

## Scottish Parliament Region: Highlands and Islands

### Case 200603164: Shetland NHS Board

#### Summary of Investigation

##### **Category**

Health: Clinical care and treatment, hospital discharge procedure

##### **Overview**

Mr C has complained about the care and treatment provided to his late mother (Mrs A) prior to and during her last hospital stay in a hospital (the Hospital) within the Shetland NHS Board (the Board) area. Mr C's mother was admitted to the Hospital on 8 March 2005 and discharged to her care home in the afternoon of 9 March 2005. Mrs A died later in the evening of 9 March 2005. Mr C has also complained that Mrs A should have remained in hospital longer.

##### **Specific complaints and conclusions**

The complaints which have been investigated are that:

- (a) the reasons for medication, prescribed for Mrs A's suspected clinical condition at the time, were unclear (*partially upheld, to the extent that the reason why medication was prescribed in the community for Mrs A's suspected condition was clear and appropriate but the reasons for the prescribing decisions made following admission to the Hospital were not clear and appropriate*);
- (b) medical and nursing staff failed to assess and record the treatment and care requirements adequately throughout this particular episode of care (*partially upheld, in relation to the actions of the Hospital*);
- (c) Mrs A was not provided with an acceptable level of fluids during her stay in the Hospital (*upheld*); and
- (d) Mrs A should have remained in the Hospital longer (*upheld*).

##### **Redress and recommendations**

The Ombudsman recommends that the Board:

- (i) share this report with the staff involved in Mrs A's care, so they can reflect on the findings relevant to the prescription of medication when Mrs A was admitted to the Hospital and identify clear and explicit indications for the use of prescribed and administered medication;

- (ii) ensure thorough assessment, recording and treatment is undertaken for the ongoing care of a patient when health remains compromised and discharge is being considered;
- (iii) ensure nursing staff are appropriately trained to record baseline observations and understand the reasons for recording them;
- (iv) ensure a fluid intake and output record is kept for an unwell patient, where feeding and drinking assistance is required; and explanations are recorded when there is a delay in supporting the early, prompt intake of fluids;
- (v) remind staff of the importance of encouraging fluid intake, when a patient is unable to attend to that aspect of care independently;
- (vi) ensure full consideration is given to any potential discharge plan, when observations continue to indicate a level of patient distress or compromise;
- (vii) ensure appropriate family members are given an opportunity to contribute to the discharge planning process of an unwell relative; and
- (viii) provide Mr C with a full formal apology for the failures in care identified in this report.

## Main Investigation Report

### Introduction

1. The Ombudsman received a complaint from the complainant (Mr C) on 31 January 2007 about the care and treatment provided to his mother (Mrs A) in the days prior to her last admission to a hospital (the Hospital) within the Shetland NHS Board (the Board) area. Mr C also complained about Mrs A's care and treatment during her admission to the Hospital on 8 March 2005 until the following day, 9 March 2005. Mrs A was admitted to the Hospital after a General Practitioner (GP) from her practice visited her. Initially, she was admitted for investigations following a number of falls and to rule out any injury. Additionally, she had been commenced on an antibiotic to treat a suspected urinary tract infection. Once investigations had been made and the presence of any injury had been ruled out, she was admitted to Ward 3 of the Hospital. Mrs A was discharged the following day as the clinical view was that the care she required could be managed at her care home. The consultant physician (the Consultant) considered Mrs A was clinically stable and could return back to her care home. Mrs A died later the same day.

2. Mr C raised his concerns with the Board on 4 December 2006 but had not, up to that point, done so as a complaint as there had been a Fatal Accident Inquiry (FAI) underway<sup>1</sup>. The FAI, held by the Sheriff Principal, considered the circumstances of the death of Mrs A in June 2006. The conclusion reached by the FAI was that there were no defects of systems of work which may have contributed to the death. After the FAI reported on 7 July 2006, Mr C complained to the Board about his mother's care. The Board declined to respond to the complaint as, in their view, it was raised outside the time scales

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<sup>1</sup> Fatal Accident Inquiries are held under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. Their purpose is to determine where and when a death took place, the cause of the death, reasonable precautions whereby the death might have been avoided, the defects, if any, in any system of working which contributed to the death or any accident resulting in the death, and any other relevant facts relevant to the circumstances of the death. Guidance on the NHS Scotland Complaints Procedure notes that all NHS organisations must report to the Procurator Fiscal any death where a complaint has been received about the medical treatment given to the patient. Where a complaint is about an incident which may result in an FAI being held, the Chief Executive of the NHS organisation should consider whether it would be appropriate to proceed with investigating a complaint before the FAI is held and, if necessary, seek advice from the Procurator Fiscal's Office.

indicated in the NHS complaints procedure, which indicates complaints should be brought within a year of the event giving rise to the complaint.

3. Mr C wrote to the Ombudsman on 31 January 2007. In view of the decision Mr C had taken to wait until after the FAI before raising his complaint, the Ombudsman decided to consider his complaint. It seemed that Mr C and his family remained unclear about aspects of the care and treatment their mother had received prior to, during and immediately after her admission to the Hospital from 8 to 9 March 2005.

4. The complaints that have been investigated are that:

- (a) the reasons for medication, prescribed for Mrs A's suspected clinical conditions at the time, were unclear;
- (b) medical and nursing staff failed to assess and record the treatment and care requirements adequately throughout this particular episode of care;
- (c) Mrs A was not provided with an acceptable level of fluids during her stay in the Hospital; and
- (d) Mrs A should have remained in the Hospital longer.

### **Investigation**

5. In writing this report I have had access to Mrs A's clinical records and the complaints correspondence from the Board. I obtained clinical advice from three of the Ombudsman's clinical advisers, those being an adviser in general practice, a hospital adviser and a nurse adviser.

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of the terms used can be found in Annex 2. Annex 3 lists the published documents referred to in this report. Mr C and the Board were given an opportunity to comment on a draft of this report.

#### **(a) The reasons for medication, prescribed for Mrs A's suspected clinical condition at the time, were unclear**

7. Mrs A was living in a local care home and was admitted to the Hospital after being seen on two occasions by two GPs from the local out-of-hours medical service. She also received a visit from a GP from her practice. There had been a suspicion of a fractured hip and an x-ray was required to confirm a diagnosis. Mrs A was also suffering from a rising temperature and increased

incontinence, which the local GPs felt may have been caused by an untreated urinary tract infection. As an early measure, she was prescribed trimethoprim. On 8 March 2005 Mrs A was admitted to Ward 3 of the Hospital, via the Accident and Emergency (A&E) Department, and remained in hospital overnight. A broad spectrum antibiotic, amoxicillin, was prescribed and given intravenously. Mrs A was discharged during the afternoon of 9 March 2005 and died later that evening.

8. Mr C complained about the lack of clarity regarding why particular medication had been prescribed for his mother when it did not appear to be appropriate. He has indicated he did not understand why Mrs A was prescribed amoxicillin in the Hospital when, in his view, this was not the correct treatment.

9. The Board have said that Mrs A was received into the A&E Department on 8 March 2005 following a request of a GP from within her practice, who had made a home visit. The Board have explained that Mrs A had been prescribed trimethoprim by a visiting GP from the out-of-hours service. The initial prescription had been for the two days prior to admission to the Hospital. This treatment was for a suspected urinary tract infection. The Board have indicated that, as Mrs A's condition had not improved, she was also brought to the A&E Department to exclude any injury following falls she had sustained. The suspicion of a fracture was excluded following x-ray. Mrs A's clinical assessment revealed her C-reactive protein was very high and her chest x-ray looked hazy and, on examination, the doctor in the A&E Department heard crepitations. The Board have said there were difficulties obtaining a sample of Mrs A's urine for analysis, as she was incontinent and exhibiting confusion. They have, however, indicated that a urinalysis was not required to support the working diagnosis of a chest infection.

10. The Board have said that the diagnosis of pneumonia was only confirmed at Mrs A's post mortem. The Board said that the medication amoxicillin 500-1000mg, three times a day, is recommended as the first line treatment for community acquired pneumonia and the dosage prescribed was in accordance with the British Thoracic Society Guidelines for the management of community acquired pneumonia.

11. Adviser 1, an adviser with experience in general practice, has advised that the decision of the GP from the out-of-hours service to prescribe trimethoprim was reasonable. This is a usual prescription in the community when a urinary

tract infection is suspected. Adviser 1 noted that Mrs A's renal function test in 2003 provided a normal result. There was a note of diabetes insipidus as a result of the use of lithium carbonate, which was stopped in 2003. His view was that renal impairment was not a problem at that time. Active diabetes insipidus might have led to a higher risk of dehydration when other complications were present, such as a urinary tract infection or pneumonia. Adviser 1 concluded that the small dose of trimethoprim was a suitable choice in an elderly patient with a complex medical history.

12. A medical adviser with specialist knowledge of elderly care (Adviser 2) has considered the use of medication in Mrs A's care and treatment on admission to the Hospital and has advised that the medication trimethoprim, prescribed in the community, had only been given for two days prior to her admission. In this regard, he noted from the clinical records that there had been concern regarding the potential effect this may have had on Mrs A's kidneys. There had been previous concerns about Mrs A's kidney function, and monitoring had been carried out in previous years, as she had received long-term treatment for another medical condition which is known to have an effect on kidney function. However, Adviser 2 has indicated this was not likely to have affected Mrs A's kidney function. He also noted that kidney function had been normal when tested previously in 2003. He added that poor fluid intake in someone who cannot concentrate their urine quickly leads to dehydration, within at least 48 hours, and Mrs A had been unwell for four days, as described by the admitting doctor. Additionally, Adviser 2 has noted that trimethoprim had been prescribed for two days and would be unlikely to have affected her kidney function from normal to failure within that short time. Severe dehydration was much more likely the cause of Mrs A's blood test result, when taken in the A&E Department, than any adverse effect of the antibiotic used. He has noted that no further attempts appear to have been made on Mrs A's admission to the Hospital to identify the organism causing the urinary infection. However, he has said the first line of treatment prescribed by the GP in the community, prior to admission, was appropriate.

13. Adviser 2 has further commented on the Hospital staff's use of amoxicillin. He has indicated there were recorded sounds of crackles when the admitting doctor saw Mrs A in the Hospital but this may not have been evident when she was examined at the care home. Adviser 2 noted that amoxicillin is used for a number of infections, of which pneumonia is one. He considered it to have been likely that Mrs A's infection was acquired in the community. However,

amoxicillin is not recommended to be used in the treatment of community acquired pneumonia, which Mrs A turned out to have had, as found at the post-mortem examination. Adviser 2 has said that other antibiotics are preferable, according to the Scottish Inter-collegiate Guidelines on the treatment of such cases (Scottish Inter-collegiate Guidelines (SIGN) 59, section 5 (2004)<sup>2</sup>). Mrs A presented with adverse prognostic features mentioned in the SIGN guidelines and should, therefore, have been treated with intravenous levofloxacin or benzylpenicillin (antibiotics), in conjunction with another intravenous antibiotic such as clarithromycin for at least 48 hours, followed by oral treatment for a further five days. He was, therefore, critical of the choice of antibiotic made when Mrs A was admitted to the A&E Department, insofar as the national guidelines were not followed and no reasons were recorded for not doing so<sup>3</sup>. He was also particularly critical of the decision to switch to oral amoxicillin after only 24 hours, in view of the inadequate length of time the intravenous medication was used for, and that the guidelines also state that a medical review should be undertaken after 48 hours.

*(a) Conclusion*

14. There is evidence of an appropriate use of medication in the community by the out-of-hours GP, who saw Mrs A prior to her admission to the Hospital, to manage what was a suspected urinary tract infection (see paragraph 9). However, the advice I have received regarding the use of amoxicillin in the management of what came to be a diagnosis of a chest infection which turned out to be a community acquired pneumonia, is that this was not appropriate (see paragraph 13) and other options should have been considered as part of Mrs A's care at the time. In view of the decisions taken about medication once Mrs A was admitted to the Hospital, I partially uphold this aspect of Mr C's complaint, to the extent that the reason why medication was prescribed in the community for Mrs A's suspected condition was clear and appropriate but the reasons for the prescribing decisions made after admission to the Hospital were not clear and appropriate.

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<sup>2</sup> These guidelines state that patients should be assessed against a list of 'adverse prognostic features': confusion, raised urea, respiratory rate and blood pressure, and the additional features of old age and low oxygen saturation levels.

<sup>3</sup> The Adviser has highlighted that in the absence of a formal SIGN guideline for the discharge of older people these guidelines can be used as a means of benchmarking services for older people in receipt of health and social care services.

*(a) Recommendation*

15. The Ombudsman recommends that the Board share this report with the staff involved in Mrs A's care, so they can reflect on the findings relevant to the prescription of medication when Mrs A was admitted to the Hospital and identify clear and explicit indications for the use of prescribed and administered medication.

**(b) Medical and nursing staff failed to assess and record the treatment and care requirements adequately throughout this particular episode of care**

16. Mr C complained that the GPs who visited Mrs A before her admission did not assess her adequately, taking into account aspects of her health. He complained that out-of-hours GPs did not have access to his mother's medical records. Mr C also complained about the level of care Mrs A received when she was in the Hospital. The issue of her fluid intake is further discussed in paragraphs 25 to 31 within this report. The remaining concerns were that observations were not recorded regularly whilst in the Hospital; staff did not attend to the requirement to see that Mrs A had her medication; and the clinical records and note taking were inadequate.

17. The Board have provided information to the Ombudsman about the issue of the Hospital's record-keeping. They have indicated that the Director of Public Health within the Board agreed that if medical records had been more detailed the Board would have more evidenced information to answer questions raised about the care. Additionally, in responding to the Ombudsman, the Board have indicated that the Director of Nursing agreed that the clinical records were lacking in several places; those particular areas being in reference to fluid intake and output and observations. The Board have indicated that they have improved the process for documenting nursing care and each care plan is evaluated at the end of each shift. They have said that the care plans, risk assessments and evaluations are now located at the end of each patient's bed and the admission documentation and on-going management of care decisions are now located centrally.

18. The Board have indicated the Activities of Daily Living assessment, used to support care planning when a patient is admitted to the Hospital, would benefit from being reviewed, to facilitate a more comprehensive nursing assessment.



19. Adviser 1 made a general comment that any improvement in access to clinical notes for an out-of-hours service would be welcome but he has not been overly critical of the usual practice followed on this occasion. Adviser 1 considered Mrs A's assessment and treatment prior to admission to the Hospital to have been clinically appropriate with an out-of-hours visit on 5 March 2005 to Mrs A and a recommendation of GP follow-up the following day. This took place with a visit in the afternoon the following day and a prescription of trimethoprim 100mg, twice daily, ordered. In Adviser 1's opinion this action represented 'suitable caution in an elderly patient of this sort with a complex medical history'. Adviser 2 concurred with this view.

20. Adviser 2 has said that, in relation to the information available in the hospital based clinical records relating to Mrs A's admission and stay in the Hospital, there is a paucity of medical and nursing records and no evidence that Mrs A was examined on the morning of discharge with any degree of diligence.

21. A nursing adviser to the Ombudsman (Adviser 3) was critical of the clinical notes, which she said were lacking in a number of areas. She has commented that, in relation to the assessment and care planning, it was difficult to determine if the information was relative to Mrs A's usual state or current state, as this was not made clear. There were also gaps in understanding Mrs A's history beyond what was recorded, for example, any record or knowledge of incontinence and how this might usually be managed or if it was a new clinical problem and what was being done to assess or manage it. Additionally, there was a lack of information about how Mrs A's sleep was being managed in the care home. Adviser 3 also identified inconsistencies in the nursing records in relation to the report of Mrs A's level of dependency on others. She noted that very little information had been recorded about Mrs A's care in the care home. Had this been available it could have been used to establish a base line from which to plan Mrs A's care in the Hospital. Adviser 3 has indicated she would have expected to see hospital based personalised care planning rather than established core care plans for Mrs A, in dehydration, sepsis and acute confusion. She has commented that a pressure area care risk assessment had been carried out and this was satisfactory. Adviser 3 has added that the overall assessment should have been able to establish a more robust person centred care plan.

*(b) Conclusion*

22. The advice I have received is that Mrs A's assessment and treatment by out-of-hours GPs in the community was clinically appropriate. However, the advice I have received in relation to the medical assessment and record-keeping after admission to the Hospital is critical of a number of aspects in this regard. Mrs A was an elderly, frail patient in the care of staff within the Hospital. During her admission, opportunities were missed to provide her with an appropriate level of care and to record the care given. I appreciate that the Board have confirmed that key reports regarding the nursing care plans were lacking and overall progress was not adequately reported within the nursing records. The Board have indicated that they have improved the process for documenting nursing records and each care plan is evaluated at the end of each shift. The information is also now located at the foot of a patient's bed with admission documentation and on-going care management decisions which are taken, recorded and held centrally; and these improvements are welcome. As stated above, the actions of the out-of-hours GPs were reasonable, however, once Mrs A was admitted to the Hospital evidence available and the advice provided regarding Mrs A's overall care is that it was inadequate in a number of areas. I, therefore, partially uphold this aspect of the complaint, in relation to the actions of the Hospital.

*(b) Recommendation*

23. The Ombudsman recommends that the Board:

- (i) ensure thorough assessment, recording and treatment is undertaken for the ongoing care of a patient when health remains compromised and discharge is being considered; and
- (ii) ensure nursing staff are appropriately trained to record baseline observations and understand the reasons for recording them.

**(c) Mrs A was not provided with an acceptable level of fluids during her stay in the Hospital**

24. Mr C complained about the level of fluids Mrs A received during her stay in the Hospital. He said there were a number of occasions when the records of Mrs A's fluid intake were unclear. These referred to the fluids given intravenously and there was no information within clinical record of fluids being given orally. He was concerned this was either an indication of poor record-keeping or poor nursing care.

25. The Board have said Mrs A was given 864mls of intravenous fluid during her admission. The Consultant assessed Mrs A's hydration at his morning round and found her to be well hydrated. The Board said the usual practice was to encourage fluids to be taken and that should be documented. The Board have agreed the recording of Mrs A's fluid intake was poor, with only the intravenous fluids having been recorded on the fluid chart. The fluid (additive drug) prescription sheet indicates intravenous fluids commenced at 23:24 on 8 March 2005. The Board have said that, at 06:45 on 9 March 2005, it was observed that Mrs A's venflon had become disconnected. When this was subsequently discussed between the doctors on the ward round they made a decision not to reinsert the venflon, as their view was that Mrs A was going to be discharged from the Hospital.

26. The Board have said the fluid recording was not likely to have been correct as Mrs A was given tablet medication at 07:00 and again at 15:00. In their view this medication would have necessitated Mrs A having fluids. Additionally, they have indicated that hot drinks are served before bedtime, again at breakfast, during the morning, with lunch and mid-afternoon. Additionally, the Board have said Mrs A would have had a jug of water by her bed which would have been refreshed throughout the day.

27. Adviser 2 has said the evidence of the administration of fluids was inadequate. There were discrepancies in the recording of the administration of medication and fluids. The clinical record showed 864mls of dextrose was given over a six and a half hour period. Adviser 2 saw the record of the first dose of amoxicillin being given by intravenous infusion at 23:00 but then the infusion was recorded as started at 23:25, where he would have expected to see this reversed. Again, a record of the drug being administered was recorded at 07:00, which was after the time noted the venflon had become disconnected. Adviser 2 commented that he was less concerned about the time error but more about the overall timing of fluids and the amount, which he considered was very important. In this respect, he has concluded the lack of fluid intake was a serious shortcoming in her care.

28. Adviser 3 has said that, as a result of being compromised with a kidney impairment caused by long-term use of lithium carbonate in the past, Mrs A would be vulnerable to rapid dehydration. During Mrs A's admission the record showed she received 864mls of intravenous fluid. It was recorded the venflon had become disconnected, which was being used to administer the fluids.

There was no record of any attempt to re-site the venflon to continue the fluid intake. Additionally, there was no other information to indicate how else Mrs A was being supported to receive fluids. Adviser 3 was surprised that the fluids were only commenced eleven hours after Mrs A's admission and commented that they should have been commenced earlier in the admission process. Adviser 3 remarked on the lack of any evidence to show fluids were being given orally and there was no record of fluid output. She considered this to be a serious shortcoming in Mrs A's care.

29. In respect of the baseline observations taken during Mrs A's hospital stay, Adviser 3 noted they were recorded whilst Mrs A was in the A&E Department. There were two other readings taken during her stay. A baseline for respiration was not recorded, which is an important indicator in detecting patient deterioration. Adviser 3 considered that regular observations should have been made to monitor Mrs A as she was suffering with low blood pressure and a rapid pulse, evidenced when each of the three sets of observations were made. This was important as she was suffering from underlying sepsis and acute dehydration. Additionally, Adviser 3 was critical of the lack of a physiological scoring system to assist in Mrs A's care and treatment.

*(c) Conclusion*

30. In view of the evidence available and the explanations provided by the Board regarding the management of fluid intake on this particular occasion, I am guided by the Advisers in their view that the management of Mrs A's fluid input and output was inadequate. This was particularly important in view of the fact that Mrs A could not attend to this aspect of care independently. I, therefore, uphold this complaint.

*(c) Recommendation*

31. The Ombudsman recommends the Board:

- (i) ensure a fluid intake and output record is kept for an unwell patient, where feeding and drinking assistance is required; and explanations are recorded when there is a delay in supporting the early, prompt intake of fluids; and
- (ii) remind staff of the importance of encouraging fluid intake, when a patient is unable to attend to that aspect of care independently.

**(d) Mrs A should have remained in the Hospital longer**

32. Mr C complained that Mrs A should have remained in the Hospital rather than be discharged back to her care home, as she remained unwell.

33. The Board have said Mrs A was assessed by the Consultant on the morning of 9 March 2005 who considered her well enough to return to the care home, particularly in view of her underlying condition, that being one of confusion. They have indicated the discharge liaison nurse (Nurse 1) planned Mrs A's discharge with the care home staff and a message was left for the community nurse advising her of Mrs A's discharge. The Board have indicated that the recollection of the ward sister attending the ward round with the Consultant was that the treatment was going to be the same at the care home as she was receiving in the Hospital and could, therefore, continue there.

34. The Board have indicated that Mrs A's observations had been recorded as being stable overnight, although she did have a temperature of 37.7 degrees Celsius. Her blood pressure had improved, there being a recording of 100/50 at 06:45 on the morning of discharge.

35. The Board have said they were assured by the Senior Care Worker at the care home that staff there could care for Mrs A. The Board have said the care home staff were to ensure Mrs A's continued intake of fluids and observe her physical condition. Hospital staff adhered to the Board's procedure on patient discharge from hospital.

36. In line with the hospital procedure, Nurse 1 made the preparations for Mrs A's discharge, noting a discussion held with Mrs A, the care home, Mrs A's son-in-law had been notified and a message left for the community nurse. The Board have indicated the GP was notified that Mrs A was due to return to the care home with a prescription of oral amoxicillin and the ambulance had been arranged for 15:00. The Board have told me they have made improvements to the discharge sheet as a result of this complaint, reflecting the conversations held between a patient's next of kin and other professionals involved in discharge planning.

37. It is recorded that Nurse 1 spoke to Mrs A's son-in-law after having attempted to contact Mr C and then Mrs A's daughter. The Board have indicated that Nurse 1 cannot recall the exact content of her conversation with Mrs A's son-in-law but they have said it would have been to let him know the details of discharge and to ask that the rest of Mrs A's family were notified by him. The Board have indicated that there were no written clinical notes to

suggest the usual practice was not followed or that the conversation had not been straightforward.

38. Adviser 2 noted that the Consultant had determined Mrs A's discharge back to her care home was preferable as this was usually more helpful to a patient in a confused state. However, Adviser 2 highlighted a temperature of 37.7 degrees Celsius recorded prior to Mrs A's discharge which was not indicative of a patient in a stable health condition. In respect of Mrs A's discharge back to her care home, the matter of dehydration (see paragraph 25), a chest examination, fluid intake (see paragraphs 25 to 28) and mobility had not been fully assessed by the Consultant during the morning of Mrs A's discharge. Adviser 2 said the care provided was not in accordance with SIGN Guidelines 56 and 64 (see Annex 3), which provide guidance on aspects of care, and Mrs A was discharged too soon.

39. Adviser 3 noted the view offered by the Consultant that discharge, following his ward round was appropriate. It was noted that Mrs A's condition had stabilised and her confusion and restlessness would be aided by a return to the familiar surroundings of the care home, with a course of oral antibiotics (see paragraph 38). She noted that there was a record of the information given to Mrs A's family about her discharge (see paragraphs 36 and 37) but no indication of a discussion having taken place. She has noted too that there was a lack of notation regarding Mrs A's physical and cognitive state before her actual discharge. There was evidence that, on admission, she was acutely confused but no further assessment was recorded, beyond an entry saying she had spent an unsettled night, recorded at 04:30 on 9 March 2005.

40. While noting the Consultant's rationale for discharging Mrs A, that she would settle better in familiar surroundings, Adviser 3 considered that Mrs A was discharged inappropriately. In her view, records indicate that Mrs A had spent an unsettled night due to her levels of confusion and there was no evidence this was resolving. Additionally, there was no evidence to suggest she had taken oral fluids or what her dietary intake had been. Adviser 3 also commented on the lack of information regarding a discussion with family members. She agreed with Adviser 2 that Mrs A's discharge was in breach of good practice statements drawn together in guidelines related to the discharge of frail elderly people from hospital (SIGN Guideline 56 section 9 and Guideline 64 section 5, see Annex 3). These provide comprehensive guidance on good

practice regarding the management of care and discharge of older people (see paragraph 13).

*(d) Conclusion*

41. The Board have not been able to provide a complete picture of the level of care provided to Mrs A, as a consequence of poorly recorded notes which should have described aspects of her care. The Board have agreed that, with hindsight, it might have been helpful to have held more discussion with some members of the family, regarding the rationale for discharge and the details of treatment given. They have indicated that they have made improvements to the discharge sheet as a result of this complaint, to reflect the nature of the conversation held with next of kin and professionals. Whilst these improvements are welcome, it remains, however, that the Hospital failed to provide the appropriate level of consideration required as part of the discharge planning for Mrs A in respect of her levels of confusion and her lack of fluid intake and her family were not given the opportunity to contribute to their mother's care in the latter stages of her life and contribute to the decisions taken about her discharge. In view of the evidence and the advice I have received, I uphold this complaint.

*(d) Recommendations*

42. The Ombudsman recommends that the Board:

- (i) ensure full consideration is given to any potential discharge plan, when observations continue to indicate a level of patient distress or compromise;
- (ii) ensure appropriate family members are given an opportunity to contribute to the discharge planning process of an unwell relative; and
- (iii) provide Mr C with a full formal apology for the failures in care identified in this report.

43. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

**Explanation of abbreviations used**

Mr C	The complainant
Mrs A	The complainant's mother
The Hospital	A hospital within the NHS Board area
The Board	Shetland NHS Board
GP	General practitioner
The Consultant	Consultant physician
FAI	Fatal Accident Inquiry
A&E	Accident and Emergency
Adviser 1	GP adviser
Adviser 2	Hospital adviser with special interest in the elderly
SIGN	Scottish Inter-collegiate Guidelines
Adviser 3	Nursing adviser
Nurse 1	Discharge liaison nurse



**Glossary of terms**

Amoxicillin	Antibiotic medication
Blood pressure	The force which the circulating blood exerts on the walls of the arteries
Crepitations	Fine crackling sounds heard when listening to the chest with a stethoscope, which are thought to denote presence of fluid or secretions accumulating in the small airways of the lungs
Intravenous infusion	The giving of fluid into a patient's vein over a prolonged period of time; a route used to add medication to the fluid
Diabetes insipidus	A form of diabetes
Lithium carbonate	Medication used to treat bipolar disorder
C-reactive protein	An indicator of acute inflammation
Trimethoprim	An antibiotic
Venflon	Flexible needle used to administer intravenous fluids; a route used to administer medication

### List of legislation and policies considered

NHS Complaints Procedure

BTS Guidelines for the management of community acquired pneumonia in adults - 2004 update

#### **SIGN Guideline 59**

Community management of lower respiratory tract infection in adults  
Section 5: Community acquired pneumonia

In the absence of a chest x-ray, the British Thoracic Society defines pneumonia as symptoms of an acute lower respiratory tract infection, including a cough and at least one other lower respiratory tract symptom, together with at least one systemic symptom, and new focal signs on chest examination. In most reported series of patients with community acquired pneumonia, no pathogen is identified in 50% or more of cases. The role of viruses will become clear with increased use of modern molecular diagnostic techniques (see Annex 2 to this guideline on the SIGN website). A wide array of organisms may cause acute pneumonia and published reports vary in the organisms isolated due to differences in patient groups, presence of epidemic organisms and diligence of the investigation:

- Streptococcus pneumoniae is the most frequently identified pathogen in community GP samples. Other organisms commonly reported include Mycoplasma pneumoniae, Staphylococcus aureus, Haemophilus influenzae and influenza viruses. A raised incidence of Staphylococcus aureus is found during influenza epidemics.
- Organisms such as Mycoplasma pneumoniae show seasonal variation with peak incidence at four yearly intervals.
- Legionella spp. were initially reported in large scale outbreaks but this organism is now known to occur sporadically particularly in patients with comorbidity such as congestive cardiac failure, diabetes and chronic obstructive pulmonary disease. Approximately three-quarters of Legionnaires' disease cases have a history of recent travel abroad.
- Chlamydia pneumoniae has recently been identified as a human pathogen, the extent to which this organism causes respiratory disease is

as yet undetermined. Infection by *Chlamydia psittaci* should be considered when there is exposure to birds.

- Patients with a history of recent foreign travel may have pneumonia caused by a wide variety of organisms rarely found in Scotland. Additionally, common pathogens such as *Streptococcus pneumoniae* which are acquired abroad may exhibit more resistance to common antibiotics than is currently seen in Scotland.

Anaerobic infection due to aspiration into the lower respiratory tract is found in patients with an alcohol problem, and in other conditions predisposing to aspiration into the respiratory tract.

## 5.1 Investigation

### 5.1.1 SPUTUM CULTURE

If sputum is available and the patient has not had prior antibiotic treatment then a Gram stain is a good indicator of the causative organisms. Overnight culture will provide confirmation and the chance to perform susceptibility studies, allowing modification of empirical therapy. Culture is also helpful in establishing the pathogenicity of any isolates. Evidence level 2+

### 5.1.2 BLOOD TESTS FOR C-REACTIVE PROTEIN (CRP)

In a study of adults with respiratory tract infection in general practice, CRP was the best test discriminating between pneumonia and non-pneumonic LRTI. In a further larger study of 402 adults, this finding was confirmed and it was found that, in the first week of the illness, viral LRTI could also produce high CRP values; with the likelihood ratio for pneumonia in the presence of a high CRP increasing after the first week of illness. In this study, although those with radiological evidence of pneumonia had a higher mean white blood cell count (WBC), a WBC of  $\geq 10.4$  was not helpful in predicting radiologically defined pneumonia unless symptoms had been present for seven days or more. Another study showed that in a hospital population with community acquired pneumonia, failure of the CRP to fall was a useful indicator of treatment failure. Evidence level 2+,3

An assessment of whether the availability of CRP tests to GPs can reduce antibiotic prescribing for respiratory tract infections in the community looked at prescribing for both upper and lower respiratory tract infections in two groups of patients: those in whom the CRP value was available and those in whom the decision was based on clinical grounds alone. This RCT found no difference in

prescribing between the two groups. In previously well patients, presenting with LRTI, a CRP level >50 mg/dl was seen more frequently in patients with indirect indications and microbiological evidence of infection but the sensitivity and specificity of the test were insufficient for it to be of value for routine management in primary care. Evidence level 1+,3

CRP levels are of limited use as a diagnostic tool for community acquired pneumonia and should not be performed routinely.

### 5.1.3 PULMONARY FUNCTION TESTS

One study has followed up a group of 95 patients presenting to their GP with an episode of cough associated with diffuse wheeze or crackles. Three years after their initial presentation, the patients completed a questionnaire and performed spirometry and methacholine challenge testing. A total of 34% of this group had findings consistent with a diagnosis of asthma or COPD. Thus a presentation with a cough associated with diffuse wheeze or crackles may raise the suspicion of an underlying airway problem. Evidence level 3

Consider spirometry in the convalescent period to diagnose asthma or COPD in patients with community acquired pneumonia presenting with a cough associated with diffuse wheeze or crackles.

### 5.1.4 CHEST X-RAY

Chest x-ray evidence of pneumonia is reported in around 40% of patients thought by their GPs to have an acute lower respiratory tract infection associated with new focal chest signs. The absence of any signs of abnormality (i.e. pulse, respiratory rate, temperature, and chest examination) makes the diagnosis of radiologically-defined pneumonia unlikely. Evidence level 2+,3

In a study of 402 consecutive adults presenting to general practice in Sweden with symptoms of respiratory tract infection, 5% were shown to have pneumonia on chest x-ray. However, in this study, lung crackles and other abnormal chest findings were interpreted too frequently as features of pneumonia. Similarly in a study of 153 adult patients with LRTI, only one of nine with pneumococcal pneumonia, and two of seven with mycoplasma infection, had radiographic evidence of pneumonia. Evidence level 2+,3

There has also been debate regarding the value of follow-up chest x-rays in those found to have pneumonia. A retrospective review of case notes of 1,011

patients admitted to hospital with pneumonia found 13 patients with bronchial carcinoma. In eight cases this diagnosis was apparent on the initial chest x-ray. Bronchial carcinoma was thus found on convalescent chest x-ray in just 0.58% of patients. The authors therefore recommended a clinical review one-two months after diagnosis, and x-raying only those with ongoing symptoms. In a separate prospective study, a convalescent chest x-ray was recommended in those patients who make a good recovery because they found that six out of 36 smokers over the age of 60 with pneumonia, had an underlying bronchial carcinoma. Evidence level 2+,3

Chest x-ray should not be used routinely for patients with acute symptoms of community acquired pneumonia.

Consider chest x-ray in the convalescent period in community acquired pneumonia patients who smoke, or if patients do not make satisfactory progress.

## 5.2 Treatment

Although there is no direct evidence due to trials not having been conducted and due to the fact that it is no longer ethical to conduct such trials, the longstanding consensus is that antibiotic treatment is essential for pneumonia. Evidence level 4

Early administration of antibiotics in patients with pneumonia is essential.

The antibiotic chosen should be effective against *Streptococcus pneumoniae*. Treatment with an aminopenicillin or a macrolide is appropriate.

In younger patients (aged <50 years) *Mycoplasma pneumoniae* should be considered, particularly if it is an epidemic year and any of the following clinical features are present:

- upper respiratory tract symptoms
- headache
- symptom duration >1 week

In these cases, and in those with a diagnosis of chlamydial pneumonia, treatment with a macrolide or tetracycline is appropriate since aminopenicillins are ineffective.

For patients with indices of severity who might normally be referred to hospital, but for various reasons are managed in the community, aminopenicillin and macrolide combination treatment and close follow-up is recommended.

Patients with features of pneumonia should be reviewed after 48 hours, or earlier if clinically indicated, when severity should be reassessed.

## **SIGN Guideline 56**

Prevention and management of hip fracture in older people

Section 9.3 Discharge

### **9.3.1 SUPPORTED DISCHARGE**

Supported discharge and early supported discharge (ESD) schemes comprise an identified team of staff (schemes vary but the teams tend to include designated medical, nursing, physiotherapy, occupational therapy and social work personnel) whose role is to assess patients on admission, to identify those suitable for supported discharge, to facilitate early mobilisation and rehabilitation and arrange appropriate support on discharge and follow up. Most schemes have an identified discharge coordinator or liaison nurse.

Patients who are mentally alert, medically well and mobile postoperatively are most likely to benefit from a supported discharge scheme, and should be identified by multidisciplinary team assessment. Such patients who have been admitted from home can be discharged directly back home, without compromising the patient's recovery. Supported discharge schemes have also been shown to improve patients' abilities to carry out activities of daily living and increase the overall proportion of patients discharged home.

Supported discharge and hospital at home schemes reduce length of acute stay and appear to free resources without transferring unacceptable costs to community health and social services. These costings do not include informal support from carers. Evidence level 2++

Local circumstances will dictate the nature of local arrangements between hospital and community health and social services.

Supported discharge schemes should be used to facilitate the safe discharge of elderly hip fracture patients and reduce acute hospital stay.

### 9.3.2 GERIATRIC ORTHOPAEDIC REHABILITATION UNITS

Geriatric orthopaedic rehabilitation units (GORUs) are multidisciplinary inpatient facilities catering for the frailer, more dependent patient and were originally associated with larger orthopaedic units. Medical care and rehabilitation are supervised by a geriatrician, often with the help of a specialist GP. Orthopaedic cover from a visiting surgeon should be available.

Geriatric service interventions after hip fractures are complex and it is not easy to quantify conclusively the effectiveness of each different type of co-ordinated inpatient rehabilitation. The observed trends favour GORU over conventional management, with a reduction in deaths and an increase in functional improvement. GORUs can increase the efficiency of acute bed use by taking on potentially long stay patients, for example, patients needing prolonged rehabilitation prior to discharge or patients who are unable to return home and are awaiting an alternative placement. Evidence level 1+

There is no evidence that length of stay is reduced in a GORU compared to a conventional unit. In both cases, excessive lengths of stay are primarily related to non-medical problems such as care needs and social support, as well as cognitive impairment. As GORUs tend to increase the chance of a patient returning to their own home, they may be cost-effective in reducing the costs of residential care.

### 9.3.3 PATIENTS ADMITTED FROM INSTITUTIONAL CARE WITH FRACTURED HIP

Data from the Scottish Hip Fracture Audit reveals that in the past five years over one third of female hip fracture patients were admitted from institutional care. One fifth of admissions were from care homes. Of these, one third die within four months of admission compared to only 14% of patients admitted from home. Short length of stay can be predicted in medically fit patients who are from care homes because of the supportive care available. A longer length of stay can be predicted in patients from institutions which do not provide nursing care. Although many can be returned to their original placement with the benefit of familiar care, outcomes are poor, with one-year mortality well over 50%.

## 9.4 Discharge management

Multidisciplinary discharge management, involving community and hospital nurses, hospital doctors and general practitioners, physiotherapists,

occupational therapists, social workers and family has been shown to improve planning and implementation of discharging patients. For example, prior to discharge, the patient may have a continued fear of falling, leading to loss of confidence and increased dependency. Supported discharge schemes with liaison nurse follow up can monitor patient progress at home and help to alleviate some of these fears.

- The patient should be central to discharge planning, and, where realistic, their needs and wishes taken into consideration. The views of a carer are also important.
- Liaison between hospital and community (including social work department) facilitates the discharge process.
- Occupational therapy home assessments assist in preparing patients for discharge.
- Patient, carer, GP, and other community services should be given as much notice as possible of the date of discharge.
- Discharge should not take place until arrangements for postdischarge support are in place and the patient is fit for discharge.
- Written information on medication, mobility, expected progress, pain control and sources of help and advice should be available to patient and carer.
- General practitioners have an important role to play in postdischarge rehabilitation and should receive early and comprehensive information on hospital stay, services arranged and future follow up arrangements. Complicated discharges that may have considerable impact on the primary care team should be discussed in advance with the GP.

Consideration should be given to the prevention of falls with particular attention being paid to potential household hazards, footwear, provision of adaptive equipment/walking aids and alarm systems.

#### **SIGN Guideline 64**

Management of patients with stroke; rehabilitation, prevention and management of complications and discharge planning

Section 5.2 Discharge

##### **5.2.1 DISCHARGE PLANNING AND TRANSFER OF CARE**



Discharge planning should be documented in a discharge document (example shown in Annex 2). Discharge documents may be paper or electronic (e.g. in Electronic Clinical Communications Implementation (ECCI) format).

The following information should be accurately and legibly displayed in the discharge documents:

- Diagnosis(es)
- Investigations and results
- Medication and duration of treatment if applicable
- Levels of achievement, ability and recovery
- Team care plan
- Further investigations needed at primary care level with dates
- Further investigations needed at hospital and dates
- Further hospital attendance with dates
- Transport arrangements
- The trust name, trust telephone number, ward name or number, ward telephone number, consultant's name, named nurse and key worker
- The date of admission and discharge

Consideration should be given to such information being retained by the patient as a patient-held record, to allow all members of the primary care team, AHPs and care agencies to clearly see what the care plan for the patient should be. The wishes of the patient in respect of the confidentiality of this record should be paramount. There is evidence that patient-held records may enhance the patient's understanding and involvement in their care. There is also evidence to show that discharge planning increases patient satisfaction. Evidence level 1+,4

The discharge document should have a minimum font size of 12 or larger as appropriate for those with visual impairment. Medical terminology given to patients or their carers should be in plain English, and discussed with the patient. The form must be signed by the staff member giving the information, and by the patient or their relative/ carer. Any information that has been given to the patient or their carer(s) should be included in the information given to the General Practitioner (GP).

At the time of discharge, the discharge document should be sent to all the relevant agencies and teams.