blood tests were checked and there were no signs of infection prior to discharge'.*

61. The Trust further explained that '[The Clinical Lead for Radiology BHSCT] *undertook a review of the patient's chest x-rays from the March admissions. The chest x-rays on 6 March 2014 noted that there were no changes in comparison to x-rays previously taken in January 2014. A chest x-ray taken on The patient's readmission to the Emergency Department on 12 March did not show any signs of a chest infection, but rather of congestive heart failure which would be in keeping with the patient's long tern medical history of Cardiac Congestive failure'.*

62. In relation to why the patient was not weighed to appropriately monitor her fluid intake and output, the Trust explained that '*There was no clinical reason to weigh the patient to monitor her fluid input and output. The patient was examined each day by medical staff and there were no concerns regarding her legs.'*

63. In relation to a respiratory consultant, the Trust explained '*the nursing documentation on 9 March 2014 state that the family were keen for The patient to see the respiratory nurse prior to discharge, which occurred on 10 March 2014. It is also documented that [*the complainant] *telephoned the ward to advise them that her mother had an appointment to see her Respiratory Consultant on 21 March 2014'.*

64. The Trust explained that '*whilst in hospital the patient was reviewed by the respiratory nurse specialist'*. The Trust also explained that '*The patient was under the care of the respiratory community nursing team who attended her at home. Visits to patient's homes are planned and agreed with the patient and their family and the respiratory nursing team would have addressed any concerns in relation to the care of the patient'.*

Discharge

65. In relation to the complaint that her mother should not have been discharged, the Trust explained that '*The patient was on oxygen in hospital. It was planned to wean her off oxygen and maintain saturations around 88%. She was weaned off her oxygen on the day of discharge and her oxygen saturations were 89%. The patient despite having COPD continued to smoke so this was an acceptable parameter. Because of her significant chest disease, it was in her best interests to get home as soon as possible to avoid the risk of developing a hospital acquired chest infection.'*

66. The Trust explained that it was documented in the nursing notes that the patient lived with her daughter as the main carer and that whilst the patient was in hospital during this admission she '*required minimal assistance of one person for personal care and was mobilising to the bathroom.*' Furthermore, the

Trust stated that there was *'…no clinical evidence of deterioration in the patient's breathing or her significantly impaired baseline. Neither the patient nor her family raised concerns that she would be unable to climb stairs when she returned home'.* In addition, in the Trust's letter to the complainant on 5 October 2015, the Trust apologised and stated *'I am sincerely sorry that on this occasion having consulted with the Social Work team that no referral was made by the ward to initiate the care package'.*

67. The Trust explained that the social worker restarts the care package on discharge and '*…unfortunately the patient was readmitted to hospital before this was restarted. There is no documentation within the notes to confirm that the package was commenced prior to discharge nor can the social work team confirm on the PARIS[12] system that her care package commenced.'*

Communication

68. In relation to communication with the complainant, the Trust stated that '*The patient had capacity to make decisions about her own care. The patient's family did not express concerns to medical or nursing staff regarding communication. The Medical and nursing staff would have been very willing with the patient's consent to speak to her family and offer as much assistance as possible*'

Clinical records

69. I considered the following relevant extracts from the patient's Nursing Assessment and Plan of Care booklet:
    - 8 March 2014 at 14:30:
      '*Assistance of 1 staff given to attend to personal care needs.*
      Mobile to bathroom with supervision
      Awaiting resp [respiratory] *nurse r/v* [review].'
    - 9 March 2014 at 10:53
      '*Minimal assistance of 1 to help wash + dress'*
      '*Family keen for respiratory nurse before discharge*'.

[12] Internal case management system.

- 10 March 2014 at 01:30:
  '[the complainant] *phoned. She* [The patient] *is due a review resp consultant in the RVH, 21 March 10:30'.*
- 10 March 2014 at 10:20am
  '*Assisted with personal hygiene and dressing needs'*
  At 18:30:
  '*S/B* [seen by] *resp nurse: see recommendations – suggested low flow O2 metre, Oramorph, refer to DT* [Dietician], *add supplements as unable to eat properly… refer to community resp team and referral for palliative assessment*'.
- 11 March 2014 at 8:10
  '*Meds taken, was washed & changed- support + assistance given'.*

Independent Professional Advice

Care and treatment

70. The A IPA was asked whether sufficient consideration was given to the patient's other co-morbidities including heart failure and COPD. The A IPA advised that the patient's primary reason for admission was a raised INR, and that '…*multiple professionals felt her breathing stable. There would therefore have been no reason to consider further her COPD or heart failure.'* The A IPA was asked whether the patient should have received a second X-ray during her admission. The A IPA advised that the patient was seen by a number of different medical professionals including the Respiratory nursing team who *'knew her well*', and The patient's primary reason for the admission was her increased INR, therefore there was '*…no indication for a second Chest X-Ray.'*

71. In relation to fluid monitoring, the N IPA advised that '*there are four elements to assessing fluid balance and hydration status; clinical assessment (including vital signs), body weight and urine output, review of fluid balance charts and review of blood chemistry'.* In addition, the N IPA advised that '*fluid balance charts are notoriously difficult to accurately maintain and are restricting for the patient (they need to pass urine into a suitable container unless they have a urinary catheter; they have to inform staff when they have had a drink) accordingly there should be a medical rationale for their completion'.*

72. The A IPA was asked whether the patient should have been treated for fluid build-up in her legs and thus should have been weighed as part of this treatment. The A IPA advised that the patient's admission was due to a respiratory problem and *'…there would have been no routine indication to weigh her every day. This would have been performed if the doctors were worried about fluid retention and heart failure.'* The A IPA further advised that the patient was '*…treated for fluid build-up in her legs with Spironolactone and Furosemide. These were the medications she was on at home for the same problem.'*

73. However, the N IPA advised that the patient should have been weighed on admission on the basis of her nutritional needs. The N IPA advised that '…*within the nursing assessment, the patient was identified as having a poor appetite and was taking food supplements pre-admission. For the purposes of a MUST assessment, the patient should have been weighed on admission. It should also be noted that the MUST concluded the patient did not have a decreased appetite.'* The N IPA advised the communication with the patient's family could have helped in this case to provide an accurate Pre-Must assessment. However, the N IPA advised that when the patient had her '*full MUST assessment completed, it appropriately reflected her nutritional needs.'*

74. The N IPA further advised that the patient was assessed by the Respiratory Nurse Specialist on 10 March 2014 and '…*she has documented "continued weight loss on fortisip, may need calogen, please weigh and refer to dietician". This was not done.'* In conclusion, the N IPA advised that '*The patient should have been weighed on admission due to her decreased appetite and risk of malnutrition but not for fluid balance purposes. It is difficult to say if this impacted on the patient, however she was not referred to a dietician and she did not receive any additional supplements (calogen).'*

75. In relation to the complainant's complaint that her mother should have been seen by a respiratory consultant. The A IPA advised that the respiratory nurse knew the patient well and felt that her breathing was '*no worse than usual'*. The

A IPA further advised that '*Escalation to a respiratory consultant would have been appropriate were this not so. This was a patient with chronic breathing problems who had been admitted for a different problem.'*

Discharge

76. The A IPA was asked whether it was appropriate to discharge the patient on 11 March 2014. The A IPA advised *'The treatment her mother [*The patient*] had seems reasonable, as does her discharge, and it is unfortunate that she caught pneumonia[13] whilst being treated for something else.* However, due to the missing observation charts covering this admission, the A IPA was unable to provide an informed opinion on the question of discharge stating that; '*The clinical notes suggest that the discharge was appropriate, however without these charts a firm conclusion cannot be drawn. Subsequent events draw in to question the veracity of her discharge. At the time she was discharged there was no reason not to do so. It is not possible for the doctors to have known that she was developing pneumonia (unless these charts suggested that).'*

77. The A IPA was asked whether tests showed any sign of infection prior to the patient's discharge on 11 March 2014. The A IPA advised that '*Blood results showed a White Cell Count of 12 (possible infection) and a CRP of 4 (unlikely infection). The White Cell Count might also have been raised as she was taking steroids so a clinical judgment would have been made as to whether she had an infection or not. In view of her CXR[14] not showing anything untoward, the doctors have rightly concluded that, on balance, there was no infection to treat.'*

78. The Investigating Officer asked the N IPA to provide detail on the assessments which were carried out regarding the patient's mobility prior to discharge. The IPA stated that the patient's *'…functional capacity was assessed by medical staff and nursing staff on admission. She mobilised from bed to toilet at home and this did not alter during her admission.'* The N IPA was asked whether further assessments should have been done prior to the patient's discharge. The N IPA advised that *'…no other mobility assessments were needed'*. This

[13] An infection that inflames the air sacs in one or both lungs.
[14] Medical abbreviation for Chest X-ray.

was because the focus of care on discharge was *'palliative'* as per respiratory nurse review on 10 March 2014. The N IPA advised it was therefore more important to ensure that *'… The patient's comfort was maintained and ensuring that her activities of daily living could be addressed on the basis of her being mainly bedbound (as documented on medical assessment).'*

79. The N IPA further stated that on admission it was documented that the patient was mobile from bedroom to bathroom and that she was mainly bedbound, '*this was her baseline'.* In addition the N IPA advised that '*…she was 'end stage' COPD and CCF*[15] *and physiotherapy interventions would not have improved her mobility (which was impaired due to extreme shortness of breath secondary to end stage COPD and CCF). Furthermore, the patient was already known to community services and she already had equipment to help her with her daily activities (a commode in her bedroom for example).'*

80. The N IPA was asked what the patient's care package was and whether this was changed on discharge. , The N IPA advised that the patient's care package remained the same on discharge '…*twice a day on Sunday, Monday and Tuesday and three times a day on Wednesday, Thursday and Friday*.' In addition, the N IPA was asked whether the failure of the ward to initiate the care package on discharge would have had any impact on the patient. The N IPA advised that the patient's family would have had to '*…phone the care agency once the patient was home to restart her package of care and this could have resulted in a delay to the care package restarting.'*

Communication

81. The A IPA was asked whether staff should have communicated more frequently with the complainant to understand what was typical in relation to her mother's condition. The A IPA advised that the respiratory team '…*knew her well. Functional assessments are mentioned throughout for example 'mainly bed bound at home- goes to the toilet and back".* The IPA concluded that the *'…medical team had the information available to them that they needed.'*

[15] Congestive Cardiac Failure- also called heart failure, it is a condition in which the heart muscle is weakened and cannot pump as well as it usually does.

Responses to draft report

The complainant's response

82. The complainant provided a detailed response to the findings regarding her mother's second admission. I will summarise these below under three headings;

Care and Treatment

83. Regarding the focus on INR, the complainant stated '*I don't quite understand this as on a previous visit to A & E with a very high INR, she was given the reversal and was required to attend A & E for the next few days for blood test and clexane injections until her readings normalised. I don't understand how they consider her COPD to be at baseline when her O2 saturations were low enough for her to require low flow oxygen up until the night previous to discharge.'*

84. In regards to her mother's x-ray, the complainant stated this was due to the deterioration in her oxygen levels and '*the doctor in A&E on her readmission in the early hours of the 12th March noticed the infection in the lungs'.* The complainant stated that her mother's footwear '*had been stretched'* due to her mother's fluid build-up in her legs.

85. The complainant explained in her response that she wished for her mother to be seen by a respiratory consultant as she had '*noticed a change in my mother's breathing. As she was due to be reviewed on the 21st March, I thought it would be more beneficial for her to be reviewed while in hospital. Though I do appreciated her being seen by the respiratory nurse'.*

Discharge

86. The complainant stated that she felt that the '*decrease'* in her mother's oxygen saturations and increased shortness of breath should have been taken into consideration and how this would impact her mother at home, especially with climbing stairs. The complainant stated that her mother '*climbed the stairs but it*

was such a struggle for her though she still did it though I ensured she took her time. I was heartbroken watching her and angry at myself for not organising an ambulance for her'. The complainant questioned whether this caused her mother's condition to deteriorate. The complainant advised that her mother returned home that evening on the 11 March and was experiencing a lot of pain, '*she was in agony and distressed'.* The complainant stated that her mother left hospital on 11 March at 8pm and was readmitted at 1.50am on 12 March, and therefore was at home for less than six hours before she was readmitted to hospital via an ambulance. The complainant feels that '*Even though observation charts are missing, evidence to date speaks volumes to the few hours she was at home and what pain and suffering she endured, which I believe my mother should never had to endure or would expect any patient discharged from hospital to experience. Should my mother have stayed in hospital I am well aware this could still have happened, but she would not have had to struggle to climb stairs, and endure the pain and suffering she went through at home*' The complainant further stated that the respiratory nurse later said to the complainant that she did not expect for the patient to have been discharged on 11 March.

Communication

87. Regarding the issue of communication of her mother's discharge, the complainant stated that she had expressed concern and has asked her mother to be seen by a respiratory consultant as well as having concerns about fluid build-up in her mother's legs. The complainant stated that she had spoken with a doctor regarding concerns for her mother; ' *When speaking with the doctor querying that if her shortness of breath increased should I increase her number of nebules to see if that would improve her breathing an option to consider before contacting out of hours GP, or her own care team. She explained that would be better to try her with one first and if her breathing didn't improve then to try another and to see if that would help, obviously keeping her care team involved. I had given reassurance to my mother that I was not looking her kept in I was just ensuring that I could try this, looking to keep her out of hospital where possible. The doctor appeared to be happy with my mother and did not*

express any concerns or informed myself of anything that I needed to be aware of. '

88. The complainant felt that her concerns were not addressed by the medical team before discharge, she stated that '*No one explained this or took myself aside to explain or even discuss in front of my mother, the impact of or what to expect or look out for with lower oxygen levels, which would now be her new normal, her new baseline. Whilst I appreciate she was under the care of the community respiratory team and I knew her nurse would be straight out to see her at home, with who I could ask questions. I believe that there should have been more discussion on the ward.'* The complainant felt that due to the communication regarding discharge in January, she felt she could not raise her concerns further for fear of upsetting her mother.

89. The complainant stated that she felt 'communication with carers needs to be *improved Yes my mother had capacity to make decisions regarding her and I totally respected this, this should not prevent the main carer who looks after them in their own home, from being told of changes in condition and what to expect and watch out for.'* The complainant advised that she '*will always regret not pushing her concerns more. I accept and will always regret not pushing my concerns more. I knew during her stay and on day of discharge that my mother was more breathless even at rest, and how eating her dinner on ward and using the bathroom was more of an effort for her.* W*hilst in my gut something told me she was dying, we were coming closer to the end of her life's journey, I doubted myself. Believing I was too closely connected I was being over protective and worrying too much. After all I thought to myself the doctor or nurse would've taken me aside to explain and understand what to expect when I took her home. An example of what I mean would be, due to the effort it takes for her mobilising instead of using the bathroom that it would be much easier and less strenuous for her to use the commode in her room. I tried to console myself that I would contact the community respiratory nurse very first thing the following morning. Sadly I did not get the opportunity to do this.'*

The Trust's response

90. The Trust accepted all findings and recommendations within the report.

Analysis and Findings

Care and treatment

91. The complainant complained that there was too much focus on INR during her mother's admission and her mother's heart failure and COPD were not appropriately taken into consideration. I accept the A IPA'S advice that that there would have been *'…no reason to consider further her COPD or heart failure'* and that '…*multiple professionals felt her breathing stable.'* I acknowledge the complaint's response to this, the complainant maintains that her mother's other co-morbidities should also have been the focus of this admission to hospital. However, I accept the A IPA's advice on this matter and therefore I do not consider there was any failure in the care and treatment provided to the patient.

92. The complainant complained that her mother should have received a second x-ray during her admission and should also have been seen by a respiratory consultant. I note the complainant stated in her response to the draft report that on readmission on 12 March to RVH, '*they noticed an infection in her lungs'*, therefore the complainant considers that her mother should have had a second x-ray before she was discharged on 11 March. I considered the Trust's response which advised that '…*there was no clinical reason to repeat a second x-ray'.* I accept the A IPA's advice that '*There was no indication for a second Chest X-Ray'*. Therefore I consider that the patient did not require a second chest x-ray during this admission.

93. The complainant complained that her mother should have been weighed during this admission to monitor her fluid input and output, the complainant was concerned about the fluid in her mother's legs. The complainant advised in her response that her mother's shoes were '*stretched'* and the complainant considers this was due to fluid build-up. I considered the Trust's response which stated that '…*there was no clinical reason to weigh the patient'* during this admission. It noted that '*the patient was examined each day by medical*

staff and there were no concerns regarding her legs'. I accept the A IPA's advice that the patient was admitted due to respiratory problems and '*there would have been no routine indication to weigh her every day*'. I acknowledge the complainants view on this issue however I remain of the view my finding that there was no reason to weigh the patient for fluid reasons as stated by the complainant.

94. However, I note the N IPA advised that the patient was identified as having a poor appetite and was taking food supplements pre-admission. The N IPA identified that the Pre Must assessment completed on this admission '…*contradicted the nursing assessment in that it incorrectly concluded The patient did not have a decreased appetite and was taking regular supplements prior to admission.'* However I accept the N IPA's advice, that *'…when the patient had her full MUST assessment completed, it appropriately reflected her nutritional needs'*. I acknowledge that there was no requirement to weigh the patient on admission due to fluid retention, however as noted by the N IPA, The patient should have been weighed on admission due to her decreased appetite and risk of malnutrition. I consider that the Trust failed to accurately complete the patient's Pre-MUST assessment and weigh the patient on admission. I consider this was a failure in care and treatment provided to the patient. I do not consider this caused an injustice to the patient as the N IPA has confirmed that despite this, her MUST assessment was completed accurately and '*appropriately reflected her nutritional needs'.*

95. The N IPA also advised that the patient was assessed by a Respiratory Nurse Specialist on 10 March 2014 who documented '"*continued weight loss on fortisip, may need calogen, please weigh and refer to dietician". This was not done.'* I consider this to be a failure in care and treatment. I note the N IPA's advised that *'It is difficult to say if this impacted on the patient, however she was not referred to a dietician and she did not receive any additional supplements (calogen).'* Therefore, I consider that the patient suffered the injustice of loss of opportunity to ensure that she was receiving adequate nutrition.

96. The complainant complained that her mother should have been seen by a respiratory consultant. I note the Trust explained that *'The patient was reviewed by the respiratory nurse specialist and was also under the care of the respiratory community nursing team, the patient also had an appointment to see her Respiratory Consultant on 21 March 2014.'* The complainant advised in response to the draft report that she felt although her mother was to be seen by a respiratory consultant on the 21 March, she felt it would have been beneficial to have the review whilst she was in hospital during the admission. I acknowledge the complainant's response. I understand the complainant's rationale, however *I* accept the A IPA's advice that the respiratory nurse who '*knew her* [The patient] *well'* reviewed the patient and felt that her breathing was no worse than usual. The A IPA concluded that '*Escalation to a respiratory consultant would have been appropriate were this not so'.* While a review by a respiratory consultant would have been beneficial and allayed the complainants concerns I consider that it was not necessary for the patient to be reviewed by a respiratory consultant

97. I have identified a number of areas where the care and treatment provided to The patient fell below the required standard:

    I. Failure to accurately complete the patient's pre-MUST assessment and weigh the patient; and

    II. Failure to refer the patient to a dietician and commence calogen.

I therefore uphold these elements of complaint.

Discharge

98. The A IPA was asked whether the patient should have been discharged on 11 March 2014. The A IPA stated that the patient's discharge '*seems reasonable'*, however the A IPA did not have all the information necessary to be confident in this position. I note that the test results were somewhat contradictory as to whether an infection was present or not. Due to the absence of observation charts for the patient's admission from 8 to 11 March 2014, I cannot conclude on the balance of probabilities that the patient was medically fit for discharge. The complainant stated that although there is a lack of medical records, other evidence should be taken into consideration. She advised that her mother was

at home for less than six hours before returning to hospital and she was crying in pain at home. The complainant also stated that she had talked with the respiratory nurse who stated that she did not expect her mother to be discharged. I acknowledge that this is very frustrating for the complainant, however I must rely on contemporaneous records and the evidence available to me. As highlighted at paragraph 127, I remain concerned that I have been unable to come to a conclusion on this matter.

99. The complainant complained that her mother should have been assessed prior to discharge due to the progression of her illness and the fact that the patient had to climb stairs at home. The Trust advised that the patient lived with her daughter as the main carer and had a care package in place. The Trust stated that whilst in hospital '*The patient required minimal of one person for personal care and was mobilizing to the bathroom'.* In addition the Trust stated '*there was no clinical evidence of deterioration in the patient's breathing or her significantly impaired baseline.'*

100. The N IPA was asked what assessments were completed regarding the patient's mobility prior to discharge. The N IPA noted that the patient's '*functional capacity was assessed by medical staff and nursing staff on admission. She mobilized from bed to toilet at home and this did not alter during her admission.'* I accept the N IPA's advice that '*no other mobility assessments were needed… because the focus of care on discharge was palliative'.* In addition, I accept the N IPA's advice which stated that the patient was at '*end stage COPD and CCF and physiotherapy interventions would not have improved her mobility…furthermore, the patient was already known to community services and she already had equipment to help her with her daily activities.'* The complainant stated that her mother struggled to climb the stairs on return to the house. The complainant maintained that her mother's decrease in oxygen levels should have been taken into consideration before she was discharged. Although I understand that it would have been very difficult for the complainant to watch her mother struggle when she returned home, I remain satisfied that the patient had access to community care teams and equipment

available to use at home. Therefore, I have not identified any reasons why further assessments of the patient were required prior to her discharge.

101. The complainant also complained that her mother's discharge was not properly managed as her community service carers were not informed of her discharge. I note the Trust stated in its response that the social work team restart the care package on discharge. I further note that in the Trust's response to the complainant on 5 October 2015, it accepted that this did not happen and stated "*on this occasion having consulted with the social work team that no referral was made by the ward to initiate the care package.'* Whilst this was clearly a failure in the management of the patient's discharge I welcome the Trust's early acknowledgement of this.

102. I accept the N IPA's comment that the patient's family would have had to phone the care agency and '*this could have resulted in a delay to the care package restarting'.* I consider this to be a failing in the patient's care and treatment as the ward should have ensured that the patient had the required community based care and support in place before discharge. I consider that the Trust failed to follow the Department of Health's discharge guidelines. However, I do not consider she suffered an injustice. This is because according to the patient's care package, her next visit would have been on Sunday 12 March 2014; however the medical records document that she was admitted to hospital in the early hours of 12 March 2014. I therefore conclude that the patient did not experience an injustice as a result of the Trust's failing as she had returned to hospital before a planned visit from a carer was due.

103. In relation to the patient's discharge, I have identified the following failure on the part of the Trust:

    I. Failure to restart the patient's care package on discharge.

104. I therefore uphold this element of the complaint. As previously stated due to the missing records, I am unable to come to a determination as to the complaint concerning whether the patient should have been discharged on 11 March 2014 and I remain concerned about the absence of records

Communication

105. The complainant also focused on the communication with family members throughout the patient's admission in hospital. In particular the complainant stated that the medical team should have communicated more frequently with the complainant to understand what was typical of her mother's condition. I note the Trust stated that medical and nursing staff would have been '*very willing'* to speak to the complainant with her mother's consent. In addition, I accept the A IPA's advice that the respiratory team knew the patient well and '…*had the information available to them that they needed'.* The complainant maintained that as her mother's carer, there should have been more communication with her on her mother's condition and what she should expect with regard to changes in her mother's condition at home and what actions to take. I understand that the complainant feels that she should have pushed her concerns more before her mother was discharged. In the complainant's response to the draft report, she stated that she '*will always regret not pushing her concerns more… I knew during her stay and on day of discharge that my mother was more breathless even at rest, and how eating her dinner on ward and using bathroom was more of an effort for her.'*

106. It is evident that it was very difficult for the complainant and that she had been very much affected by her experience of communication with staff from her mother's admission in January. However it is evident from the records and the complainant's response to the draft report that she acted in her mother's best interests throughout the three admissions. I accept the complainant's thoughts that Trust staff should consider discussing treatment and care with a carer with the patient's consent. However I acknowledge the response from the Trust which stated that staff would have been willing to discuss any concerns that the complainant had at the time. It is evident from the records that concerns that the complainant voiced were noted, for example the Nursing plan of care records '*Family keen for respiratory nurse before discharge*' on 9 March 2014. Although I accept the complainant's comments regarding the importance of communication with carers; I am satisfied that the staff had the information

available to them to provide care and treatment to her mother and do not consider there was a failure in communication with the complainant.

12 March 2014 to 14 March 2014 admission

Detail of complaint

107. The complainant complained that her mother was not provided with adequate pain relief in a timely manner during her end of life care following her admission on 12 March 2014.

Evidence considered

Legislation/policies/guidance

108. I considered the following national guidance and standards. Relevant extracts of these guidelines are included in Appendix 3 to the report.
    - 2010 NICE COPD guidelines
    - 2015 NICE guidelines on care of dying adults

Trust's response to investigation enquiries

109. The Trust stated that *'It is documented in the medical notes and nursing notes that the patient was given regular subcutaneous Midazolam 1.25mgs and morphine 2.5mgs. On 13 March 2014 at 10:00 a syringe driver of Morphine 10mgs and Midazolam 5mgs was commenced at 0.63mgs per hour. At 20:35 that evening the Morphine was increased to 15mgs and the Midazolam increased to 0.4mgs hour* (sic). *Nursing notes and medical notes do state at times the patient was anxious but settled after PRN[16] medication was administered. Once the syringe driver[17] was in progress, the medical notes state that the patient was not in pain*.'

Clinical records

As part of the investigation, I reviewed the patient's records from the Nursing Assessment and Plan of Care booklet from 12 to 14 March 2014

- 12 March 2014 at 10:00:

[16] 'Pro re nata" Latin term meaning 'as needed'.
[17] A small battery-powered pump that delivers medication at a constant rate through a small plastic tube under the skin.

'*Pt refused her meds* [medications] *this am* [morning]'.

- 13 March 2014 at 20:00:
  '*Patient appears comfortable and pain free this pm*'.
- 14 March 2014 at 01:00:
  '*Pt* [patient] *received in bed with family present. IV Tazocin continued. As per handover same to continue until canula* (sic) *no longer viable. IV fluids in progress at 4.2ml/hour. Syringe driver in situ to (R) side of abdomen and site appears satisfactory. Pt appears comfortable and pain free.*
- 14 March 2014 at 16:00:
  '*Care continues as per care plans. Remains comfortable*'.

I considered the patient's clinical notes from 12 March 2014:

- 14:15:
  '*Patient looks dist …. breathing more but <u>not</u> in pain*…
  Mx [medications] - *1.25mg Diamorphine*
  - *20mg IV Furosemide*
  - *2g IV Magnesium*'.
- 15:55:
  '*Good response to IV Furosemide. Another 20mg IV prescribed*
  - *C/o* [continue with] *Medazolam 5mg Monday, Wednesday, Friday*'.
- The patient's clinical notes dated 12 March 2014 at 16:20:
  '*She* [The patient] *is comfortable*'.
- 19:30:
  '*Very comfortable… family present and happy with current management. Advised to let staff know if they have any concerns or if there are signs of discomfort*'.
- 10:45:
  '*Palliative - syringe driver in situ… very comfortable – has not received any stats or medication. Explained to family it will be a matter of hours. Happy with current management.*

I considered the patient's clinical notes dated 14 March 2014:

11:40:

'*Currently: - now off N/V. Appears comfortable. Family in attendance. They*

report no issues at present. Reinforced for them to ask if need anything'.

I considered the patient's 'Medicine Prescription and Administration Record' dated 12 March 2014:

- 5mg Metolazone at 10:00
- 20mg Furosemide at 14:40
- 1.25mg Diamorphine at 14:45
- 20mg Furosemide at 15:50

Independent Professional Advice

110. The R IPA was asked whether there were any occasions where pain relief was not sufficient and what action was taken to rectify this. The R IPA was unable to find any documentation to the medical records that '*…indicate that the patient was in pain'.* The R IPA highlights that there is one entry on 12 March 2014 at 12.15 which states that the patient was distressed, however she received a dose of diamorphine and the entry at 16.20 states that the patient was '*comfortable'.*

111. The R IPA was asked whether there was sufficient monitoring to determine whether more pain relief was necessary. The R IPA advised that there was sufficient monitoring. The R IPA advised of '…*multiple entries*…' which documented whether the patient was comfortable, and also indicated that the patient was comfortable '…*bar one entry on the day of admission*…' as referenced above.

112. The R IPA was asked whether the patient should have received a syringe driver earlier on 14 March 2014. The R IPA advised that '*The NICE guidance states that a syringe driver should be considered if more than 2-3 doses of "as required" medication have been given within 24 hours. The patient had three doses of "as required" morphine prior to starting her syringe driver on 13/3/14. I considered that this is adherent to NICE guidance.'* The R IPA concluded that '*I do not find any evidence that she was in pain. Pain relief and anxiety relieving medication was given in line with NICE guidance'.* The R IPA states that the records suggest that the patient was *'comfortable until the end'.*

113. The R IPA advised that in relation to note keeping and communication with the family members, *'I found this to be of a high standard. In particular, there are multiple entries in the records documenting whether or not The patient was comfortable and informing the family that they should let the staff know if they had any concerns regarding this.'* Moreover, the A IPA states reiterates the entries which evidence communication with the family, and states that '*…there is not much evidence that it* [communication] *was a problem at the time.'*

Responses to draft report

The complainant's response

114. The Complainant advised that this was '*more of a query rather than a complaint.'* The complaint felt that pain relief should be investigated if pain relief could be given to patients earlier. She explained that her mother awoke with pain and was crying out, and the nurses then provided her with pain relief. The complainant felt that pain relief could have been given before this to ensure that her mother was comfortable. The complainant also mentioned a meeting that she had with Trust staff and the issue of pain relief.

The Trust's response

115. The Trust accepted all findings and recommendations within the report.

Analysis and Findings

Pain relief

116. The complainant complained that her mother was not provided with adequate pain relief in a timely manner during her end of life care. I note the Trust stated that the patient was '*anxious but settled after PRN medication was administered'.* The Trust further stated that once the syringe driver was in progress, medical notes stated that '*The patient was not in pain'.*

117. On review of the clinical records, I accept the R IPA's advice that there were *'multiple entries'* documenting whether the patient was comfortable. I note the NICE 2015 guidelines which provide the following advice; *'Consider using a*

syringe pump to deliver medicines for continuous symptom control if more than 2 or 3 doses of any 'as required' medicines have been given within 24 hours.' I accept the R IPA's advice that the R IPA did not find '…*any evidence that she was in pain. Pain relief and anxiety relieving medication was given in line with NICE guidance.'*

118. Furthermore, I accept the R IPA's advice that there was not '*any evidence that she* [The patient] *was in pain. Pain relief and anxiety relieving medication was given in line with NICE guidance. The records suggest that apart from one occasion on the day of admission, that the patient was comfortable until she died.'* Therefore I do not uphold this element of the complainant's complaint.
119. I am unable to comment on the meeting with Trust staff on this issue as this is outside the remit of this investigation.

Communication

120. On review of the patient's records, I accept the R IPA's advice that communication was of a very high standard on this admission and there are '*multiple entries'* informing the family that they should let the staff know if they had any concerns regarding this. Moreover, the A IPA advises that '*…there is not much evidence that it* [communication] *was a problem at the time.'* Therefore I do not uphold this element of the complainant's complaint.

CONCLUSION

121. The complainant submitted a complaint to this office about the actions of the Trust in relation to the care and treatment provided to her late mother. The investigation did not find maladministration nor failures in care and treatment of the patient in relation to the following matters;
    I. The decision to discharge the patient on 1 February 2014;
    II. The focus on INR with regards to the patient's treatment during her second admission;
    III. The decision not to take a second X-ray during her second admission in hospital;

IV. The patient's review by a respiratory nurse instead of a respiratory consultant;
V. The assessments prior to this discharge on 11 March 2014 ;
VI. Communication with the patient's family during her second and third admission; and
VII. The medication and frequency of pain relief provided to the patient during her third admission.

122. I found failures in the care and treatment received by the patient in relation to the following matters:
VIII. Failure to prepare for the patient's discharge and provide her with her TTO medications in a timely manner on 1 February 2014;
IX. Failure to adequately address the complainant's concerns regarding her mother's confusion and accurately record why the complainant was concerned about her mother being discharged on the discharge letter dated 1 February 2014;
X. Failure to accurately complete the patient's pre-MUST assessment and weigh the patient on her second admission;
XI. Failure to refer the patient to a dietician and commence calogen; and
XII. Failure to initiate the patient's care package on discharge on 11 March 2014.

123. I am satisfied that the failure to provide the patient with her medication on discharge on 1 February 2014 resulted in the patient experiencing loss of opportunity to receive her medication in a timely manner. In addition, I am satisfied that this failing caused the patient and her family to suffer the injustice of frustration and uncertainty. This is because they had to organise to collect her medication the following day and did not know if this had any impact on the patient.

124. I also consider that the failure on the part of the Trust to adequately address concerns regarding the patient's confusion and to record these accurately in the discharge letter amounted to maladministration on the part of the Trust. I am satisfied that this caused the patient's family to suffer the injustice of uncertainty

as they were not provided with reassurance regarding her confusion. I also consider that this caused the complainant to suffer the injustice of frustration, as her concerns were not accurately recorded in the discharge letter.

125. I am satisfied that the Trust also failed to accurately complete the patient's pre MUST assessment and weigh her on her second admission. However I do not consider the patient experienced an injustice due to this as her MUST assessment was completed accurately.

126. I consider the Trust failed to refer the patient to a dietician as was directed by the respiratory nurse on 10 March 2014 and therefore the patient suffered the injustice of loss of opportunity to ensure she was receiving adequate nutrition. Further I consider that the Trust failed to initiate the patient's care package on discharge on 11 March 2014. However I do not consider that this resulted in an injustice for the patient or her family as the patient was readmitted to the ward on 12 March 2014 before the care package was due to commence.

127. I find the loss of the patient's personal data in the form of her observation records from her second admission, to have considerably impeded my ability to investigate fully the issues arising from the complainant's complaint. Due to this, I am unable to determine whether the patient should have been discharged on 11 March 2014 and thus whether there was a failing in care and treatment. This is particularly concerning as the patient was readmitted to hospital on 12 March 2014 following her discharge on the previous day and subsequently passed away on 14 March 2014. Though I note that the patient did have end stage COPD and a number of other co-morbidities. This is also contrary to the relevant data protection and information security standards and the Principles of Good Administration, Section 3 which state public service providers should aim to keep proper and appropriate records. I am pleased to note that the Trust completed an incident report form into the loss of the patient's records and have apologised to the complainant.

Recommendations

128. I recommend that within one month of the date of this report:

I. The Trust provide the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice of uncertainty and frustration as a consequence of the failings identified in this report;

II. I recommend the following service improvements;

    i. The Trust completes an audit of discharge checklists and reviews discharge planning on Ward 7a. The Trust should remind relevant nursing staff on this ward of the importance of completing discharge checklists.

    ii. The Trust reminds relevant nursing staff of the national and local guidance relating to discharging patients with medication.

    iii. The Trust reminds relevant staff of the importance of ensuring that directions for patient referrals are acted upon.

III. The Trust implement an action plan to incorporate the recommendations and should provide me with an update within **three months** of the date of my final report. The action plan is to be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

IV. I am pleased to note the Trust accepted my findings and recommendations.

PAUL MCFADDEN
Acting Ombudsman **July 2020**

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.