# EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

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| REPORT TO: | **COUNCIL OF GOVERNORS** |
| DATE: | **16 JANUARY 2015** |
| SUBJECT: | **PATIENT STORY (PRESENTED TO THE NOVEMBER BOARD OF DIRECTORS)** |
| REPORT FROM: | **CHIEF NURSE & DIRECTOR OF QUALITY, DEPUTY CHIEF EXECUTIVE** |
| PURPOSE: | **Discussion**<br>**Information** |

## CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

The Board of Directors have been using patient stories to understand from the perspective of a patient and/or a carer about the experiences of using our services.

Patient stories are a key feature of our ambition to revolutionise patient and customer experience. Capturing and triangulating intelligence pertaining to patient and carer experience from a variety of different sources will enable us to better understand the experiences of those who use our services.

Patient stories provide a focus on how, through listening and learning from the patient voice, we can continually improve the quality of services and transform patient and carer experience.

## SUMMARY

This month's story relates to the experiences of an 84 year old lady with confusion who was discharged home inappropriately from the Clinical Decision Unit at Queen Elizabeth Queen Mother Hospital prematurely and without her medications. There was a serious breakdown in communication between the teams. The Safe Discharge Checklists were not completed, nor was there any evidence that the discharge had been authorised. This resulted in the patient returning to the hospital. The event caused distress for the patient and her family who lived a long way from their mother. The complaint was referred to the PHSO, and although the complaint process was satisfactory, the PHSO upheld the complaint and requested a number of actions to be implemented. These actions have been progressed and the learning has been shared.

## RECOMMENDATIONS:

The Board of Directors are invited to note the key themes of this story and the actions in place to prevent reoccurrence.

**NEXT STEPS:**

None. The actions outlined in the story are being monitored by the Division.

**IMPACT ON TRUST'S STRATEGIC OBJECTIVES:**

Improving patient experience and satisfaction with the outcomes of care are essential elements of our strategic objectives.

**LINKS TO BOARD ASSURANCE FRAMEWORK:**

This story links to AO1 of the BAF: Implement the third year of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person Centred Care.

**IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:**

The risks identified in this story were around staff not ensuring that adequate communication among the different professional groups took place to facilitate a safe discharge.

**FINANCIAL AND RESOURCE IMPLICATIONS:**

None

**LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:**

None

**PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES:**

None

**ACTION REQUIRED:**

**(a) Discuss**
**(b) To note**

**CONSEQUENCES OF NOT TAKING ACTION:**

If we do not learn from events such as these there is an increased risk of further occurrences which may adversely affect both patient experience and outcomes.

**Board of Directors**
**Patient Experience Story**
**November 2014**

## Introduction

This month's story relates to the experience of an 84 year old woman (Mrs H) who was discharged from the Clinical Decision Unit (CDU) at the Queen Elizabeth Queen Mother Hospital (QEQM) without any discharge paperwork or medication. This lady returned hours later following contact with her daughter who was dismayed about her mother being discharged unsafely.

## The Patient Story

The story is told from the perspective Mrs J, the patient's daughter. Mrs H was admitted by ambulance to the Emergency Department at QEQM on a Saturday with a urinary tract infection. In the evening she was transferred to CDU. Mrs J visited her mother on Sunday where she found her health to be improving, but her mother still confused. Mrs H was receiving intravenous antibiotics and had a urinary catheter in place.

Mrs J lived a long way from her mother in Berkshire with no relatives living locally. She had called 111 from her home in order to facilitate her mother's admission to hospital. Mrs J explained on several occasions to the nursing staff that her mother lived alone and had a failing memory. She also discussed with the staff that she was concerned about her returning home without ensuring that she was well enough to do so. She was informed that a member of Social Services would review her mother prior to discharge.

On Monday lunchtime Mrs J received a call from the ward to say that Mrs H was being discharged and was waiting for collection by her to take her home. The rapid nature of the discharge surprised Mrs H's daughter. She asked if Social Services had reviewed her mother. The nurse replied that there was no need. She again explained that she was 110 miles away and unable to get to Margate to pick her up. She was also informed that her mother had been given oral antibiotics to take home. She requested that a taxi was called to take Mrs H home.

Mrs H finally arrived home at around 17.45. Mrs J called a neighbour to check that her mother was safe and settled in. Unfortunately, the neighbour telephoned Mrs J to say that she was concerned and had found Mrs H confused and still with her urinary catheter in place which was full. Mrs J panicked in view of the distance between her and her mother. She called the CDU and spoke to a Sister. The Sister was concerned and was unsure as to why and who had discharged her mother. She also highlighted that the notes were not fully completed. Sister confirmed that Mrs H should not have been discharged especially with her catheter still fitted. She was also discharged with no medication. At the request of the Sister Mrs J telephoned an ambulance to return Mrs H back to the CDU.

In her story, Mrs J then says how appalled she was that her 84 year old mother was discharged when she should not have been, still with a catheter fitted and without medication for a serious infection and that she went back to an empty house. Because Mrs H was still confused she was unaware that the catheter should have been removed. Mrs J said that had it not been for her neighbour calling in, she dreads to think of the serious consequences. Apart from the distress caused to her mother, she had to call again on what she perceived as stretched medical services to return her to hospital. This incident has caused her mother and the rest of the family emotional trauma and upset at a time when they believed they had left Mrs H in a

safe and caring environment. She felt that this was a catalogue of errors that was appalling as was the communication between the nursing staff in the CDU. In her words she certainly did not feel that we had followed our moto of 'putting patients first'.

**Care and Service Delivery Problems**

The ward and Matron commenced their investigation but sadly did not provide a response that Mrs J really felt answered her initial complaint. There was difficulty in ascertaining who had actually authorised the discharge, plus the documentation was poor. Indeed it stated that Mrs H was to be discharged on day 3 of her stay and with oral antibiotics. There was nothing further recorded in the clinical notes to indicate a change to this plan or a rationale for deciding that Mrs H was medically fit for discharge. Mrs J wanted assurance that we would take action to prevent a similar event happening to another family. She also felt that the response letter she received from the Trust just repeated the concerns she had raised in her original letter and did not offer these assurances. The Division remained in contact with Mrs J and sought further information and answers to her concerns, however Mrs J felt the only option was to refer her case to the Parliamentary Health Service Ombudsman (PHSO).

The Ombudsman investigates complaints about the NHS in England and determines whether there has been '*maladministration*' or '*service failure*' referred to as 'fault'. If there has been fault, the Ombudsman considers whether it has caused injustice or hardship (*Health Service Commissioners Act 1993, section 3(1)*) and if it has, they may suggest a remedy. Recommendations might include asking the organisation to apologise or to pay for any financial loss, inconvenience or worry caused. They might also recommend that the organisation takes action to stop the same mistakes happening again. The PHSO undertook a thorough investigation of this complaint and the complaint process that was undertaken to adequately respond to the concerns. Their findings were that there was evidence of fault in the care provided to Mrs H and they upheld the complaint.

The findings of the PHSO complaint investigation were:

1. Mrs H was inappropriately discharged, as the plan was for her to remain in hospital for three more days and to receive further antibiotics;
2. There was no documentation about Mrs H's discharge or who arranged or authorised it;
3. The episode caused considerable distress to Mrs H as a result of being discharged in a confusional state;
4. The family members were distraught that she had been discharged in these circumstances, without any family living locally who could provide support;
5. When Mrs J brought her complaint to the Ombudsman, she said that she wanted procedures to be put in place to prevent another patient from going through a similar experience.

The PHSO stated that the Trust have done all that we could in terms of investigating the incident. The Division interviewed all of the staff on duty, looked at the electronic and handwritten clinical notes, and despite this have been unable to get to the bottom of which staff were involved in the decision to discharge Mrs H. The Ward Manager has been held ultimately responsible for what happened, as she was in charge of all nursing staff on the ward at that time.

**Learning and Actions**

A number of actions were taken as a result of the complaint. These included:

1. Apologies have been given for the distress caused;
2. Matron has discussed the incident with the CDU Team at a team meeting to ensure wider learning;
3. The issue has been discussed at the Ward Managers' meeting, to ensure that all teams were reminded of the need to communicate and record any changes in discharge plans;
4. The complaint and the issues arising from it were discussed at the Medical Directorate Physicians' meeting;
5. The importance of Completion of EDNs (Electronic Discharge Notifications) has been discussed;
6. The Medical Teams have put a robust weekend handover in place;
7. Staff now ensure the Safe Discharge Checklist is completed and that the Integrated Care Pathway is followed and updated;
8. Five sets of records per month have been audited for the Division to assure themselves that these are being completed.

**Summary**

An 84 year old lady with confusion was prematurely discharged home inappropriately from the CDU at QEQM Hospital and without her medications. There was a serious breakdown in communication between the teams. The Safe Discharge Checklists were not completed, nor was there any evidence that the discharge had been authorised. This resulted in the patient returning to the hospital. The event resulted in distress for the patient and the family who lived a long way from their mother. The complaint was referred to the PHSO, and although the complaint process was satisfactory, the PHSO upheld the complaint and requested the above listed actions. These actions have been progressed and the learning shared.

Mrs H was discharged home a day or two after this incident. She received the necessary support from the Community Nursing Teams and her discharge was appropriately managed.