Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 17984

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Publication date: May 2019

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. She may also investigate and report 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.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

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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EXECUTIVE SUMMARY

I received a complaint from a patient about the actions of Belfast Health and Social Care Trust in relation to her discharge from the Royal Victoria Hospital, Belfast on 20 May 2016.

Issues of Complaint

I accepted the following issue of complaint for investigation:

i. Whether the assessment of the patient's needs upon discharge was appropriate and reasonable?

Findings and Conclusion

The investigation identified failures in the patient's care and treatment in respect of the Trust, and its staff's failure to:

(i) Adequately assess her care needs by referring her for OT and/or SW assessment prior to discharge on 20 May 2016;

(ii) Involve her in its decision to discharge her;

(iii) Follow the DoH's Discharge Planning Guidance and the Trust's Discharge Guiding Principles;

(iv) Accurately record and complete nursing notes and the patient's 'Discharge checklist' in accordance with the record keeping requirements in the NMC Code; and

(v) Accurately record physiotherapy patient assessment notes in accordance with relevant guidelines.

I am satisfied that the failures in care and treatment I have identified caused the patient to experience the injustice of inconvenience and upset. She lost the opportunity to have a suitable care package in place post discharge. I also consider the failures in care and treatment and maladministration caused her the injustice of having to wait for a care package; upset, distress and anxiety in having to care for herself over the weekend period, and having to independently source a care package assessment three days after discharge.

Recommendations

I recommended within **one** month of the date of this report:

(i) The Trust provide a meaningful apology for the inconvenience, upset and anxiety caused to the patient as a result of the failings in care and treatment and maladministration.

(ii) I recommended the Trust provide the patient with a further apology for the above failures causing the subsequent failure by it to appropriately arrange a care package for her on discharge.

(iii) Provide to the patient by way of solation a consolatory payment of £750 for the injustices I have identified above.

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

  (i) Provide training to multi-disciplinary teams on the importance of recording clear and accurate records of all multi-disciplinary discussions, assessments, referrals, decisions and communication with patients, in particular, concerns raised regarding help at home and care packages on discharge;

  (ii) Remind nursing staff in ward 4B to adhere to the NMC record-keeping standards and local discharge planning guidance; and

  (iii) Remind physiotherapy staff to adhere to the relevant record keeping standards.

(v) The Staff Nurse is no longer employed by the Trust. I therefore recommend that she refreshes her awareness of the requirements of section 24.2 of the NMC Code. In particular, '*uses this complaint as a form of feedback and an opportunity for reflection and learning to improve practice*' in her current employment.

THE COMPLAINT

1. The patient fell at home on 30 April 2016, fracturing her right humerus. She was admitted to the fracture ward at the Royal Victoria Hospital for a right reverse geometry shoulder replacement on 17 May 2016. She complained that Trust staff failed to provide her with an Occupational Therapy (OT) and/or Social Work (SW) assessment prior to discharging her on 20 May 2016. She complained that in failing to do so, Trust staff further failed to appropriately provide her with a care package. The patient had to refer herself to the Northern Health and Social Care Trust's re-ablement team on 23 May 2016.

Issue of complaint

2. The issue of complaint which I accepted for investigation was:

   Whether the assessment of the patient's needs upon discharge was appropriate and reasonable?

INVESTIGATION METHODOLOGY

3. 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.

4. As part of the investigation process, I provided the Trust, the Staff Nurse and the patient with the opportunity to comment on the findings and recommendations detailed in the draft investigation report. These comments are reflected in this final report.

The Independent Professional Advice I Sought:

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

- Consultant Orthopaedic Surgeon (OS IPA);
- Staff Nurse (N IPA); and
- Physiotherapist (P IPA).

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

Relevant Standards

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

8. The general standards are the Ombudsman's Principles[1]:

   i. The Principles of Good Administration; and
   ii. The Public Services Ombudsmen Principles of Remedy.

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

10. The specific standards relevant to this complaint are:

   i. Department of Health (DoH) Northern Ireland. *Ready to go: Planning the discharge of patients from hospital and intermediate care*. 2010. (Hereafter referred to as 'DoH's Discharge Planning Guidance');
   ii. Health and Social Care Trusts. *Getting Patients on the Right Road*

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

for Discharge: Guiding Principles to enable the effective Discharge Planning for Adults from Hospital and Transition Setting. 2015. (Hereafter referred to as 'Trust Discharge Guiding Principles')

iii. The Regulation and Quality Improvement Authority (RQIA). *Review of Discharge arrangements from acute hospitals*. 2014;

iv. Nursing and Midwifery Council (NMC). *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives*. March 2015; and

v. Chartered Society of Physiotherapy. *Guidance on Record Keeping*. Version 2, November 2014.

11. The OS IPA has referred to the National Institute for Health and Care Excellence (NICE) Guideline 27 (NG27), *Transition between inpatient hospital settings and community or care home settings*, December 2015. I note that NG27 has not been endorsed by the DoH, Northern Ireland. However, NG27 was used by the DoH as a best practice guideline at the time of the patient's discharge.

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

THE INVESTIGATION

Detail of Complaint

13. The patient sustained an injury to her right shoulder. She complained that following treatment on the fracture ward at the Royal Victoria Hospital, the Trust failed to appropriately assess her needs prior to discharge. She explained that she had raised her concerns about her ability to cope at home with nursing and physiotherapy staff. Prior to her discharge, she explained to Trust nursing staff that given her age (67 years), complex health conditions

and the fact that she lived alone at home in a three bedroom two storey house, she would have difficulty coping. She further explained that her next of kin was her 72 year old cousin who also suffered from various health conditions. She complained that Trust staff ought to have referred her to the OT and/or SW team(s) for assessment. She believed that had she been appropriately assessed by an OT and/or SW, a care package would have been arranged for her prior to discharge from the hospital.

14. The following are the policies and guidance considered as part of the investigation. I have highlighted the relevant extracts:

(i) DoH's Discharge Planning Guidance (2010):

'*The need for timely discharge and care transfer requires clinicians and others to plan, communicate, negotiate and ensure a smooth transition for individuals and their families. Underpinning this is the need for:*

- *effective communication with individuals and across settings;*
- *alignment of services to ensure continuity of care;*
- *efficient systems and processes to support discharge and care transfer;*
- *clear clinical management plans;*
- *early identification of discharge or transfer date;*
- *identified named lead co-ordinator;*
- *organisational review and audit; and*
- *seven-day-a-week proactive discharge planning*

'*Step 1: 'Start planning for discharge or transfer before or on admission*: *Discharge is a process and not an isolated event at the end of the patient's stay'.*

'Step 7: Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence'.

1. Use integrated care pathways for the most common conditions to enable practitioners to anticipate and plan for needs and risks.

2. Manage patient and carer expectations by involving them at all stages of decision-making.

'Operating principles

1. *Discharge and transfer planning starts early to anticipate problems, put appropriate support in place and agree an expected discharge date.*
2. *A person-centred approach treats individuals with dignity and respect, and meets their diverse or unique needs to secure the best outcomes possible.*
3. *The care planning process is co-ordinated effectively.*
4. *Communication creates strong and productive relationships between practitioners, patients and carers.*
5. *The MDT* [Multi-disciplinary Team] *works collaboratively to plan care, agree who is responsible for specific actions and make decisions on the process and timing of discharges and transfers.'*

(ii) I refer to the Trust's Discharge Guiding Principles (2015). I have highlighted the relevant extracts below:

'*As Trusts have a duty of care and a legal obligation for the provision of effective health and social care and to the wellbeing of patients and their family and/or carers it is fundamental that these Guiding Principles are reflected in Trust's operational protocols*'.

I refer to Section 2.2 of the Trust's Discharge Guiding Principles which outline the objectives:

'*To ensure patients who have been assessed as "medically fit" and are ready to leave hospital are discharged in a safe and timely manner to an environment which can safely and appropriately meet the patient's needs*';

'*To ensure that patients, families and/or carers are adequately prepared for discharge*'.

At Section 3 the Trust's Discharge Guiding Principles identify the need for early identification of patients with complex needs as follows:
'*Complex needs may include:*
Patients who are living alone, and/or who are frail and/or elderly, or live with a carer who may have difficulty coping'.

The following key Guiding Principles are identified at Section 3.1:
'*Each Health and Social Care Trust:*
Must ensure that the patient, family and/or carer is central to the assessment and discharge process with clear and transparent communication throughout the patient's journey and with due regard to the patients', families' and/or carers' rights to confidentiality and privacy'.

I refer also to Section 4.2 of the Trust's Discharge Guiding Principles: Person-centred Practices:
'*Each Health and Social Care Trust:*
Must ensure that the multi-disciplinary team involves the patient, family and/or carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence';
Must ensure, that on admission, the patient, their family and/or carer receives an information leaflet on "getting ready to leave hospital";

15. In 2014 the Regulation and Quality Improvement Authority (RQIA) published a review of discharge arrangements from acute hospitals. The following extracts of that review are relevant:
    (i) Section 5.3.6: this states that '*Effective multidisciplinary working is an essential component of any discharge process, and early involvement of social work and AHP [allied health professional] staff will help to prevent delays in the process*'.

(ii) RQIA recommend that: *'Trusts should ensure that there is good collaboration between all departments to facilitate the discharge process.' (Recommendation 19).*

(iii) I refer also to Recommendation 20: *'Trusts should ensure that the discharge process is transparent for patients and carers, and that patients and carers are fully engaged in the process.'*

16. I refer to the patient's Nursing Assessment and Plan of Care record which includes a Discharge Checklist. In the Trust's correspondence to my office dated 6 September 2017 it confirmed that this checklist was the relevant procedure to be followed by nursing staff when discharging patients.

17. I refer also to the Nursing and Midwifery Council's Code of Practice (2015) (NMC Code). In particular I refer to paragraph 2: 'Listen to people and respond to their preferences and concerns'. To achieve this, you must:

2.1: '*work in partnership with people to make sure you deliver care effectively*'.

I refer also to paragraph 3 of the NMC Code which states: 'Make sure that people's physical, social and psychological needs are assessed and responded to'. To achieve this, you must:

3.1: '*pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*'.

At paragraph 8 of the NMC Code it states: 'Work Co-operatively'. To achieve this, you must:

8.1: '*respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*'.

Further, at paragraph 10, the following requirements are stated: 'Keep clear and accurate records relevant to your practice'. To achieve this,

you must:

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

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*'.

10.3: '*complete all records accurately…'*

10.4: '*attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed*'.

18. I refer to the standards set out in the Chartered Society of Physiotherapy Guidance on Record Keeping, version 2, (November 2014). The relevant extract in relation to record keeping is set out below:

'*It is important to understand that a court or disciplinary/investigatory panel will assume that "if it is not recorded, it has not been done". Therefore all action taken, decisions made or information provided should be recorded.*

The following points should be kept in mind when generating both paper and electronic records:

- *Pages of a written record should be numbered including date and time of consultation;*
- *In paper format you must sign the records at the end of your notes;*
- *Written notes should be legible and written in black ink'.*

19. I refer to the Health and Social Care Board's Regional Reablement Service for Northern Ireland Frequently Asked Questions':
http://www.northerntrust.hscni.net/services/Reablement.htm
The relevant extract in relation to this complaint is:
'*Who can use the Reablement Service?*
If you are 65+ and requiring a support package (ie a Domiciliary Care Package) or need an increase in your existing support package to help with your daily

living activities; and

If you have experienced a crisis, such as illness, deterioration in health or sustained an injury.'

20. I refer to NI Citizens Advice information: http://www.citizensadvice.org.uk/nireland/family/looking-after-people/social-care-and-support-ni
In particular, I refer to the 'Eligibility' section which states:
'*If you need help after leaving hospital, you will be assessed before you leave*'.

21. In response to investigation enquiries, the Trust explained that '*there is no evidence of [the patient] raising any major concerns at the point of discharge. She appears to have accepted to be discharged that day as arranged.*' The Trust further explained that '*the nursing record also indicates that [she] was eating and drinking well, mobilising independently and was deemed safe for discharge by the physiotherapist, medical and nursing team. The medical discharge note indicated that she was reviewed by the physio team who felt she could manage at home without any extra assistance. In error the doctor included the OT in this decision and the Trust has previously apologised for this error in our complaint response dated 3 August 2016.*'

22. The Trust explained that '*on her day of discharge, 20 May 2016, there is a short reference to [the patient] querying home help. However, this was not actioned further and we can find no other reference from her regarding any concerns about her proposed discharge.*' The Trust further explained that '*the letter* [the Discharge Note'] *also indicates that the patient was being discharged home with a supply of analgesia and that she would be reviewed in the Fracture Clinic on 27 May 2016. The doctor also has included in this letter that [she] was aware that she could contact her GP before this appointment should she need any assistance.*'

23. The patient stated that she was discharged without being assessed by an OT or SW. The Trust's response to investigation enquiries on this issue was '*there*

is nothing in the clinical notes to indicate that the services of a Social Worker or Occupational Therapist was required or requested'. The Trust further explained that '*had [the patient] or her relative made ward staff aware of any major concerns regarding her proposed discharge, staff would have sought additional advice/assessment as required. Medical, nursing and physiotherapy staff records indicate that [she] was deemed fit to be discharged home with a fracture review appointment arranged for the 27 May 2016 and an outpatient physiotherapy appointment requested.*'

24. In response to the challenges the patient faced when she returned home on 20 May 2016, the Trust stated that '*The Trust appreciates that [the patient], when she was discharged, encountered problems with her activities of daily living. The Trust has previously apologised in both Trust's responses for her feeling let down by our service. Not all patients require referral to each member of the multi-disciplinary team. It is at the discretion of the ward staff which patients are referred to the various members of the team. They base the referral on the needs of the patient. It is also actioned at the request of the patient as appropriate.*'

25. The Trust also stated that '*The Trust has in both previous complaint responses offered an apology in relation to her dissatisfaction with her discharge from Ward 4B. Her concerns have been shared with the multi-disciplinary team. The team has reflected on the decision, however, there is nothing in the notes that indicate the decision to discharge was made incorrectly at the time*.' The Trust further stated that '*The Trust acknowledges that when discharged [she] experienced pain, distress and anxiety in relation to no package of care having been provided. It is always our intention to ensure that patients are assessed appropriately for discharge and any arrangements agreed with the patient and put in place to facilitate safe discharge. The Trust would again sincerely apologise for [the patient's] experience of pain, distress and anxiety*'.

26. The Trust's response to further enquiries stated that '*The decision on a patient's requirement for support at home post discharge is taken following a*

needs assessment and shared discussion within the multi-disciplinary team. There is a multi-disciplinary meeting involving medical, nursing, physiotherapy and occupational therapists held daily on each of the fracture wards to discuss treatment pathways and discharge plans for all patients. There are no documented notes from these meetings as they are in the form of a discussion and decisions regarding onward referrals would then be documented in patient records.' The Trust explained that '*Appropriate referrals are made to the relevant disciplines in the community following discussion at the multi-disciplinary meeting. An example of this has been documented in [the patient's] nursing notes on the day of discharge for referral to community physiotherapy*.'

27. The Investigating Officer obtained the medical notes and records. In her 'Nursing Assessment and Plan of Care' booklet dated 20 May 2016 at 07:30 - 20:30 it is recorded that:
'*minimal assistance with ADL* [Activities of Daily Living]*...? Home help when discharged*'. An 'update' note records '*Pt* [patient] *to go home today safe with physio*'. A further note at 19:10 in this document records: '*physio will liaise with community physio to see patient at her own home*'.

28. I note that the patient's 'Discharge checklist' recorded within her 'Nursing Assessment and Plan of Care' booklet was completed by a Staff Nurse at 19:10 on 20 May 2016. There were no special discharge arrangements recorded.

29. I refer to the 'Discharge Note' completed by a Doctor from the orthopaedic team dated 20 May 2016 records:
'*…pain remains present. She was reviewed by the physio team and OT who felt she could manage at home without an* [sic] *extra assistance. [She] is being discharged home with a supply of Paracetamol and Tramadol as the ward policy is not to supply Oxynorm on discharge. [She] is aware and understanding of this. [She] will be reviewed on 27/5/16 in Fracture clinic. She was aware she could contact her GP/Out of hours GP before this period should she need assistance.*'

30. I have examined the physiotherapy treatment notes dated 20 May 2016 which record:
'*Managed with arm in sling prior to surgery - advice re similar scenario but NO ACTIVE movements R* [right] *shoulder at all. 2/52* [two weeks]…
Advice on washing/dressing techniques as well as difference between active and passive movements, A [Action] *to be referred urgently in RVH OPD* [Outpatient Department] *next week, P* [Plan] *R/V* [Review] *if req* [required], *see referral OPD attached, issued an appointment card*.'

31. The Domiciliary Services (self) Referral Form, Northern Health and Social Care Trust, completed by a SW, dated 23 May 2016 records:
'*.. no family support apart from a cousin (who is in her 70s). [She] has requested assistance with P/C* [personal care] *and meals*'.
'*Action Taken: Funding approval gained. POC* [Plan of care] *secured on brokerage with THC* [Trust Home Care] - *Reablement.*
POC = am [morning] *(p/c, dressing and breakfast) and tea (prep* [prepare] *and serve meals) to commence 24-05-16 tea call*.
Other information: [She] has a history of Crohn's disease, chronic back pain and carpal tunnel syndrome in her left hand. She has limited movement in her right arm due to a shoulder fracture sustained 3+ weeks ago (30 April 2016), caused by her fall in the home… would also have weakness in her left leg due to reported nerve damage'.

<u>Care Plan</u> - '*Assist to wash her body (NB. She cannot have a shower at present due to wearing a sling on her right arm), assist with upper and lower half dressing, prepare and serve breakfast – 30 minutes in morning weekly.*
Prepare and serve tea – 15 minutes at tea time weekly.
Public holiday cover required – yes.
Total hours required – 5 hours 15 minutes.
Date service commenced 24/05/2016, time service commenced – tea call'.

<u>Screening Outcome</u> - '*POC secured – to commence 24-05-16 at tea call (w/ THC Reablement). To be assigned key worker*.'

32. The 'Community Care Support Worker Record', was completed by a Social Worker on 2 June 2016. The record states:
Aids and Equipment: '*OT called 1.6.16.*
Proposed Action: '*OT will continue to review. No current changes required. Red Cross for transport to appointments*'.

33. I note that the 'Domiciliary Services Amendment Form' was completed by the Social Worker dated 5 July 2016 records:
Amendment Details: '*Permanent decrease of 1hr 45 minutes, cease date 5.7.16. Reason for increase/decrease: Cease tea call as per Reablement OT. Also amendment to morning call to supervise showering and no assistance with breakfast required*'.

34. Further, on 20 July 2016, the 'Domiciliary Services Amendment Form' was completed by an OT dated 20 July 2016 records:
Amendment Details: '*Permanent decrease of 3.5hrs, cease date 20.7.16. Reason for increase/decrease: Client now at baseline level of function, independent with personal care*.'

35. On 20 July 2016 the 'Occupational Therapy Discharge Summary' dated 20 July 2016 records:
Baseline/Recommendations:
'*Client now independent with strip wash. Client requires supervision with showering. However client reporting her friend who visits regularly now can assist with showering. Although client has restricted range of movement in right shoulder from review, client seems to be 1 with washing and dressing. OT recommends POC to cease from today*'.

36. As part of investigation enquiries, the advice of an Independent Professional Orthopaedic Surgeon (OS IPA) was sought. The Investigating Officer asked

the OS IPA to clarify the appropriate discharge assessment process for a patient such as the patient, in light of her various clinical symptoms and home conditions. In particular, it was noted that she was 67 years old, living at home alone in a two storey house with a number of health conditions. The OS IPA advised that '*The appropriate process for discharge is to form a multidisciplinary team under the guidance of a discharge co-ordinator and the constituents of the team depends on the individual needs of the patient. The team can assess the patient and once all members are satisfied that the needs of the patient have been assessed and all support is in place then the patient can be safely discharged. The patient and the family should be involved in the process and kept informed at all stages.* (https://www.nice.org.uk/guidance/ng27/chapter/Recommendations#discharge-from-hospital). These NICE guidelines are referred to in this report as NG 27'.

37. The Investigating Officer also sought advice as to whether the patient's physiotherapy notes were sufficient to inform the discharging Consultant Orthopaedic team that she did not require a care package on discharge. The OS IPA advised that '*as per the NICE guidelines the decision or not regarding the need for a care package needs to be taken jointly by the members of the MDT along with the involvement of the patient and the family*.'

38. The OS IPA advised that '*She was assessed by the nursing team, medical team and physiotherapists before discharge and she was deemed fit for discharge without any additional support. Various members of the team were involved in the discharge process but it appears that the patient and the family were not fully involved in the process. The concerns of the patient regarding her ability to cope at home do not seem to have been fully acknowledged or addressed. She may have benefitted from occupational therapist assessment and social input as appropriate.*'

39. The Investigating Officer enquired of the OS IPA whether the patient ought to have been assessed by an OT and/or SW prior to discharge. The OS IPA advised that '*she should have been assessed by an OT before discharge*

especially because she had raised concerns about her ability to cope at home without support'. The OS IPA further advised that '*the patient's concerns should have been addressed and further assessment requested as appropriate.*'

40. The Investigating Officer sought advice as to the team who ought to have considered the arrangement of a care package. The OS IPA advised that '*the discharging consultant/medical team would only be responsible to make a decision regarding the medical fitness for discharge from the ward. He would rely on other members of the team like nursing staff, physios, etc. to advise regarding the social needs and arrange support as appropriate*'. The OS IPA further advised that '*in the nursing notes there is mention of concerns raised by the patient regarding discharge without support but it does not appear this was addressed or indeed flagged up to the medical team to be able to act on this.*'

41. The Investigating Officer enquired of the OS IPA whether it was appropriate that the patient was discharged on 20 May 2016 without a care package. The OS IPA advised that '*it was not appropriate to discharge [the patient] without support on 20 May and left to her to arrange her own care package through the GP. The care needs should have been fully assessed and arranged before discharge*.' The OS IPA further advised that '*in this case on review of the medical records it seems that [the patient] was not fully assessed regarding her needs before discharge and she was left to source and arrange her own social care through the GP. This caused undue distress and anxiety to the patient.*'

42. The OS IPA advised that '*the ward nursing staff and other members of the MDT should be educated regarding the discharge guidance and the need to involve patients and families in decision-making. Discharge co-ordinators should be identified to monitor and implement safe discharge process.*'

43. The Investigating Officer enquired of the independent nursing advisor (N IPA) the action required in response to the concerns recorded in the nursing records on 20 May 2016. The N IPA advised that '*given the concerns expressed on the*

day of discharge "? home help"; it would be in line with the NMC Code to take advice from another practitioner in the best interests of the patient. In this case a Physiotherapist to assess [the patient's] physical abilities (this is documented as occurring at some point before 19:10, documented as "update") and furthermore, given that [she] had a sling restricting the movement of her right arm and was also in a lot of pain with her right shoulder; an OT assessment to assess her ability to undertake her ADL's at home (activities of daily living, including cooking, hygiene, dressing, shopping, mobilising up and down her stairs and safety with regards to locking and unlocking her external doors.'

44. The N IPA advised that '*NI guidance states there should be an "effective person-centred approach" and "fully integrated approach" to discharge planning. Furthermore staff must "ensure that the patient, family and/or carer is central to the assessment and discharge process with clear and transparent communication throughout the patient's journey. Thus there should be evidence of [the patient's] involvement in discharge planning as well as Physio and OT involvement. There is no evidence of [her] involvement in discharge planning at any stage and I do note that [she] contacted Social Services Re-ablement team in Carrickfergus independently on 23.05.2016 (three days after discharge). It is therefore clear that the Trust failed to involve [the patient] in the discharge process*.'

45. The Investigating Officer sought the advice of the N IPA as to whether the patient ought to have been referred to an OT. The N IPA advised that '*The facts that we have available to us are that [the patient] lived alone in a house with stairs. She had right sided shoulder pain necessitating opioid analgesia (oxynorm documented within nursing notes on page 34) and a sling restricting the mobility in the right arm on the day of discharge. Based on these facts, an OT was indicated to assess the home situation; for example was [the patient] able to safely ascend and descend the stairs? Given that her right arm was in a sling, did she have a grab rail on the left hand side of the stairs to ensure her safety? In the absence of an OT review outlining [the patient's] abilities to undertake her ADL's at home, discharge was potentially unsafe*.'

46. The Investigating Officer enquired of the N IPA whether a SW assessment was required. The N IPA advised that '*This would be dependent on the outcome of an OT assessment. If the OT assessment concluded that support would be needed on discharge, referral to SW would be indicated in order to source and implement the appropriate level of support. NI guidance states "Effective multidisciplinary working is an essential component of any discharge process, and early involvement of social work and AHP [allied health professional] staff will help to prevent delays in the process" (RQIA "Review of discharge arrangements from acute hospitals" 5.3.6)'* (see paragraph 15).

47. The N IPA advised that '*It was potentially unsafe to discharge [the patient] at this time. There is no OT review to provide us with absolute certainty, however, where there is any uncertainty, discharge should not go ahead. In accordance with NI guidance, the Trust should ensure that patients are discharged in a safe and timely manner to an environment which can safely and appropriately meet the patient's needs (Health and Social Care "Getting patients on the right road for discharge")'.*

48. In relation to the nursing note recorded in the nursing records from 07:30 – 20:30 on 20 May 2016 the N IPA advised that '*This represents a thirteen-hour timeframe. NMC standards state that nurses should "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 "attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed"… Thus this entry should have been timed accurately, rather than documenting a time-range*.'

49. In relation to the nursing note recorded in the nursing records at 19:10 on 20 May 2016 the N IPA advised that '*The note recorded at 19:10 was the only one that day that was in line with NMC standards in that we can clearly identify that [the patient] was discharged at 19:10. The fact that it was documented at 19:10*

further compounds the inappropriate use of the timeframe 07:30 - 20:30, because that note must have been written prior to 19:10. There is also an untimed note documented as "update" between the 07:30 - 20:30 note and the 19:10 note… This also should have been timed as per NMC standards.'

50. The N IPA advised that '*National discharge guidelines advocate a "minimum dataset to effect safe and effective discharge planning" and to reduce the paperwork required for discharge. The Trust's discharge checklist does include the minimum dataset for a simple discharge such as [the patient's] but it has not been fully completed. Please note that the second page of the checklist (page 41) is for post-operative patients such as this and that it is completely blank. We know from the nursing documentation recorded on the day of discharge that [the patient] was in pain from her shoulder and yet her pain score is not included, we also know from the same source that an out-patient's appointment was made for her and that she was given "# advice" (fracture advice) and yet none of this information is included on the discharge checklist. Thus local discharge planning guidance has not been followed*.'

51. The N IPA advised that '*The discharge information available to me points to a complete lack of patient-centred care. [the patient] was not involved in discharge planning*'. The N IPA further advised that '*The patient should be at the heart of the discharge process. Any patient concerns should be identified and acted upon*.' The N IPA advised that '*The Trust did not adhere to local and national discharge planning standards for the reasons identified throughout this advice. This meant that once [the patient] was discharged home, she had to phone Social Services independently for an assessment of her needs. The impact on [her] was that she was discharged home without the help and support that she was later identified as needing*.'

52. The Investigating Officer enquired of the physiotherapy advisor (P IPA) whether the physiotherapy treatment from 18 May 2016 to 20 May 2016 was appropriate. The P IPA advised that '*the physiotherapy treatment between 18 May and 20 May 2016 was appropriate: the physiotherapists followed the*

surgeon's post-operative instructions and issued the patient with an information booklet (local policy/guidance). Although we do not have a copy of this booklet, it is usual for such booklets to detail the post-operative rehabilitation and exercise regimen'.

53. The Investigating Officer requested from the Trust a copy of the information booklet provided to the patient on discharge. The P IPA considered the information booklet and advised that '*The Reverse Geometry Shoulder Replacement patient information booklet (July 2015) has been supplied by the Trust, which supports the 20.05.16 entry in the notes*.' The P IPA further advised that '*There is evidence that [the patient] was given a patient information leaflet containing exercises, which was appropriate and represented best practice*.'

54. The P IPA advised that '*the physiotherapy plan was for [the patient] to be discharged on 20 May 2016 (3 days post-operation) with outpatient physiotherapy to follow. The comment about [her] having managed before the surgery with her right shoulder immobilised in a sling is ambiguous, because we do not know if this represents [her] self-assessment/views or the opinion of the physiotherapist. There is no record of a more detailed subjective assessment or objective assessment to clarify the physiotherapist's statement*.'

55. The Investigating Officer enquired of the P IPA whether the physiotherapy notes evidence that she was physically fit for discharge and able to mobilise independently at home on 20 May 2016. The P IPA advised that '*there is no evidence in these physiotherapy notes that specifically relates to [her] being physically fit for discharge or to her ability to mobilise independently at home. On 20 May 2016, the physiotherapist merely states that [she] "managed with arm in sling prior to surgery". All we really know is that [she] had a passive shoulder range of right shoulder movement at approximately 50° flexion (taking the arm forward, away from the body) and 75° of abduction (taking the arm out to the side, away from the body).'*

56. The Investigating Officer enquired of the P IPA whether the Trust's response to my office dated 6 September 2017 which stated that the patient *'was deemed safe by the physiotherapist… the physio team who felt that she could manage at home without any extra assistance',* was evidenced within the physiotherapy records. The P IPA advised that '*I cannot find any evidence in the physiotherapy notes to support the Trust's statement that [the patient] "was deemed safe by the physiotherapist…"* The P IPA further advised that '*there is no reference to an assessment of activities of daily living or reference to the help needed at home before her admission for surgery. The only comment I can see in the physiotherapy notes is the one about [her] managing with a sling before that surgery and that what she was dealing with post-operatively was "similar" (except that she would not be allowed to move the shoulder at all for two weeks). And, as stated above, we do not actually know if this statement reflects [her] own views or the opinion (not backed up by any assessment) of the physiotherapy team*.' The P IPA advised that '*The "minimal assistance with ADL" comment and "?Home help when discharged" comment would indicate that [she] would indeed require some help at home, but this does not seem to have been assessed or investigated further.'*

57. The Investigating Officer enquired of the P IPA as to the responsible person for arranging a patient's care package on discharge. The P IPA advised that the Belfast Trust website http://www.belfasttrust.hscni.net/services/Reablement.htm '*link says that it is usually the responsibility of the hospital social worker to refer a patient to reablement. The responsibility of the hospital to arrange care at home before discharge is supported by this guidance from Citizens Advice (Northern Ireland) where it states, "If you need help after leaving hospital, you will be assessed before you leave"*.'

58. The Investigating Officer enquired of the P IPA whether the patient ought to have been referred to an OT and/or SW before she was discharged. The P IPA advised that '*I find this a difficult question to answer because there is just not enough information in the notes i.e. I cannot see an assessment of [her] needs following discharge and I can see no evidence of the "multidisciplinary*

discussions" – referred to [in a] letter of 16 Aug 2016 – where the Trust stated that the decision not to refer [the patient] to occupational therapy was made.' The P IPA further advised that '*there does not seem to have been any "multidisciplinary discussion" about this lady's care on discharge*'.

59. In relation to issues regarding record keeping by the relevant professional, the P IPA advised that '*The physiotherapy continuation sheet has the date of the first entry (18 May 2016) but no time is given - all we know is that it is "AM" - and there is no page number on the top of the continuation sheet. This documentation falls short of the professional practice recommendations for record keeping*' (paragraph 16 refers).

60. The Investigating Officer forwarded all independent advice to the Trust for comment. In relation to the OS IPA's advice the Trust commented that, '*The Trust agrees that the appropriate process for discharge of patients with complex needs is to fully involve the multi-disciplinary team (MDT), the patient and the family and to carry out appropriate assessments. From [the patient's] records there is no evidence that [she] was referred to Occupational Therapy or the Social Work service… Nonetheless, from the records it would appear that [she] could have benefitted from assessment by the Occupational therapy and Social Worker teams to ascertain whether additional support was needed; therefore the Trust would agree that the MDT assessment would have been indicated. The Trust would sincerely apologise to [the patient] that this did not happen in her case*.'

61. The Trust further commented that '*There is also no evidence in the nursing and medical notes that [the patient] raised or expressed concerns regarding her ability to cope at home without support. If any concerns had been indicated by the patient, the ward nurse would have contacted a Social Worker to discuss with [her] what support she may have required prior to her discharge. On reflection and review of this case, the Trust would agree with your IPA that [she] could have benefitted from an Occupational Therapy assessment. However, as previously stated, [she] did not raise concerns with the staff which*

would have prompted referral to the OT service during her inpatient stay… referral to additional services is not always indicated or required therefore a referral is not automatic but is according to assessed needs.'

62. In relation to the nursing note '*? Home help when discharged*' the Trust commented that '*Regrettably this comment is unclear as it does not outline if the patient requested help at home on discharge and there is no evidence of a social work referral at that time. Therefore it would appear that this comment is unclear in its origin and does not appear to have been actioned by the nursing team. The Trust is extremely sorry that this was not followed up. If a patient raises concerns prior to discharge, the ward nursing team should refer the patient to the relevant service i.e. Social Work/Occupational Therapy service in [this] specific case*.'

63. The Trust commented that '*Following review of [the] Physiotherapy notes, the Trust would conclude that these were sufficient to inform the patient's condition and as no referral for services had been made, a care package was not recommended or indicated at that stage. Nonetheless, [we] would conclude from further review of the documentation and agree with your IPA that [she] could have benefitted from Occupational Therapy and Social Worker assessment prior to discharge had she been referred for these assessments*.'

64. The Trust agreed with the independent nursing advice in relation to a patient-centred approach to the discharge process; the requirement of a SW assessment for home support if indicated by an OT assessment; the safe and timely discharge of a patient to a safe and appropriate environment; and the completion of all nursing records in accordance with NMC guidelines. However, the Trust reiterated that '*unfortunately we can find no evidence in the nursing or medical notes that [the patient] had raised or expressed concerns regarding her ability to cope at home without support'.* The Trust also commented again that '*the comment regarding "? home help when discharged", regrettably, this is unclear as it does not outline if the patient requested help at home on discharge and also there is no evidence of a social work referral at*

that time. Therefore it would appear that this comment is unclear in its origin but also that it does not appear to have been actioned by the nursing team.'

65. In conclusion, the Trust commented that '*The learning points raised by the IPA will be shared with the multi-disciplinary team at a number of divisional meetings. The Trust will highlight the relevant discharge guidance and the importance of involving patients and family in the discharge process. The Fracture Discharge Co-ordinators will be included in this process*.'

66. The Trust had not previously indicated in response to investigation enquiries that "Discharge Co-ordinators" were utilised in the Trust's discharge process. The Investigating Officer therefore enquired whether Fracture Discharge Co-ordinators were employed in the RVH at the time of the patient's discharge. The Trust explained that '*I can confirm that Fracture Discharge Co-ordinators were employed in May 2016 at the time of [the patient's] discharge*.' The Investigating Officer sought an explanation of the key responsibilities and duties of a Fracture Discharge Co-ordinator. The Trust further explained that '*The Fracture Discharge Co-ordinator is responsible, in conjunction with the multi-disciplinary team, for the co-ordination of timely discharge of patients from the Trauma and Orthopaedic Service in the Royal Victoria Hospital to the appropriate facility. The Fracture Discharge Co-ordinator has daily communication with all members of the multi-disciplinary team ensuring continual update of patients' condition and treatment plan. This communication process facilitates the co-ordination of the safe discharge of patients to the correct destination'.*

67. The Trust informed the Investigating Officer that '*In [this] case, there was no direct involvement required from the Discharge Co-ordinator as there was no indication that [the patient] required further assistance at home*. *As there was no involvement from the Discharge Co-ordinator, no notes were recorded*.'

68. I provided the Trust with the opportunity to comment on the draft investigation

report. I note the Trust accepted my findings and recommendations.

69. I also provided the Staff Nurse with the opportunity to comment on the draft report. She stated that '*I am a strong defender for the rights of all my patients and would stand up for them at all times to see that they receive fair treatment. On this occasion I cannot recall [the patient] raising the issues stated, i.e. home help. It was the weekend and the patient was of sound mind, able to make her own decisions and therefore when asked about discharge she was happy to go and I felt she was fit for discharge. As it was the weekend no OT, Physio or Social Worker Service was available*.'

70. The patient was also provided with the opportunity to comment on the draft report. Her comments were received on 23 October 2018. She stated that '*I would however like to express my concern that I feel a lot of blame has been attributed to the Staff Nurse who I believe discharged me. As I stated in my complaint, whether or not it was documented by other staff members. I did tell staff, both nursing and physio that I lived on my own and would not be able to manage on discharge without help at home. In particular I voiced my concerns to a member of the nursing staff the day prior to my discharge to no avail. I also expressed my concerns to a care assistant as well. I feel that it is not only the Staff Nurse but all the medical and nursing staff, including managers involved in my care who need, perhaps reminding and updating of assessing the genuine needs of the patient of whose care they are entrusted with*.'

Analysis and Findings

71. In considering the complaint I note that the OS IPA advises NICE guideline (NG27) is the appropriate patient discharge process. This guidance outlines that the appropriate discharge process involves: the formation of a MDT (the members of which depends on the patient's individual needs); the MDT assess the patient and the patient is discharged when all members are satisfied the patient's needs have been assessed and the relevant support is in place; and the patient and family are fully involved and kept informed at all stages of the discharge process. I note NG27 was not endorsed in Northern Ireland at the

time of the patient's discharge. I also note the DoH's advice that NG27 was used as a best practice guide by the Trust at the time. However, the Trust accept the OS IPA's advice that the patient discharge process is appropriate (paragraph 60 refers). Therefore I am satisfied that this discharge process was the appropriate process for the Trust to follow when discharging the patient. Furthermore the DoH's Discharge Planning Guidance and the Trust's Discharge Guiding Principles are the appropriate guidelines in which I will assess the actions of the Trust in this case.

72. I have considered the role and involvement of the MDT in the patient's discharge. The DoH's Discharge Planning Guidance clearly states that '*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.'* The RQIA's 'Review of Discharge arrangements from acute hospitals' (2014) also states that '*Effective multidisciplinary working is an essential component of any discharge* process'. The Trust explained that '*There is a multi-disciplinary meeting involving medical, nursing, physiotherapy and occupational therapists held daily on each of the fracture wards to discuss treatment pathways and discharge plans for all patients*'. The Trust also explained that there are no notes or records from these meetings and that discussions and decisions regarding onward referrals are recorded within the patient's relevant medical notes.

73. The patient's medical records evidence that she was individually assessed by the medical, nursing and physiotherapy teams prior to, and on the day of, her discharge. Each assessment was recorded separately within her relevant medical records. Her nursing record dated 20 May 2016 recorded, '*Pt* [patient] *to go home today safe with physio*' (paragraph 27 refers). This note implies that nursing staff reviewed and/or discussed her discharge plan with the physiotherapist. However, I note the P IPA advice that '*there is no evidence in these physiotherapy notes that specifically relate to [her] being physically fit for discharge or to her ability to mobilise independently at home*'. I will comment further on her physiotherapy records later in my report.

74. A Doctor recorded within the discharge note that, *'she was reviewed by the physio team*' (paragraph 29 refers). This record implies that the medical team reviewed her physiotherapy notes and/or discussed the discharge plan with the physiotherapist. However, I accept the physiotherapist IPA's advice that there is no evidence in her physiotherapy records that she was deemed fit for discharge by the physiotherapy team.

75. Having examined the medical records, these provide no evidence of any MDT meetings with all the relevant teams involved in the patient's care and discharge plan. I note, with some concern, the nursing and medical team's understanding of her physiotherapy assessment. Namely that both considered it was safe for her to be discharged home with no pre-arranged package of care and support. I consider a clear record of the MDT discussion about the patient's care and discharge plans ought to have been separately recorded and/or clearly recorded in her medical notes. A contemporaneous and full record of the MDT meeting ought to include a record of those clinical disciplines involved in the consideration of her discharge plan, their individual patient assessments and a decision as to post discharge care.

76. The Trust stated that '*from the records it would appear that [the patient] could* [my emphasis] *have benefitted from assessment by the Occupational Therapy and Social Worker teams to ascertain whether additional support was needed*' (paragraph 60 refers). I have carefully considered the IPAs' advice, the Trust's comments and the patient's SW and OT assessments by the Northern Health and Social Care Trust. The later assessments are dated 23 May 2016 and 1 June 2016 respectively. I note that the SW assessment was completed three days after discharge from the RVH on 20 May 2016. I consider the conclusion of this assessment i.e. the arrangement of a daily care package to commence the following day, evidences that the patient would have benefitted from a SW assessment. Furthermore the patient's OT assessment on 1 June 2016 evidences her need for such an assessment. I consider these assessments ought to have been carried out by the appropriate SW and OT teams at the

RVH prior to discharge on 20 May 2016. The Trust ought to have been alerted to the need for these assessments given that the patient raised the concerns with nursing and physiotherapy staff throughout her admission and with the Staff Nurse on the day of her discharge.

77. The Trust confirmed, as part of the investigation that a Discharge Co-ordinator works with members of the MDT to ensure the safe and timely discharge of a patient. I note the OS IPA's advice on the identification of Discharge Co-ordinators '*to monitor and implement safe discharge process*' (paragraph 42 refers) and the reference to Discharge Co-ordinators in the NG27. I further note the DoH's Discharge Planning Guidance refers to the need for a 'named lead co-ordinator'. The Trust has confirmed that '*there was no direct involvement required from the Discharge Co-ordinator as there was no indication that [the patient] required further assistance at home*'. I acknowledge the Trust's comments in this regard.

78. However, I consider the Trust failed to follow the DoH's Discharge Planning Guidance and the Trust's Discharge Guiding Principles in this case. I accept the advice of the N IPA that the patient's discharge was potentially unsafe. The Trust failed to involve all relevant disciplines in its assessment prior to her discharge. An OT and/or SW assessment did not occur and therefore the patient's safety was not considered in relation to her current physical ability and home setting. I consider this failing is a failure in care and treatment which caused her to suffer the injustice of upset, inconvenience and distress as she was discharged without an appropriate care package in place.

79. A patient-centred approach to discharge is highlighted in the DoH's Discharge Planning Guidance, Trust Discharge Guiding Principles, RQIA guidance and IPA advice advises that staff adopt such an approach. I note that Trust staff are required to fully involve the patient, family and/or carer in the discharge process. The Trust's Discharge Guiding Principles states that the MDT: *'Involves the patient, family and/or carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise*

their independence'. I refer to Step 7 of the DoH's Discharge Planning Guidance which states: '*Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence'.* I note the OS IPA advised '*… it appears that the patient and the family were not fully involved in the process*' (paragraph 38 refers). I also note the N IPA advised that '*the discharge information available to me points to a complete lack of patient-centred care*' (paragraph 51 refers).

80. The Trust stated that '*there is no evidence of [the patient] raising any major concerns at the point of discharge*'. I note the nursing record in her nursing notes i.e. '*? Home help on discharge*'. The Trust commented that '*Regrettably… it would appear this comment is unclear in its origin*' (paragraph 62 refers). However, I note in the Trust's earlier response to my office dated 6 September 2017 it states that '*there is a short reference to [the patient] querying home help'*. Furthermore the Trust states that it is '*extremely sorry that this was not followed up*'. This is an instance of inconsistency in the Trust's responses to investigation enquiries about the nursing note. I note however that the Trust states the comment is '*unclear in its origin*', yet the Trust acknowledges that the patient queried home help and sincerely apologies that the comment was '*not followed up*'?

81. I have carefully considered the patient's complaint to me, clinical records and comments on the draft investigation report. I have also considered the Staff Nurse's comments on the draft investigation report. I am satisfied that the Staff Nurse nursing record evidences that the patient verbally raised her concerns about coping at home on 20 May 2016. However, I note the complaint to me dated 2 August 2017 and her comments on the draft report. The patient has consistently stated that she raised her issues about coping at home with nursing and physiotherapy staff during her hospital admission. I note there is one record of these concerns recorded in the nursing notes as documented by the Staff Nurse at 19:10 on 20 May 2016. I further note, with some concern, that the concerns were not recorded within her nursing notes elsewhere. I also note the physiotherapy notes do not record any of concerns on coping at home

on discharge. I consider the relevant nursing staff failed to adhere to paragraph 10.2 of the NMC Code. I also consider relevant physiotherapy staff failed to adhere to the 'Chartered Society of Physiotherapy Guidance on Record Keeping'.

82. I am satisfied that the decision to discharge the patient was a collective decision made by the relevant nursing, orthopaedic, physiotherapy, OT and SW teams. I do not consider that the Staff Nurse was solely responsible for the discharge of the patient on 20 May 2016. Furthermore, according to Step 1 of the DoH's Discharge Guidance, the discharge ought to have been a '*process and not an isolated event at the end of the patient's stay'*. I therefore consider the MDT failed to respond to, follow up or escalate the patient's concerns about coping at home to the relevant team prior to her discharge at 19:10 on 20 May 2016. The MDT also failed to follow the DoH's Discharge Planning Guidance and the Trust's Discharge Guiding Principles in this respect.

83. I conclude that the MDT failed to follow DoH's Discharge Planning Guidance and the Trust's Discharge Guiding Principles in relation to a patient-centred approach. I also consider Trust staff failed to fully involve the patient at any stage in the discharge process to ensure a personalised discharge plan was delivered for her. I consider this to be a failure in care and treatment. As a consequence of this failing I consider that the patient suffered the injustice of inconvenience, upset and anxiety due to the inadequate post discharge care.

84. In reference to the recorded nursing notes, I consider the nursing note recorded between 07:30 - 20:30 on 20 May 2016 evidences the Staff Nurse's failure to adhere to section 10.1 of the NMC Code: '*complete all records at the time or as soon as possible after an event, recording if the notes are written sometime after the event*'. I conclude a further failure by the Staff Nurse to complete the relevant 'Post-operative Patients' Discharge Checklist within the Nursing Assessment and Plan of Care booklet on 20 May 2016. In particular, there is a failure to record the patient's pain score, a pre-arranged out-patients appointment and fracture advice provided to her prior to discharge. The Staff

Nurse also failed to adhere to the requirements of section 10.3 of the NMC Code, in that she did not '*complete all records accurately*', and failed to follow the Trust's discharge process. These failings in completing the necessary notes and records do not meet the Third Principle of Good Administration 'Being Open and Accountable' which requires full and accurate records to be kept. I consider this to be a failure in care and treatment. I note, however, that the Staff Nurse is no longer employed by the Trust. Therefore, my recommendation, in relation to this failure, reflects this fact.

85. I note the P IPA's advice in relation to the record-keeping by the physiotherapy team as they had failed to record the specific times of the patient's physiotherapy assessments from 18 - 20 May 2016. The team further failed to appropriately paginate the physiotherapy continuation sheet. I consider this evidences a failure by the physiotherapy team to adhere to the Chartered Society of Physiotherapy Guidance on Record Keeping (2014) which are the relevant professional practice recommendations for physiotherapy record keeping. I also note the P IPA's advice in relation to the lack of detailed subjective or objective assessment by the physiotherapist (paragraph 54 refers) in the recorded comment that the patient *'managed with arm in sling prior to surgery*'. I consider this record was unclear and failed to provide sufficient detail and clarity as to whether she positively or negatively managed with her arm in a sling prior to surgery. A failure to follow guidance does not meet the requirements of the First Principle of Good Administration 'Getting it Right'. Further, failures to complete full and accurate records do not meet the requirement to be 'open and accountable' (Third Principle of Good Administration). I therefore consider this failure in record-keeping to be a failure in care and treatment. This caused the patient to suffer the injustice of not being assessed by other clinical staff accurately.

86. I consider Trust staff failed to appropriately assess the patient's needs on discharge. The MDT failed to refer her for OT and/or SW assessment following concerns on how she would cope at home on discharge. The patient raised these concerns with nursing and physiotherapy staff throughout her admission.

As a result of the maladministration and failures in care and treatment, she suffered the injustice of being discharged from the RVH without an appropriate pre-arranged package of care and support. I uphold this issue of her complaint.

CONCLUSION

87. The patient complained to me about the actions of the Trust and its staff in relation to her discharge from the Royal Victoria Hospital.

88. I have investigated the complaint and found failures in her care and treatment in relation to the Trust and it's staff's failure to:

(i) Adequately assess her care needs by referring her for OT and/or SW assessment prior to discharge on 20 May 2016;

(ii) Involve her in its decision to discharge her;

(iii) Follow the DoH's Discharge Planning Guidance and the Trust's Discharge Guiding Principles;

(iv) Accurately record and complete nursing notes and a 'Discharge checklist' in accordance with the record keeping requirements in the NMC Code; and

(v) Accurately record physiotherapy patient assessment notes in accordance with relevant guidelines.

89. I am satisfied that the failures in care and treatment I have identified caused the patient to experience the injustice of inconvenience and upset. She lost the opportunity to have a suitable care package in place post discharge. I also consider the failures in care and treatment and maladministration caused her the injustice of having to wait for a care package; upset, distress and anxiety in having to care for herself over the weekend period and independently source a care package assessment three days after discharge.

Recommendations

90. I recommend within **one** month of the date of this report:

(i) The Trust provide the patient with a meaningful apology for the inconvenience, upset and anxiety caused to her as a result of the failings

in care and treatment and maladministration.

(ii) I recommend the Trust provide the patient with a further apology for the above failures causing the subsequent failure by it to appropriately arrange a care package for her on discharge.

(iii) Provide to the patient a consolatory payment of £750 for the injustices I have identified above.

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

  (i) Provide training to multi-disciplinary teams on the importance of recording clear and accurate records of all MDT discussions, assessments, referrals, decisions and communication with patients, in particular, concerns raised regarding help at home and care packages on discharge;

  (ii) Remind nursing staff in ward 4B to adhere to the NMC record-keeping standards, and;

  (iii) Remind physiotherapy staff to adhere to the relevant record keeping standards.

(v) The Staff Nurse is no longer employed by the Trust. I therefore recommend that she refreshes her awareness of the requirements of section 24.2 of the NMC Code. In particular, that she '*uses this complaint as a form of feedback and an opportunity for reflection and learning to improve practice*' in her current employment.

Marie Anderson

MARIE ANDERSON
Ombudsman

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.