Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 20700

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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

I received a complaint regarding the care and treatment provided to the complainant's mother (the patient) at the Royal Victoria Hospital (RVH) in Belfast. The patient fell and broke her hip at home and was admitted to RVH, undergoing a right hemi-arthroplasty[1] on 20 September 2017. She was discharged on 29 September to Chestnut Grove, a residential care home. On 30 September she became unwell and was taken to the RVH Emergency Department (ED).

The complainant raised concerns that her mother was not fit for discharge on 29 September 2017 and that she did not receive a Zimmer frame on discharge. The complainant also said that the patient's wound was '*bloody and oozing'* on 30 September in ED and that there was a delay in getting admitted to a ward. The complainant also raised concerns regarding a urine test completed on 29 September 2017, the results of which were not made available until 3 October. These results confirmed the patient had e-coli. Unfortunately the patient passed away on 3 October in Belfast City Hospital.

The investigation of the complaint identified the following failings in relation the care and treatment provided to the patient at RVH;

- Failure to consider providing the patient with a review by a senior clinician on 28 or 29 September before discharge
- Failure of the OT to provide an observed assessment before discharge;
- Failure of the Physiotherapist to review the patient on 28 and 29 September;
- Failure to provide the patient with a Zimmer frame on discharge;
- Failure to provide the patient with a multidisciplinary review before discharge;
- Failure of the OT and Physiotherapist to adhere to record keeping standards;
- Failure of the Locum middle grade doctor and nursing staff to provide the

[1] A surgical procedure that involves replacing half of the hip joint

patient with antibiotics in a timely manner in adherence with Sepsis guidelines on 30 September;

- Failure of the Locum middle grade doctor to prescribe the patient with pain relief on 30 September 2017;
- Failure of the Locum middle grade doctor to record the patient's oxygen levels and treatment; and
- Failure of the nursing staff to record treatment given to the patient's wound per WHO guidelines prior to discharge on 29 September 2017.

I recommended that the Trust apologise to the complainant for the injustice resulting from the failures identified in the report. I also recommended that the failings identified should be shared with all staff involved in the patient's care in order to encourage reflection of the care and treatment provided to the patient.

THE COMPLAINT

Background

2. The patient fell at home and was taken by ambulance to the ED on 20 September 2017. She was admitted to ward 4A (fractures) and was diagnosed with a fractured right neck of femur[3]. She underwent a right hemi-arthroplasty on 24 September 2017 and was discharged on 29 September 2017 to Chestnut Grove. The patient became unwell at Chestnut Grove and it was noted at 06.15 on 30 September 2017 that she was in a lot of pain. The General Practitioner (GP) out of hours service was contacted at 11.29 and the patient was transferred to the RVH ED at approximately 14.15. The patient was treated in ED and the dressing to her wound was changed. She was then transferred to the BCH at 20.37 and was admitted to Ward 6 South. Unfortunately, the patient passed away on 3 October 2017.

Issues of complaint

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

Issue 1: Whether the patient's discharge from RVH on 29 September 2017 was appropriate and reasonable?

In particular the investigation focused on;

i. Whether the patient was medically fit to be discharged; and

ii. Whether there was appropriate planning in place for discharge.

Issue 2: Whether the care and treatment provided to the patient in the ED in RVH on 30 September 2017 was reasonable and in accordance with the relevant standards?

In particular the investigation focused on;

i. the dressing of the patient's wound; and

ii. Whether there was appropriate planning in place for the patient's admittance to BCH.

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

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

- **Consultant in Emergency Medicine (ED IPA)** – FRCEM, FRCSEd(A&E), MBBS, LLM (Medical Law), RCPathME. He has worked as a consultant in emergency medicine since 2007 in a district general hospital.
- **Occupational Therapist (OT IPA)-** Dip.C.O.T S.R.O.T M.R.C.O.T. He qualified in 1992, has experience in in-patient and community physical health adults and experience in complex discharge planning.
- **Consultant Orthopaedic Surgeon, (O IPA)** – MBBS, MRCSEd, MRCSGlas, MSc, FRCS (Tr. & Orth.) MBA, Consultant Trauma & Orthopaedic[2] Surgeon in the NHS with over 15 years' experience in clinical orthopaedics. He has been in a senior management position in trauma and orthopaedics within the NHS for over 7 years.
- **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.
- **Physiotherapist (P IPA) DProf** MSc BSc (Hons) MCSP MMACP. She qualified in 1992, has experience in in-patient and community physical health adults and experience in complex discharge planning.

[2] Relating to the branch of medicine dealing with the correction of deformities of bones or muscles.

6. The information and advice which informed my findings and conclusions are included within the body of my report. The IPA provided me with 'advice'; however how I 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[3]:

- The Principles of Good Administration
- The Principles for Remedy

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

The specific standards relevant to this complaint are:

- *The Belfast Health and Social Care Trust laboratory Procedure on the Investigation of Urine*, M-380, 2 March 2017;
- British Orthopaedic Association, British Geriatrics Society, *'The blue book: the care of patients with fragility fracture'* Sep 2007 (Blue book guidelines);
- National Institute for Clinical Excellence (NICE) Guidelines*, 'Hip fracture: management. Clinical guideline'* [CG124], June 2011 (NICE Hip guidelines);
- National Institute for Clinical Excellence (NICE) '*Hip Fracture in Adults. Quality Standards 2017'* (NICE Hip fracture quality standards);

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

- National Institute for Clinical Excellence (NICE) '*Trauma and Orthopaedic Guidelines'* 2014 (Trauma & Orthopaedic Guidelines);
- Academy of Medical Royal Colleges, '*Seven Day Consultant Present Care',* December 2012 (Consultant care guidelines);
- National Hip Fracture Database (NHFC) Annual report 2018;
- HSE Health Protection surveillance Centre 2011, *'Guidelines for the Prevention of Catheter associated Urinary Tract Infection'* Published on behalf of SARI by (Catheter guidelines);
- Santonocito et al. C – '*Reactive protein Kinetics after Major Surgery. Anesthesia & Analgesia'*, September 2014- Volume 119, Issue 2, P 624629;
- Royal Liverpool and Broadgreen University Hospitals NHS Trust, '*Guidelines for Antibiotic prophylaxis in relation to urinary bladder catheterization'*, (No date) ;
- Gloucestershire Hospitals, '*Arthroplasty Patients with Urethral Catheters – role of antibiotics for prophylaxis and treatment'*, 2014;
- World Health Organisation '*Global guidelines for the prevention of surgical site infection'*, November 2016 (WHO guidelines);
- Nursing and Midwifery Code 2015 '*The Code. Professional standards of practice and behaviour for nurses and midwifes'* (NMC Code);
- Department of Health, '*Provisional Accident and Emergency Quality Indicators',* December 2012 (DOH quality standards);
- The College of Emergency Medicine, Clinical Standards for Emergency Departments, '*Severe Sepsis and Septic Shock in Adults'* February 2013, (Septic Shock standards);
- Royal College of Occupational Therapy, '*Professional Standards for Occupational Therapy'*, 2017 (RCOT Professional Standards);
- *'Standards of Proficiency- Occupational Therapists'*, 2013 (OT Proficiency standards);
- Chartered Society of Physiotherapy (CSP), '*Record Keeping Guidance',* November 2016 (CSP record keeping guidance);
- CSP Code of Members' Professional Values and Behaviours, October 2011 (CSP Code);

- Belfast Health and Social Care Trust (BHSCT), Chestnut Grove Intermediary Care Unit, Admission Criteria (Chestnut Grove Criteria);
- BHSCT '*The handover of patient care in times of consultant leave'*, June 2017;
- National Institute for Clinical Excellence (NICE) '*Transition between In-patient Setting and Community or Care Home Setting for Adults with Social Care Needs',* 2015 (Guidelines for Adults with Social Care Needs);
- Department of Health (DOH), '*Discharge Planning, Ready to go?',* March 2010 (DOH discharge guideline);
- The Regulation and Quality Improvement Authority (RQIA) '*Review of Discharge Arrangements from Acute Hospitals'* 2014 (RQIA Discharge report);
- Department of Health, Northern Ireland Hospital Statistics: Emergency Care 2017/2018 (NI ED Statistics 2017);
- The Manchester Triage system[4];
- Nursing and Midwifery Council 2009 *'Standards of medicines management';*
- Infusion Nurses' Society,2011 '*Infusion nurses standard of practice';*
- Royal College of Nursing, 2012, '*Standard for Infusion therapy'* ; and
- Wound Care Advisor, Nancy Morgan, 2014 '*How to asses wound exudate' (*no date) (Wound care guidance).

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.

[4] One of the most commonly used triage systems in Europe.

INVESTIGATION

Issue 1 Detail of complaint

11. The complainant made a complaint to this office about the care and treatment the patient received at the RVH. She complained that

    A. The patient ought not to have been discharged from the RVH as she was not medically fit. She said this discharge was due to bed shortage at the hospital. The patient was admitted to the RVH again less than 24 hours after discharge;
    B. The RVH did not send a Zimmer frame with the patient to Chestnut Grove and the patient could only manage with the help of two people;
    C. On 30 September the patient arrived at ED in the RVH in the afternoon but was not allocated a bed until around 21.00;
    D. The patient's wound was changed in ED and it was '*bloody and oozing';* and
    E. The patient had a urine test completed on 28 September 2017. She believed that the results of this were not available until 3 October 2017 and it confirmed that the patient had e-coli.

Evidence Considered Legislation/Policies/Guidance

12. I reviewed the Blue book guidelines including the standards which reflect good practice at key stage of hip fracture care:

    '1. All patients with hip fracture should be admitted to an acute orthopaedic ward within 4 hours of presentation

    2. All patients with hip fracture who are medically fit should have surgery within 48 hours of admission, and during normal working hours

    3. All patients with hip fracture should be assessed and cared for with a view to minimising their risk of developing a pressure ulcer

4. All patients presenting with a fragility fracture should be managed on an orthopaedic ward with routine access to acute orthogeriatric[5] medical support from the time of admission

5. All patients presenting with fragility fracture should be assessed to determine their need for anti-resorptive[6] therapy to prevent future osteoporotic[9] fractures 6. All patients presenting with a fragility fracture following a fall should be offered multidisciplinary assessment and intervention to prevent future falls'

'High quality management of older fracture patients relies on excellent communication between the various members of the multidisciplinary team (MDT). Successful peri-operative [7]care, rehabilitation and discharge requires close cooperation between patients and their relatives, nursing staff, physiotherapists, occupational therapists, social workers and discharge coordinators. A readily available geriatrician can only enhance this process, and the presence of an orthogeriatrician may enable the whole rehabilitative process to take place in the initial fracture ward.'

13. I considered the NICE hip guidelines:

'1.7.1 Offer patients a physiotherapy assessment and, unless medically or surgically contraindicated, mobilisation on the day after surgery. [2011]
1.7.2 Offer patients mobilisation at least once a day and ensure regular physiotherapy review. [2011]…
1.8.1 From admission, offer patients a formal, acute, orthogeriatric or orthopaedic ward-based Hip Fracture Programme that includes all of the following:

- *orthogeriatric assessment*
- *rapid optimisation of fitness for surgery*

[5] Orthogeriatrics is defined as the care of elderly orthopaedic inpatients, most often following a fractured hip
[6] tending to slow or block the resorption of bone antiresorptive therapies for osteoporosis may include the use of bisphosphonates or selective estrogen receptor modulators an antiresorptive agent [9] Osteoporosis is a bone disease that occurs when the body loses too much bone, makes too little bone, or both
[7] Literally, around (the time of) surgery.

- *early identification of individual goals for multidisciplinary rehabilitation to recover mobility and independence, and to facilitate return to pre-fracture residence and long-term wellbeing*
- *continued, coordinated, orthogeriatric and multidisciplinary review*
- *liaison or integration with related services, particularly mental health, falls prevention, bone health, primary care and social services*
- *clinical and service governance responsibility for all stages of the pathway of care and rehabilitation, including those delivered in the community. [2011]'*

14. I reviewed the NICE Hip fracture quality standards:
***'Healthcare professionals** (such as physiotherapists and nurses) offer rehabilitation at least once a day to people with hip fracture, starting no later than the day after surgery.'*

15. I reviewed the following relevant extract from the Consultant Care guidelines:
    - *'Standard 1: Hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.*
    - *Standard 2: Consultant-supervised interventions and investigations along with reports should be provided seven days a week if the results will change the outcome or status of the patient's care pathway before the next 'normal' working day. This should include interventions which will enable immediate discharge or a shortened length of hospital stay.*
    - *Standard 3: Support services both in hospitals and in the primary care setting in the community should be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken….*

      The Academy does not see the three standards as a panacea for all patient safety issues, but as a strong contribution to improving parity and quality of patient care in all four countries of the UK. Whilst championing

equitable, effective and excellent care for patients, the Academy recognises that the direct and indirect costs to implement these standards may be substantial and likely to have varying degrees of impact for service providers depending on their current levels of seven day consultant-present care. The Academy does not believe that the standards proposed in this report can be universally achieved within existing local resourcing arrangements and NHS tariff levels'

16. I reviewed the Catheter guidelines which advise of the following in recommendations for antibiotics after removal of a catheter:

'Recommendations

'• There is no role for routine antimicrobial prophylaxis[8] in patients with urinary catheters.

• Antimicrobial prophylaxis, upon change or instrumentation of urinary catheters (both short and long-term) are not indicated in the majority of patients.'

17. I reviewed the following relevant extracts from the RCOT Professional Standards:

'4.2 Your analysis of the assessment outcomes shows how the service user's current situation or conditions affect their occupational performance and ability to participate.

5. You develop appropriate intervention plans, or recommendations, based upon the occupational performance needs, choices, and aspirations of service users, as identified through your assessments.

7.1 You provide a comprehensive, accurate and justifiable account of all that you plan or provide for service users.'

18. I reviewed the following relevant extract from the OT proficiency standards ;

'10.1 be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines.'

[8] Treatment given or action taken to prevent disease.

19. I reviewed the following relevant extract from the CSP code;

'1.1.5. Justify and account for their decisions and actions

2.1.2 Complete records in accordance with legal, ethical, and organisational requirements'

20. I reviewed the following relevant extract from the CSP record keeping guidance;

'Written records should be:

- *legible and written in permanent ink*
- *signed at the end of each entry*
- *paginated, including date and time of consultation*
- *amendments should be dated, timed, signed and the original entry still clearly visible.*

Electronic recording systems should be able to:

- *show who has made the record*
- *show revisions or amendments*
- *lock the notes'*

21. I reviewed the following relevant extracts from the Guidelines for Adults with Social Care Needs;

'1.5.2 Ensure that the discharge coordinator is a central point of contact for health and social care practitioners, the person and their family during discharge planning. The discharge coordinator should be involved in all decisions about discharge planning…

1.5.12 Ensure that any pressure to make beds available does not result in unplanned and uncoordinated hospital discharges

1.5.18 The discharge coordinator should discuss the need for any specialist equipment and support with primary health, community health, social care and housing practitioners as soon as discharge planning starts. This includes housing adaptations. Ensure that any essential specialist equipment and support is in place at the point of discharge.'

22. I reviewed the following relevant extract from the DOH Discharge guidelines:

'5. The 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.
6. Schedule ward rounds in a way that allows, at least daily, a senior clinical review of all patients in acute hospitals.'

23. I reviewed the following relevant extract from the RQIA discharge report which advises the following:
'The decision that a patient is medically fit for discharge can only be made by the patient's medical consultant (or by someone to whom the consultant has delegated his/her authority) or by another doctor who is responsible for the care of the patient.

Patients who have both health and social care needs must only be discharged when they are clinically fit, a decision made by the multidisciplinary team after consideration of all relevant factors. These include the relative safety of remaining in hospital compared to an alternative preferred place of care, and the patient and carer views of associated risks.'

24. I reviewed the following relevant extract from the Chestnut Grove Admission Criteria :

- *'Patient must have permanent residency in BHSCT*
- *Patients over 18 years*
- *Patients medically fit at time of referral*
- *Patient requires assistance of one person only (patients requiring assistance of 2 people are not accepted)*
- *Patient is not experiencing faecal incontinence*
- *Patient must be assessed as appropriate for rehab by both Physiotherapy and Occupational Therapy*
- *Patient must be able and willing to engage in rehabilitation Patient with dementia or delirium will not be accepted'*

The Trust's response to investigation enquiries

25. *The Trust explained that the physiotherapist assessed the patient and* provided details of the physiotherapy assessment from each day as follows; - *'[The patient]… was seen and assessed by the physiotherapist on 25 September 2017, day 1 following her surgery. It is documented… that she required the assistance of two people to sit out over the edge of the bed and treatment was limited by her post-operative pain.*

- *On 26 September 2017 the physiotherapist has noted that the patient was able to sit out over edge of the bed and step transfer with the assistance of two people…*
- *On 27 September 2017 it was noted that [the patient]… was able to step transfer to a chair with a wheeled Zimmer frame, with the assistance of two people.*
- *On 29 September 2017 the patient was treated twice by the physiotherapist. On the first occasion the patient was mobilising with the assistance of two people. On the second occasion she was mobilising with the assistance of one person. The physiotherapy transfer record indicated that the patient functionally required assistance of one person to transfer and mobilise.*
- *On 29 September 2017 the patient was seen and assessed by Occupational Therapy in preparation for her discharge planning to Chestnut Grove. During this assessment, the patient was found to require assistance of one person with transfers in and out of bed and she required the assistance of one person with the use of a Zimmer frame.'*

26. The Trust stated that the patient's discharge involved a '…*multi-disciplinary team approach, which includes medical, nursing and allied health professionals…'* and she was '*deemed fit for discharge'*. The Trust further stated that '*the patient was assessed by Occupational Therapy and Physiotherapy as being fit to mobilise with the assistance of one and with the aid of a Zimmer Frame. On reviewing* [the patient's] *notes, it is not documented that the Zimmer Frame was transported with her to Chestnut Grove on discharge, 29 September 2017.'*

27. The Trust were asked to comment on how many patients were waiting for a bed allocation in Ward 4A. The Trust stated that '*On 29 September 2017, Ward 4a received two admissions from Emergency Department, two admissions from other hospitals and two admissions directly from fracture clinic, which was a total of 6 patients. At 08:00hrs on 30 September 2017, I can advise that Trauma & Orthopaedics were in escalation with 29 fracture patients outlying throughout the Royal Victoria Hospital.'*

28. In relation to the urine sample, the Trust gave the following explanation '*a urine specimen was recorded as having being obtained on Thursday 28 September 2017 at 22:48 and received in Microbiology laboratory soon afterwards at 23.00.'* The Trust stated that the request was a '*standard request for initial microscopy of the specimen to look for cells and organisms, followed by culture of the specimen…. It is unclear from the laboratory perspective what prompted this specimen to be sent, the urinary catheter having apparently been removed at 06:00 that morning. However it was a routine request, in keeping with the absence of any apparent clinical indication for urgent processing at that time- there was no pyrexia*[9]*, the white cell count was entirely normal and the CRP which had been (predictably) raised postoperatively was falling spontaneously. The sample was therefore processed the following morning, as is the standard operating procedure for routine samples.'*

29. The Trust further stated that *'the laboratories operate on a 24/7 basis for urgent work. However, in common with other NHS microbiology laboratories, routine services are not provided during "out of hours" periods… and processing of routine work is carried out on the next working day.* The Trust also stated that the '*urine specimen from September 28 was processed in line with the laboratory standard operating procedure for non-urgent samples, in*

[9] Raised body temperature; fever.

keeping with the clinical circumstances at the time the sample was obtained… There is a general move towards reporting routine microbiology work at weekends, but this move has significant resource implications and Belfast Trust is not in a position to offer this service currently'.

30. The Trust was asked to comment on whether it had a policy for administering antibiotics on the removal of a catheter. The Trust stated that it did not have a policy relating to this and stated that '*NICE guideline NG113, on antimicrobial prescribing for catheter related urinary tract infection, specifically does not recommend antibiotic prophylaxis to prevent catheter-associated urinary tract infections (UTI) in patients with a short-term catheter'.*

Clinical Records

31. I reviewed the typed notes from the ward round conducted by the consultant Orthopaedic Surgeon , the last entry is dated 27 September 2017 and documents the following;

'This lady has been mobilising slowly following her right cemented hemiartroplasty. I screened her in theatre and confirmed?? Splint? Fracture. Her check [sic] x-ray is satisfactory. She can continue to mobilise.'

32. I reviewed the clinical records and note the following:

- On 25 September the patient was reviewed by a? FY2[10]
- On 27 September, the patient was reviewed by an ST3
- On 28 September, the patient was reviewed by an ST3, the medical records document '*no issues'.*
- On 28 September, A FY2 reviewed the patient again, the plan of care is listed as *'t/f[11] 1 unit, analgesia[12], physio, laxative'.*
- On 29 September, a ST3 reviewed the patient, the notes document

[10] A Foundation doctor (FY1 or FY2 also known as a house officer) is a grade of medical practitioner in the United Kingdom undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training.

[11] Transfer

[12] Medication that acts to relieve pain.

'*recovering well'* and the plan is '*Belfast rehab'.*

- On 29 September, there is also an entry from the Community Flow Manager, which documents; 'Complex *discharge service* [community flow manager].[13]*Referral received….client currently assistance x1 @ward level as per nursing/physio/OT reports'.*

33. I reviewed the letter from the Trust to the complainant's family dated 24 January 2019

'[the Community Flow Manager] assists in facilitating discharge of patients who are deemed medically fit for discharge. On 29 September 2018, she was requested by the T&O [Trauma & Orthopaedics] Service to assist in exploring discharge options for [the patient], as she had been declared medically fit for discharge by the medical team.'

34. I reviewed the physiotherapy records from the patient's admission. The

'Physiotherapy Treatment Form' has entries beginning on 25 September, the last entry is on 27 September 2017, it documents
'Consent (tick). Feeling well, Pain controlled today
In bed bath insitu. Lie SOEOB[17] AO2[14] ST5 AO2
Step t/f to chair (under care) AO2 + wzf[15]
Anxious but done well
R/V[16] Mobilise.'

There are no further entries on this form after 27 September 2017.

35. I reviewed the Physiotherapy '*Select'* form which is a form completed online which gives general details about the patient. Under mobility it states '*Assistance x 1'* and under '*Type of aid used'* it states '*Wheeled Zimmer*

[13] It is now known as The Community Discharge & Social Work Service. This is a community facing service – which provides a central point for all hospital wards to make referrals for patients who are medically fit but who may require assistance for discharge home or who require community bed based services such as Chestnut Grove. It must be noted that this service only facilitates discharge for patients declared medically fit by the medical team. [17] Sit on edge of bed.
[14] 'Assistance of two people (AO2)
[15] Wheeled Zimmer Frame
[16] Review

Frame'. The form is blank relating to the section on '*Modified Rivermead Mobility Index*[17]*'*. This form is electronically signed by the physiotherapist at the bottom and is dated 28 September 2017.

36. I reviewed the '*Occupational Therapy Discharge Summary'.* At '*Functional Activity'* it states '*Current on the ward the patient is transferring with a zimmer frame and assistance x 1. Steps short distances.'*

37. I reviewed the '*Transition plan for care & Support'.* The Patient's general details and a brief summary is given regarding her admission to hospital and treatment. The rest of the form has not been completed. This includes sections relating to skin and wound conditions, the patient's handling risk assessment including equipment to be ordered and the discharge planning section.

38. I reviewed the patient's discharge letter which was dated 29 September 2017. I note the discharge letter noted the patient's CRP was 121.7. I reviewed the patient's records from her attendance at ED on 30 September 2017. I note the 'clinical notes' record the patient's CRP as '134.7'.

39. I reviewed the Level One- Significant Event Audit Report[18] which related to 29 and 30 September 2017 and is entitled '*SEA into Patient Discharge from Ward 4a RVH to Chestnut Grove on 29.9.17'.* The report documented that the Significant Event meeting was held on 20 October 2017. The report provided detail on the patient's discharge from the RVH and admittance into Chestnut Grove. The report also documented that after being admitted to Chestnut Grove '*the patient has been complaining of severe pain from the outset of her admission into the Unit…. From the outset in Chestnut Grove, [*the patient*] required the assistance of two people to mobilise… she was non-weight*

[17] This is an index recommended to assess post-stroke mobility.
[18] This is a way of formally analysing incidents with implications for patient care in order to improve services. An effective significant event audit usually seeks contributions from every member of the healthcare team and involves a meeting to discuss what happened, why and what lessons can be learned.

bearing at this point….. her wound site appeared to be oozing'. The report documented that the GP was contacted and the patient was transferred back to the ED at the RVH.

40. Under the heading '*Why did it happen',* the report documented: *'The patients* [sic*] was designated medically fit, the AHP*[19] *assessments indicated that she required the assistance of one person to mobilise and the nursing staff reported that the wound was clean and dry with a Braden* [20]*of 20. It would appear that [the patient] was appropriate to discharge but the account provided here does not provide sufficient detail and insight to establish why [*the patient*] deteriorated so quickly and whether transfer may have contributed to her deterioration'.*

What has been learned

The unit should establish that patient's pain is well under control before accepting patient.

What has been changed?

The unit will establish that pain control is adequate before accepting.

Recommendations following the level one SEA

To liaise with fracture wards to establish any underlying reasons that may assist in understanding this case.'

Relevant Independent Professional Advice Orthopaedic Surgeon (O IPA)

41. The O IPA was asked to explain the examinations and tests carried out prior to discharge and what medication the patient was prescribed on discharge. The O IPA advised that she was being '*investigated with routine blood tests and pelvic x-rays which were deemed satisfactory. She had been examined medically and was deemed fit for discharge. In the absence of any specific symptoms, no further tests and examinations would be indicated'.* In terms of medication, the O IPA advised that '*the patient was prescribed a large number of medications on discharge. The key ones here would be low*

[19] Allied Health Professionals

[20] The Braden Scale is an evidenced-based tool, developed by Nancy Braden and Barbara Bergstrom, that predicts the risk for developing a hospital or facility acquired pressure ulcer/injury.

molecular weight heparin to prevent DVT[21] and painkillers and was prescribed those appropriately'.

42. The O IPA was asked to comment on the state of the patient's wound prior to discharge, the O IPA advised that '*there is no mention of the state of the wound in the medical notes. Nursing notes indicate dry wound dressing on 27.9.17. Nursing notes on 28.9.17 at 0800 hours comment dressing in situ[26] and later at 1600 hours comment that no ooze was noted. The last medical notes post-operatively from 27.9.17 and the discharge letter do not mention any wound problems either. Therefore I would have to assume that condition of the wound was satisfactory at the time of discharge'.*

43. The O IPA was asked to comment on the urine sample taken from the patient on the removal of the catheter. The O IPA advised that '*it is not routine practice for a urine sample to be taken on removal of catheter. However it is commonly done and antibiotics are often prescribed at the time of catheter removal during the early period after a joint replacement…. I could not find any evidence that she had been given antibiotics at the time of catheter removal before discharge. There are no clear guidelines or evidence for this practice as it is documented in the "Guidelines for Prevention of Catheter-Associated Urinary Tract Infection". The practice varies amongst different units and some units recommend that after recent joint replacement, catheter insertion or removal should be done under antibiotic cover whereas others don't. Neither of this can be faulted but there should be clear published departmental guidance.*

44. The O IPA was asked if the urine sample sent to the lab for testing ought to have been diagnosed as urgent, the O IPA advised that '*in the absence of any particular urinary symptoms or other signs of sepsis[22] in the patient, there is no requirement to designate such a sample as urgent'.* The O IPA further advised

[21] Deep Vein Thrombosis
[26] In the original place.
[22] Sepsis is a potentially life-threatening condition caused by the body's response to an infection. The body normally releases chemicals into the bloodstream to fight an infection. Sepsis occurs when the

that '*there should also be clear departmental policy in Orthopaedics with regard to antibiotic prophylaxis during catheter insertion and removal, in post-operative patients to prevent variation in practice….I am hoping that following this case such a department policy can be implemented and circulated.'*

45. The O IPA was asked whether the patient was medically fit to be discharged on 29 September 2017. The O IPA advised that the patient's '*CRP was 121.7 on discharge on 29.09.17. Her CRP had been 334 on 26.07.17 after her surgery and was progressively improving. Therefore, in the absence of any clinical signs of sepsis, it would have been acceptable to discharge with this CRP reading. However, there should have been a plan in place to have further CRP checks in the subsequent days, to ensure that the CRP level was continuing to decrease. If there was any increase in the CRP levels after discharge, provisions should have been made for this to be monitored by a doctor, so appropriate action could be taken i.e. checking for sepsis. I am not aware of specific guidelines regarding this, but this would be considered acceptable clinical practice.'*

46. The O IPA further advised that '*there is no indication in the medical notes to suggest that the patient was not fit for discharge on 29.09.17. She was assessed by orthopaedic registrar (ST3) on 29.9.17 and was considered safe for discharge to Belfast rehabilitation. She was also assessed by FY2 in orthomedicine on 28.9.17, but there does not appear to have been any Consultant level assessment or decision with regard to her discharge. I would like reassurance that this had happened and was perhaps not documented. Otherwise I would consider this as a failing in* [the patient's] *care.* However, the O IPA advised that *'There is documentation from the complex discharge service on 29.9.17 that the patient was fit for discharge to a residential rehabilitation unit at that stage… it would appear that a residential care home with local GP cover was an appropriate place for the patient to be discharged'.*

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body's response to these chemicals is out of balance, triggering changes that can damage multiple organ systems.

47. The O IPA advised that *'the combined British Orthopaedic Association and British Geriatric Society guidelines for care of patients with fragility fractures published in 2007 and the NICE guidelines for hip fracture management [CG124] suggest that patients with hip fractures should be managed in close co-operation with Orthopaedic team and geriatric team and have surgery early.'* The O IPA also advised that '*Hospital inpatients should be reviewed by an onsite consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway…. The Trust should ensure that these standards are being met for this vulnerable group of patients'.* The O IPA advised that '*the orthopaedic registrar reviewing* [the patient] *(equivalent to a 1st year registrar in the old training system) and the ortho-physician was FY2 and neither of them can be classified as senior medical staff. I note the Trust's response that any concerns or issues would be discussed with* [the consultant Ortho-physician] *over the phone but this does not reassure me that elderly patients are being cared as per recommended national guidelines.'*

Occupational Therapist (OT IPA)

48. The OT IPA was asked to describe the OT assessment detail prior to the patient's discharge. The OT IPA advised that '*the Occupational Therapist completed an initial interview assessment of the patient dated 29.9.17. This assessment is routine and widely used in order to gain information about the patient's previous level of function thus giving an indication of what the patient needs to be able to do in order to return home. There is no record of further assessment after this initial interview other than a discharge summary.'* The OT IPA advised that '*there is no evidence in the clinical records provided to show that the OT undertook any observed assessment to form the basis of this summary as described in RCOT Professional Standards.'*

49. The OT IPA also advised '*On page two of the Functional Assessment there is a contradiction in findings – in the second column "current ability" the patient is recorded as needing assistance of 1*[23] *(AO1) but in the third column*

[23] 1 person needed to assist the person (AO1)

"comments/recommendations and or actions taken" it is recorded that the patient requires assistance of 2 (AO2). In the Trust's response to the family (04.07.19) they state that [the patient] was assessed by both OT and Physio as needing AO1. Keeping accurate records is a fundamental duty of all Allied Health Professionals.' The OT IPA further advised that '*On page four in the conclusion, the OT states clearly that the information had been gained from [*the patient's] *daughter, it is not clear which information this refers to. It is noted that the OT initial assessment and discharge summary are recorded as being completed on the same day 29.09.17 which strongly suggests that little, if any, other assessment took place. '*

50. The OT IPA was asked whether there was appropriate planning in place for the patient's discharge. The OT IPA advised that '*It is noted that the OT initial assessment and discharge summary are recorded as being completed on the same day 29.09.17 which strongly suggests that little, if any, other assessment took place. The notes show that the discharge coordinator spoke with the family on the 29.09.17 and the decision was taken to send the patient to the rehabilitation unit. There is no evidence of any Multi-Disciplinary discussion about this plan. It is not clear when the referral for the patient was received by OT and if there was a delay in assessment. The clinical records show that "Belfast rehab" was mentioned during the ward round on 28.09.17 which suggests that the plan to send the patient to the rehabilitation unit was initiated before the OT had even seen the patient. The notes show that the discharge coordinator spoke with the family on the 29.09.17 and the decision was taken to send the patient to the rehabilitation unit.'*

51. The OT IPA further stated that '*The evidence provided does suggest that it would have been appropriate for a rehabilitation unit if medically fit and the rationale documented at the end of the OT discharge summary is reasonable from the information noted; there is, however, no evidence of objective assessment by the OT to support this.'*

52. The OT IPA was asked to comment on whether the patient was provided with a wheelchair, the OT IPA stated *'It is likely that the patient had been provided*

with the wheeled Zimmer frame referred to in the clinical records by the Physiotherapist who documents mobility and transfer assessments in the notes. It would be considered normal practice to transfer a patient with the equipment they require unless there is a local operating policy that states otherwise. It is not common for the Allied Health Professional (OT/Physio) to be present at the point of discharge and ensuring that the person leaves the ward with all that they require is usually the responsibility of ward staff (nursing).'

53. The OT IPA concluded by advising that '…*the information but does not provide assurance that any observed assessment was carried out in order to formulate the discharge summary and recommendations…. The evidence provided does suggest that, had [the patient] been medically fit, a period of time at the rehabilitation unit would have been appropriate to improve her mobility, transfers and anxiety. There is, however, a lack of documented evidence to show how this decision was reached, which professional assessment contributed to it and how person centered it was.'*

Physiotherapist (P IPA)

54. The P IPA was asked to detail the physiotherapy assessments which took place prior to the patient's discharge. The P IPA advised that '*This lady was seen on 25 Sept 2017 by the physios on the ward – in too much pain to do any transfers/mobilising. She was seen again by physio on 26 Sept– needing AO2 to transfer. She was seen again by physio on 27 Sept and still needing AO2 and a frame to transfer. There does not appear to be any further physiotherapy input after this date from the records supplied.'* The P IPA also advised that the OT discharge summary report states that the patient was '*managing with AO1 BUT*[24] *it also mentions that she requires the AO2.'* The P IPA advised that '*…it remains unclear from this OT discharge summary quite what level of assistance this lady needed at the point of discharge*.

55. The P IPA was asked whether the patient received adequate and appropriate physiotherapy assessments before discharge. The P IPA advised that it

[24] IPA emphasis

appeared to be a '*rushed discharge and sections of the physiotherapy 'select form' (dated 28/9/17) have not been fully completed- whole sections have been left blank e.g., on page 3 of 4 there is nothing filled in for the section detailing equipment required for discharge / date equipment ordered Therefore, although on page two of this form it states that this lady requires a wheeled Zimmer frame (see functional mobility section, under type of aid used and under the discharge assessment column) we can't be sure if she was actually discharged with a frame – there are no notes in the adjacent 'comment/recommendations and/or actions taken column. And we don't know if she needed the assistance of 1 or 2 when using this frame. This physiotherapy 'select' form appears to have been completed by the same physiotherapist who visited the patient on the ward on 25, 26 and 27 Sept 2017.'* The P IPA further advised that '*it looks as if there were no further visits after 27 Sep (although the 28 Sept 2017 physiotherapy 'select' form was completed on 28 Sept 2017 – the day before discharge).'* The P IPA advised that it is '*likely…that the patient would have needed the assistance of 2 on discharge with some activities… but the documentation is very poor and this makes it difficult to draw any firm conclusion'.*

56. The P IPA was asked whether the patient received a Zimmer frame on discharge, the P IPA advised that '*we cannot be sure due to poor record keeping… Furthermore, although (page 2 of 4) under the functional mobility section it says this lady needed a wheeled Zimmer frame in the discharge assessment column – we don't know if she was using this with the assistance of 1 or assistance of 2, the documentation isn't there and it should be.'*

The Trust's response to Independent Professional Advice

57. On receiving advice from the O IPA, the Trust was asked to comment on whether there was any input from a consultant geriatrician in to the patient's care prior to her discharge. The Trust stated that '*A consultant physician in orthogeriatrics is attached to the fracture service to provide a medical liaison service for the fracture inpatients. The consultant physician looks after all patients irrespective of age and therefore is termed an Orthophysician, as*

opposed to a Geriatrician[25] who would only assesses older patients. As the service is primarily a trauma unit, the patients are admitted under a named orthopaedic surgical consultant who has ultimate 24-hour responsibility for the patient. In England and Wales, patients are admitted under a consultant geriatrician and consultant surgeon, in Northern Ireland they are admitted under a consultant orthopaedic surgeon.'

58. The Trust stated that an Orthophysician completed her medical assessment on 21 September 2017. The same staff member also spoke with the patient's relatives on 22 September, and the Orthophysician team also reviewed the patient on 25 September 2017. The Trust stated that '*on 28 September 2017, the patient would have been discussed with [the Consultant Orthophysician on the daily orthophysician ward round. On 29 September 2017, the senior medical staff would undertake the orthophysician ward round and any concern or issues discussed via telephone with [*the Consultant Orthophysician*], who works in Musgrave Park Hospital on Fridays'.* The Trust explained that the patient was '*reviewed on a regular basis between the surgical staff that completed her surgery and the orthopaedic physician staff that assessed and treated any medical issues.'* The Trust further stated that the '*ST3 Registrar[26]…reviewed her post-operatively on 25 September 2017, 27 September 2017, 28 September 2017 and on 29 September 2017.'*

59. The Trust were asked if they had a policy on patients receiving a review from a consultant on a daily basis whilst in hospital. The Trust stated it *'does not and did not have a specific policy on patients receiving review from consultants on a daily basis whilst in hospital. The surgical staff would have the senior registrar complete the review of patients. If there were surgical concerns, they would be raised with the surgical consultant. The Orthopaedic physician team would also undergo reviews on a daily basis and both of these teams, although different specialities, work together to ensure that patient safety and treatment is maintained at a high level.'*

[25] A geriatrician is a doctor who specialises in care of the elderly and the diseases that affect them.
[26] Speciality Trainee 3 is a point at which subspecialty training is commenced.

Response to Draft report

Complainant's response

60. The complainant advised that she was grateful to the Ombudsman for the investigation and it was important to her that '*this will never happen again to other families.'* The complainant advised that before her fall, her mother enjoyed '*being with her Great Grandchildren, she would play games with them, read them stories, knit jumpers for them and enjoyed life, at 87 she had slowed up, was still climbing stairs and only used a walking stick when going out with my sister whom she lived with.'*

61. The complainant said that she did not feel that Chestnut Grove was an appropriate place to send her mother due to their acceptance criteria. The complainant also advised of the distress caused due to the absence of a Zimmer frame for her mother, the complainant said '*We feel when Chestnut Grove had policies in place that they do not accept patients who require two people, they do not have the staff or have Zimmer frames and no frame was sent with her, that she should have been sent back to the Royal and not accepted at Chestnut Grove. My sister did ring Ward 4A on the Friday night to ask about the zimmer frame, and was rang back the next day to say she could come and collect a simmer frame from the ward, in which she replied it was not needed as Mum was very ill and is going back to the Royal.'*

62. The complainant suggested that '*a leaflet might be produced for help to families whose relative goes into Hospital, questions and answers and other information that may help including who they may speak to.* The complainant further stated that she hoped the '*findings of your report that changes will be made for the good of all, and the staff involved in my Mum's care will take notice and try and remember how they would feel if they were in the relative's situation, if it was their mum how would they feel.'*

Occupational Therapist

63. The OT advised that '*The patient was referred to me by an unknown member of the MDT on the 29 September 2017; i.e. the date of discharge to rehabilitation. Normally, referral would take place at least a few days if not a week prior to discharge. The decision to send the patient to rehabilitation had already been made by another member of the MultiDisciplinary Team, (person unknown). Late referral required the whole O.T. process to be carried out in less than one day and, inevitably, this was done rapidly.'*

64. The OT stated '*An initial interview was carried out and documented and this involved contact with the patient's daughter. It is not clear if this was by phone or face to face. Hand written notes that state referring person (MDT), reason for referral and mode of contact with daughter would have been generated as a result, but these are not available and appear missing from the patient's file. An assessment of the patient's current functional status, as defined in the Discharge Summary, was carried out on the 29th September on the ward which included transfers and mobility assessments and summarised the patient's functional ability. Hand written notes would have been generated and inserted into the patients file. In the absence of these notes however, there is still proof of the assessment taking place as completion of the Discharge Summary would have been impossible had one not been carried out. Ref 'Current Functional Status'. A Discharge Summary was produced which would have required reference to hand written notes. Due to the nature and lateness of the referral, I would certainly have brought this to the attention of a more senior member of the Therapy Team. The details of this would have been written in my hand written notes, previously mentioned above.'*

65. The OT concluded by stating that '*An appropriate assessment was carried out on the 29 September, prior to the patient being transferred to rehabilitation. All documentation would have been fully completed and inserted into the patient's file prior to discharge. The hand written notes include information that cannot be easily inserted into either the initial interview or discharge*

summary pro forma documents. Unfortunately these notes are not available to corroborate this.'

The Trust's response

Consultant review before discharge

66. The Trust advised that there are *90 beds within the Trauma & Orthopaedic (T&O) Service and some of our patients are nursed in outlying wards as the demand on T&O beds often outweighs capacity. Twenty five percent of our total patient population would receive treatment for hip fractures. A senior decision maker, who is not necessarily a consultant, reviews all T&O patients daily, including weekends. However, there is 24-hour consultant availability and problems/concerns are escalated as required. The T&O team would wish to highlight that despite pressures and time constraints, our patients are carefully monitored and a lot of time is spent with sick patients, which is evidenced by our Morbidity and Mortality outcomes and the National Hip Fracture Database. We would draw attention to the 2018 National Hip Fracture Database report looking at data from January to December 2017. The Royal Victoria Hospital was one of only two units commended in this report for having one of the lowest 30-day mortality rates in the UK. The report stated that this finding was "consistent with these units' excellent performance over a number of years".*

67. In relation to the patient's care, the Trust stated that the patient was *'assessed by an FY2 doctor in ortho-medicine on 28 September 2017 and she was also assessed by the orthopaedic registrar ST3 on 29 September 2017. A consultant saw the patient post-operatively on 27 September 2017. Within the T&O Service, patients are reviewed daily, including weekends, with 24-hour consultant cover. Consultant advice is readily available for these doctors where required.'*

68. The Trust stated that *The Royal Victoria Hospital (RVH) provides a multidisciplinary model of care to all hip fracture patients from admission through discharge and beyond. Ortho-geriatric care is embedded within this*

pathway, an ortho-physician being present at morning x-ray meetings (along with orthopaedic surgeons, theatre nursing staff and trauma coordinators) to discuss daily admissions and operation lists and carrying out regular ward rounds on all fracture wards. Physiotherapists assigned to the fracture service ensure early mobilisation of hip fracture patients post-surgery (when possible). During the inpatient stay patients are cared for by dedicated fracture nurses who are conscious of all aspects of the patient journey and the need to plan for discharge, this is coordinated with Social Work and Occupational Therapy colleagues. Data collection by the Fracture Outcomes and Research Database (FORD) submitted to the National Hip Fracture Database (NHFD) enables benchmarking against other hip fracture units in the UK (excluding Scotland). The 2019 report indicates a high level of

- perioperative medical assessment
- Consultant surgeon and anaesthetist supervision at surgery
- physiotherapy by the day after surgery and
- mobilisation out of bed by the day after surgery

Other favourable comparisons include the assessment of bone health, falls assessment and the type of anaesthesia administered. For some years now the RVH has had a low 30-day and one-year mortality for hip fracture patients even though it is one the largest centres in the UK. The patient's discharge followed a well-recognised pathway for post-operative hip fracture patients, which included early mobilisation and onward progression to rehabilitation services. The patient followed this process, which was monitored by the consultant as evidenced by consultant documentation on 27 September 2017. The T&O medical team would wish to advise that the orthopaedic consultants work across sites covering surgical lists and outpatient clinics and are not always based in the Royal Victoria Hospital, however as previously advised our patients are assessed daily by a senior decision maker.

69. *The Trust would emphasise that T&O patients are seen by an ortho-physician not a Geriatrician. The patient was assessed by the ortho-medicine team on 21 September 2017, 25 September 2017 and 28 September 2017.*

The Consultant in ortho-medicine has explained that T&O welcomes feedback and he has taken learning from previous Ombudsman reports. T&O documentation has improved and it is now the consultant's practice to insert a stamp of evidence in the notes after seeing the patient. There is also a rehabilitation Geriatric consultant working within the service who undertakes a rehabilitation ward round twice a week and documents their findings in the notes.'

Multidisciplinary assessment

70. The Trust stated that '*The orthopaedic, medical and multidisciplinary team would like to provide reassurance concerning their level of care and would assure your office that discharges are properly managed and not dictated by service pressures. The medical and nursing care is individualised and patients are not discharged or moved to a rehabilitation facility unless they are deemed medically fit, as our focus is on patient outcomes. Bed pressures have no bearing on the decision to discharge. T&O patients follow a care pathway, which involves pre-operative optimisation, undergoing surgical procedure, mobilisation and transfer to rehabilitation facility if required. The patient's discharge followed this well-recognised pathway for post-operative hip fracture patients, which included early mobilisation and onward progression to rehabilitation services. The patient was found fit for onward progression to rehabilitation services on 29 September 2017. The Trauma & Orthopaedic Service at RVH provides acute surgical and post-operative care to patients. However, rehabilitation services are ideally provided in specialist rehabilitation units.*

Antibiotics post Catheter

71. The Trust stated that the '*T&O Chair of Division, has advised that caution needs to be applied when prescribing antibiotics for older people. The T&O Chair explained that in patients with joint replacement, the majority do receive prophylactic antibiotics; however, they should not be continued unnecessarily. T&O had previously discussed this matter with the microbiology team in the Belfast Trust and they explained that NICE guideline NG113, on antimicrobial*

prescribing for catheter related urinary tract infection, specifically does not recommend antibiotic prophylaxis to prevent catheter-associated urinary tract infections (UTI) in patients with a short-term catheter.

The relevant section of the NG113 guidance is detailed below:

Based on evidence, the committee agreed not to recommend routine antibiotic prophylaxis to prevent catheter-associated UTI in people with a short-term catheter in hospital. Prophylaxis is not recommended routinely before insertion of a short-term catheter for surgical, non-surgical or urodynamic procedures, while the catheter is in place, or at the time of removal.

- *Before or during short-term catheterisation, there is only limited evidence of benefit with antibiotic prophylaxis for symptomatic bacteriuria in surgical patients.*
- *During short-term catheterisation for urodynamic studies, antibiotic prophylaxis did not reduce episodes of symptomatic UTI.*
- *At the time of catheter removal, there is evidence of benefit for antibiotic prophylaxis for symptomatic UTI, but in subgroup analysis, this was limited to surgical patients, and predominantly those who had either prostate surgery or had a catheter in place for longer than 5 days. The committee discussed that antibiotic prophylaxis for all short-term catheter removal in hospital would be a change in practice, and widespread prophylaxis is not warranted taking into account the principles of antimicrobial stewardship.*

Misuse of antibiotics in frail older patients is a potent cause of clostridium difficile infections with an associated increase in morbidity and mortality.

CRP

72. In regards to CRP, the Trust stated that '*A raised CRP is common post-surgery due to the inflammatory response. The patient's CRP was decreasing on discharge and in the absence of any signs of sepsis; there was no*

indication to repeat her CRP. The medical team have advised me that there needs to be a clinical indication for taking blood samples from patients.'

Analysis and Findings

Whether the patient was medically fit to be discharged

Urine sample

73. The complainant said that the patient had a urine sample taken on 28 September 2017, the results of which were not made available until 3 October 2017 and confirmed that the patient had e-coli. I note the O IPA advised that '*it is not routine practice for a urine sample to be taken on removal of catheter. However it is commonly done and antibiotics are often prescribed at the time of catheter removal during the early period after a joint replacement'.* The Trust stated the urine specimen was a '*routine request , in keeping with the absence of any apparent clinical indication for urgent processing at that time- there was no pyrexia, the white cell count was entirely normal and the CRP which had been predictably raised post operatively was falling spontaneously.* The Trust also stated the sample was processed per the '*standard operating procedure for routine samples'.* As the sample was taken on a Friday and marked as routine, it was not processed until the Monday (2 September 2017). The Trust stated that '*there is a general move towards reporting routine microbiology work at weekends…. Belfast Trust is not in a position to offer this service currently'.* I note that the Trust further stated that NICE guidelines on antimicrobial prescribing for catheter related urinary tract infection, '*specifically does not recommend antibiotic prophylaxis'.*

74. I accept the O IPA's advice that '*in the absence of any particular urinary symptoms or other signs of sepsis in the patient, there is no requirement to designate such a sample as urgent'.* Therefore, I consider that the sample was designated correctly as routine and did not find a failing about this matter. Therefore I do not uphold this element of the complaint. I discussed the implications of this routine sample further at paragraph 104.

Discharge

75. The complainant said that the patient was not medically fit for discharge and that she was '*pushed out'* due to a bed shortage in the RVH on 29 September 2017. I note the Trust's response which stated that the patient's discharge planning was a '*multi-disciplinary team approach, which includes medical, nursing and allied health professionals (AHPs). She was deemed fit for discharge for further rehabilitation to Chestnut Grove.'* The O IPA further advised that the patient should have received a review from a senior clinician before discharge, which I will discuss below. However I accept the O IPA's advice that '*there is no indication in the medical notes to suggest that* [the patient] *was not fit for discharge on 29.9.17.'* Therefore based on the O IPA's consideration of the record, I consider the patient was medically fit for discharge and do not uphold this element of the complaint.

Whether there was appropriate planning in place for the patient's discharge

Review by senior clinician

76. The O IPA advised that from the medical records, it is not evident that there was any '*consultant level input in her care from geriatric medicine, although she had Consultant review from orthopaedics until 27.9.17'.* The O IPA advised that she was assessed by '*an orthopaedic registrar (ST3) on 29.9.17 and was considered safe for discharge to Belfast rehabilitation. She was also assessed by FY2 in ortho-medicine on 28.9.17, but there does not appear to be have been any Consultant level assessment or decision with regard to her discharge.'*

77. The Trust responded to the O IPA advice and said that it '…*does not and did not have a specific policy on patients receiving review from consultants on a daily basis whilst in hospital. The surgical staff would have the senior registrar complete the review of patients. If there were surgical concerns, they would be raised with the surgical consultant.'* In response to the draft report, the Trust stated that the patient's discharge followed a '*well-recognised pathway for post-operative hip fracture patients, which included early mobilisation and onward progression to rehabilitation services.'* The Trust stated that a

consultant saw the patient on 27 September 2017. Furthermore the Trust advised that the patient was '*assessed by an FY2 doctor in ortho-medicine on 28 September 2017 and she was assessed by the orthopaedic registrar ST3 on 29 September 2017. As previously advised the Trust would wish to highlight that consultant advice is readily available for these doctors where required.'* The Trust also provided a policy regarding handover of patients when consultants are on leave. As part of this investigation, I reviewed the policy but was unable to find any relevance to this patient's situation.

78. The Trust also provided information on the statistics for the department. The Trust stated that '*2018 National Hip Fracture Database report looking at data from January to December 2017. The Royal Victoria Hospital was one of only two units commended in this report for having one of the lowest 30-day mortality rates in the UK. The report stated that this finding was consistent with these units excellent performance over a number of years'.* The Trust also advised that following a previous Ombudsman's report from late 2018, '*the weekday ortho-medical ward round is recorded in the notes using a stamp and it is stated whether the Consultant physician was present on the ward round. This should help demonstrate in future continue consultant input in the care of our patients.'*

79. I acknowledge the Trust's response to the draft report including the information provided relating to the statistics of the hip fracture unit at RVH. I acknowledge that the unit is recognised in the UK for the care provided to their patients and that '*for some years now the RVH has had a low 30-day and one year mortality for hip fracture patients even though it is one of the largest centres in the UK.'* Furthermore, I acknowledge that due to resources provided to the health service, it may not be possible to provide all patients with a review by a consultant every day, as stated in the Consultant care guidelines '*The Academy does not believe that the standards proposed in this report can be universally achieved within existing local resourcing arrangements and NHS tariff levels'*

80. Nevertheless, there is no evidence that a consultant reviewed the patient from 27 September 2017 until discharge. It is evident from the Significant Event Audit Report that the patient arrived at Chestnut Grove in '*severe pain*, her wound was '*oozing'* and she was '*non-weight bearing'.* The patient had to be transferred back to hospital less than 24 hours later, the patient appeared unwell and the Out of Hours GP advised that she should be transferred back to hospital. I accept the O IPA's advice that '*hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours…..the Trust should ensure that these standards are being met for this vulnerable group of patients'.* I also considered the DOH discharge guidelines which states that ward rounds should be scheduled in such a way that '*at least daily, a senior clinical review of all patients in acute hospitals'* can occur. The O IPA advised that an ST3 registrar '*cannot be classified as senior'.* The Trust stated that '*consultant advice is readily available for these doctors where required.'* I accept that due to resources, it is impossible for a Consultant to review every patient daily, however I consider that the Trust should have considered providing the patient with a review by a more senior member of staff on either of the final two days before discharge. I accept than an ST3 registrar '*cannot be classified as senior',* this calls into doubt whether the ST3 registrar would have had the experience to recognise if the patient needed the attention of a more senior member of staff. Therefore I consider the Trust failed to provide the patient with a review by a senior clinician before discharge. I consider this to be a failure in care and treatment.

Monitoring of CRP levels on discharge

81. The O IPA stated that it was '*acceptable to discharge [*the patient] *with this CRP reading.'* However the O IPA noted that there should have been a plan in place to have further CRP readings checked in subsequent days. I note the patient's discharge letter recorded her CRP level on discharge but does not advise that CRP readings should be monitored for the patient over the next few days. The patient returned to RVH less than 24 hours later, therefore there is no record within the Chestnut Grove notes of the patient's CRP reading. I also note the patient's CRP level in ED was recorded as 134.7. I

considered the Trust response to the draft report concerning the rationale for taking a blood sample post discharge to monitor CRP levels in this case. I note the comments of the IPA however I consider that there was no clear rationale to arrange for blood samples post discharge and therefore the failure to do so did not impact upon the patient.

OT assessment

82. I note the Trust stated that ‘*‘On 29 September 2017 the patient was seen and assessed by Occupational Therapy in preparation for her discharge planning to Chestnut Grove.’* It is unclear from the records whether the OT assessment was made pre or post the decision to discharge. I reviewed the patient’s OT records including the initial interview assessment dated 29 September 2017 and the discharge summary which was also completed on 29 September 2017. I accept the OT IPA’s advice that this ‘*strongly suggests that little, if any, other assessment took place’* and ‘*there is no evidence of objective assessment by the OT’.* The OT IPA advised that it is not clear when the OT received the patient’s referral and if ‘*there was a delay in assessment’.* The OT IPA further advised that ‘*there is no evidence of any multi-disciplinary discussion about this plan’* and the medical records suggest that ‘*the plan to send* [the patient] *to the rehabilitation unit was initiated before the OT had even seen* [the patient].’ I note the response to the draft report from the OT who advised that the patient was referred to her on the day of discharge and the ‘*decision to discharge had already been made by another member of the multidisciplinary team. Late referral required the whole O.T. process to be carried out in less than one day and, inevitably, this was done rapidly.’* The OT further advised that due to the late referral, she would have brought this to the attention of a more senior member of the team. However there is no evidence in the records to suggest that this was escalated to a more senior member of the OT team.

83. In relation to the OT’s assessment, the OT IPA highlights that there is reference in the records to the patient needing assistance of one and also assistance of two. I refer to the OT proficiency standards which state that an

OT should '*be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines'.* I note in the OT's response to the draft report, the OT advised that there would have been hand written records that state' *reason for referral and mode of contact with daughter would have been generated, but these are not available and appear missing from the patient's file.'* The OT further stated that '*The hand written notes include information that cannot be easily inserted into either the initial interview or discharge summary pro forma documents. Unfortunately, these notes are not available to corroborate this.* 'During the course of the investigation, I asked the Trust to provide me with all relevant records for the patient. I generally give significant weight to contemporaneous records made available to me, and the absence of records in this regard has made it much more difficult to conclude that a full assessment was completed.

84. I consider the fact that the OT records document assistance by one (AO1) and assistance by two (AO2), along with the fact that the patient was referred to OT on the day of discharge as evidence that the patient did not receive an observed assessment from the OT. I accept the OT IPA's advice that '*the information does not provide assurance that any observed assessment was carried out in order to formulate the discharge summary and recommendations…. There is a lack of documented evidence to show how this decision was reached, which professional assessment contributed to it and how person centered it was.'* I acknowledge the OT's response to this office, the patient was referred to her on the day of discharge; however I am satisfied that the patient should have been provided with an observed assessment by the OT and as there are no records that this occurred I consider the patient was discharged without being adequately assessed. I reviewed the OT proficiency standards which advise that OTs should '*keep accurate, comprehensive and comprehensible records'.* I consider the error in the OT records regarding what level of assistance the patient required and the lack of documented evidence to show how decisions were reached also amounts to a failure in record keeping in relation to the OT records

Physiotherapy assessment

85. I reviewed the patient's physiotherapy records and considered the advice of the P IPA. The physiotherapy treatment form is hand written and details a description of the treatment that the physiotherapist provided to the patient. It records that the patient was last reviewed on 27 September and was designated as '*AO2'.* I note there are no further entries on the physiotherapy treatment form after 27 September. The Trust stated that the patient was treated twice by a physiotherapist on 29 September 2017, however I was unable to find any records which provide evidence of this. The P IPA also advised the patient '…*was seen again by physio on 27 Sept and still needing AO2 and a frame to transfer. There does not appear to be any further physiotherapy input after this date from the records supplied'*.

86. I reviewed the physiotherapy select form completed on 28 September 2017. This is an electronic form and does not provide a description of any treatment provided to the patient. Large sections of this form are not completed, however it does state that the patient requires '*Assistance x 1'* and '*wheeled Zimmer frame'.* I accept the P IPA's advice that due to the poor record keeping it '*it is difficult to drawn any firm conclusion'* on whether the patient required assistance of one or two people.

87. I reviewed the guidance for patients in hospital who require physiotherapy treatment. The NICE hip guidelines state that patients should be offered '*mobilisation at least once a day and ensure regular physiotherapy review'.* The physiotherapy treatment form shows that the patient received physiotherapy review until 27 September 2017. There is no further evidence to demonstrate that the patient received a physiotherapy review on 28 or 29 September.

88. I accept the P IPA's advice that the discharge appeared to be '*rushed',* the documentation is '*poor and this makes it difficult to draw any firm conclusion'.* It is evident from the documentation that there is no consistency as to the

level of assistance that the patient needed. The physiotherapy records document that the patient is AO2 until 27 September. The physiotherapy select form documents the patient is assistance AO1 on 28 September. However, the form completed by the OT on 29 September records both A01 and A02. I reviewed the criteria for entry to Chestnut Grove which states that patients must be AO1.

89. The medical notes detail notes from the complex service team detail that the patient was '*assistance x1@ward level as per nursing/physio/OT reports'.* It is difficult to come to a conclusion on whether the patient was A01, as it is highlighted in the significant event audit report that the patient was in pain and required A02 people from entry into Chestnut Grove. In light of this and the records available, I consider that the physiotherapist failed to provide the patient with a review on 28 and 29 September 2017.

90. I also accept the advice from the P IPA that the record keeping was '*poor'* for this discharge. It is unclear how the decision was arrived at in terms of designating the patient as A01 on the day of discharge, there is no record of review on 28 or 29 of September to support this. I am mindful of the CSP code which states that the physiotherapists should '*justify and account for their decisions and actions'* and '*complete records in accordance with legal, ethical and organizational requirements'.* I consider the physiotherapy records do not meet this standard and amount to a failure of record keeping by the physiotherapist. However, I do not consider this failing resulted in the patient suffering an injustice.

Provision of a Zimmer frame

91 The Trust stated '*it is not documented that the Zimmer frame was transported with her to Chestnut Grove on discharge on 29 September 2017'.* I note the clinical records specifically the physiotherapy select form completed on 28 September 2017 which documented that the patient requires '*a wheeled Zimmer frame'.* This is also documented in the OT Occupational Therapy discharge summary. I note the Guidelines for Adults with Social Care Needs

state that Trusts should '*ensure that any essential specialist equipment and support is in place at the point of discharge'.* Furthermore, the DOH discharge guidelines state that a Multidisciplinary team should work '*collaboratively to plan care, agree who is responsible for specific actions and make decisions on the process and timing of discharges and transfers.'* It is unclear from the medical records who was responsible for providing the patient with a Zimmer frame at the point of discharge. The lack of a coordinated discharge between the staff at hospital resulted in a lack of appropriate equipment being provided to the patient on discharge. Based on the evidence and the Trust's response, I am satisfied the Trust failed to provide the patient with a Zimmer frame on discharge to Chestnut Grove. I consider this resulted in the patient suffering the injustice of uncertainty as she was not provided with the appropriate equipment to help her with her rehabilitation. I acknowledge the complainant's response to the draft report. She states that her sister had to ring the hospital to enquire about the provision of a Zimmer frame to her mother and was advised to come and collect it. I consider this also caused the complainant to suffer the injustice of uncertainty as they had to make arrangements to collect the equipment for their mother.

Multidisciplinary team approach to discharge

92. I am concerned that although the Trust stated that the patient's discharge was a '*multidisciplinary team approach',* the failings identified above do not support this. I also considered the Blue Book guidelines which state that '*successful peri-operative care, rehabilitation and discharge requires close cooperation between patients and their relative, nursing staff, physiotherapists, occupational therapists, social workers and discharge coordinators'.* The failure of the Trust to provide a Zimmer frame, the physiotherapy and occupational therapy records which record that the patient required the assistance of both one and two people, the lack of records and missing details relating to how decisions were reached, the lack of review from a senior member of staff and the failure to provide the patient with physiotherapy treatment do not illustrate close cooperation nor communication between the

teams involved in the patient's care. There is no evidence of any communication between these different teams and no evidence of a meeting regarding the patient and her needs before she was discharged. I accept the OT IPA's advice which stated that '*there is no evidence of any multidisciplinary discussion about this plan' a*nd the advice from the P IPA who advised that the discharge appeared '*rushed'*.

93. The Trust advised that on 29 September, Ward 4A received six admissions in total and on 30 September '*Trauma & Orthopaedics were in escalation with 29 fracture patients outlying'.* I reviewed the Guidelines for Adults with Social Care Needs which state that Trusts should '*ensure that any pressure to make beds available does not result in unplanned and uncoordinated discharges'.* In response to the draft report, the Trust stated that it would like to provide '*reassurance concerning their level of care and would assure your office that discharges are properly managed and not dictated by service pressures.* The Trust stated that their focus is '*on patient outcomes. Bed pressures have no bearing on the decision to discharge.'* The Trust stated that the patient followed the '*well-recognised pathway for post-operative hip fracture patients, which included early mobilisation and onward progression to rehabilitation.'* I acknowledge the Trust's response and I am satisfied that the patient was being managed in accordance with this pathway. However, overall in relation to the patient's discharge there was poor coordination and joint working between the different teams involved in the patient's care as cited at paragraph 76. The OT in response to the draft report indicated that he/she only received the notification to review the patient on the day of discharge and that the decision to discharge had already been taken by the MDT. Failures in this process can severely undermine people's trust and confidence. I acknowledge that O IPA advised that based on the records, he considered that the patient was medically fit for discharge. However, I consider that overall the Trust failed to provide the patient with a sufficient review by a multidisciplinary team

94. In summary, the investigation did not identify failings as to the designation of the urine sample as routine or as to whether the patient was medically fit to be discharged. However the investigation identified the following failings:

a. Failure to consider providing the patient with a review by a senior clinician on 28 or 29 September before discharge;

b. Failure of the OT to provide an observed assessment before discharge;

c. Failure of the Physiotherapist to review the patient on 28 and 29 September;

d. Failure to provide the patient with a Zimmer frame on discharge;

e. Failure to provide the patient with a multidisciplinary review before discharge; and

f. Failure of the OT and Physiotherapist to adhere to record keeping standards.

95. As a consequence of the failings I identified I consider the patient experienced an unplanned and uncoordinated discharge. I consider this caused the patient to suffer the injustices of distress and anxiety as she was not afforded the opportunity to receive a review from the many different specialties involved in her care whilst in hospital. I also consider these failings resulted in the complainant suffering the injustice of uncertainty as her mother was discharged without receiving a review from a multidisciplinary team and this would have caused the complainant to worry about her mother and her wellbeing.

96. I note the Chestnut Grove acceptance criteria states that patients must require the assistance of one. I acknowledge the response from the complainant in which she said that she did not believe her mother should have been accepted to Chestnut Grove and should have been sent back to RVH. However, as a consequence of the failings in record keeping I am unable to determine if the patient required A01 or A02 before discharge. Therefore I am unable to conclude whether Chestnut Grove was the appropriate location for the patient's rehabilitation I also consider that it is not possible to conclude that the patient's rapid readmission to the RVH was

caused by failings in the discharge process however that remains a concern given the lack of a coordinated approach to discharge.

Issue 2:

Detail of complaint

97. The patient became unwell at Chestnut Grove during the early morning of 30 September 2017. The Serious Audit report recorded that on admission she was unable to weight bear and required two people to transfer. The staff noted that at 06.15 on 30 September, the patient was experiencing '*excruciating pain'.* The GP out of hours service was contacted at 11.29 to request assessment and the patient was transferred back to the RVH ED at 14.42. A locum middle grade doctor reviewed the patient at 15.29 and a nurse changed her dressing at 16.20. A bed was requested for the patient in BCH and the patient was transferred to Ward 6 South at 20.37.The complainant expressed dissatisfaction about the delay in her mother receiving a bed after being readmitted via the ED of the RVH. She further complained that her mother's dressing was '*bloody and oozing'.*

Evidence Considered Legislation/Policies/Guidance

98. I considered the Trust's policy on urine analysis and identified the following key extract:

'***Urgent Samples***

Any urgent samples including all for BHSCT A&E should be registered and processed immediately.'

99. I considered the NMC code and identified the following extract :

'10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some-time after the event" and

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need'.

100. I reviewed the Septic Shock standards, particularly standard 7; *'7. Antibiotics administered:*
    - *50% within 1 hour of arrival*
    - *100% before leaving the ED'*

101. I reviewed the NI ED statistics 2017 which referred to the ministerial targets for Northern Ireland on emergency care waiting times for 2017/2018; '*95% of patients attending any Type 1, 2 or 3 Emergency Department should be either treated and discharged home, or admitted, within four hours of their arrival in the department, and no patient attending any Emergency Care Department should wait longer than 12 hours. By March 2017, at least 80% of patients to have commenced treatment, following triage, within 2 hours'.*

102. I reviewed the Manchester Triage scale which indicated that patients designed as '*very urgent'* should be seen within 10 minutes of arrival.

103. I reviewed the GMC code, particularly the following relevant sections: '*15.b Promptly provide or arrange suitable advice, investigations or treatment where necessary…16.c Take all possible steps to alleviate pain and distress whether or not a cure may be possible.'*

The Trust's response to investigation enquiries

104. In the Trust's response to the complainant on 24 January 2019, the Trust stated that the patient was reviewed by the doctor in ED at 15.29. The clinical notes documented that the patient was complaining of fever, pain around wound site and nausea. The treatment plan consisted of blood tests, chest Xray, ECG and intravenous fluids. The Trust further stated that the staff nurse documented in the clinical notes that the wound dressing was changed and *'…the wound was clean and dry and her skin was checked for pressure damage at this time. There was some blanching erythema*[27] *noted to your*

[27] Blanching redness on the skin, which essentially represents inflammation on the skin and can be present in a variety of different disorders. When something blanches, it typically indicates a temporary obstruction of blood flow to that area.

mother's sacrum[28] *and pressure area care was given. I understand from your family meeting on 29 August 2018, you had referenced that the ED nurse stated the dressing was dirty. Unfortunately, this is not documented in the clinical notes and [*the RVH Service Manager] *is unable to confirm or deny this. He apologises that he is unable to provide a definitive answer to this particular query, only that the dressing was changed'.*

105. Regarding the patent's stay in ED on 30 September, the Trust stated in a letter to the complainant that '*Your mother spent just under 6 hours in the RVH ED. Irrespective of the circumstances; both your mother and family left the ED dissatisfied and upset with the level of care and compassion provided. This should not have been the case.* [The RVH Service Manager] *would like to apologise again and assure you that all staff involved in your mother's care in the ED have been made aware of your concerns so that they might learn from your experience…'*

106. The Trust were asked to provide an indication as to how many emergency attendances there were on 30 September 2017. The Trust stated *'…from 00:00 -23:59 hour period, there were 263 attendances at the Emergency Department. The system does not retain the number of patients waiting to be seen at any given time. '*

107. The Trust was asked whether it had any policies regarding patients who are re-admitted shortly after discharge. The Trust confirmed it did not have a policy regarding patients who have recently been discharged.

Clinical Records

108. I reviewed the patient's notes from her time in ED on 30 September 2017. I included relevant notes below relating to her wound care. At 16.20, the notes record '*wound dressing changed- wound dry & clean'*

[28] Bone structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis.

109. I reviewed the records from Chestnut Grove for the patient. I reviewed the '*Individual daily notes'* which document the following on 29 September: '*Admitted to have ½ hip operation. Dressing and stitches on right leg from knee to hip. Cannot weight bare…'* The patient's '*Contact Record'* gives observations made by the care worker who came on duty that morning on 30 September 2017 that '*R hip was dressed but it appeared dirty. Fluid/Blood seeping from it?? Patient expressed feeling generally unwell. Ambulance arrived, morphine was administered and patient was transferred to RVH'.*

Relevant Independent Professional Advice ED IPA

110. The ED IPA was asked to comment on whether the patient received the appropriate tests and examinations on arrival at the ED department on 30 September 2017. The ED IPA advised that '*Following arrival to the emergency department the patient was attended by a triage nurse within 15 minutes of arrival this is in keeping with good practice. It is also noted that she had undergone an assessment by a doctor which had been completed with prescriptions written within about 60 minutes of arrival which is good practice (2011 DOH quality standards recommend patients should be attended by a decision maker within 60 minutes of arrival)– whilst the patient was prioritised as category 2 indicating that she should have been attended within 10 minutes of arrival it is not possible to confirm whether or not this was done due to the lack of detail in the medical notes. However, as the doctor had completed his assessment and written the medical notes, prescribing medications at 16:00, having obtained advice from an on-call pharmacist. I consider the medical assessment to have been undertaken in a reasonable timeframe. In addition, the patient was noted to have multiple medication allergies, so it was appropriate for the doctor to seek further advice before prescribing antibiotics to treat the possible sepsis. The doctor prescribed three antibiotics on the advice of the pharmacist.'*

111. The ED IPA further advised that '*Unfortunately, the administration of these took rather a long time. Vancomycin which needed to be given as a 2-hour infusion was administered first 1 hour and 10 minutes after request. The*

Gentamicin and Ciproxin were administered at 20:05. This was over 4 hours after the initial request was made. This does not meet with good practice standards for sepsis management (RCEM- Severe Sepsis and septic shock in Adults 2013). Sepsis management guidelines are very clear that time is critical in terms of early administration of antibiotics in patients with suspected sepsis. Antibiotics should be administered within 1 hour of arrival in cases of suspected sepsis. I consider that it would have been more appropriate to have administered the two stat/bolus dose antibiotics first followed by the slow infusion. This would avoid delaying the benefit of the 2 antibiotics which occurred on this occasion. It appears the nursing staff have simply followed the order in which the medications were written on the prescription chart. It is not recorded but by virtue of the medications being administered sequentially, I conclude that the patient had one intravenous cannula sited during her assessment. The medications could have been given quicker if a second cannula had been sited as this could have also been used for medication administration.'

112. The ED IPA advised on the type of antibiotics that '*It is very unfortunate that microbiology reports were not available until after the patient had died as these showed that the choice of antibiotics would not be effective due to resistance of the organisms causing the urine infection to multiple antibiotics. However, as outlined in the Trust response it does take a few days for this type of result to be available. With the benefit of hindsight and the microbiology results it is difficult to determine whether the delay in administration of antibiotics in the emergency department had an adverse impact on the patient as the results show subsequently showed that the antibiotics chosen as first line medications were not effective against the infection she was suffering with'.* The ED IPA further advised that the antibiotics were '… *given in best interests based on the information available at the time following a reasonable clinical assessed… we know that despite guidance and best assessment it is impossible to be 100% certain that a particular antibiotic will be effective in a given situation unless there is laboratory testing to confirm this.'* In conclusion, the EP IPA advised '*On the*

face of it even if the antibiotics had been administered early the outcome would most likely have been the same, however, if the antibiotics had been given early the patient would have been treated in line with sepsis standard guidelines and to a standard of care I would expect from the Emergency department.'

113. The ED IPA further advised that '*despite it being noted at time of triage assessment that the patient had low oxygen levels there is no comment about this by the attending emergency department doctor nor is there a record of oxygen administration in the notes until she was assessed by the medical doctor at 18:35. It would have been good practice to administer oxygen and repeat the observations to avoid the patient being hypoxic. It is considered good practice to prescribe oxygen in the same way as other medications.'* The ED IPA further advised '*From my reading not giving oxygen has not adversely affected the patient though she may have felt symptomatically better if she had received supplemental oxygen during her time in the emergency department. This is more an observation of where best practice was not followed…*'*In addition, there does not appear to have been any pain relief offered or administered to the patient in the emergency department despite it being noted that she was in pain (5/10 at triage).'*

114. The ED IPA concluded by advising '*I appreciate it was highly likely that the department at Royal Victoria hospital was very busy at the time of the patient's arrival to hospital (14:42 on a Saturday). It is also likely that the hospital was under extreme pressure meaning the patient was later admitted to Belfast City hospital rather than to a ward at Royal Victoria hospital. There is documentation of care in terms of hip wound dressing change and handover, also a record of concerns raised by the patient's family at the time which is all good practice. However, despite most emergency departments being very high pressure and high activity environments, the delays in medication administration and lack of records to demonstrate assessment and management of painful symptoms and low oxygen levels experienced by*

the patient do not support care being delivered at a standard I would expect to be delivered in the emergency department.'

Nurse (N IPA)

115. The N IPA was asked whether the appropriate procedures were followed in relation to the care of the wound prior to the patient's discharge. The N IPA advised that *'The patient's wound was a surgical incision that was closed at the skin level…..Postoperative care bundles recommend that surgical dressings be kept undisturbed for a minimum of 48 hours after surgery unless leakage occurs. However, there are currently no specific recommendations or guidelines regarding the type of surgical dressing (World Health Organisation 'Global guidelines for the prevention of surgical site infection' page 172). Generally speaking therefore, a simple protective dressing is used to cover the wound site for at least two days.'*

116. The N IPA advised that '*In line with NMC record keeping standards (referenced below) there should be a record of when the wound dressing was removed or changed and what dressing was used. The condition of the wound should also be documented on dressing changes. As referred to, for the first two days, the dressing can be left in place. There is no mention of wound care within the records that I have reviewed. It is therefore not possible to say if wound-care was appropriate. Record keeping was thus not in line with national guidance.* 'The N IPA concluded that '*The patient's wound management was not documented post operatively. Despite this, there is evidence that the wound looked 'clean and dry' on readmission [to] and thus there does not appear to have been any impact.*'

117. The N IPA was provided with the photo of the patient's wound taken by the complainant for review and was asked to provide a comment on the condition and appearance of the wound. The N IPA stated;

'With regards to how wound dressings should be described, the following descriptors are advised:

- *Dry—the primary dressing is unmarked by exudate[29]; the dressing may adhere to the wound.*
- *Moist—Small amounts of exudate are visible when the dressing is removed; the primary dressing may be lightly marked.*
- *Saturated—the primary dressing is wet and strikethrough occurs.*
- *Leaking—the dressings are saturated, and exudate is leaking from primary and secondary dressings onto the patient's clothes'*

118. The N IPA stated that *'Exudate is a liquid produced by the body in response to tissue damage and is therefore present in wounds as they heal. Small amounts of serous[30] exudate in the acute inflammatory stage of wound healing is normal. Serous exudate is watery and clear. Sanguineous [36]exudate is fresh bleeding, seen in deep partial-thickness and full-thickness wounds. Again a small amount may be normal during the inflammatory stage of wound healing. Small volumes of serous exudate from a healing wound and blood from surrounding skin, can also be seen on wound dressings and until the dressings are removed it is often not possible to say if the stains on dressings relate to sanguinous exudate or serous exudate from the wound and blood from the scratching of surrounding skin or surgical interventions such as stitches or staples.*

119. The N IPA provided an assessment of the photo. The N IPA advised that; '*The photographs reviewed do not show images of an exposed wound but do show images of a covered wound. With regards to 'what can be seen' the dressings look clean (they are white) and there is evidence of a small volume of sanguinous exudate or serous exudate and blood to the padded section of the dressing. There appears to be just one dressing covering the wound (a primary dressing). Utilising the wound dressing descriptors above, this would be described as 'moist' whereby the primary dressing is lightly marked. The*

[29] A mass of cells and fluid that has seeped out of blood vessels or an organ, especially in inflammation.
[30] of, resembling, or producing serum
[36] resembling or containing blood.

images reviewed do not show evidence of wound infection. However it should be noted that assessing a wound involves many other factors such as odour, heat, swelling and increased pain.'

120. The N IPA was asked to comment on the condition of the wound from the medical records when the patient was admitted to hospital on 30 September. The N IPA advised that '*On initial observation from an ED doctor, the wound was described as 'clean, mildly tender, no exudate, not hot to touch'. The dressing to the wound was removed by an ED nurse and the wound was described as 'dry and clean'. In summary, the wound was intact and with no signs of infection. There was no documented evidence of blood or exudate from the patient's wound on 30.09.2017.' '* The N IPA was asked whether there was a delay in the patient receiving nursing care on 30 September the N IPA advised that '*there was no delay; the wound was redressed at 16:20 shortly after it had been reviewed by the doctor.'*

121. The N IPA was asked to explain the appropriate procedures for nurses to follow when medication is prescribed to a patient. The N IPA advised that the '…*standards state "The patient medicines administration chart is not a prescription but a direction to administer medication. It must be signed by a registered prescriber and authorises the delegation to administer medication on the prescriber's behalf" (page 14). Prior to administering a medication, the nurse should ensure that the medication chart:*

"2.4 specifies the substance to be administered, using its generic or brand name where appropriate and its stated form, together with the strength, dosage, timing, frequency of administration, start and finish dates, and route of administration

2.5 is signed and dated by the authorised prescriber".

122. *'I am a nursing advisor and therefore for information only, doctors follow different standards as set out by their governing body (General Medical Council 2013 'Good practice in prescribing and managing medicines and devices'); this states "You should make sure that anyone to whom you*

delegate responsibility for administering medicines is competent to do what you ask of them". Thus, if the antibiotics are time and order specific…this should have been clearly communicated to nursing staff. In summary, nurses are responsible for ensuring that the medication chart clearly outlines the medication to be administered, noting the timing that administration is expected. Medication should be administered in line with the medication chart.'

123. The N IPA was asked whether the appropriate procedures were followed in this instance by nursing staff. The N IPA advised that '*The IV antibiotics that were prescribed on 30/09/2017 did not specify a timeframe for administration. The prescribing instructions were:*

Vancomycin to be given IV in 250mls over two hours.
Gentomycin to be given IV.
Ciproxin to be given IV.

Vancomycin was administered by nursing staff at 17:10.
Gentomycin was administered by nursing staff at 20:05.
Ciproxin was administered by nursing staff at 20:05.

The IV antibiotics were administered on 30/09/2017 in line with the prescriber's instructions. If the prescriber wanted the bolus/stat doses of Gentomycin and Ciproxin to be administered first, this should have been clearly documented and communicated to nursing staff as nursing staff would be working within the prescription/ medication chart in line with nursing standards.'

124. The N IPA explained the process in relation to administering medication through a cannula. The N IPA advised that '*The IV medication should be checked by two members of staff and administered in accordance with the prescription…. The first antibiotic administered was Vancomycin which was to run over to hours. The second two that were administered would be given as*

a 'bolus' (a one off slow IV administration). The start and finish time of infusions should be documented, this is in line with good clinical care and treatment and evidence based practice standards: Infusion Nurses' Society (2011) 'Infusion nurses standard of practice'. The N IPA further advised that 'T*here are some omissions from the national standards quoted in the above response. It is not clear when the Vancomycin finished, only that it was started at 17:05. The cannula site used has also not been documented.'*

125. The N IPA concluded that '*For medications such as these, which have been prescribed to be given as a 'one off' they should be administered as close to the prescribed time as possible. This is the responsibility of the nurse. There is no guidance for this because staff, environmental and patient factors will affect the timing of administration; for example if the unit is busy and there are patients requiring life-saving interventions, if the prescriber has communicated with nursing staff or not, if there are two nursing staff available – as is needed to check IV medications, if the patient is doing something else (for example hygiene or elimination), if the patient has vascular access or if a cannula needs to be inserted…. There were no specific instructions regarding the administration of the IV antibiotics. They were therefore administered in the order that they were documented on the prescription chart and one hour and five minutes after they were prescribed.*

Responses to Draft report

Complainant's response

126. The complainant said '*We (My Sister & I) were both shocked and upset to learn from the report that our Mum was in extreme pain from 06.15am and we were not contacted until around 10/ 10.15am. My sister was told that they had sent for the Doctor and she would be going back to the Royal, when my sister asked about coming over to Chestnut Grove she was told it would be better if she went straight to the hospital and that they would ring back and let her know when the ambulance was taking her to the A & E so we could meet her there.*

127. The complainant also said '*To also learn that she should have been given 3 antibiotics at one time and within a time frame when she had sepsis, we feel my Mother's fate was already doomed when she had E-Coli, although urine sample taken on Thursday 28/9/17 at 10.50pm and did not come back until the 3rd October 2017, the day she passed away. It was so distressing the length of wait from the long day that she put in, not getting a bed at the City Hospital until after 9pm. It is also worthwhile to note that I had to go to the Sister on duty that day and ask why my mum was waiting in the middle of the A & E and we were told she had sepsis and that the Doctor said she was to get a drip up, or it might have been longer, the A & E sister came over and looked at the notes on the bed and immediately got the drip administered. '*

Locum middle grade doctor

128. The doctor advised '*As set out above, I attended on Patient A at 15:29. Patient A was admitted as a 'priority 2' patient which identifies the urgency of care required. A nurse is assigned to a 'priority 2'patient upon admission. Following an examination of Patient A, I identified that she was allergic to a number of antibiotics (as listed above) and contacted the pharmacist on duty for advice. Following this discussion, I prescribed Patient A antibiotics as detailed above.*

129. *My standard practice following the examination of a patient is to explain to the patient the plan I have developed and what, if any, treatment they are to receive. When prescribing antibiotics my standard practice is to pass the directions for medications to be administered to the nursing staff. In the case of a priority 2 patient to whom a specific nurse has been assigned, my standard practice would be to pass the directions to this nurse. The nurse is then responsible for administering the antibiotics. Nurses are only permitted to administer IV antibiotics after they have undergone specific training.*

130. *The recorded directions for the medication to be administered sets out the name of the drug, the dose, the route and the date/time for administration. As*

can be seen from Patient A's notes and as set out above, I had recorded that the medications were to be given to Patient A at 16:00.

131. *It was my expectation that the antibiotics would be started promptly and within an hour as per the sepsis guidelines. It was also my expectation that the bolus doses of Gentamicin and Ciproxin would have been given before the Vancomycin was commenced, which was to be administered, by way of an IV infusion, over two hours. Ciproxin can be given over 30 minutes. Of the three antibiotics that I prescribed, only the Gentamicin could be given as a single 'push' dose.*

132. *It is established practice at the Emergency Department of the Royal Victoria Hospital that nurses administer prescribed antibiotics. It is my experience that most nurses would be aware that bolus doses should be given before an IV infusion which is likely to take a number of hours to be administered. This ensures that the patient receives treatment as promptly as possible. There is an IV administration guide available to the nurses which details doses and rates of infusion for prescribed medication. I do not know why there was a delay in the antibiotics being administered to Patient A. It was my expectation that the administration should have started shortly after 16:00. I do not recall the nursing staff returning to me to advise of a problem with the administration of the antibiotics.*

133. *A learning point which I have taken from my reflection in this case, is the opportunity for improved communications with nurses with regard to the administration of antibiotics in suspected cases of sepsis and indeed, in respect of all medications. Going forward, where relevant, I will also record in my notes any specific directions and instructions for the nurses in respect of the order or timing in which medication should be administered.'*

134. In terms of the provision of oxygen and pain relief to the patient, the doctor stated '*To the best of my recollection, Patient A was already on oxygen when I attended on her. With reference to Patient A's medical notes, upon arrival at the Emergency Department, her oxygen saturation was noted to be 88% at*

14:29. Patient A had a chronic lung condition, namely bronchiectasis, and it is normal for a patient with this condition to have lower than normal oxygen saturation levels. It would, however, be standard practice for a patient presenting with saturations at this level, even with a pre-existing condition, to be administered 2 litres of oxygen via nasal specs. The purpose of administering oxygen is to make a patient more comfortable. Whilst there does not appear to be any entry in the notes recording that Patient A had been administered oxygen whilst in A&E, I note that by the time Patient A was examined at 18:25, her oxygen saturation level had improved to 96%. This is consistent with Patient A having been put on oxygen upon admission. It is unlikely that Patient A's saturation levels would have improved from 88% to 96% over a number of hours, had oxygen not been administered.

I also note that the treatment plan recorded following the assessment at 18:25 included that Patient A should be weaned off oxygen, as tolerated, with an aim for saturations of 96%. This plan infers that Patient A was already on oxygen at the time of this assessment and that the oxygen being administered was to be gradually reduced. I accept that it would have been helpful if I had recorded whether Patient A was on oxygen when I examined her and recorded whether it should continue to be administered.

Following my examination of Patient A, I did not consider that she required additional pain relief at that time. Where a patient is admitted by ambulance, it is my normal practice to review whether pain relief has been administered by the ambulance crew. I was aware that Patient A had been administered 5mg of morphine by the ambulance crew approximately 1 hour and 30 minutes prior to my consultation with her. At the time of my examination, Patient A appeared comfortable and more pain relief was not immediately indicated. Upon reflection, I accept that I have not recorded that Patient A appeared comfortable within the notes and I appreciate it would have been good practice to record this detail. As a learning point, I will record this detail in future.'

Trust response

135. The Trust stated that '*The RVH Trauma & Orthopaedic Service provides acute surgical and post-operative care to patients. If we were in an ideal scenario running at 85% capacity, which is never the case, we could re-admit patients, if there was a fracture issue. However, our elderly patients have complex co-morbidities and following assessment in the Emergency Department, it is important to admit them to the relevant specialty, which can meet their clinical needs. Following ED assessment, the patient was appropriately admitted to the acute geriatric medical ward in Belfast City Hospital.'*

Analysis and Findings

Whether the patient received appropriate treatment in ED

Wound Management

136. In order to assess the wound on arrival at ED on 30 September and the care provided to the patient's wound, it is important to look at the condition of the wound before the patient's discharge on 29 September. Regarding the records relating to the wound the N IPA advised that '*there is very little mention of the wound site from the records that I have reviewed… I am thus unable to say what the condition of the patient's wound was prior to discharge'. T*he N IPA advised that '*there should be a record of when the wound dressing was removed or changed and what dressing was used. The condition of the wound should also be documented on dressing changes…..record keeping was thus not in line with national guidance'. I consider the absence of full and adequate records about the wound dressing a failing by nursing staff.* Due to the absence of records relating to the condition of the wound, I am unable to confirm the condition of the wound before discharge and if it was checked and changed regularly as per the WHO guidelines, I consider this to be a failure in record keeping on the part of the nursing staff. However, I do not consider this caused the patient to suffer

an injustice, as the patient's wound was recorded as '*dry and clean'* on 30 September 2017 in ED.

137. I reviewed the patient's records along with the advice from the N IPA and ED IPA. The complainant said that the patient's wound appeared '*bloody and oozing'* on readmission to ED on 30 September 2017. The Significant Event Audit Report detailed that the patient's wound '*appeared to be oozing'* when she arrived at Chestnut Grove. The records from Chestnut Grove state that the care worker observed the wound as '*Fluid/Blood seeping from it??'* I considered the photo provided to the office by the complainant and the N IPA's assessment of the photo. I note the N IPA advised that '*the dressings look clean (they are white) and there is evidence of a small volume of sanguinous exudate or serious exudate and bloody to the padded section of the dressing.'* I accept the N IPA's advice that '*the images reviewed do not show evidence of wound infection. However it should be noted that assessing a wound involves many other factors such as odour, heat, swelling and increased pain'.*

138. I also considered the records from the patient's ED attendance on 30 September 2017. The records documented that the wound was described as '*clean, mildly tender, no exudate, not hot to touch.'* A nurse also removed the dressing to the wound and recorded it as '*dry and clean'.* The N IPA stated that '*in summary, the wound was intact and with no signs of infection. There was no documented evidence of blood or exudate from patient's wound on 30.09.2017.'* The N IPA also advised that there was '*no delay'* in the patient's wound receiving nursing care.

139. I acknowledge the record from the care worker from Chestnut Grove, however I consider that the patient's wound was '*intact…with no signs of infection'* on arrival at ED on 30 September 2017 from the medical notes available and hope the complainant is reassured that her mother's wound was showing no signs of infection in ED. I also consider that the patient's wound received the

appropriate treatment in ED and therefore I do not uphold this element of the complaint.

Provision of antibiotics

140. The ED IPA advised that the patient was prescribed three antibiotics. The ED IPA considered that it was '*entirely appropriate for the attending doctor to seek advice from the pharmacist on which antibiotics to prescribe for the patient due to multiple known drug allergies'*. However the ED IPA advised that '*unfortunately the administration of these took rather a long time. Vancomycin which needed to be given as a 2-hour infusion was administered first 1 hour and 10 minutes after request. The Gentamicin and Ciproxin were administered at 20.05. This was over 4 hours after the initial request was made.'* The ED IPA further advised that the '*nursing staff have simply followed the order in which the medications were written on the prescription chart…The medications could have been given quicker if a second cannula had been sited as this could have also been used for medication administration'.*

141. I considered the Septic Shock standards which advise target timelines; 50% of antibiotics should be administered within 1 hour of arrival and 100% before leaving ED. I accept the advice received from the N IPA regarding the provision of antibiotics from the nursing staff, which states that '*the IV antibiotics were administered on 30/09/2017 in line with the prescribers instructions. If the prescriber wanted the bolus/stat does of Gentomycin and Ciproxin to be administered first, this should have been clearly documented and communicated to nursing staff*.' The N IPA stated that medications *'should be administered as close to the prescribed time as possible. This is the responsibility of the nurse.*' However, the N IPA stated that there is *'no guidance for this because staff, environmental and patient factors will affect the timing of administration'*; *for example if the unit is busy and there are patients requiring life-saving interventions, if the prescriber has communicated with nursing staff or not, if there are two nursing staff available – as is needed to check IV medications, if the patient is doing something else (for example*

hygiene or elimination), if the patient has vascular access or if a cannula needs to be inserted.'

142. The patient arrived at the hospital at 14.42, the three antibiotics were prescribed at 16.00, the patient's dressing was changed by nursing staff at 16.20 and the first antibiotic was given at 17.10. The patient received her first set of antibiotics 1 hour and 10 minutes after the request. This meant that she did not receive 50% of her antibiotics within 1 hour of arrival in ED per the Septic Shock guidelines, however she did receive 100% of antibiotics before leaving ED on 30 September. I accept the ED IPA's advice that there was a delay in providing the antibiotics to the patient; '*On the face of it even if the antibiotics had been administered early the outcome would most likely have been the same, however, if the antibiotics had been given early the patient would have been treated in line with sepsis standard guidelines and to a standard of care I would expect from the Emergency department*.'

143. I accept the ED IPA's advice and consider the patient did not receive the antibiotics in line with sepsis guidelines nor in the most efficient way as stipulated by the ED IPA. The locum middle grade doctor ought to have stipulated the order in which medications were to be administered and ought to have considered advising the nursing staff to site a second cannula to ensure that the patient received the three antibiotics in a timely manner. However, I also accept the N IPA's advice that a nurse's role is to provide medication to the patient as close to the prescribed time as possible. I note that the nursing staff changed the patient's dressing at 16.20 and also acknowledge that a Saturday in ED is an extremely busy time for all staff. However, I consider there was a lack of co-ordination between medical and nursing staff to ensure that the antibiotics were administered in the appropriate order and as close to the prescribed time as possible. Therefore I consider that both the Locum middle grade doctor and nursing staff failed to provide the antibiotics to the patient in a timely manner and in adherence with Sepsis guidelines on 29 September 2017. I am pleased to note the locum middle grade doctor's learning point from this; '*Going forward, where relevant,*

I will also record in my notes any specific directions and instructions for the nurses in respect of the order or timing in which medication should be administered.'

144. However, I accept the advice from the ED IPA who advised that '*it is difficult to determine whether the delay in administration of antibiotics in the emergency department had an adverse impact on the patient as the results show subsequently that the antibiotics chose as first line medications were not effective against the infection she was suffering with.'* The ED IPA advised that the antibiotics '*were given in best interests based on the information available at the time… we know that dispute guidance and best assessment it is impossible to be 100% certain that a particular antibiotic will be effective in a given situation unless there is laboratory testing to confirm this.'* Therefore, I do not consider that the patient received an injustice due to the delay in receiving antibiotics, as if she had received these antibiotics in adherence with the Septic Shock standards, it is unlikely this would have made a difference. It is very unfortunate that the laboratory tests were not made available earlier but as concluded at paragraph 61, I do not consider that the Trust failed in its designation of sending the sample to be tested as routine with the information it had available at the time.

Pain relief

145. The ED IPA also considered the pain relief provided to the patient during her time in ED. The medical records documented the patient's pain level was '*5/10 at triage';* however the ED IPA advised that the patient was not provided with any pain relief during this time. I refer to the GMC code which states that doctors must '*take all possible steps to alleviate pain' and 'promptly provide or arrange suitable advice, investigations or treatment where necessary'.* I acknowledge the response from the Locum middle grade doctor to the draft report. The doctor states that he '*did not consider that she required additional pain relief at that time'* after his examination of the patient as the patient '*appeared comfortable.'* I welcome the doctor's reflection that he had not recorded his observations regarding the patient's pain level in the notes and

appreciated '*it would have been good practice to record this detail. As a learning point, I will record this detail in future.'* However I accept the advice from the ED IPA and consider that the patient spent just over six hours in ED and her pain levels should have been considered and she should have been offered additional pain relief. I therefore consider that the locum middle grade doctor failed to provide the patient with pain relief. I consider this failing caused the patient to suffer the injustice of distress as she spent a considerable time in RVH ED in pain as her pain was recorded as five out of ten.

146. I also accept the ED IPA's advice regarding the recording of the patient's oxygen levels. The ED IPA advised that '*Despite it being noted at time of triage assessment that the patient had low oxygen levels there is no comment about this by the attending emergency department doctor nor is there a record of oxygen administration in the notes until she was assessed by the medical doctor at 18.35.'* In response to the draft report, the locum middle grade doctor stated that '*I accept that it would have been helpful if I had recorded whether the patient was on oxygen when I examined her and recorded whether it should continue to be administered.'* The GMC code states that doctors must '*record your work clearly, accurately and legibly.'* Therefore, I consider the locum middle grade doctor failed to record the patient's oxygen levels and oxygen treatment.

Whether there was appropriate planning in place for the patient's admittance to BCH

Delay in care in ED

147. The complainant expressed dissatisfaction that her mother arrived at ED RVH at 14.42 and was not allocated a bed until 21.00 in the BCH. I reviewed the medical records and the advice from the ED IPA. The ED IPA advised that the patient was reviewed by a triage nurse within '*15 minutes of arrival, this is in keeping with good practice. It is also noted that she had undergone an assessment by a doctor which had been completed with prescriptions written within about 60 minutes of arrival which is good practice'.* The ED IPA advised that the patient was triaged as '*category 2'* on the Manchester Triage

Scale, this indicated the patient should have been attended within '*10 minutes of arrival'*. The ED IPA was unable to confirm if this happened due to the '*lack of detail in the medical notes. However, as the doctor had completed his assessment and written the medical notes, prescribing medications at 16.00, having obtained advice from an on-call pharmacist. I consider the medical assessment to have been undertaken in a reasonable timeframe.* Therefore I am unable to determine if the patient was reviewed by a doctor in accordance with triage category due to the standard of records provided to this office.

148. I reviewed the ministerial target regarding waiting times for 2017 which stated that '*no patient attending any Emergency Care Department should wait longer than 12 hours'.* The Trust advises that there were 263 attendances to ED on 30 September 2017. The patient spent just under six hours in ED on 30 September. Although this is unfortunate and difficult for the patient and her family, it is under the 12 hours target. While I consider that the patient's waiting time for a bed was not unreasonable that does not diminish the stress that this causes to patients and their families. I acknowledge the response from the complainant to the draft report, in stating'*It was so distressing the length of wait from the long day that she put in, not getting a bed at the City Hospital until after 9pm.* I also note the Trust's apology to the complainant regarding her mother's experience in ED. It is unfortunate that the patient had to go to ED as she had just recently been discharged; however I acknowledge the response to the draft report by the Trust. The Trust stated that '*Our elderly patients have complex co-morbidities and following assessment in the Emergency Department, it is important to admit them to the relevant speciality, which can meet their clinical needs.'* The patient was admitted and diagnosed with a urine infection and therefore it was appropriate for her to attend the ED and be triaged appropriately so she could avail of the correct treatment pathway for her presenting symptoms. A return to the ward from which the patient had been discharged would not have been appropriate in this case. I understand that there is a need for assessment to ensure that a patient is on the correct care pathway and that for most patients this assessment is carried out in the ED. However I would urge the Trust to

continue to consider ways that they can minimise the stress on frail elderly patients as a result of long waits in the ED particularly where patients have only recently been discharged.

CONCLUSION

149. The complainant submitted a complaint to this office in relation to the care and treatment provided to her mother by the Trust in September 2017. I did not find failings in relation to the following matters:

- The urine sample taken and processed as routine;
- The patient was medically fit for discharge on 29 September 2017;
- The treatment provided to the patient's wound on 30 September 2017; and the delay in receiving a bed on 30 September 2017.

150. I found failures in care and treatment in relation to the following matter:;

- Failure to provide the patient with a review by a senior clinician on 28 or 29 of September before discharge;
- Failure of the OT to provide an observed assessment before discharge;
- Failure of the Physiotherapist to review the patient on 28 and 29 September;
- Failure to provide the patient with a Zimmer frame on discharge;
- Failure to provide the patient with a multidisciplinary review before discharge;
- Failure of the OT and Physiotherapist to adhere to record keeping standards;
- Failure of the Locum middle grade doctor and nursing staff to provide the patient with antibiotics in a timely manner in adherence with Sepsis guidelines on 30 September;
- Failure of the locum middle grade doctor to prescribe the patient with pain relief on 30 September 2017;
- Failure of the locum middle grade doctor to accurately record the patient's oxygen levels and treatment; and

- Failure of the nursing staff to record treatment given to the patient's wound per WHO guidelines prior to 29 September 2017.

151. I am satisfied that these failings resulted in the patient suffering the injustice of distress, anxiety and upset. I also consider the complainant suffered the injustice of uncertainty as her mother was discharged without receiving a review from a multidisciplinary team and this would have caused the complainant to worry about her mother and her wellbeing.

Recommendations

152. I recommend the Trust should within **three months** of the date of this report:

a. Provide the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice identified as a result of the failures in care and treatment identified in this report;

153. I also recommend the Trust complete the following;

a. The Trust should undertake a review of their position in Trauma and Orthopaedics regarding providing patients with a review by a senior clinician prior to discharge and daily review by a Consultant in adherence with national guidelines;

b. Conduct an audit on discharge planning and practice in ward 4A of RVH

c. The findings in this report should be fed back to the relevant staff so that they can they reflect on their practice and discuss with their appraiser/manager as part of their next appraisal. Evidence should be kept of any reflection and discussion.

154. I recommend the Trust develops an action plan which outlines the steps considered in implementing my recommendations, and provides me with an update within three months of the date of the 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 relevant policies).

MARGARET KELLY **26 October 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.