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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint

by Mrs W

against Aneurin Bevan Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201204681

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Introduction

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

In accordance with the provisions of the PSOW 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 Mrs W and her late husband as Mr W.

Summary

Mrs W complained about the care provided by Aneurin Bevan Health Board ("the Health Board") to her late husband ("Mr W") when he was a patient at Nevill Hall Hospital ("the Hospital") in September and October 2011. Mr W was 80 years old when he died in hospital on 7 October 2011.

Mrs W said that Mr W was deaf, but despite advising staff of this, it was not noted on his records. Mrs W said she believed that her husband was not treated in his best interests and that his care was compromised because staff did not consider his deafness. Mrs W said that she and her husband were not told about a cancer diagnosis by the Hospital. She also said that she was dissatisfied with the way that the Health Board communicated with her and her family both during the time Mr W was a patient and when the Health Board was considering the complaint she made about his care.

The investigation found that, as required by the Equality Act 2010, the Health Board failed to make reasonable adjustments to accommodate Mr W's deafness. The investigation also found that the Health Board failed to:

- Record a significant clinical discussion with Mr W about scan results.
- Complete and record appropriate assessments relating to the risk of falling and the use of bed rails.
- Consult Mr W and record his consent for the insertion of a catheter.
- Follow national and local guidance on effective discharge planning.
- Keep appropriate records related to the discharge process.
- Follow relevant guidance on record-keeping.

The Ombudsman upheld the complaint and the Health Board agreed to:

a) give Mrs W an unequivocal written apology for failures identified by this report and make a payment of £500 to reflect the time and trouble taken in pursuing her complaint with the Health Board and this office.
b) formally instruct the nursing and clinical staff involved in Mr W's case that they must assess patients properly on admission and ensure that all relevant records of such assessments (for example, the Patient Care Record) are completed fully.

c) formally instruct the nursing and clinical staff involved in Mr W's case to follow the relevant record keeping guidance.
d) formally instruct the clinical staff involved in Mr W's case to ensure that significant clinical discussions with patients (such as the results of a scan) are recorded properly.
e) formally instruct the nursing staff involved in Mr W's case to ensure that all appropriate risk assessments are completed and properly recorded.
f) formally instruct the nursing and clinical staff involved in Mr W's case to follow the relevant discharge planning guidance.
g) share this report with all staff involved in Mr W's care so that the lessons that should be learned from the report can be understood.
h) ensure that this report is discussed at a meeting of each Directorate that cared for Mr W so that the lessons of the report are disseminated.
i) ensure that this report is discussed at a meeting of the working group responsible for the Health Board's "Dignified Care?" action plan.

The complaint

1. On 27 February 2013, Mrs W complained[1] to me about Aneurin Bevan Health Board ("the Health Board"). Mrs W said that her husband ("Mr W") was a patient at Nevill Hall Hospital ("the Hospital") between 9 and 16 September 2011 ("the first admission") and then between 5 October and 7 October 2011 ("the second admission"). Mr W was 80 years old when he died in hospital on 7 October 2011.

2. Mrs W said that Mr W was deaf, but despite advising staff of this, it was not noted on his records. She said she believed that, as a result, her husband was treated as if he had dementia.

3. Mrs W said that Mr W was catheterised without a continence assessment being completed. She was concerned that her husband would have found wearing a catheter humiliating. Mrs W said that he fell while trying to get out of bed and she believed that he was trying to get to the toilet because he did not like the catheter. Mrs W asked the Health Board to explain why bed rails[2] were not used on her husband's bed. Mrs W also said she asked for information about any continence assessments that were completed, but the Health Board has not provided it.

4. Mrs W said that she believes that her husband was not treated in accordance with his best interests at all times; that the Health Board did not follow their own policies regarding catheterisation of patients and that her husband's care was compromised because staff did not consider his deafness. She also said that she was dissatisfied with the way that the Health Board communicated with her and her family both during the time Mr W was a patient and when the Health Board was considering the complaint she made about his care.

Investigation

5. My investigator obtained Mr W's records, copies of relevant documents and comments from the Health Board and met with Mrs W and her daughter.

1 Mrs W agreed the complaint summary on 15 April 2013.
2 Sometimes called cot-sides.

I considered all the evidence obtained in conjunction with the information the family gave my investigator. I obtained advice from Ms E Onslow, one of my Professional Advisers ("the Adviser"). The Adviser is an experienced senior nurse with particular expertise in the care of older people. She reviewed the medical records and responded to questions raised about the complaint. I accept her advice and it is referred to below. However, the conclusions reached on this complaint are mine.

6. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

Relevant legislation and guidance

7. The legislation, guidance and reports that were considered during the investigation are summarised and listed at Appendix 1.

A summary of the events leading to the complaint with comments from Mrs W and the Health Board.

8. On 9 September 2011, as a result of a referral by his GP, Mr W attended the Emergency Assessment Unit ("the EAU") of the Hospital. A provisional diagnosis of probable pulmonary embolism was made. This was later revised to a possible chest infection. Antibiotic therapy was started and Mr W was admitted to a ward where he was under the care of a Consultant Physician ("the Consultant Physician").

9. Mrs W later complained to the Health Board about her husband's experience in the EAU.[3] She also told me that the EAU Triage[4] nurse would not let her accompany Mr W whilst he was being assessed. She said that Mr W was very deaf and although he did wear hearing aids, background noise would have made it very difficult for him to hear anything the Triage nurse said to him.

3 15 November 2011.
4 Triage is the action of prioritising treatment for people who attend an Emergency Assessment Unit according to clinical priority.

10. When Mr W was admitted to the ward, Mrs W said her daughter asked staff to record his deafness on the front of his records, but this was apparently not done.

11. The Health Board's response[5] to Mrs W's complaint included an apology for how tiring the Triage process had been for Mr W. Later, during a meeting to discuss the complaint,[6] a Senior Nurse agreed to investigate Mrs W's comments about her experience of Triage. An update added to the notes of that meeting stated that the Triage nurse had apologised sincerely about the shortcomings in the Triage process.

12. When commenting on the draft of this report, the Health Board said that it would like to sincerely apologise to Mrs W for the poor experience she had when Mr W was in Triage.

13. The Health Board told my investigator[7] that a range of information was available for staff about how best to communication with patients who are deaf.

14. When commenting on the draft of this report,[8] the Health Board agreed that Mr W had a hearing impairment and that he wore hearing aids. It that said that Mr W said he did not wear them. The Health Board said that it would not have been appropriate to record his deafness on his records unless he was registered deaf and there was no record that he was registered. The Health Board also said that Mr W did not ask for his medical records to note that he was deaf. It said that whilst it acknowledged that Mr W was hard of hearing this was not a concern in his care.

15. On 14 September, Mr W had a CTPA scan.[9] The scan indicated a possibility of malignancy.

5 15 December 2011.
6 21 May 2012.
7 12 June 2013.
8 22 November 2013.
9 A Computed Tomographic Pulmonary Angiography scan looks at the lung arteries.

16. Mrs W said they were told that the scan "had found a mass on his right lung". She said that neither Mr W nor his family were told of a possible cancer diagnosis while he was in hospital. She said they were not told about it until they visited Mr W's GP.[10]

17. The Health Board told Mrs W[11] that a doctor from the first Consultant Physician's team recalled discussing the possibility of lung cancer with Mr W.

18. The Health Board initially told my investigator[12] that two junior doctors from the first Consultant Physician's team did discuss the possibility of lung cancer with Mr W, but that one of the junior doctors omitted to note the discussion in Mr W's records. The Health Board also said that following Mrs W's complaint the first Consultant Physician discussed the omission with the junior doctor but that this discussion was not recorded anywhere.

19. In the same letter, the Health Board also told my investigator that it was

> "…not routine to discuss cancer unless staff are clear on the diagnosis and it is confirmed by further investigations. Staff are aware of breaking bad news, and the fact that a 'shadow' was present was discussed. The final, confirmed, results were provided on 21 September and it was at this point that it was felt appropriate to break the bad news…".

20. When commenting on the draft of this report, the Health Board said that patients are not informed of a diagnosis of cancer until all investigations have been carried out and the diagnosis is confirmed by test results. It also said that the conversation which took place between the junior doctors and Mr W was a "discussion and not a diagnosis". It also said that "it is not practice or appropriate for junior medical staff to inform patients that they have cancer, when the diagnosis has yet to be confirmed."

10 21 September 2011.
11 15 December 2011.
12 22 May 2013.

21. The GP records note that during a discussion with Mrs W which took place after Mr W passed away, Mrs W told the GP that she was unhappy that the Hospital had not mentioned the cancer diagnosis.

22. Mrs W said that on 16 September, Mr W was given a provisional discharge date for the following week. When commenting on the draft of this report, the Health Board said that Mr W was not told that he would not be discharged until the following week. It said the records indicate that there was a possibility of him being discharged on 14 or 15 September.

23. On 16 September, a Respiratory Consultant reviewed Mr W. The Respiratory Consultant noted that Mr W's case would be discussed at a lung multi-disciplinary team ("MDT") meeting the following week. He noted that Mr W did not need to stay in hospital until the MDT discussion took place.

24. The records note that at 4.30pm on 16 September, Mr W was awaiting discharge; that his medications would be ready the following day; and that Mr W had said that a family member could collect the medication the next day. At 7:15pm, in response to a query, Mrs W was told that Mr W could go home, but the medicines which had been prescribed for him would need to be collected the following day. Mrs W advised staff that she was not happy with the situation. Mr W was then discharged home.

25. Mrs W said that she thought the discharge was not properly planned and that when he was discharged, Mr W was not given a discharge letter.

26. The Health Board told Mrs W that when the Respiratory Consultant reviewed Mr W on 16 September he had decided that Mr W would not need to stay in hospital until the MDT. The Health Board also explained that the discharge paperwork was not properly completed but that staff had checked with both Mr W and her that he had all the necessary medication at home. The Health Board apologised for the inconvenience that this issue may have caused.

27. The Health Board told me that around that time a new electronic discharge system was being introduced and, due to a mistake, the electronic process was not completed properly and the discharge letter was not produced by the system.

28. On 20 September, Mr W's case was discussed by the lung cancer MDT. The Health Board said that the MDT arranged for a Macmillan Nurse Specialist to contact Mr W and check on his progress.

29. On 21 September, Mr W visited his GP. The records of this consultation note "suspected lung cancer". Mrs W told my investigator this was the first time they were told of a possible cancer diagnosis.

30. On 4 October, Mr W took Zopiclone[13] that had been prescribed for him.

31. On 5 October, he was readmitted to the Hospital, as an emergency. He was drowsy and was in Type II respiratory failure.[14]

32. His daughter said that when he was admitted she asked staff to help her father get to the toilet because she could not do that alone. The Health Board said that on admission to the ward at 8:50pm, he was reviewed by a doctor and, as he had not passed any urine that day, he was catheterised.[15] The records note that Mr W got out of bed a few times during the night.

33. Mrs W said that Mr W was catheterised without a continence assessment being completed and that he would have found wearing a catheter humiliating. She said that Mr W was not incontinent and she thought he was catheterised for the convenience of staff. Mrs W said she asked the Health Board for information about any continence assessments that were completed, but she was not been given the information.

13 Zopiclone is used to help with sleeping problems.
14 Respiratory failure occurs when gas exchange at the lungs is sufficiently impaired to cause a drop in blood levels of oxygen. Respiratory failure is divided into type I and type II. Type I involves low oxygen with normal or low carbon dioxide levels. Type II involves low oxygen with high carbon dioxide.
15 A catheter (a thin tube) is inserted into the patient's bladder via the urethra. This allows the patient's urine to drain freely from the bladder for collection.

34. The Health Board told my investigator that it had not provided the information because Mrs W's advocate[16] had said[17] that she did not want to have any further correspondence from the Health Board.

35. Mrs W said she was told that, on 5 October, Mr W had had a quiet night. She said that the records indicated otherwise. She said that if she had been told how disturbed the night of 5 October had been she would have stayed with Mr W the following night.

36. On 6 October, Mrs W was told that Mr W's condition was deteriorating and it was decided that palliative care was appropriate. Mrs W asked that her husband be nursed at home and a community palliative care plan was discussed. As Mr W was clinically unstable at that time, it was agreed that the plan would be reviewed after the weekend. The records note that during the night Mr W was agitated and that he got out of bed and removed the catheter.

37. Mrs W said she was again told that, on 6 October, her husband had again had a quiet night but that the records indicated otherwise. Mrs W said Mr W fell while trying to get out of bed. She said he must have been trying to get to the toilet because he did not like the catheter. Mrs W later complained to the Health Board that bed rails should have been placed on his bed to prevent such a fall. Mrs W also said that a falls risk assessment should have been completed but was not.

38. On 7 October, because noise from renovation work in a nearby room was causing Mr W distress, the family asked for him to be moved to another room. Mr W's clinical records include comments about his family's alleged negative conduct on the day. Sadly, later that day, Mr W passed away in Hospital.

39. Mrs W told my investigator that the comments about the family's conduct were incorrect and she was distressed to see them in her husband's records.

16 At certain points when making her complaint Mrs W was supported by an advocate from the local Community Health Council.
17 Email 1 August 2012.

40. On 15 November, Mrs W complained to the Health Board about the care her husband had received. Mrs W told the Health Board she was dissatisfied with the Triage process; the discharge following the first admission; the way in which she found out about the possible cancer diagnosis; and the distressing experience of Mr W's last days. Mrs W said she thought Mr W's age influenced the standard of care given.

41. On 15 December, the Health Board gave Mrs W a response to her complaint which expressed sincere condolences for her loss and included:

- An explanation of the Triage process and an apology for how tiring it had been for Mr W
- Details of the conversation the junior doctor recalled having with her husband about the possible cancer diagnosis
- An explanation of the events that led to Mr W's discharge on 16 September and an apology for the inconvenience caused
- An explanation of the decision to catheterise Mr W when he was readmitted on 5 October
- An overview of the care given to Mr W from 5 October to 7 October and an apology for the impact the noise from building work had on the family at this time
- A reassurance that Mr W was appropriately assessed and that the relevant teams were involved in his care
- An offer of a meeting to discuss the Health Board's investigation of her complaint

42. On 21 May 2012, Mrs W met with Health Board staff. The meeting notes indicate that she asked to discuss:

- Experience in Triage - first admission
- Diagnosis made and frequent reference to long term oxygen therapy and over sedation — second admission[18] [19]
- Prescribing of Oramorph – second admission[18] [19]

18 Mrs W did not mention these issues in the complaint made to the Health Board on 15 November.
19 Mrs W included these elements in her complaint to this office.

- Risk Assessment — second admission[18]
- Catheterisation — second admission
- Communication between staff and family — both admissions

43. The meeting notes record that the Health Board staff gave Mrs W an explanation for each of the issues and agreed to take follow up action on her comments about Mr W's Triage experience and the later decision to catheterise him.

44. On 1 August, her advocate told the Health Board Mrs W did not want to meet again, but that she was still waiting for the information about her husband's catheterisation.

Professional advice

45. The Adviser reviewed the medical records and responded to questions my investigator raised about the complaint.

Communication with Mr W and his family

46. My Adviser said that assessment is a core principle of the National Service Framework for Older People and is the cornerstone to establishing the needs of any older person admitted to hospital. She said that a proper assessment should have identified Mr W's deafness and an effective communication strategy should then have been developed and documented in a person-centred care plan.

47. My Adviser said that it is established good practice for nursing staff to engage with family members. She said that this is necessary to enable nursing staff to identify any particular support that family members may require.

Discharge planning

48. The Adviser said that timely discharge is achieved when the patient is discharged home as soon as they are clinically stable and fit for discharge. A patient can be defined as clinically stable when tests such as bloods and investigations are considered to be within the normal range for the patient. A

patient is 'fit for discharge' when physiological, social, functional, and psychological factors or indicators have been taken into account following a multidisciplinary assessment if appropriate. The Adviser said that the Health Board's discharge policy reflects national guidance.

49. The Adviser said Mr W's home circumstances were documented. However, the patient care record contained no assessment information for discharge, planning for simple discharge or involvement of Mr and Mrs W in the process. She also said that the discharge checklist had not been completed.

50. When commenting on the draft of this report, the Health Board accepted that there was a clear failure to complete discharge documentation. However, it also said that assessment information was not required for the September 2011 discharge required as Mr W lived with his wife at home, was independent and did not require any Social Service input.

51. The Adviser said that there was no explicit record that Mr W was fit for discharge, but it was clear from the clinical entry in the notes, that the Respiratory Consultant considered that he was. The Adviser said that there was also no written entry from a member of the Consultant Physician's team responsible for Mr W, documenting that he was fit for discharge. The Adviser said that the first reference to discharge on the Nursing Information sheet (4.30pm, 16 September) noted that Mr W was awaiting discharge, that medications would be ready the following day and that Mr W had said that a family member could collect the medication. The records indicate that Mr W wanted to go home. The Adviser said that it was clear from an entry in the nursing records (7.15pm, 16 September) that Mrs W had not been told that her husband was being discharged; that take home medication was not available and that there was also a delay in completion of the discharge summary. The Adviser said that this was evidence of poor discharge planning and practice.

Catheterisation

52. The Adviser said nurses must ensure that catheterisation is based on a balanced decision suggesting more benefits than disadvantages, in consultation where possible, with the patient.[20] She said that one of the key criteria for deciding whether to insert a urinary catheter in an acutely unwell patient was for the monitoring of kidney function. The Adviser said that at 8:00pm on 5 October 2011 it was noted that Mr W had not passed urine all day. Due to this, and his elevated respiratory and heart rate, nursing staff appropriately requested a medical review. The doctor identified the risk of acute kidney injury ("AKI"). Included in the plan of care was the requirement to catheterise Mr W so that his urine output could be monitored accurately.

53. The Adviser said that the rationale for catheterisation was clearly documented and was based on Mr W's clinical need. She said there was no indication that he was catheterised for the convenience of nursing staff.

Falls risk assessment and the use of bed rails

54. My Adviser said that older people are particularly at risk of falling in hospital and all staff should be trained to recognise when they are at risk. If a high risk is identified then an individual plan to deal with the risk factors was required.[21] The decision whether or not to use bed rails should also be informed by a risk assessment.[22] The Adviser said that the records noted that Mr W was usually able to keep himself safe. However, there was no evidence of any falls risk screening being undertaken and no indication of a risk assessment concerning the decision whether or not to use bed rails.

55. My Adviser said that it was important to understand that the use of bedrails was not appropriate for all patients. For patients who can get about by themselves bedrails would create a barrier to independence. They could also create a greater risk of falls and injury for patients who were confused but mobile enough to climb over them.[23]

20 Catheter Care: Guidance for nurses, Royal College of Nursing 2007, updated 2012.
21 National Patient Safety Agency 2007 Slips, Trips and Falls in Hospital.
22 Department of Health MHRA DB 2006 (06) Safe use of bed rails.
23 National Patient Safety Agency 2007 Safer Practice Notice 2007 using bedrails safely and effectively.

56. My Adviser said that the lack of a falls risk screening, and a risk assessment of the decision whether or not to use bed rails, was a failing. However, she also said that the decision not to use bed rails was correct because the bed rails could have put him at greater risk of injury from falling and would therefore have been inappropriate.

Analysis and conclusions

57. My role is to consider the reasonableness of the treatment, care or service provided by the Health Board. To uphold a complaint I must be satisfied that the complainant has been caused an injustice, as a result of any failing identified by an investigation. Looking at each of the issues highlighted by the complaint:

The Health Board's failure to take note of Mr W's deafness.

58. Mr W was deaf and wore hearing aids. However, his wife said that even then, he would struggle to understand what was said to him if there was background noise.

59. In the Equality Act,[24] ("the Act") deafness is defined as a disability, even though many deaf people do not think of themselves as disabled. The Act requires public bodies such as the Health Board to make "reasonable adjustments"[25] to the services it provides so that disabled people are not at a "substantial disadvantage". The duty to make reasonable adjustments covers the way things are done, physical features (such as steps to a building), and the provision of auxiliary aids or services (such as an induction loop or an interpreter).

60. Also, in any clinical situation it is clearly important to identify whether or not a person is able to hear and, if not, to identify a suitable way to communicate properly with them.

24 Appendix 1.
25 As defined by the Equality Act 2010.

61. During Triage, Mrs W was denied the opportunity to help staff communicate with Mr W. Later, when he was admitted to the ward, Mr W's daughter asked for a note of his deafness to be made on Mr W's records. Action on Hearing Loss[26] also recommends this as an appropriate action. However, this was not done.

62. My Adviser said that a proper assessment should have identified Mr W's deafness and an effective communication strategy should have been developed and documented. Both my Adviser and my investigator reviewed Mr W's medical records; Mr W's deafness was not recorded during the first admission. It was briefly noted during the second admission, but the entry wrongly noted that he did not wear a hearing aid.

63. There is no record of any discussion with Mr or Mrs W to establish whether or not Mr W wore hearing aids. There is also no record that the staff considered how to improve communication with him. My Adviser said there is also no evidence of a care plan generated in response to his deafness.

64. The Health Board had appropriate policies in place; unfortunately there is no evidence that the staff who cared for Mr W were aware of them or implemented them. I have seen no evidence that demonstrates that the Health Board considered how to communicate effectively with Mr W. I have seen no evidence that it made reasonable adjustments in Mr W's case and I think he was disadvantaged by the Health Board's failures. It is also disappointing that no account was taken of what the family told staff about his deafness.

65. In its comments on the draft of this report, the Health Board agreed that Mr W had a hearing impairment and that he wore hearing aids. However, it said that it would not have been appropriate to record his deafness on his records unless he was registered deaf and there was no record that he was registered.

26 Action on Hearing Loss was formerly known as the Royal National Institute for Deaf people ("RNID").

66. I have considered this aspect of the complaint and the Health Board's comments on it very carefully. I do not accept the Health Board's view of this issue. I am concerned that the Health Board failed to properly consider Mr W's communication needs.

The standard of communication between Health Board staff and Mr W and his family.

67. There are no specific guidelines on standards of communication. However, as noted by my Adviser, it is established good practice for nursing staff to engage with family members.

68. Both my Adviser and my investigator reviewed Mr W's medical records; there is no evidence of any communication between nursing staff and members of Mr W's family, or between medical staff and Mr W's family, during the first admission apart from an entry on 16 September which noted Mrs W dissatisfaction with the lack of medication for Mr W on discharge. There are a number of entries recording discussions between medical staff and members of Mr W's family during the second admission.

69. As a result of the standard of record keeping, which I discuss further below, it is not possible to identify whether the lack of evidence of any communication with Mr W's family during the first admission is a reflection of poor record keeping or an indication that there was no communication with the family. Both possibilities are unacceptable and therefore cause me concern.

The discharge that occurred on 16 September.

70. The Discharge Guidance indicates that discharge is a process, not an isolated event; planning for discharge should start at the earliest opportunity. Patients and their carer(s) should understand and be able to contribute to care planning decisions as appropriate.

71. The Health Board's discharge policy reflects national guidance. My Adviser and investigator reviewed Mr W's clinical records; there is very little evidence to suggest that the actual discharge planning reflected either local

or national guidance. The patient care record contained no assessment information for discharge, planning for simple discharge or involvement of Mr and Mrs W in the process. The discharge checklist had not been completed.

72. Mr W was reviewed on 16 September and included in the plan of care was the requirement to "chase respiratory referral". Mr W was then reviewed by the Respiratory Consultant later that day (the exact time was not documented) who concluded that Mr W did not need to stay in hospital for the MDT meeting, which was due the following week.

73. There was no explicit record that Mr W was fit for discharge, but the Adviser said that the Respiratory Consultant considered that he was. The Adviser also said that there was no entry by a member of the Consultant Physician's team responsible for Mr W, documenting that he was fit for discharge. The Adviser said that the nursing records show that his take home medication was not available and that there was also a delay in completion of the discharge summary. This was evidence of poor discharge planning and practice. The lack of specific entries about whether Mr W was fit for discharge are also examples of poor record keeping.

74. The Health Board did give Mrs W an explanation for the failures when it responded to her complaints. It also explained to my investigator that the issue occurred because of problems staff had with a new electronic discharge system. I am not convinced that this reason gives a full explanation as it does not explain the other failures in the discharge process. Based on the Adviser's comments, I am satisfied that Mr W was fit to be discharged on 16 September, but I am not satisfied that the discharge process was properly planned, managed, documented or communicated to Mr W and his family.

75. It its comments on the draft of this report, the Health Board said that assessment information was not required for the discharge. I disagree with the Health Board on this point and I am concerned that the discharge process did not follow the Health Board's policy or national guidance.

The decision to catheterise Mr W on 5 October and whether an appropriate assessment was completed.

76. Mrs W complained that Mr W was catheterised without a continence assessment being completed. She said that Mr W was not incontinent and she thought he was catheterised for the convenience of staff. Mrs W also said that Mr W would have found wearing a catheter humiliating.

77. The Adviser said that the rationale for catheterisation is clearly documented and was based on Mr W's clinical need. She said there is no indication that he was catheterised for the convenience of nursing staff.

78. Based on my Adviser's comments, I am satisfied that the use of a catheter was clinically appropriate. Mr W was catheterised because he was at risk of AKI, not because he was incontinent. However, I am concerned that there is no record of a discussion of this plan with Mr W or his family. As noted by the Adviser, the decision to catheterise a patient should, where possible, involve consultation with the patient. Although Mr W was drowsy when he was admitted, he was conscious and he was accompanied by his daughter. However, there is no record that he was consulted or that he gave consent for the catheter to be inserted. I accept that a catheter would still have been clinically necessary, but I am concerned by this further example of lack of recorded discussion with him about his care. If the requirement had been properly discussed with, and explained to, him and his family he may not have found the situation so humiliating. I am concerned that the Health Board failed to consider the impact this matter would have on the dignity of an elderly patient.

79. When commenting on the draft of this report, the Health Board said that staff undertake "implied and verbal consent" when catheterising a patient. It said this is standard practice and is therefore not recorded in the patient's medical notes.

80. I disagree with the Health Board on this point. My investigator reviewed the medical records; Mr W's verbal consent for catheterisation is not noted in the records. In contrast, on 14 September 2011, verbal consent was

noted in the records for a separate procedure. 27 Further The RCN guidance entitled: "Catheter care RCN guidance for nurses" states:

> "catheterisation is an invasive procedure with associated serious risks, therefore obtaining documented, valid consent is vital prior to the procedure."

81. Mrs W asked for information about continence assessments that were completed, but the Health Board did not provide it. Referring to an email that the advocate sent, the Health Board told my investigator that it had not provided the information because Mrs W did not want to have any further correspondence from the Health Board. However, the email does not say that. It says that Mrs W did not want to meet again, but that she was still waiting for the information about her husband's catheterisation. I am disappointed by this further example failure to communicate.

82. In its comments on the draft of this report, the Health Board said that as Mr W was catheterised for clinical reasons a continence assessment was not appropriate in Mr W's case. I am grateful for the Health Board's clarification on this point, but I remain disappointed that the Health Board did not explain this properly to Mrs W at the outset.

The lack of bed rails and whether a risk assessment was completed.

83. After Mrs W found out that Mr W had fallen while trying to get out of bed, Mrs W asked the Health Board to explain why bed rails were not used on his bed.

84. My Adviser said that for patients who can get about by themselves bedrails would create a barrier to independence. They could also create a greater risk of falls and injury for patients who are confused and mobile enough to climb over them.[28] She also said that the decision not to use bed rails was correct because the bed rails would have put Mr W at greater risk of injury from falling and would therefore have been inappropriate.

27 "USS & possible diagnostic tap"
28 National Patient Safety Agency 2007 Safer Practice Notice 2007 using bedrails safely and effectively.

85. Based on the advice given, I am satisfied that the use of bed rails would have been inappropriate in Mr W's case. However, I am concerned that there is no record of any falls risk screening being undertaken and no indication of a risk assessment concerning the decision whether or not to use bed rails.

Record keeping

86. Good record keeping is essential. It is an integral part of good medical practice[29] particularly when there are a number of clinicians involved. A range of statutory guidance applies to the keeping of clinical records, for example, the RCP Guidance[30] says that an entry should be made in the medical record whenever a patient is seen by a doctor and that every entry in the medical record should be legible, dated, timed, and signed by the person making the entry. Entries to the medical record should be made as soon as possible after the event to be documented and before the relevant staff member goes off duty.

87. The NMC Guidance says that details of any assessments and reviews undertaken should be recorded and clear evidence of ongoing and future care arrangements should be noted. It also says that good record keeping is important in helping to improve accountability; showing how decisions related to patient care were made; supporting the delivery of services; supporting patient care and communication; improving continuity of care; promoting better communication between members of the multi-professional healthcare team; supporting clinical audit and helping to address complaints or legal processes.

88. The investigation found a number of record keeping failures, one of which was the junior doctor's failure to record the discussion with Mr W of the CTPA scan results. Mrs W said they were told that the scan "had found a mass on his right lung" and they were not told of the possible cancer diagnosis until they visited Mr W's GP.

29 Medical Protection Society 2012.
30 Appendix 1.

89. The Health Board originally told my investigator[31] that a junior doctor from the first Consultant Physician's team did discuss the possibility of lung cancer with Mr W, but forgot to note the discussion in Mr W's records. However, in the same letter, the Health Board also told my investigator that it was not routine to discuss cancer unless the results were clear and the diagnosis was confirmed by further investigations. The Health Board said the confirmed results were provided on 21 September. This contradicts the junior doctor's assertion that he told Mr W about a possible cancer diagnosis but forgot to note the conversation.

90. I am concerned that the Health Board included the junior doctor's assertion in the letter to Mrs W on 15 December without investigating the matter further. This incorrect information caused Mrs W unnecessary distress. Based on the available evidence, I conclude that Mr W was not told about the possibility of a cancer diagnosis until 21 September when he was given the news by his GP. The Health Board's comments on the draft of this report do not allay my concerns about this issue.

91. Turning now to the inclusion of comments about Mr W's family's alleged negative conduct on 7 October. Mrs W told my investigator that the comments about the family's conduct were incorrect and she was distressed to see them in her husband's records.

92. The Caldicott Principles require that staff making entries in records should "Justify the purpose(s) of using person-identifiable … information" and "only use it when absolutely necessary". The Health Board's Record Keeping Policy also indicates that "only facts should be documented, not opinions or subjective statements…".[32]

93. I think that the inclusion of negative comments about the family of a very ill patient was completely unnecessary. The family was obviously going through a very distressing experience and staff should have focused on providing sympathetic care for Mr W and his family at such a difficult time.

31 22 May 2013.
32 Section 4.4.

94. I am concerned by the poor standard of record keeping by both nursing and clinical staff that was found on this case.

95. In summary, based on the evidence available to me and the advice given by my Adviser, I conclude that the Health Board failed to:

- Assess Mr W's care needs properly, and as a consequence of that failure it failed to communicate with him and his family properly.
- Make reasonable adjustments[33] to the way in which it provided services to Mr W in order to accommodate his deafness.
- Record the significant clinical discussion with Mr W of the findings of the CTPA scan.
- Complete and record appropriate assessments relating to risk of falling and the use of bed rails.
- Consult Mr W and record his consent for the insertion of a catheter.
- Follow national and local guidance on effective discharge planning.
- Keep appropriate records of the discharge process.
- Follow relevant guidance on record-keeping.

Therefore, for the reasons explained above, **I uphold this complaint.**

Recommendations

96. I recommend that:

a) Within one month of the date of this decision, the Health Board should give Mrs W an unequivocal written apology for failures identified by this report and make a payment of £500 to reflect the time and trouble taken in pursuing her complaint with the Health Board and this office.

(I require a copy of the written apology and confirmation that the payment has been made at the time it is sent)

b) Within one month of the date of this decision, the Health Board should formally instruct the nursing and clinical staff involved in Mr W's case that they must assess patients properly on admission and ensure that

33 As required by the Equality Act 2010.

all relevant records of such assessments (for example, the Patient Care Record) are completed fully.

c) Within two months of the date of this decision, the Health Board should:

i. formally instruct the nursing and clinical staff involved in Mr W's case to follow the relevant record keeping guidance.
ii. formally instruct the clinical staff involved in Mr W's case to ensure that significant clinical discussions with patients (such as the results of a scan) are recorded properly.
iii. formally instruct the nursing staff involved in Mr W's case to ensure that all appropriate risk assessments are completed and properly recorded.
iv. formally instruct the nursing and clinical staff involved in Mr W's case to follow the relevant discharge planning guidance.

(I require a copy of the formal instructions completing actions (b) and (c) at the time they are sent)

d) Within two months of the date of this decision, the Health Board should share this report with all staff involved in Mr W's care so that the lessons that should be learned from the report can be understood.

(I require a copy of the internal correspondence completing this action at the time it is sent)

e) Within two months of the date of this decision, the Health Board should:

i. ensure that this report is discussed at a meeting of each Directorate that cared for Mr W so that the lessons of the report are disseminated.
ii. ensure that this report is discussed at a meeting of the working group responsible for the Health Board's "Dignified Care?" action plan.

(I require a copy of the minutes of each meeting within one month of the meeting date)

97. I am pleased to note that, when it commented on the draft of this report, the Health Board agreed to comply with these recommendations.

Prof Margaret Griffiths 3 December 2013
Acting Ombudsman

Appendix 1

The Equality Act 2010

98. The Equality Act 2010 ("the Act") consolidated all previous equality legislation in England, Scotland and Wales. The Act includes a public sector equality duty ("the duty") which consists of a general equality duty[34] and specific duties which are imposed by secondary legislation. Public bodies are legally obliged to comply with the duty. The duty covers eight protected characteristics: disability,[35] race, sex, age, religion or belief, pregnancy and maternity, sexual orientation and gender reassignment. In summary, those subject to the duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

99. The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

100. The Act also specifies that public bodies must make reasonable adjustments for disabled people so that they are not disadvantaged by the way in which the public body carries out its functions. The requirement to make reasonable adjustments applies to policies, practices and procedures, premises, and the provision of auxiliary aids or services.

34 set out in section 149 of the Equality Act 2010.
35 The Act explains that a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.

Record keeping

101. The Royal College of Physicians ("the RCP") and the Nursing and Midwifery Council ("the NMC") each publish guidance on records and record keeping. The RCP Guidance entitled "A Clinician's Guide to Record Standards" sets out 12 approved standards which it says define good practice and apply to all clinical note-keeping. The standards include:

- "…Every entry in the medical record should be dated, timed … legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature...
- Entries to the medical record should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded.
- Every entry in the medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made...
- The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital…"

102. The NMC Guidance says that "…good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow…". The NMC's principles of good record keeping include:

- "…In line with local policy, you should put the date and time on all records. This should be in real time and chronological order, and be as close to the actual time as possible.
- Your records should be accurate and recorded in such a way that the meaning is clear…
- You should use your professional judgement to decide what is relevant and what should be recorded.

- You should record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment.
- Records should identify any risks or problems that have arisen and show the action taken to deal with them.
- You have a duty to communicate fully and effectively with your colleagues, ensuring that they have all the information they need about the people in your care…
- Where appropriate, the person in your care, or their carer, should be involved in the record keeping process…"

103. The report on the Review of Patient-Identifiable Information published by the Caldicott Committee in December 1997 set out six principles ("the Caldicott Principles") that health and social care organisations should use when reviewing its use of client information. The principles are set out below:

- Justify the purpose(s) of using person-identifiable and confidential information
- Only use it when absolutely necessary
- Use the minimum that is required
- Access should be on a strict need-to-know basis
- Everyone must understand his or her responsibilities
- Understand and comply with the law

Discharge planning

104. The Department of Health issued guidance on discharge planning entitled: "Discharge from hospital: pathway, process and practice" (issued in 2003) and "Achieving timely simple discharge from hospital: toolkit for the multidisciplinary team (issued in 2004) (referred to collectively as "the Discharge Guidance").

Complaint handling

105. The Welsh Government has issued statutory guidance on NHS complaint handling entitled "The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011" ("the Regulations") and "Putting Things Right, Guidance on dealing with concerns about the NHS from 1 April 2011" ("PTR"). The Regulations and PTR set out specific actions that health boards should complete and specific timescales that they should comply with when considering complaints.

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- A Clinician's Guide to Record Standards – Parts 1 and 2 ("the RCP Guidance")
- Report on the Review of Patient-Identifiable Information, The Caldicott Committee, December 1997 ("the Caldicott Principles")
- Discharge from hospital: pathway, process and practice (Department of Health, 2003)
- Achieving timely simple discharge from hospital: toolkit for the multidisciplinary team (Department of Health, 2004) (referred to collectively as "the Discharge Guidance")
- Slips, Trips and Falls in Hospital (National Patient Safety Agency, 2007)
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- The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations")
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