The investigation of a complaint by Ms P against Hywel Dda Local Health Board

A report by the Public Services Ombudsman for Wales

Case: 201002404

Contents

Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of this Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Ms P.

Summary
Ms P complained that her late mother, Mrs P, was inappropriately discharged home from Bronglais Hospital in Aberystwyth in February 2008; that communication with her about her mother's condition was poor; and that the Health Board did not robustly investigate her complaints or provide her with a reasonable and timely response. Sadly, Mrs P died within hours of being discharged home.

The Ombudsman found that Mrs P had suffered marked falls in her oxygen saturations (a measure of respiration efficiency) during the two nights before she was discharged. While the first fall was reported to the doctors the next day, there was no evidence that they were notified of the second fall, or that other abnormalities in Mrs P's pulse and blood pressure were recognised or acted on. The Ombudsman concluded that given Mrs P's abnormal observations, she should not have been discharged when she was. The Ombudsman also found that communication with Ms P about her mother's condition was poor, in part because of the failure to recognise the abnormal observations. The Ombudsman upheld these parts of Ms P's complaint.

Turning to the handling of Ms P's complaint, the Ombudsman was concerned that the process became protracted, and that there were some unavoidable delays. He also noted that the Health Board's internal investigations had not identified any concerns about the lack of response to Mrs P's abnormal observations. The Ombudsman also upheld this complaint.

The Ombudsman recommended that the Health Board apologise to Ms P and pay her £100 in recognition of the time and trouble she had been put to in pursuing her complaint. He also made recommendations aimed at improving responses to abnormal observations and record keeping on the ward concerned. The Health Board has agreed to implement the Ombudsman's recommendations.

The complaint

1. Ms P complained that:

- The standard of communication with her about her late mother's condition before her mother's discharge from Bronglais Hospital on 8 February 2008 was poor.

- Her mother was inappropriately discharged home on 8 February 2008.

- The Health Board did not investigate her complaint robustly and did not provide her with a reasonable and timely response to her concerns.

Investigation

2. I obtained comments and copies of relevant documents, including clinical records, from Hywel Dda Local Health Board and considered those in conjunction with the evidence provided by Ms P and her advocate. I also obtained clinical advice from two of the Ombudsman's professional advisers – a senior nurse and a consultant physician specialising in the medical problems of elderly people. Their advice is summarised at paragraphs 39 – 56 of this report. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

3. Both Ms P and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

NHS re-organisation

4. At the time of the events complained about, Bronglais Hospital was run by Hywel Dda NHS Trust. Following a re-organisation of the NHS, the Trust was abolished and replaced by Hywel Dda Local Health Board on 1 October 2009.

Relevant guidance

5. The National Institute for Health and Clinical Excellence (NICE) has produced guidance (the NICE Guidance) on the care of acutely ill patients in hospital.[1] It includes:

> "**Foreword**
> Patients who are admitted to hospital believe that they are entering a place of safety, where they, and their families and carers, have a right to believe that they will receive the best possible care. They feel confident that, should their condition deteriorate, they are in the best place for prompt and effective treatment.
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> "…
>
> **"1.2 List of recommendations and care pathway**
>
> **1.2.1 Key priorities for implementation**
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> - Adult patients in acute hospital settings, including patients in the emergency department for whom a clinical decision to admit has been made, should have:
>
> - physiological observations recorded at the time of their admission or initial assessment
> - a clear written monitoring plan that specifies which physiological observations should be recorded and how often. The plan should take account of the:
> - patient's diagnosis
> - presence of comorbidities
> - agreed treatment plan.
>
> Physiological observations should be recorded and acted upon by staff who have been trained to undertake these procedures and understand their clinical relevance.

[1] Acutely ill patients in hospital: recognition of and response to acute illness in adults in hospital; NICE Guideline 50, 2007

- Physiological track and trigger systems should be used to monitor all adult patients in acute hospital settings:

    - Physiological observations should be monitored at least every 12 hours, unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient.
    - The frequency of monitoring should increase if abnormal physiology is detected, as outlined in the recommendation on graded response strategy.

- Staff caring for patients in acute hospital settings should have competencies in monitoring, measurement, interpretation and prompt response to the acutely ill patient appropriate to the level of care they are providing. Education and training should be provided to ensure staff have these competencies, and they should be assessed to ensure they can demonstrate them."

6. The Welsh Assembly Government (as it then was) issued guidance called "Fundamentals of Care" about the standards of care patients can expect to receive from providers of health and social care.[2] The guidance sets out a number of principles, which include:

> "Basic human rights to dignity, privacy and informed choice must be protected at all times, and the care provided must take account of the individual's needs, abilities and wishes."

7. The Nursing and Midwifery Council (NMC) issues a Code of Professional Conduct which its members are expected to follow. The edition of the Code which was current at the time of the events Ms P complains about[3] includes:

[2] Fundamentals of Care; WAG, 2003.

[3] The NMC code of professional conduct: standards for conduct, performance and ethics; NMC, 2004 (superseded 1 May 2008).

"1.4 You have a duty of care to your patients and clients, who are entitled to receive safe and competent care.

"…

"6. As a registered nurse, … , you must maintain your professional knowledge and competence.

"6.1 You must keep your knowledge and skills up-to-date throughout your working life. In particular, you should take part regularly in learning activities that develop your competence and performance.

"6.2 To practise competently, you must possess the knowledge, skills and abilities required for lawful, safe and effective practice without direct supervision. You must acknowledge the limits of your professional competence and only undertake practice and accept responsibilities for those activities in which you are competent.

"6.3 If an aspect of practice is beyond your level of competence or outside your area of registration, you must obtain help and supervision from a competent practitioner until you and your employer consider that you have the requisite knowledge and skill."

The background events

8. Ms P's mother, Mrs P, was in her late eighties and lived with Ms P with support from social services and the district nursing service. Mrs P was admitted to Bronglais Hospital (the Hospital) in Aberystwyth on the evening of 5 February 2008 after she had developed a temperature, had vomited, was in pain, and had been off her food.

9. On admission Mrs P was assessed by a locum staff grade doctor and she was reviewed by another staff grade doctor (the Staff Grade Doctor) the following morning. It was felt at that point that Mrs P may have had a urinary tract infection and that she was dehydrated. She was prescribed normal saline to address the dehydration. The Staff Grade

Doctor spoke to Ms P later that afternoon to discuss her mother's future care. He noted that Ms P wanted her mother to go home "asap". Mrs P says that she did not say this, and asked for the discharge not to take place until 8 February.

10. During the night of 6 – 7 February, Mrs P's oxygen saturation[4] fell to 85% (time not recorded), 86% (at 10.00pm) and 83% (at 6.20am). She was given oxygen to try to correct this fall. The fall was noted by the Staff Grade Doctor when he saw Mrs P during the ward round on the morning of 7 February. He recorded that it was felt to be caused by the way Mrs P was lying in bed. The Staff Grade Doctor also noted that Mrs P was not in pain and that her chest was clear. The plan was for Mrs P to be discharged home on 8 February.

11. Ms P states that she visited her mother on 7 February and was concerned about her condition. She says that she spoke to the ward sister[5] about her concerns. Unfortunately, there is no note of any such discussion with Ms P in the nursing records; the only record of any dialogue being a note stating that Ms P would notify her mother's carers that she was due home the next day so they could resume the home visits. Ms P states that she also telephoned the ward on the morning of 8 February to check her mother's condition and to confirm the discharge arrangements. Again, there is no record of this conversation in the nursing notes.

12. Mrs P's oxygen saturation fell again during the night of 7 – 8 February, this time to 56% (at 9.45pm). She was given 100% oxygen and by 6.10am her oxygen saturation had recovered to 95%. A note in the nursing records at 5.00am on 8 February states:

> "[Oxygen] Sats 54% on air [over night] 100% O_2 given Sats ↑ 94% Drs busy in A/E please inform Drs today."[6]

[4] A measure of efficiency of respiration – normally above 94%.

[5] The Charge Nurse later commented (after Ms P had complained) that neither he nor the ward sister had been working that day.

[6] The figures quoted in the nursing records differ slightly from those recorded on the observation chart as quoted above.

13. Mrs P was seen by the Staff Grade Doctor on 8 February before she was discharged home. It is not clear whether the fall in oxygen saturation overnight was brought to his attention. The Staff Grade Doctor's note simply states:

> "Patient stable, no concerns. Home today."

14. Mrs P was taken home by ambulance. Ms P states that when her mother arrived home, she was dressed in a soiled hospital gown, smelt of vomit, and was breathing heavily. She also found a night-dress covered in vomit in her mother's bag. Ms P says she then telephoned the ward to find out what had happened. She says that she was told that Mrs P had been sick while being helped to eat some porridge. She says she was also told that Mrs P had been given fluids and that her breathing rate would return to normal. Again there is no record of this conversation in the nursing notes. Sadly, Mrs P died within three hours of her return home.

15. Ms P complained to the Trust (as it then was) via an Advocate from the local Community Health Council (CHC) on 24 April 2008. She complained, in particular, that the Hospital had either not noticed Mrs P's deterioration or had failed to act on it, and that her mother's dignity had been compromised by being discharged in a soiled gown. The Advocate asked that Ms P's concerns be investigated, and said that once the investigation was complete, Ms P would like to meet with the Trust's Director of Nursing to discuss her experiences.

16. The Trust acknowledged receipt of the Advocate's letter on 29 April (it had been received the previous day) and noted that the consent form (indicating that Ms P agreed to the CHC acting on her behalf) enclosed with the letter had not been signed. The CHC provided a signed consent form on 22 May.

17. On 10 June, the Trust's Acting Director of Nursing and Patient Services (the Acting Director of Nursing) wrote to Ms P to say that a meeting had been arranged for 25 July. She said that she was sorry that it had not been possible to identify an earlier date for the meeting.

18. The meeting between Ms P and the Acting Director of Nursing took place on 25 July and a note of what was discussed was produced by the Advocate (who had also been present, together with a friend of Ms P). The notes of the meeting state that the Acting Director of Nursing apologised to Ms P for her experience and for the fact that staff "appeared not have followed the most appropriate processes for discharge". The notes state that Ms P said that she had been shocked when her mother returned home as Mrs P looked very unwell, was gasping for breath, was dressed in a hospital gown, and smelt of vomit. Ms P said that when she rang the ward, a nurse told her that Mrs P's breathing would improve, but gave no additional advice. The notes state that the Acting Director of Nursing said that she was disappointed to hear about Ms P's experience and said that she would not expect an ill, elderly patient to be sent home in that manner. She commented that dignity and respect were considered to be fundamental in patient care.

19. The notes of the meeting also state that the Acting Director of Nursing stated that she would review the nursing records and charts to try to identify what had happened. She also invited Ms P to contribute a "patient story" which would be used to help staff learn from her complaint. The Acting Director of Nursing wrote to the Advocate on 22 August enclosing an amended copy of the meeting notes. She said that she had arranged to meet Ms P to record her "patient's story".

20. The Advocate e-mailed the Trust's Complaints and Litigation Officer (the first Complaints Officer) on 16 September. The Advocate said that she had met Ms P, who had some outstanding concerns. The Advocate said that she was keen to resolve these before the Acting Director of Nursing was due to move to a new post later that month. The Advocate said that Ms P's outstanding concerns were about:

- Who actually decided to discharge Mrs P.
- Who prepared Mrs P for discharge.
- The process followed when her mother was discharged.

- The fact Ms P was not contacted by the ward staff.

- The fact Mrs P was discharged in a gown and smelling of vomit.

- What she was told by the nurse when she rang the ward after her mother was discharged.

- That she was not told how ill her mother was.

21. The Acting Director of Nursing wrote to the Advocate on 23 September. She said that the Head of Nursing for Medicine and Surgery would go through Ms P's concerns at the Ward Sister Forum and also with the staff on the ward where Mrs P was a patient. She noted that there had been a breakdown in communication and said that she had apologised to Ms P for this. The Acting Director of Nursing concluded by saying:

> "Unfortunately, there is no documented concern [about Mrs P's condition] in the health records and I am unable therefore to provide any further detailed responses over an (sic) above the answers already given. I hope, however, that I have reassured [Ms P] that her complain (sic) has been taken seriously and that short and long term actions have been undertaken.
>
> "Once again, I would like to apologise to [Ms P] and the family and offer our deepest condolences."

22. Ms P decided that she would like to see her mother's health records, and she viewed them at the Trust's offices on 18 November. On 19 November the Advocate e-mailed the first Complaints Officer to request a written response to the outstanding issues in her e-mail of 16 September.

23. The Trust's Associate Director of Nursing for Ceredigion (the Associate Director) wrote to Ms P on 28 November. He confirmed that the decision to discharge Mrs P was made by the medical team at the ward round on 8 February. He also noted that the records stated that

Mrs P's oxygen saturations had fallen, but that they had recovered by the time of the ward round on 8 February and the doctors were happy for Mrs P to go home. The Associate Director went on to say that there was a discharge checklist in the notes completed by a named nurse. He said that no concerns were recorded about Mrs P's condition by either the nursing or medical teams.

24. Turning to the complaint about Mrs P being discharged in a hospital gown, the Associate Director said that a report written by the Charge Nurse indicated that Mrs P had vomited after breakfast; however, the Charge Nurse had been unable to establish why Mrs P had been dressed in a hospital gown when a nightdress was available. The Associate Director said that the Charge Nurse had discussed the events at a ward meeting and had reminded staff of the importance of preserving patients' dignity at all times.

25. The Associate Director said that he had been unable to take Ms P's concerns about what she had said she was told by the ward sister further as the staff rota indicated that neither the ward sister nor the charge nurse were on duty at the time. He reiterated, however, that there was nothing in the records to suggest that Mrs P had deteriorated to such an extent that she should not have been discharged. He said that he felt sure that if there had been concerns, the staff would have asked the doctors to review Mrs P and reconsider whether she should have been discharged. The Associate Director concluded by saying that he would be happy to meet with Ms P if she had any outstanding concerns.

26. Ms P then decided to request an independent review of her complaint, and the Advocate wrote to request this on her behalf on 7 April 2009. The Lay Reviewer obtained clinical advice from a senior nurse and wrote to Ms P with her decision on 16 July. The Lay Reviewer explained that she had decided to refer Ms P's complaint back to the Trust as she considered that there were a number of significant outstanding matters that needed to be addressed. In particular, the Lay Reviewer felt that Ms P should be given more information about what happened at the time of Mrs P's discharge and about the action the Trust had taken in response to her complaint. The Lay Reviewer said

that she had written to the Chief Executive of the Trust to let him know her decision and to suggest that a further meeting between Trust staff and Ms P might be helpful.

27. The Advocate wrote to the Chief Executive on 26 September to say that Ms P was dissatisfied that she had not heard anything more from the Trust since the Lay Reviewer's decision. The Chief Executive acknowledged the Advocate's letter on 29 September and said that he had asked his staff to contact her to arrange a meeting as suggested by the Lay Reviewer. A member of staff in the complaints department contacted the Advocate's assistant on 12 October and, after a number of e-mails about the availability of the various parties, it was agreed that Ms P would meet the Associate Director and the Consultant who had been responsible for Mrs P's care (albeit he had not actually seen her as he had been away at the time of her admission) on 16 December.

28. Unfortunately, the 16 December meeting was cancelled as the Associate Director had flu. The meeting was re-arranged for 29 January 2010. A Patient Support Services Officer (the second Complaints Officer) at the Health Board (as it had now become) wrote to Ms P on 9 February enclosing the draft notes of the meeting. She said that she would also arrange a meeting between Ms P and the new ward sister when she started her post the following month.

29. The notes of the 29 January meeting (which the Consultant was unable to attend) state that Ms P felt that there was a breakdown in communication around her mother's discharge from hospital. The notes state that the Associate Director said that the findings of the investigations that took place when Ms P made her complaint had been fed back to the ward team. The notes state that he apologised for shortfalls in the care Mrs P received and acknowledged that standards had fallen below what was acceptable. He went on to outline some of the changes that had been, or were being, made to improve services for patients. These included:

- An audit of Fundamentals of Care standards had been undertaken, and action plans drafted to address any shortcomings that had been identified.

- The ward which Mrs P was nursed on was being refurbished.

- A new ward sister had been appointed.

- A new Head of Nursing had been appointed for Ceredigion.

- A training programme had been introduced for healthcare support workers.

- Professional accountability sessions were being arranged for registered nurses.

The Associate Director acknowledged that it was unfortunate that the tape of Ms P's "patient story" had been lost.

30. The note of the meeting recorded that Ms P was concerned that while she had had meetings with senior staff, her concerns were not reaching the ward level. The Associate Director agreed to raise the issues discussed at the meeting with the Senior Nurse for Surgery (the Senior Nurse) and it was also agreed that a meeting would be arranged between Ms P, the Senior Nurse, and the new ward sister. The Associate Director also agreed to send Ms P a copy of the Fundamentals of Care audits.

31. The second Complaints Officer wrote to Ms P on 26 March to say that she hoped to be able to offer her a list of dates to meet the Ward Sister shortly and said that she understood that the Associate Director would also be sending her details of the audits in the near future. The Associate Director wrote to Ms P on 8 April to summarise the details of the audits. The meeting with ward staff took place on 27 April, and on 7 May the second Complaints Officer wrote to Ms P enclosing an action plan to address Ms P's outstanding concerns.

32. The Advocate wrote to the second Complaints Officer on 8 June to say that Ms P remained dissatisfied and was concerned that her complaint had not been fully resolved two years after she had made it. The Advocate noted that Ms P was awaiting the results of the audits and

action plan that had previously been agreed. The results of the audits and an updated action plan were sent to Ms P on 2 July. The final, completed, action plan was sent to Ms P on 20 August.

Ms P's evidence

33. The Advocate, writing on Ms P's behalf, said that Ms P had been very distressed by the events surrounding her mother's discharge. She said that Ms P felt that Mrs P should not have been discharged in such a state and that there should have been better communication from the ward.

34. The Advocate said that Ms P had gained the impression that due to changes in staff, her complaint had never been robustly investigated by the Trust and Health Board. She said that Ms P felt the loss of her "patient story" was disrespectful and inconsiderate. The Advocate said that Ms P felt that there had been a lack of genuine impetus from the Health Board to address her concerns, learn from them, and respond to her appropriately. The Advocate said that the poor experience Ms P had of her mother's care was compounded by the repeated and ongoing poor management of her complaint.

The Health Board's evidence

35. In its formal comments to the Ombudsman on Ms P's complaint, the Health Board said that it acknowledged that it was unacceptable from Ms P's point of view that she experienced such delays in the handling of her complaint. The Health Board said that the delays unfortunately occurred due to a succession of changes to the senior staff who were dealing with Ms P's complaint, together with changes to the structure of the organisation itself.

36. The Health Board said that its staff had made efforts to resolve Ms P's concerns through correspondence and meetings. The Health Board also said that communication within the ward had improved considerably following the appointment of a new ward manager. It said that regular staff meetings are held on the ward where any concerns can be discussed openly. The Health Board said that the minutes of one of these meetings were sent to Ms P as an example.

Professional advice

37. The Ombudsman's **Consultant Physician Adviser**, Dr Kalman Kafetz BSc MB BS FRCP, noted that Mrs P's oxygen saturation fell to 85% on the night of 6 – 7 February 2008. He commented that oxygen saturation is a measure of efficiency of respiration and is easy to monitor in acute hospitals. He said that it is usually above 94%. The Adviser said that a fall in oxygen saturation below 90% means that the delivery of oxygen around the body is severely compromised. The Adviser noted that at the same time Mrs P's pulse and blood pressure rose. He noted that the nurses added oxygen to Mrs P's treatment but did not call a doctor.

38. The Adviser said that Mrs P was seen by the Staff Grade Doctor the next morning who noted the fall in oxygen saturations and also noted that when seen her rate of breathing was normal and her chest clear. The Adviser noted that there was no comment by the Staff Grade Doctor about Mrs P's raised blood pressure or pulse the previous night. The Adviser said that the fall in oxygen saturations was put down to Mrs P's position in bed which was thought to have made her breathing inefficient.

39. The Adviser said that Mrs P's oxygen saturation dropped again the next night at 9.45pm, apparently to the seriously low level of 54% or 56%. He noted that at the same time Mrs P's blood pressure fell. The Adviser said that Mrs P's oxygen saturation returned to normal following a very high dose of oxygen (12 litres). He noted that the nursing records stated that: "Drs busy in A&E please inform doctors today". The Adviser said that Mrs P was seen by the Staff Grade Doctor the next day before discharge, with no apparent consideration of the previous night's events.

40. The Adviser commented that Mrs P seemed to have been seriously ill the night before she was discharged home. He said that this was not considered at the medical review on the day of discharge. The Adviser said that he therefore did not feel that the decision to discharge Mrs P home was clinically reasonable. The Adviser noted that Mrs P was reviewed by a doctor before she was discharged; however, he considered that the nurses should have asked for an urgent medical review when Mrs P's observations became abnormal the night before,

rather than accept that the doctors could not attend as they were busy in the A&E department.

41. The Adviser referred to the NICE Guidance on the management of acutely ill patients in hospital (see paragraph 6). He commented that the NICE Guidance recommends that physiological observations should be done at least every 12 hours and that the frequency should increase if abnormal results are detected. He said that the NICE Guidance also advises that physiological measurements should be incorporated into a "track and trigger" system. He explained that this is a way of amalgamating the different variables to provide a simple measure of illness severity and trigger an appropriate urgency of response. The Adviser said that Mrs P's observations were done at approximately 12 hourly intervals on 6 and 7 February; however, no measurements were taken between 6.20am and 9.45pm (15 hours) on 7 February, even though the frequency of observations should have increased in view of the previous abnormalities. The Adviser said that a track and trigger system was not used. He commented that the standard of care was therefore not up to the standards of the NICE Guidance which had been published the previous year and which reflect good basic ward practice.

42. The Adviser noted that Mrs P's death was sudden and that she had been ill for some time. He said that even if the abnormal observations had been taken into account and Mrs P kept in hospital, it was, sadly, extremely unlikely that her death could have been prevented. However, he noted that the issues surrounding discharge, and the upset caused by those, would not have occurred had Mrs P been kept in.

43. Turning to the standard of communication between staff and Ms P, the Adviser noted that one of the doctors spoke to her on 6 February and provided a summary of Mrs P's management and an estimated date of discharge. The Adviser noted that there was no record of further communication between the doctors and Ms P; however, he noted that from the point of view of the medical staff there was nothing more to communicate as Mrs P's abnormal observations had not been appreciated.

44. Turning to the actions taken by the Health Board in response to Ms P's complaint, the Adviser commented that there appeared to have been no emphasis on the implementation of the NICE Guidance. He noted that there was no comment on this, or on the issues around Mrs P's physiological observations, in the Health Board's response to the Ombudsman or the action plan from April 2011. He noted that within the audit forms provided by the Health Board there is a document about the audit of MEWS scores (MEWS is an acceptable track and trigger system), so such a system was in use at the Health Board. However, the Adviser commented that this complaint raised issues about the measurement of, and response to, physiological variables and what systems the Hospital has in place for this.

45. In summary, the Adviser said that there was little consideration of Mrs P's abnormal physiological measurements during her admission in February 2008. He said that had the abnormal observations been properly considered, Mrs P would probably not have been discharged when she was and this would have avoided distress to both Mrs P and her daughter. The Adviser recommended that there should be a full review of the application of the NICE Guidance to the work of the Hospital, if this has not already been done.

46. The Ombudsman's **Nursing Adviser**, Rona McKay RN BSc(Hons) said that she did not consider the decision to discharge Mrs P was clinically reasonable in light of the drop in her oxygen saturation during the night of 7 – 8 February. The Adviser commented that this was a very significant drop, to 56% (as noted on the observation chart). The Adviser said that this was accompanied by a fall in blood pressure. The Adviser observed that a nurse had noted on the observation chart that he/she gave Mrs P 12 litres of oxygen and that the saturations rose to 94%. The Adviser commented that the nurse should have ensured that a doctor attended Mrs P to investigate the reason for this very significant drop in oxygen saturation.

47. The Adviser noted that Mrs P's oxygen saturations had also fallen the previous night – to 83-86% - and she reiterated the Consultant Physician Adviser's point that a fall in oxygen saturation below 90%

means that the delivery of oxygen around the body is severely compromised.

48. The Adviser said that there was no evidence that the nursing staff recognised the significance of the low oxygen saturations, took any action to investigate the cause, or took any action to escalate the findings to medical staff. The Adviser said that it was of real concern that the low oxygen saturations took place over a period of almost 48 hours yet did not appear to have been recognised as abnormal by the nursing staff. The Adviser said that it was also of note that Mrs P's pulse was abnormally fast (from 10.00pm on 6 February it was approximately 108bpm, 114bpm, 96bpm and 104bpm). The Adviser said that these were all significant readings, especially when considered with the low oxygen saturations.

49. The Adviser said that the failure to recognise and act on the abnormal observations was a significant failure in care and meant that Mrs P did not receive medical intervention and that staff continued to take her observations far too infrequently. The Adviser commented that it is reasonable to expect staff undertaking observations to understand their meaning and act accordingly.

50. The Adviser said that there was no evidence that the Health Board had implemented the NICE Guidance. She said that it was evident that the nursing staff did not take account of Mrs P's abnormal observations before she was discharged. She said that the observations should have given cause for concern and raised questions about Mrs P's suitability for discharge. She commented that nurses are usually the last clinicians to see patients before they are discharged, and it is their responsibility to ensure a patient is clinically fit to be sent home.

51. The Adviser said that she could see little evidence in the records of communication between the ward staff and Ms P. She noted, however, that it appeared that the ward had since implemented a more robust system for recording communication with patients and their families.

52. The Adviser said that the Health Board appeared not to have recognised that there was a failing in care in response to Mrs P's

abnormal observations and the impact this may have had on the decision to discharge Mrs P.

53. Although not part of Ms P's complaint, the Adviser noted that the Medicine Administration Record in the notes indicates that a supplementary prescribing chart is needed to administer oxygen; however, she could not find any evidence of this chart in Mrs P's notes. The Adviser said that the prescription for oxygen should state the flow rate, the duration, and the target saturation. The Adviser said that while she acknowledged that in an emergency oxygen may be given to a patient without a formal prescription, and the lack of a prescription should not prevent oxygen being given, the prescription should be written up at some point.

54. In conclusion, the Adviser said that Mrs P's observations were significantly abnormal over a period of time, yet no nurse took action. She said that this was especially important when Mrs P's oxygen saturation dropped to 54 – 56%, which is extremely low. The Adviser said that it was of real concern that none of the nursing staff took account of these observations, and that there is no evidence that they were brought to the attention of the doctors, who could have investigated the reasons for the ongoing abnormalities. She noted, too, that the Health Board did not appear to have recognised this failure in care.

Analysis and conclusions

55. In reaching my conclusions I have been guided by the advice of my professional advisers. Ms P complained that that standard of communication with her about her mother's condition before discharge was poor; that her mother was inappropriately discharged home on 8 February 2008; and that the Health Board did not investigate her complaint robustly or provide her with a reasonable and timely response to her concerns.

56. I will deal first with Ms P's complaint that her mother was inappropriately discharged home on 8 February. It is clear from the records that Mrs P suffered falls in her oxygen saturation on both the nights of 6 – 7 and 7 – 8 February. The first fall was brought to the attention of the medical staff, albeit at the ward round the next morning

rather than at the time of the fall. The fall was put down to Mrs P's position in bed, but no mention was made of the fact that her pulse rose and blood pressure fell overnight, and it is not clear whether any further consideration was given to these observations.

57. The fall in oxygen saturations on the night of 7 – 8 February was more severe – to 56% (normally 94%). The nurse rightly gave Mrs P oxygen and her saturations recovered; however, the doctors were not informed due to them apparently being busy elsewhere in the Hospital. The Staff Grade Doctor's note in the records the next morning does not refer to the fall in oxygen saturations over night. It is not clear whether he was aware of the fall but felt it was not significant, or whether he was not told about the fall by the nursing staff. There was also a fall in Mrs P's blood pressure that night, which is also not referred to in the notes.

58. My Advisers state that given Mrs P's abnormal observations she should not have been discharged on 8 February. I agree. I also share their concerns that despite the fact that a number of Mrs P's observations (oxygen saturations, blood pressure, pulse) were found to be abnormal (and significantly so in the case of the oxygen saturations), the frequency of observations was not increased, nor was a doctor called so the cause of the abnormalities could be investigated. These are examples of poor practice and are contrary to the NICE Guidance. While it seems that the Hospital does use a track and trigger system (MEWS), it was not used in Mrs P's case. Had it been, it is more likely that her poor condition would have been recognised and a medical opinion obtained at an earlier stage.

59. While it is, sadly, unlikely that Mrs P would have survived even had she remained in hospital, the state she was discharged in caused additional and unnecessary distress to her and her daughter. I therefore uphold this part of Ms P's complaint.

60. I turn next to the standard of communication with Ms P. Ms P says that her mother's condition was not made clear to her before she was discharged and that when she spoke to staff on the ward they effectively told her that there was nothing to worry about. There is very little in the

notes about discussions with Ms P: a conversation with the Staff Grade Doctor on 6 February about arrangements for Mrs P's ongoing care and a note in the nursing records that Ms P was asked to inform Mrs P's carers that she was due to be discharged on 8 February so that they could restart their home visits. Ms P states that she had other discussions with nursing staff both before and after Mrs P was discharged in which she raised concerns about her mother's condition and checked the arrangements for her discharge. It is disappointing that there is no record of these conversations in the notes.

61. To an extent, Ms P's complaint about the failure to inform her of her mother's condition before she was discharged is linked to the complaint about the decision to discharge Mrs P on 8 February. As I have said above, the staff caring for Mrs P failed to appreciate the severity of her condition as her abnormal observations were not acted on. As the staff failed to recognise Mrs P's poor condition, they could not then inform Ms P about it. As also mentioned above, if Mrs P's observations had been recognised and acted on it is likely that she would not have been discharged and the problems relating to communication with Ms P would not have arisen. It follows that I uphold this part of the complaint.

62. The final part of Ms P's complaint relates to how the Trust and Health Board dealt with her complaint. Ms P feels that her concerns were not robustly investigated and that there were unacceptable delays. When the Advocate first wrote to the Trust with Ms P's complaint she asked for the complaint to be investigated and, following that investigation, a meeting with the Director of Nursing. While a meeting with the Acting Director of Nursing duly took place, there was no comprehensive written response to Ms P's complaint until the Associate Director became involved some months later. While meetings are often a useful tool in helping to resolve complaints, I do consider that a formal written response to the complaint should also have been provided at an earlier stage. Following the independent review of Ms P's complaint, further meetings took place and the Health Board undertook to provide Ms P with various pieces of information, such as details of audits. It does seem to me that by this stage the complaints process had become protracted and there were some delays in responding to Ms P. In

fairness to the Health Board, not all the delays were within its control (as, for example, when the meeting of 16 December 2009 had to be cancelled due to the illness of the Associate Director); however, I do consider that some were unacceptable. In particular, it is disappointing that the Advocate had to chase the Trust for a response to the independent review after Ms P had heard nothing for over two months.

63. It is also worth noting that the investigations carried out by the Trust and Health Board did not identify the concerns set out in this report surrounding the lack of response to Mrs P's abnormal observations. I consider that this does cast some doubt on the robustness of the Trust's handling of the complaint. I uphold this part of Ms P's complaint.

Recommendations

64. I recommend that the Health Board:

1. Apologises to Ms P for the failings identified in this report

2. Pays Ms P £100 in recognition of the time and trouble she was put to in pursuing her complaint.

3. Reviews the use of the NICE Guidance at the Hospital.

4. Reminds the staff on the ward on which Mrs P was nursed of the importance of escalating concerns to the medical staff and increasing the frequency of observations when a patient's observations are abnormal.

5. Reminds the ward staff of the importance of recording relevant discussions with patient's family members.

6. Reminds the nursing staff of the need to obtain a prescription for oxygen if this is given to a patient.

I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Peter Tyndall 23 August 2011
Ombudsman