Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 19665

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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 about the actions of the Western Health and Social Care Trust (the Trust) regarding the care and treatment provided to the complainant's late mother (the patient) during an attendance at the Emergency Department of Altnagelvin Area Hospital (the hospital) on 20 July 2018. The complainant was concerned that his mother had not been properly assessed and should not have been discharged.

The investigation did not find a failure in the assessment and management of the patient, nor in the decision to discharge her from the Emergency Department. However, the investigation established that there was a failure to record the patient's oral intake. The investigation also established that clinicians failed to document and retain a record of its handover to the staff of the care home following the patient's discharge from the Emergency Department.

The Trust accepted the failings. It explained that it had identified learning as a result of the complaint, and intended to undertake a review of the information recorded and shared with other care settings when a patient is discharged from the Emergency Department.

THE COMPLAINT

1. I received a complaint about the actions of the Western Health and Social Care Trust (the Trust) in relation to the care and treatment provided to the complainant's mother (the patient) during her attendance at the Emergency Department (ED) of Altnagelvin Hospital (the Hospital) on 20 July 2018.

Background

2. The complainant noticed that his mother was unwell when he visited her on 20 July 2018 at the care home in which she resided. An ambulance was requested and took the patient to the Hospital shortly afterwards. The doctors in the ED diagnosed that the patient was '*suffering from a general decline in her baseline function'* and a possible urinary tract infection (UTI). An ST5 Medical Registrar[1] (the ST5), who also reviewed the patient while she was in the ED, agreed with the diagnosis. The patient was prescribed oral antibiotics to take (liquid form) and was discharged to the care home in the early hours of 21 July 2018.

3. The patient was again admitted to the Hospital on 22 July 2018 and sadly passed away on 28 July 2018.

4. The complainant raised concerns about the medical staff's assessment and treatment of his mother while in the ED of the Hospital on 20 July 2018. He also complained about the decision to discharge her that evening.

Issues of complaint

5. The issues of complaint accepted for investigation were:

Issue 1: Whether the patient was appropriately assessed and treated while she was in Altnagelvin Hospital's Emergency Department on 20 July 2018.

[1] Junior doctor in year five speciality training (medical).

Issue 2: Whether the decision to discharge the patient from the Emergency Department on 20 July 2018 was reasonable, appropriate and in accordance with relevant standards.

INVESTIGATION METHODOLOGY

6. 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. This documentation included information relating to the Trust's handling of the complaint.

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

- A consultant in emergency and critical care medicine for over 10 years; and
- A Registered Nurse with 17 years of clinical experience including working in the emergency department.

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

Relevant Standards

9. 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[2]:

- The Principles of Good Administration
- The Public Services Ombudsmen Principles for Remedy

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

10. 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 General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC guidelines);
- The Nursing and Midwifery Council's (NMC) Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates, 2015 (the NMC Code);
- The National Institute for Health and Care Excellence's (NICE) Clinical Guideline [CG68] Stroke and transient ischaemic attack[3] (TIA) in over 16s: diagnosis and initial management, as updated March 2017 (NICE CG68);
- The Royal College of Physicians' (RCP) National Early Warning Score (NEWS): Standardising the assessment of acute illness severity in the NHS, as updated December 2017 (the RCP NEWS Guidance); and
- The National Institute for Health and Care Excellence's (NICE) Clinical Guideline [CG50] Acutely ill adults in hospital: recognising and responding to deterioration, July 2007 (NICE CG50).

11. 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.

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

[3] Also referred to as a "mini stroke". It is caused by a temporary disruption in the blood supply to part of the brain. The disruption in blood supply results in a lack of oxygen to the brain.

INVESTIGATION

Issue 1: Whether the patient was appropriately assessed and treated while she was in Altnagelvin Hospital's accident and emergency department on 20 July 2018.

Detail of Complaint

13. This issue of complaint is about the care and treatment of the patient during her attendance at the Hospital on the evening of 20 July 2018. In particular, the complaint is about the management of the patient's oral intake while she was in the ED.

Evidence Considered

Legislation/Policies/Guidance

14. I refer to the following guidance which was considered as part of investigation enquiries:

    i. I considered the GMC Guidance and identified the following relevant extracts:

    '[Standard] 15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

    a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient

    b promptly provide or arrange suitable advice, investigations or treatment where necessary

    [Standard] 16 In providing clinical care you must:

    a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs

    b provide effective treatments based on the best available evidence

    c take all possible steps to alleviate pain and distress whether or not a cure may be possible'.

ii. I considered the NMC Code and identified the following relevant extract:

'*[Standard] 10 Keep clear and accurate records relevant to your practice…*

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

iii. I considered NICE CG68 and identified the following relevant extracts:

'***1.2.1 Suspected TIA – referral for urgent brain imaging***

…1.2.1.2 People who have had a suspected TIA who are at high risk of stroke (for example, an ABCD2[4] score of 4 or above, or with crescendo TIA[5]) in whom the vascular[6] territory or pathology is uncertain should undergo urgent brain imaging (preferably diffusion-weighted MRI[7] [magnetic resonance imaging]).

1.2.1.3 People who have had a suspected TIA who are at lower risk of stroke (for example, an ABCD2 score of less than 4) in whom the vascular territory or pathology is uncertain should undergo brain imaging[13] (preferably diffusion-weighted MRI).

1.2.2 Type of brain imaging for people with suspected TIA

1.2.2.1 People who have had a suspected TIA who need brain imaging (that is, those in whom vascular territory or pathology is uncertain) should undergo diffusion-weighted MRI except where contraindicated, in which case CT (computed tomography[8]) scanning should be used'.

iv. I considered the RCP NEWS guidance and identified the following

[4] The ABCD2 score is used to determine the risk for stroke in the days following a TIA. It is based on five parameters (age, blood pressure, clinical features, duration of TIA, and presence of diabetes).

[5] A term commonly used to describe multiple recurrent episodes of TIA over hours to days.

[6] Vessel or vessels, which carry blood.

[7] The use of specific MRI sequences as well as software that generates images from the resulting data that uses the diffusion of water molecules to generate contrast in MR images

[8] Computerised x-ray imaging procedure to generate cross-sectional images of the body.

relevant extracts:

'1.2 As a minimum, the following physiological observations should be recorded at the initial assessment and as part of routine monitoring:

- *heart rate*
- *respiratory rate*
- *systolic blood pressure*
- *level of consciousness*
- *oxygen saturation*
- *temperature'*.

Listed Authority's Response

15. In response to enquiries made, the Trust explained that *'it is not documented whether her [the patient's] oral intake was reduced from what it previously had been. It is documented on [the patient's] transfer information from the nursing home to the Emergency Department that her appetite had been poor on the day of attendance. This has not been specifically addressed by the treating doctor and it has likely just fitted into a picture of general decline. It is accepted that we should have paid more attention at the time. It is unclear whether it would have materially affected any decisions that were made on this case and whether it would have affected her outcome. We acknowledge that the patient was in the Emergency Department for approximately 6 hrs [sic] and we have no documentation relating to her having any oral intake. This will be highlighted to the ED [emergency department] team'*.

16. In relation to learning the Trust has already identified, it explained that '*the Emergency Department will raise awareness among staff of the importance of recording that drinks have been offered to patients (as appropriate), particularly those requiring support'*. The Trust added that it '*apologies [sic] to [the complainant] for any distress experienced associated with his mother's attendance at the Emergency Department'*.

Clinical Records

17. The patient's clinical records relating to her attendance at the ED on 20 July 2018 were carefully considered.

18. The records contain a form entitled, '*Information for Transfer to Hospital/Other Facilities for Residents of Nursing Homes'*. This form was provided to the hospital. The form documents the patient's nutritional needs as '*puree stage 3 thickened fluids*[9]*'*. The form further documents that the patient had a '*poor appetite all day'*.

19. The patient's clinical records document that she was triaged at the hospital at 18:07. The triage notes state that she presented with '*facial droop in NH [nursing home] today. Recent deterioration. ↓ communication*[10]*. Hx*[11] *dementia'*.

20. The records document that the ED's Senior House Officer (the SHO[12]) attended the patient at 19:15. The SHO noted that the patient presented with '*new right facial droop and not moving right arm. Communication poor at baseline. Bed bound at baseline. Alert eyes open. Localising pain. Incomprehensible sounds. Some secretions. Obs [observations] normal. Afebrile*[13]*. No increased work of breathing at rest. Chest clear. No hx trauma/injury'*.

21. The records document that the patient underwent a CT [computed tomography[14]] brain scan which showed '*chronic changes but no acute abnormality'.* The SHO further documented that she *'discussed with…ED Consultant, no acute medical issue, ambulance available to return to NH [nursing home]. Impression: vascular dementia/ongoing decline'*. The records document that the patient was prescribed 625mg co-amoxicillin[15] to be taken

[9] Pudding consistency, holding its own shape.
[10] Reduced communication.
[11] Medical history.
[12] A junior doctor in their second year of foundation training.
[13] Not feverish
[14] A test that uses x-rays and a computer to create detailed pictures of the inside of the body.
[15] A type of antibiotic

orally.

22. The records state that the ST5 reviewed the patient at 22:50 on 20 July 2018. The ST5 documented the reason for admission as '*no ambulance to take back to nursing home'*. He further noted, '*care home happy to take back'* and '*general decline [due] to dementia. Could well have aspirated*[16]*'*. In relation to action to be taken, the ST5 documented, '*co-amoxicillin liquid, back to NH [nursing home], consider managing further decline in nursing home, DNACPR*[17] *discussion [with] son in AM*…'.

23. The Trust provided a report for its investigation into the complaint. The ED Consultant on shift at the time the patient was treated undertook this investigation. In the report, the ED Consultant explained that '*it was felt that [the patient] was suffering from a general decline in her baseline function. It was felt that this was possibly related to an underlying infection such as a urinary tract infection. The treating SHO discussed [the patient's] care with me at that time. I felt that it was most appropriate to treat this with oral antibiotics back in her nursing home'.*

Relevant Independent Professional Advice

24. As part of investigation enquiries, the advice of a physician specialising in emergency medicine was obtained (E IPA).

25. The E IPA advised that the patient presented at the emergency department (ED) with '*a facial droop and generally unwell'*. He further advised that a stroke was not diagnosed '*but that is certainly a thought of the ambulance clinicians and the junior doctor'*.

26. The E IPA advised that the clinicians in the ED department undertook '*clinical observations using the NEWS*[18] *tool. These were all normal. Baseline blood tests were taken. These were summarised as 'nil acute' suggesting there was*

[16] Accidental inhalation of an object or fluid into the windpipe and lungs

[17] Do not attempt cardio-pulmonary resuscitation

[18] An early warning score is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs.

no abnormality that required urgent interventions. Blood glucose tests[19] were taken by both the ambulance service and the hospital. Both were normal. A CT scan was performed. This was reported as showing only chronic (long-term) changes'. The E IPA was asked if the clinicians ought to have conducted additional tests for the patient. He advised that '*neither of the standard UK guideline publishers [including NICE CG68]…recommend any other tests in this situation'*.

27. The E IPA advised that he agreed with the diagnosis noted in the patient's clinical records. He advised that '*[the patient] likely had an upper respiratory chest infection. This may have been related to her end stage vascular dementia'*. In relation to the diagnosis that the patient may have been suffering from a urinary tract infection, the E IPA advised that '*the team were seeking a cause for the acute decline that [the patient] suffered. In this patient, group infection of the urine or chest are the commonest causes. Infection was supported by a rise in the CRP [C-reactive protein[20]] blood test. This indicates inflammation in the body. [The patient] was incontinent of urine in the long-term and so a specific test of that was not possible. The conclusion of a urinary tract infection was therefore based on probabilities as is normal in emergency medicine'*. The E IPA agreed that the tests undertaken to find the source of the infection were appropriate. He added that '*the antibiotic treatment provided would have covered the common bacterial causes of urinary and chest infections'*.

28. As part of investigation enquiries, the advice of a registered nurse with experience of working in the emergency department was obtained (N IPA). The N IPA provided a chronology of the observations nursing staff took of the patient during her time in the emergency department on 20 July 2018.

29. In relation to the observations undertaken of the patient, the N IPA referred to the RCP NEWS guidance. He advised that '*in [the patient's] case the NEWS score was 0 at 19:20 and 20:00 and no medical response was required until*

[19] Measures the amount of glucose (type of sugar) in the blood.
[20] A blood test marker for inflammation in the body.

[the patient's] oxygen level was slightly reduced at 21:00. This resulted in a NEWS score of 1. The doctor was informed of this slight change in her clinical condition and [the patient's] airway was suctioned to improve her breathing. At 21:55 [the patient's] oxygen level was recorded as normal resulting in a NEWS score of zero and no further medical intervention was needed, apart from continued clinical observations while [the patient] was in the Emergency Department'.

30. The N IPA further advised that '*the nursing team recorded their clinical observations in line with guidelines from the National Institute for Health and Care Excellence and utilised the Royal College of Physicians NEWS Score to monitor for clinical deterioration. In [the patient's] case, the nursing team recorded their clinical observations appropriately, in full, and in line with guidelines'*. He added that '*in doing so there was no negative impact on [the patient's] health'*.

31. In relation to the recording of the patient's oral intake, the N IPA advised that '*there is no record of any oral intake given to [the patient] by the nursing team during her time in the Emergency Department on 20th July 2018'*. The N IPA was asked if the nursing team ought to have recorded this information. He advised that '*there is no specific clinical guidance regarding the recording of oral intake, however the Nursing and Midwifery Council Code of Conduct [the NMC Code] (2015) advises that nurses must 'keep clear and accurate records relevant to your practice' and 'complete records at the time or as soon as possible after an event'. I consider that [the patient's] oral intake should have been recorded and there is no evidence to suggest this happened'*.

32. In relation to the potential impact this had on the patient, the N IPA advised that '*it is unlikely that the lack of recording of any oral intake had a negative impact on the health of [the patient]*.

33. The N IPA concluded that '*[the patient] spent just under six hours in the Emergency Department of Altnagelvin Emergency Department on the 20th July, 2018 following a deterioration in her health at her nursing home. During [the patient's] time in hospital the nursing team performed an ECG, checked*

blood sugar levels and regularly checked her blood sugar, heart rate, respiratory rate, blood pressure, level of consciousness, oxygen saturation and temperature. These were checked and recorded in line with recommended clinical guidelines to monitor for signs of deterioration and to assess if medical intervention was needed. [The patient's] airway was suctioned appropriately when indicated. While there was no record of any oral intake given to [the patient] by the nursing team during this time it is unlikely that this had a negative impact on the [the patient's] health. Altnagelvin Hospital since recognise that they need to highlight the importance of recording that drinks have been given while patients are in the Emergency Department, which may improve nursing care in the future'.

34. The IPA received was shared with the Trust for its review and comment. The Trust did not provide any comments in response to the IPA received.

The complainant's response to a draft copy of this report

35. The complainant raised concerns with the decision to prescribe the patient an oral (liquid) antibiotic given her swallowing difficulties. He explained that the patient was unable to take the antibiotic as she could not swallow.

Further Relevant Independent Professional Advice

36. Further advice relating to the medication prescribed to the patient was obtained. The E IPA advised that '*the nursing and medical staff involved in [the patient's] care were aware of the swallowing difficulty. There is written information on the transfer information from the nursing home including the diagnosis and prescription of thickener. The A&E doctor's prescription included the comment "co-amoxiclav suspension – thickened as per usual fluids". The medical team doctor's notes documented the diagnosis and the prescription also commented about liquid thickener*'. He further advised '*in my opinion the decision to prescribe oral antibiotic was appropriate… I do not believe there were any failings in the acute care of [the patient] on this occasion*'.

Analysis and Findings

Care and treatment of the patient

37. This complaint is about the care and treatment provided to the patient during her attendance at the ED of the Hospital on 20 July 2018. I note that the patient was diagnosed as suffering from a '*general decline'* in her vascular dementia, '*possibly related to an underlying infection such as a urinary tract infection*'.

38. I note the E IPA's advice that the patient's presentation upon her arrival at the ED indicated that she may have been suffering from a stroke. He advised that this was '*certainly a thought of the ambulance clinicians and the junior doctor'*. I note the tests performed on the patient while she was in the ED on 20 July 2018, which included a CT scan. I accept the E IPA's advice that '*neither of the standard UK guideline publishers [including NICE CG68]…recommend any other tests in this situation'*. I consider that the tests performed on the patient were taken in accordance with NICE CG68, which details the recommended tests for patients presenting signs of a stroke.

39. I note that the tests performed on the patient showed a rise in her CRP level. I also note that the clinical records document that this indicated an '*underlying infection such as a urinary tract infection'*. I note that the records do not evidence that a urine sample was taken from the patient to confirm this diagnosis. However, I accept the E IPA's advice that '*[the patient] was incontinent of urine in the long-term and so a specific test of that was not possible. The conclusion of a urinary tract infection was therefore based on probabilities as is normal in emergency medicine'*. I note the GMC Guidance, which states that doctors must '*adequately assess the patient's conditions, taking account of their history'* and '*promptly provide or arrange suitable advice, investigations or treatment where necessary*'. I consider that the tests undertaken to find the cause of the patient's decline in her health were reasonable, appropriate and in accordance with both NICE CG68 and GMC Guidance.

40. I note from the clinical records that the patient was prescribed antibiotics to treat any possible infection. I also note the E IPA's view that '*[the patient] likely had an upper respiratory chest infection. This may have been related to her end stage vascular dementia'*. I note that this differs from the ED clinical team's diagnosis of an '*underlying infection such as a urinary tract infection'*. However, I accept the E IPA's advice that '*the antibiotic treatment provided would have covered the common bacterial causes of urinary and chest infections'*.

41. I note in his response to a draft copy of this report, the complainant questioned the decision to prescribe his mother an oral (liquid) antibiotic given that she had difficulties with her swallow. I note from the clinical records that at the time of her attendance, the patient's oral intake consisted of thickened fluids. I also note that the liquid antibiotic prescribed was to be '*thickened as per usual fluids*'. Given the information regarding her oral intake available to the clinicians at the time of the patient's attendance at the ED, I accept the E IPA's advice that the decision to prescribe an oral antibiotic in the thickened form was *'appropriate'*. I consider that the ED doctors acted in accordance with the GMC Guidance, which states that they must '*provide effective treatments based on the best available evidence*'. I am satisfied that the care and treatment provided to the patient was reasonable, appropriate and in accordance with relevant guidelines. I do not uphold this element of the complaint.

Management of the patient's oral intake

42. This complaint was also about the management of the patient's oral intake while she was in the ED on 20 July 2018. I carefully considered the patient's clinical records. I note that the transfer form provided to the paramedics from the care home stated that the patient had a '*poor appetite all day'*.

43. I note from the clinical records that the nursing team recorded medical observations taken of the patient during her time in the ED. I accept the N IPA's advice that *'in [the patient's] case, the nursing team recorded their clinical observations appropriately, in full, and in line with guidelines'*.

44. I note that there are no records that specifically document the patient's oral intake during her time in the ED. I also note that the ED Consultant's report stated that this was not '*specifically addressed by the treating doctor'* and he accepted that the medical team ought to have *'paid it more attention at the time'*.

45. I note that the N IPA agreed that '*there is no record of any oral intake given to [the patient] by the nursing team'*. Given that there was a concern with the patient's oral intake on 20 July 2019, I would have expected the clinical team to have paid significant attention to her oral intake and made frequent attempts to have encouraged this given the information provided by the care home. I am concerned that there is no record of any food or drink having been offered to the patient who was elderly and frail. I cannot conclude whether food or drink was offered to the patient. I note and accept the N IPA's advice that '*[the patient's] oral intake should have been recorded and there is no evidence to suggest this happened'*. I consider that this is not in accordance with Standard 10 of the NMC Code, which relates to record-keeping. I consider that the failure to complete this record resulted in a service failure.

46. In relation to the impact of this failure on the patient, I accept the N IPA's advice that '*it is unlikely that the lack of recording of any oral intake had a negative impact on the health of [the patient]*. I do not consider that the failure to record the patient's oral intake contributed to a decline in her health. Therefore, I have not identified an injustice to the patient arising from this service failure.

47. I note that the Trust acknowledged that '*[the patient] was in the Emergency Department for approximately 6 hrs [sic] and we have no documentation relating to her having any oral intake. This will be highlighted to the ED [emergency department] team'*. I also note that the Trust explained that '*the Emergency Department will raise awareness among staff of the importance of recording that drinks have been offered to patients (as appropriate), particularly those requiring support'*. I welcome this learning the Trust already identified.

Issue 2: Whether the decision to discharge the patient from the accident and emergency department on 20 July 2018 was reasonable, appropriate and in accordance with relevant standards.

Detail of Complaint

48. This issue of complaint is about the decision to discharge the patient from the Hospital on the evening of 20 July 2018. In particular, the complainant questioned why his mother was discharged at this time when she was unable to eat or drink.

Evidence Considered

Legislation/Policies/Guidance

49. I refer to the following guidance which was considered as part of investigation enquiries:

    i. I considered the GMC Guidance and identified the following relevant extracts:

    '[Standard 19] Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards…

    [Standard 21] Clinical records should include:

    a relevant clinical findings
    b the decisions made and actions agreed, and who is making the decisions and agreeing the actions
    c the information given to patients
    d any drugs prescribed or other investigation or treatment
    e who is making the record and when.

    [Standard 44] You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

    a share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care

as you go off duty, and when you delegate care or refer patients to other health or social care providers

Listed Authority's Response

50. In response to enquiries made, the Trust explained that it does '*not have a specific guideline or policy relating to discharge of patients from the Emergency Department. The Emergency Department Flimsy (documentation for patients attending ED) contains a pre-discharge checklist. Unfortunately, in [the patient's] case, this was not completed*'.

51. The Trust further explained that '*it is also normal practice that in the event of a patient returning to a Nursing Home, the Emergency Department would phone the Nursing Home and provide a verbal handover. It was documented by Nursing staff that one of the doctors had telephoned [the patient's] Nursing Home. We recognised following review of [the patient's] attendance that documentation around patients returning to Nursing Home or other care settings requires review*'.

52. In relation to learnings already identified, the Trust explained that it will '*review the use of the discharge checklist and documentation of information shared with other care settings*'.

Clinical Records

53. The patient's clinical records relating to her discharge from the ED were carefully considered.

54. The ST5 who examined the patient prior to her discharge recorded a handwritten note of his review. The note documents, '*care home happy to take back'* and '*back to NH [nursing home], consider managing further decline in nursing home, DNACPR discussion [with] son in AM*…'.

55. The ED Consultant's report for the investigation into the complaint states that '*I felt that it was most appropriate to treat this [infection] with oral antibiotics back in her nursing home. Transport was requested at 21.55hrs [sic]. At this time her blood sugars remained normal and her NEWS score was also 0'*. The

report further states that '*the Medical Registrar [ST5] was happy with the plan to discharge her back to the nursing home'*.

Additional information received

Information from the Care Home

56. The patient resided at a care home at the time of her attendance at the Hospital. She returned to the care home following her discharge from the ED in the early hours of 21 July 2018.

57. The care home explained that it examined the records it retained for the patient. It further explained that it was unable to locate any documents relating to the patient's discharge that the Hospital would have provided following her return to the care home in the early hours of 21 July 2018.

Relevant Independent Professional Advice

58. As part of investigation enquiries, the advice of a physician specialising in emergency medicine was obtained (E IPA).

59. The E IPA advised that '*the decision to discharge [the patient] was reasonable and appropriate. Patients with dementia frequently become disorientated in new environments, particularly when acutely unwell. This is distressing to the patient and family. Unnecessary hospital stays also increase risks of infection and harm. It is widely accepted that patients who can be managed at home (or their usual place of residence) should be'*.

60. In relation to the patient's oral intake at the time of her discharge, the E IPA advised that '*decreased appetite in the context of an acute illness is normal. In of itself, this is not an emergency department issue'*.

61. The E IPA was referred to the phone call the SHO made to the care home. He advised that '*there is no record of the call in [the] notes…some notes should have been made. At its simplest, documenting the date and time and who was spoken to. In the notes of ST5…at 2250hr on the 20 July it is recorded that the care home where [the patient] lived were happy to take her back'*.

62. The E IPA was also referred to the clinical records relating to the patient's discharge from the hospital. He advised that '*a discharge note should be sent with the patient summarising the journey in the hospital, any therapy changes and any information for caring team members (doctors, nurses, therapists) to be aware of or to action. I think this is the final page of the Emergency Department assessment…however it is incomplete'*.

63. The E IPA advised, in conclusion, '*I acknowledge the concerns of the complainant and distress suffered from the death of his mother. I do not find any issues of significance with the discharge of the patient from the Altnagelvin Emergency Department on 20 July 2018. Where I have raised issues I do not consider that they had an impact on [the patient's] health and certainly not her decline and subsequent death which I believe was due to her terminal dementia'*. In relation to learning identified, the E IPA advised that '*even though I believe the medical records to be adequate there are some minor deficiencies, and this would be a useful case to refresh awareness of GMC Good Medical Practice content, specifically sections 22 (a, b, c) and 44 (a, b) and its importance in transitioning care'*.

The complainant's response to a draft copy of this report

64. The complainant raised concerns with the decision to discharge his mother from the ED given her decreased appetite that day and her history of diabetes. He believed that she ought to have been admitted to hospital so that her blood sugars could be stabilised.

Further Relevant Independent Professional Advice

65. The E IPA advised that '*the nursing and medical staff involved in [the patient's] care were aware of the diabetes. There is written information on the transfer information from the nursing home including the diagnosis and prescription of diabetic medicine. The A&E doctor's notes record the diagnosis. The medical team doctor's notes documented the diagnosis and prescribed the diabetic medicine'*.

66. In relation to the decision to discharge the patient from the ED, the E IPA also advised that '*[the patient] was known to be diabetic. Her blood sugar recorded throughout her stay was normal and stable. As I have previously stated, decreased appetite in the context of acute illness is normal. The type of diabetes that [the patient] had does not require her to eat to keep her blood sugars stable. The dose of anti-diabetic medication was small. The medical doctor considered stopping it altogether. [The patient] was admitted to the A&E department from a nursing home and it was appropriate to return her there after her assessment, diagnosis and management'*.

Analysis and Findings

67. This issue of complaint is about the decision to discharge the patient from the ED on 20 July 2018 considering she had difficulties with her oral intake. I note that an ambulance transported the patient to the care home in the early hours of 21 July 2018.

68. I note that the patient was diagnosed with a '*general decline'* in her vascular dementia, '*possibly related to an underlying infection such as a urinary tract infection'*. In relation to the patient's oral intake at the time of her discharge, I note the E IPA's advice that '*decreased appetite in the context of an acute illness is normal. In of itself, this is not an emergency department issue'*.

69. I note the complainant's concerns that his mother was discharged despite her decreased appetite and her history of diabetes. I considered the Trust's report for its investigation into the complaint. I note that the report states that '*transport was requested at 21.55hrs. At this time, her [the patient's] blood sugars remained normal and her NEWS score was also 0'*. It further stated that it was '*most appropriate to treat this [infection] with oral antibiotics back in her nursing home'.* I note the E IPA's advice that '*patients with dementia frequently become disorientated in new environments, particularly when acutely unwell. This is distressing to the patient and family. Unnecessary hospital stays also increase risks of infection and harm. It is widely accepted that patients who can be managed at home (or their usual place of residence) should be'*. I accept the E IPA's advice that the patient's '*blood sugar recorded throughout her stay*

was normal and stable'. I also accept his advice that *'the type of diabetes that [the patient] had does not require her to eat to keep her blood sugars stable. The dose of anti-diabetic medication was small. The medical doctor considered stopping it altogether. [The patient] was admitted to the A&E department from a nursing home and it was appropriate to return her there after her assessment, diagnosis and management'.*

70. Having reviewed the records relating to the patient's discharge from the ED, I accept the E IPA's advice that '*the decision to discharge [the patient] was reasonable and appropriate'.* I consider that the clinicians treating the patient used their clinical and professional judgement, based on the results of the tests undertaken at that time, to make the decision to discharge her from the ED for treatment at her home. I do not uphold this element of the complaint.

71. In relation to the records relating to the patient's discharge from the ED, I note that the Trust explained that '*it is also normal practice that in the event of a patient returning to a Nursing Home, the Emergency Department would phone the Nursing Home and provide a verbal handover'.* I note that the clinical records contain a handwritten note documenting that the SHO telephoned the care home. I also note that the ST5 indicated in his notes that the care home was content for the patient to return. I consider, on the balance of probabilities, that the SHO did contact the care home to hand over the patient's care. However, the clinical records do not contain a documented record of this conversation. I note the E IPA's advice that *'some notes [of this conversation] should have been made'.*

72. I have no reason to doubt that the SHO provided an appropriate handover to the care home. However, in the absence of this record, I am unable to conclude if the SHO informed the care home of the diagnosis reached or of the antibiotics prescribed, including the dosage and method of administration. I consider that a contemporaneous note of the discussion ought to have been taken and retained in the patient's clinical records. This note ought to have detailed the information provided to the care home regarding the care and treatment the patient received at the ED. I also consider that it ought to have detailed any ongoing care and treatment to be provided by the staff in the care

home.

73. I note that in its response to this office, the Trust referred to *'the Emergency Department Flimsy (documentation for patients attending ED)'.* I examined the clinical records and find no evidence to suggest that appropriate information relating to the patient's discharge was recorded. I note that the care home was also unable to confirm if it received this document from the hospital. I note the E IPA's advice that '*a discharge note should be sent with the patient summarising the journey in the hospital, any therapy changes and any information for caring team members (doctors, nurses, therapists) to be aware of or to action. I think this is the final page of the Emergency Department assessment…however it is incomplete'*.

74. I consider that if the discharge information was recorded, it would have been retained in the medical records and/or provided and retained by the care home. On the balance of probabilities, I consider that the SHO failed to complete record discharge information for the patient when she left the ED in the early hours of 21 July 2018.

75. The GMC Guidance states that a doctor must '*keep clear, accurate, legible and contemporaneous patient records which report…the decisions made, the information given to patients'.* I consider that when discharging the patient from the ED, the SHO failed to act in accordance with this standard of the GMC Guidance. I consider that where patients are returning to a care home setting following a stay in the ED, the discharging doctor ought to provide pertinent information relating to their care and treatment, especially if this is to be continued in the care home. I also consider that this handover ought to be documented and retained in the patient's medical records. I am not satisfied that the hospital sufficiently exercised this duty. I consider this to be a failure in the care and treatment of the patient. As a consequence of this failure, I consider that the patient experienced the injustice of the loss of opportunity to be discharged with an appropriate handover of her care.

76. I note that the Trust explained that it *'recognised following review of [the patient's] attendance that documentation around patients returning to Nursing*

Home or other care settings requires review'. In relation to learnings already identified, the Trust explained that it will '*review the use of the discharge checklist and documentation of information shared with other care settings'*. I welcome this learning.

CONCLUSION

77. I received a complaint about the actions of the Trust regarding the care and treatment provided to the patient during her time at the ED of the hospital on 20 July 2018.

78. The investigation of the complaint did not find a failure in the care and treatment provided to the patient while she was treated in the ED on 20 July 2018. It also did not find a failure in the decision to discharge the patient from the ED. However, the investigation established that there was no record of the patient's oral intake while she was in the ED, resulting in a service failure. I do not consider that this failure contributed to a decline in her health. Therefore, I have not identified an injustice to the patient arising from this failure.

79. The investigation of the complaint found a failure in the patient's care and treatment in relation to the following matter:

    i. The failure to document and retain a record of the handover of the patient's care to the staff of the care home following her discharge from the ED.

80. I am satisfied that the failure in care and treatment I identified caused the patient to experience the injustice of the loss of opportunity to be discharged with an appropriate handover of her care.

Recommendations

81. The Trust acknowledged the failings in its response to this office. It explained that '*the Emergency Department will raise awareness among staff of the importance of recording that drinks have been offered to patients (as*

appropriate), particularly those requiring support'. I welcome this learning.

82. I note that the Trust also explained that it would '*review the use of the discharge checklist and documentation of information shared with other care settings'*. I welcome this learning identified by the Trust. The Trust ought to provide me with an update of its review within **three months** of the date of my final report. This is to be supported by evidence to confirm that appropriate action was taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

PAUL MCFADDEN
Acting Ombudsman **July 2020**

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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