Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar rhyddhau cleifion o ysbytai ac effaith hynny ar y llif cleifion drwy ysbytai

This response was submitted to the Health and Social Care Committee consultation on Hospital discharge and its impact on patient flow through hospitals

HD 11

Ymateb gan: | Response from: Ombwdsmon Gwasanaethau Cyhoeddus Cymru | Public Services Ombudsman for Wales

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Mae'r ymateb yma hefyd ar gael yn Gymraeg.

This response is also available in Welsh.

Ombwdsmon Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Response by the Public Services Ombudsman for Wales to the Health, Social Care and Sport Committee's consultation 'Hospital discharge and its impact on patient flow through hospitals'

I am pleased to have the opportunity to respond to this consultation.

Our role

As Public Services Ombudsman for Wales (PSOW), I investigate complaints made by members of the public who believe they have suffered hardship or injustice through maladministration or service failure on the part of a body in my jurisdiction, which essentially includes all organisations that deliver public services devolved to Wales. These include:

- local government (both county and community councils)
- the National Health Service (including GPs and dentists)
- registered social landlords (housing associations)
- the Welsh Government, together with its sponsored bodies.

I can consider complaints about privately arranged or funded social care and palliative care services and, in certain specific circumstances, aspects of privately funded healthcare.

I also investigate complaints that elected members of local authorities have breached their Codes of Conduct, which set out the recognised principles of behaviour that members should follow in public life.

The 'own initiative' powers I have been granted under the Public Services Ombudsman (Wales) Act 2019 (PSOW Act 2019) allow me to investigate where evidence suggests there may be systemic failings, even if service users themselves are not raising complaints. The Act also established the Complaints Standards Authority (CSA) to drive improvement in public services by supporting effective complaint handling through model procedures, training and collecting and publishing complaints data.

General remarks

I understand that the Committee is interested primarily in good patient flow and delayed transfers of care. We have certainly seen over the recent years some cases relevant to that focus. For example,

- Ms A experienced difficulties and delays in receiving necessary aftercare arrangements following her discharge from detention under the Mental Health Act (MHA). As a result, Ms A remained an inpatient at the Hospital for almost a year after her discharge from detention, on a locked rehabilitation ward with other patients detained under the MHA. (**201701616**)

However, these are not issues that we have been seeing commonly in our recent casework related to hospital discharge. In fact, much more frequently, the complaints reaching us relate to patients being discharged prematurely or being discharged without adequate planning and communication to ensure good quality care at home and in the community. These themes continue to recur since my thematic report 'Home Safe and Sound: Effective Hospital Discharge', published in 2018.

I believe it is important to draw the Committee's attention to the prominence of these themes in my casework concerning discharge. Although I understand the need to relieve the pressures on A&E departments, ambulance services and the NHS in general, I would argue that such cases illustrate the potential risks of an excessive focus on good patient flow. I also want to point out that, in some of these cases, premature or inadequately planned discharge resulted in patients requiring further treatment and being readmitted to hospital. This increases the pressures on the health service, whilst also compounding individual injustice experienced by the complainants. I hope that these risks will be considered by the Committee when it formulates its recommendations.

Below, I include several examples of cases since 2020 in which I upheld complaints about premature discharge or inadequate discharge planning.

Premature discharge

- Mrs X complained that Betsi Cadwaladr University Health Board and a Health Board managed GP Practice failed in their care and treatment of her mother, Mrs Y, following a fall in which Mrs Y injured her head. We found, amongst other matters, that Mrs Y was inappropriately discharged, and she should have been referred to an Emergency Department for further investigations, including a CT head scan. Following her discharge, Mrs Y attended another hospital and sought help from an 'out of hours' GP at another community hospital. (**201905743**)

- Mrs T complained about the care provided to her late mother, Mrs M, by Betsi Cadwaladr University Health Board during 3 admissions to hospital in May, June and July 2019. Mrs T said that there were failures to diagnose and treat

Mrs M for sepsis, to appropriately consider the concerns raised by Mrs M's GP and her family and to ensure that Mrs M was well enough to be discharged in May and June. We found that Mrs M's discharge in June was inappropriate and that the Health Board failed to conduct appropriate sepsis screening and to address Mrs M's symptoms of infection in June and July, despite both Mrs M's GP and her family raising concerns that she might have had sepsis. (**201906268**)

- Mrs X complained about the overall care and treatment that her mother, Mrs Y, received in November and December 2018 at Ysbyty Glan Clwyd and Llandudno Hospital. Amongst other matters, Mrs X was unhappy about the decision to discharge Mrs Y after only a few hours following her emergency admission. Mrs X was also concerned by the overall lack of communication and compassion shown by staff to her mother at both hospitals and Mrs Y's bowel cancer not being diagnosed until 6 weeks after her admission. We found that the discharge of Mrs Y was not assessed to a reasonable standard when she attended the Emergency Department at Ysbyty Glan Clwyd. We also found that staff communication and compassion was lacking and, had medical staff paid more attention to some of Mrs Y's symptoms, this would likely have resulted in an earlier diagnosis of her cancer. (**201905009**)

- Mrs K complained about the overall care and treatment she received at Nevill Hall Hospital between June and December 2018. Mrs K was unhappy at waking during her first endoscopic retrograde cholangiopancreatography ("ERCP") procedure and having to be physically restrained. She complained that, following the removal of her gallbladder, she was discharged too soon after the operation and had to return to hospital only a few days later. During a further hospital stay, she contracted E-Coli which caused severe vomiting and diarrhoea which she said was caused by poor hygiene and a second ERCP procedure. Although we did not uphold all aspects of Mrs K's complaint, we did find that, following the removal of Mrs K's gallbladder, she was discharged too soon after the operation without a proper plan in place to monitor the possible issue of fluid and electrolyte imbalance. We also found that, following the insertion of a tube to drain excess bile, the drainage levels were not monitored correctly, and Mrs K was discharged when her levels were still too high. (**201906102**)

- Mrs T complained that her late mother-in-law, Mrs G, was prematurely and unsafely discharged from University Hospital Llandough following a hip replacement operation. Amongst other matters, we found that Mrs G was discharged despite clinicians being informed by the family that her home was undergoing refurbishment and would not be habitable for some considerable time. We also found that, in discharging Mrs G, clinicians failed to consider that Mrs G's grandson, for whom she cared, was a minor who, since his grandmother's admission, had been living alone with a serious (and possibly

life-limiting) condition. We were concerned that no attempt was made to check on his welfare and, in view of the risk to which he was exposed, considered that this amounted to a safeguarding failure. (**201901286**)

A lack of effective planning of patient discharge

- Mrs A complained about her late husband, Mr A's, care at the Royal Gwent Hospital's Medical Assessment Unit (MAU), including the investigations undertaken, the treatment of his chest infection and the adequacy and appropriateness of his discharge from the MAU as well as poor communication. We found that Mr A's discharge was not safe, seamless or effective and was compounded by poor documentation and record-keeping, especially when it came to the nursing records. The failure to carry out key assessments properly, such as those relating to falls, coupled with the Discharge Policy not being adhered to, meant that an occupational therapist/physiotherapy referral and assessment was also not completed. We also identified that communication was not as effective as it should have been. (**202000360**)

- Mr D complained about the care and treatment that his late mother, Mrs M, received at Glan Clwyd Hospital and Llandudno General Hospital. Amongst other matters, Mr D complained that clinicians failed to accurately assess Mrs M's frail condition and discharged her without appropriate home care support in place. This was subsequently provided by the Council but was inadequate and, within days, Mrs M was readmitted. We found that the attempt to discharge Mrs M failed due to multiple shortcomings on the part of both the Health Board and the Council in relation to pre-discharge planning and to the post-discharge support Mrs M received. (**202000661**)

- Ms X complained about the treatment her father, Mr Y, received by Betsi Cadwaladr University Health Board for multiple myeloma (a type of bone marrow cancer) between January and March 2020. Amongst other matters, we found that Mr Y's discharge without a clear diagnosis and management plan may have rendered his discharge unsafe. (**202001338**)

- Ms A complained about the care she received when she was admitted to hospital between January and February 2018 with severe confusion and agitation. She said that Hywel Dda University Health Board failed to adequately manage her risk of falls, diagnose and treat her shoulder injury promptly and appropriately, inform her of the nature of her injury and treatment options and ensure that she was discharged safely. We found, amongst other matters, that Ms A was not given adequate information on how to care for her injury or where to seek support once she was home, and an identified need for community support was not confirmed with the relevant authority. (**201902057**)

- Mr and Mrs A's complaint centred on whether the inpatient discharge of Mrs A's elderly uncle, Mr B, from the Royal Gwent Hospital was safe and whether more should have been done in terms of his post-discharge care. Mr B, whose health issues included heart failure, lived in an extremely cluttered first floor bedsit accessed by a flight of stairs. Mr B was found dead at home shortly after his discharge. We found that there were nursing and documentation failings, including around Mr B's discharge, which meant the care he received was not as person-centred as it should have been. In particular, there was a lack of engagement by healthcare staff when it came to Mr B's wellbeing, social and home circumstances post-discharge. (**201901095**)

- Mr A complained, amongst other matters, that Aneurin Bevan University Health Board failed to arrange appropriate aftercare services for Mr & Mrs A after Mrs A was discharged. We found that, although the Health Board referred Mrs A to the Rapid Response Team (which provides short-term intervention), it did not check that Mrs A's previous support from a charity providing palliative care was ongoing - it was not. The Rapid Response Team discharged Mrs A from its service when it referred Mrs A back to the charity, but there was a period of 12 days when Mr & Mrs A did not receive care and support while Mrs A's condition deteriorated. The co-ordination of continued aftercare services was not appropriate, and we upheld that part of Mr A's complaint. (**201804550)**

Nick Bennett

Public Services Ombudsman for Wales

January 2022