Scottish Parliament Region: North East Scotland

Case 200603082: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; Care of the Elderly, Physiotherapy, Orthopaedics, Discharge Planning

Overview

The complainant (Mr C) raised a number of concerns about a lack of physiotherapy assessment, provision and follow-up as well as the quality of the in-patient care provided and the overall discharge planning by Tayside NHS Board (the Board) following his late mother (Mrs A)'s admission to Ninewells Hospital, Dundee on 17 February 2006. Mr C was also dissatisfied with the Board's responses to his concerns which he considered to be deliberately confusing and contradictory. Mr C considered that these many failures had hastened his mother's death.

Specific complaint and conclusion

The complaint which has been investigated is that the Board failed to properly assess and provide appropriate care and treatment to Mrs A (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) reflect on the failures identified by the advisers in the management of Mrs A as part of the on-going reviews already being undertaken by the Board;

(ii) monitor compliance with the revised template for the discharge letter as part of the existing review of record-keeping; and

(iii) review the Guidelines for (physiotherapy) Referrals and consider specifically how it impacts on those discharged to a nursing home (particularly in light of the advisers' comments that this appears to be discriminating against such patients).

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 11 January 2007, the Ombudsman's office received a complaint from the complainant (Mr C) about the care and treatment of his mother (Mrs A) prior to and following her discharge from Ninewells Hospital, Dundee (the Hospital) to her nursing home (the Nursing Home) on 21 February 2006. Mr C's complaint had previously been raised with Tayside NHS Board (the Board), both through his brother (Mr D)'s MSP and directly, and Mr C received a final response from the Board on 12 July 2006. Mr C remained dissatisfied that the Board had not understood or addressed the issues causing him concern and complained to this office. I note here that sadly, Mrs A died of pneumonia at the Nursing Home on 9 March 2006.

2. The complaint from Mr C which I have investigated is that the Board failed to properly assess and provide appropriate care and treatment to Mrs A.

3. During the Board's investigation of this complaint they agreed that there had been inadequate communication from the Hospital to the Nursing Home when Mrs A was discharged. The Board took steps to remind staff of the importance of including all necessary information in the discharge letter and have introduced a revised template for the discharge letter which includes reference to mobility status and other relevant issues. The Board also acknowledged that there had been a failure to notify Mrs A's family of her imminent discharge because of technical problems with the telephone system but have not yet managed to produce a solution for this problem (see paragraph 9). The Board also noted shortfalls in the assessment of Mrs A's nutritional needs and the provision of a pressure mattress. As the Board have accepted these failures I have not specifically investigated these issues although the advisers' comments and our recommendations do impact on these.

Investigation

4. Investigation of this complaint involved obtaining and reviewing a copy of Mrs A's clinical records and the Board's complaint file. I have also sought comments from a medical adviser (Adviser 1) and a nursing adviser (Adviser 2) to the Ombudsman and sought comments from the Nursing Home. Following on from comments received on the first draft of this report I sought further comments from a clinical adviser to the Ombudsman (Adviser 3). Adviser 3

also spoke directly with the Director of Nursing at the Board regarding a number of planned reviews by the Board which are relevant the events of this complaint.

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report and changes were made to the draft to reflect the comments received from both parties. Mr C and the Board were given a further opportunity to comment on the revised draft of this report.

Medical background

6. Mrs A was a resident of the Nursing Home. She was partially blind and suffered from mild dementia. At the time of her admission to the Hospital she had a known chest infection for which she was receiving antibiotics. She was admitted to the Hospital on 17 February 2006 following a trip in the Nursing Home where she sustained a left femur fracture. Following surgery to repair the fracture on 18 February 2006, Mrs A was assessed on 20 February 2006 by the consultant surgeon (the Consultant) as being ready for discharge and was discharged back to the Nursing Home on 21 February 2006.

Complaint: The Board failed to properly assess and provide appropriate care and treatment to Mrs A

Mr C's views

7. Mr C complained that none of the family were advised of Mrs A's discharge and on the contrary had expected her to remain in hospital for seven to ten days post-operatively (more than one member of the family having been told this by various staff at the Hospital). Mr C complained that while Mrs A had been independently mobile prior to her trip she was immobile at the time of her discharge. Despite this he noted that no physiotherapy assessment had been conducted prior to her discharge and no follow-up arranged for her to receive physiotherapy support at the Nursing Home. Mr C told me that Mrs A had in fact died before any proper physiotherapy could be arranged. Mr C considered that Mrs A's lack of mobilisation had contributed to the progressive severity of the chest infection which caused her death. Mr C noted that despite the Board taking action to remedy some of his concerns, the same problems could continue to arise in the future for other patients who were similarly discharged too hastily to a nursing home.

8. Mr C told me that he had tried to arrange a more speedy community physiotherapy referral himself for Mrs A on 28 February 2006 but had been advised by the Community Therapy Service that Mrs A was not a priority because she was an orthopaedic early discharge rather than a medical discharge. Mrs A's GP sought to arrange physiotherapy after her discharge but Mr C was advised there was a waiting list of three to four weeks and Mrs A would not be prioritised.

9. Mr C also noted that hospital staff had not been able to contact his brother, Mr D, to advise him of Mrs A's discharge because Mr D's telephone would not accept calls from withheld numbers. The Board had acknowledged that this was a problem affecting a number of calls but that they had not yet found a solution to this. Mr C also noted that the Board had agreed Mrs A should have had a nutritional review as her dietary intake was noted to be poor, and that because of her risk of pressure sores it would be expected that a dynamic pressure relieving mattress would be obtained.

10. Mr C considered that the Board had tried to shift blame for Mrs A's lack of physiotherapy input on to the Nursing Home and had told him that responsibility for Mrs A's mobilisation transferred to the Nursing Home on discharge and they should have arranged this. Mr C noted that the Nursing Home were not party to any such agreement in Mrs A's case and in fact had expected follow-up to be arranged by the Hospital. Mr C also noted that the discharge letter had contained no information about Mrs A's mobility. Mr C noted that in any event, when the Nursing Home sought to arrange physiotherapy services through Mrs A's GP, this had not happened because Mrs A was not considered a priority precisely because she was in a nursing home rather than her own home.

The Board's views

11. In response to Mr C's complaint the Board noted that Mrs A had been assessed by the Consultant on 21 February 2006 and assessed as ready for discharge. In response to the draft report the Board also noted that when Mrs A was reviewed on 19 February 2006 her chest was clear. The Board noted that the physiotherapist had tried to assess Mrs A on 20 February 2006 but that this had not been possible due to Mrs A's dementia and non-compliance. The Board advised that there was a standard assessment tool used for assessing the priority for individual physiotherapy referrals in the community and that no preference was given to one referral pathway over another.

12. Mr C noted that the Guidelines for Referrals supplied by the Board did in fact contain a list of referral priorities of which Mrs A was considered the lowest. I also note that the Guidelines for Referrals imply that there is a specific early support discharge scheme for orthopaedic patients who should be reviewed within five days of discharge but that there was never any indication at the time, or subsequent to Mr C raising his complaint, that Mrs A might be eligible for this scheme.

The Nursing Home's views

13. In response to our inquiries the Nursing Home told us that they had not been informed that Mrs A would be returning to the Nursing Home prior to her discharge on 21 February 2006, and that they would have wished to carry out their own assessment of Mrs A prior to accepting her back. The Nursing Home manager also stated that they would not have accepted Mrs A back had they had the opportunity to review her prior to discharge as they were concerned about her inability to weight bear, her high level of sedation, recent weight loss and poor general condition. The Nursing Home manger stated that the deputy manager had discussed Mrs A's condition with nursing staff at the Hospital on 20 February 2006, but no mention had been made then of her imminent discharge. Mr C told me that the nursing staff at the Nursing Home had advised him that they had been told by hospital staff that the Hospital would arrange follow-up physiotherapy for Mrs A after her discharge.

The clinical records

14. The Consultant reviewed Mrs A on the morning of 20 February 2006 (not 21 February 2006 as advised by the Board) and considered she was ready for discharge – there is no further entry to indicate a review the following day and I must assume this was an error in the Board's response. The clinical records indicate that a physiotherapist also reviewed Mrs A on 20 February 2006. It is not clear from the record what time of day this took place and whether this was before or after the ward round by the Consultant. The physiotherapist noted two actions as follows:

> 'Liaise with n[ursing] s[taff] re transferring with hoist
> Try to a[ssess] at another date when p[atient] more compliant.'

The physiotherapist noted that the goal was for Mrs A to be mobile in two weeks. There are no entries in the nursing record relating to the physiotherapist's visit or assessment and no plan was made to progress the points noted by the physiotherapist.

The advisers' views

15. Adviser 1 told me that Mrs A's records in the Nursing Home, completed prior to her admission and sent with her on admission, indicated her dementia was usually mild and certainly not suggestive of the degree of confusion she was noted to be experiencing during her admission. Adviser 1 noted that there was no evidence of any planning for her changed mental state (which was not unusual in itself for an older post-operative patient) or communication about this changed state with the Nursing Home. Adviser 1 also noted that Mrs A was independently mobile prior to her trip and that this too had changed significantly at the time of discharge but there was no planning around this. Adviser 1 also told me that Mrs A was still in need of oxygen therapy on the day of her discharge (although her levels were recorded as normal at the point of discharge). Adviser 1 concluded that while it was not unreasonable to have a policy of discharge back to a nursing home within 48 hours of surgery, such a policy was not without risk and required an appreciation of the patient's overall medical condition before deciding to discharge so promptly. There was no evidence of such an appreciation in this case.

16. Adviser 2 noted that there was no evidence in the nursing records of an assessment of Mrs A's problems that had arisen as a result of her fracture and subsequent surgery, and whether these could be properly managed in the Nursing Home. Adviser 2 noted that none of Mrs A's known or possible problems were referred for action or investigation prior to Mrs A's discharge and the discharge planning sheets were poorly filled out – the implication being that because Mrs A was being discharged to a nursing home no planning was necessary. There is no comment in the physiotherapy assessment about whether or not Mrs A required physiotherapy on account of her chest infection. Adviser 2 concluded that she was very critical of the failure of nursing staff to properly plan and co-ordinate the needs of Mrs A prior to her discharge. Adviser 2 noted that she considered the overall care was of the poorest quality and did not meet this elderly frail patient's post-operative needs. Adviser 2 noted that while the Board's action plan addressed the problems of lack of detail in the discharge letter it did not address other failings.

17. Adviser 3 told me that there were some clinical indicators that suggest it may have been more prudent to keep Mrs A in hospital for a further 24 hours to ensure that she had stabilised and to ensure adequate discharge planning and discussion with the Nursing Home. These included her pre-operative chest

infection, reduced mobility because of surgery and IV therapy that was only discontinued on the morning of discharge. Adviser 3 also noted that a physiotherapy assessment had not been possible on 20 February 2006 and could have been attempted again if there was more time so that the Nursing Home could be advised on the best approach to mobilisation and if any specific intervention was needed for Mrs A's chest. Finally Adviser 3 noted that the referral criteria for physiotherapy post-discharge is rigid and that on the face of it one could conclude that people discharged to a nursing home are discriminated against. Adviser 3 considered it was not unreasonable for the Hospital to stipulate that the Nursing Home should be responsible for arranging physiotherapy providing it is possible for them to do so according to need. The Nursing Home did ask Mrs A's GP to arrange physiotherapy but he was hampered by the same inflexible system which meant that Mrs A had to go on a waiting list whether her condition merited immediate intervention or not. Adviser 3 noted that Mrs A died before she would have been eligible for assessment.

18. During her discussion with the Director of Nursing, Adviser 3 was advised that the Board are undertaking a review of record-keeping which would consider the use of the revised discharge letter. The Director of Nursing also noted that the Board are currently reviewing the discharge planning process in general but that they are also considering issues relating to care of the elderly and discharge to care homes, looking specifically at the connections between hospital services and care homes.

Conclusion

19. There appear to have been multiple failures in this case. All the advisers have told me that in their view Mrs A was discharged sooner than was clinically appropriate (even where discharge was to a nursing home) and that the care in the Hospital was not holistic but focussed on the hip fracture and immediate post-operative needs. The Board have suggested that Mrs A's discharge was reasonable given that she was returning to the Nursing Home with qualified staff on hand, but accepted that there was a failure to identify her on-going physiotherapy needs to the Nursing Home. Adviser 2 and Adviser 3 both expressed concerns that Mrs A's rapid discharge to a nursing home in fact prevented her being properly and appropriately assessed, particularly in relation to her need for physiotherapy to manage her chest infection and mobility problems. Mrs A was placed in a priority category which did not afford her a prompt review by physiotherapy services. It is not clear to me why a process

for managing orthopaedic early discharge patients apparently exists but was not applicable in this case. I conclude then that there were failures to properly assess Mrs A's overall health while she was an in-patient, to properly plan and provide information to the Nursing Home on discharge and in the inflexibility of the community physiotherapy guidelines. Based on these failures I uphold this complaint.

Recommendations

20. The Ombudsman notes the reviews already underway in the Board and commends these. The Ombudsman recommends that the Board reflect on the failures identified by the advisers in the management of Mrs A and consider these as part of the on-going review of discharge arrangements, and also that the Board monitor compliance with the revised template for the discharge letter as part of their review of record-keeping. The Ombudsman also recommends that the Board review the Guidelines for (physiotherapy) Referrals and consider specifically how it impacts on those discharged to a nursing home (particularly in light of the advisers' comments that this appears to be discriminating against such patients).

21. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her of progress towards achieving the recommendations.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs A	Mr C's mother (the aggrieved)
The Hospital	Ninewells Hospital, Dundee
The Nursing Home	The nursing home where Mrs A resided prior to and following her hospital admission
The Board	Tayside NHS Board
Mr D	Mr C's brother
Adviser 1	A medical adviser to the Ombudsman
Adviser 2	A nursing adviser to the Ombudsman
Adviser 3	A clinical adviser to the Ombudsman
The Consultant	The consultant surgeon who performed Mrs A's operation

Annex 2

Glossary of terms

Guidelines for Referrals	Guidelines produced by the Board detailing the process for accessing community physiotherapy services