Investigation of a complaint against the Northern Health & Social Care Trust

Report Reference: 202002199

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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SUMMARY

This complaint is about care and treatment the Northern Health and Social Care Trust, (the Trust) provided to the complainant's late mother (the patient).

The patient was admitted to Antrim Area Hospital (the hospital) on 6 June 2021 with an acute exacerbation of Chronic Obstructive Pulmonary Disease (COPD) and with 'new' confusion. Discharge planning began on 9 June 2021 with a care package put in place. The Hospital Social Worker (HSW) applied for one carer calling four times daily, however this could not be confirmed, and the complainant agreed to assist with the morning visit until the care package could be fully delivered.

The Trust discharged the patient on 12 June 2021. Due to a further deterioration in her condition, the patient was again admitted to hospital on 15 June 2021 and sadly passed away on 19 June 2021. The complainant questioned the decision to discharge her mother on 12 June 2021 and was not satisfied that her mother's symptoms were fully diagnosed prior to her discharge from the hospital. The complainant also outlined her concerns in relation to her mother's mental capacity and her ability to care for herself. The complainant referred to her mother hallucinating, being delusional, and refusing foods and medication prior to discharge.

The investigation found a failure by the Trust. The investigation established the patient should not have been discharged from hospital without fully exploring a diagnosis of delirium. The patient was displaying delirium symptoms and the investigation identified that delirium, although referred to on one occasion on medical notes for the patient, was not diagnosed, nor the underlying issue identified. The patient was deemed 'medically fit for discharge' and discharged home with a care package following a multi-disciplinary team assessment.

Unfortunately the patient was readmitted to hospital three days later, presenting with general deterioration and ongoing confusion since her previous discharge. She sadly passed away four days later in hospital.

I considered the failing identified caused the patient a loss of opportunity to have her symptoms diagnosed, and to receive possible treatment options. I also considered the patient's 'failed' discharge caused both the patient and the complainant upset and uncertainty.

The investigation did not find any failings about the assessments which were conducted with the patient to formulate her post-discharge care plan.

I recommended the Trust apologises to the complainant for the failure identified. I also recommended actions for the Trust to undertake to prevent the failure recurring.

THE COMPLAINT

1. This complaint is about care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's late mother (the patient) in June 2021. The complaint related to the patient's pre-discharge assessments and her post-discharge Care Plan.

Background

2. The complainant's mother was admitted to Antrim Area Hospital (the hospital) on 6 June 2021 with an acute exacerbation of Chronic Obstructive Pulmonary Disease (COPD)[1] and 'new' confusion. The patient was very underweight on admission. She was investigated for possible malignancy. Discharge planning began on 9 June 2021 with a care package put in place. The Hospital Social Worker (HSW) applied for one carer calling four times daily, however this could not be fully sourced immediately, and the patient's daughter, the complainant, agreed to assist her mother with the morning visit until the care package could be fully sourced. The hospital discharged the patient on 12 June 2021.

3. Once home, the patient's condition deteriorated, and she was readmitted to the hospital on 15 June 2021. The patient sadly passed away on 19 June 2021 in the hospital.

Issue of complaint

4. I accepted the following issue of complaint for investigation:

   Whether the care and treatment the Trust provided to the patient in June 2021 was appropriate, reasonable and in accordance with relevant procedures, guidance, and standards.
   In particular this considered the pre-discharge assessments and the care package the hospital put in place.

[1] Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties. It includes emphysema – damage to the air sacs in the lungs.

INVESTIGATION METHODOLOGY

5. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised.

Independent Professional Advice Sought

6. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

    - A Consultant Geriatrician with 40 years' experience and an accredited Geriatrician since 2001 (G IPA); and
    - A Social Worker with 33 years' experience, including in hospital work (SW IPA).

    I enclose the clinical advice received at Appendix three to this report.

7. I included the information and advice which informed the findings and conclusions within the body of this report. The IPAs provided 'advice'. However, how I weighed this advice, within the context of this complaint, is a matter for my discretion.

Relevant Standards and Guidance

8. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

    The general standards are the Ombudsman's Principles[2]:

    - The Principles of Good Administration

9. The specific standards and guidance referred to are those which applied at the

[2] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's Guidance: Decision making and consent, September 2020 (The GMC Consent Guidance); and
- The National Institute for Health and Care Excellence Guidance: Delirium: prevention, diagnosis and management in hospital and long-term care, July 2010 (NICE Delirium Guidance).

I enclose relevant sections of the guidance considered at Appendix four to this report.

10. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I considered everything relevant and important in reaching my findings.

11. I shared a draft copy of this report with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

12. **Whether the care and treatment the Trust provided to the patient in June 2021 was appropriate, reasonable and in accordance with relevant procedures, guidance and standards.**
This included the hospital pre-discharge assessments, and the post-discharge care package put in place for the patient following assessments.

Detail of Complaint

13. The complainant raised concerns about the patient's discharge from hospital on 12 June 2021. The complainant said the Trust sent the patient home without a full and adequate assessment of her needs. She also said the patient was '*hallucinating, delusional, and was refusing food and medication*'. The

complainant said the Trust's decision to discharge the patient caused her mother '*undue suffering'*. She said, '*in her final days [the patient] was in pain, terrified, and lost every shred of dignity'*. The complainant believed this was completely avoidable.

14. The complainant said the Trust rushed to discharge her mother on 12 June 2021, and she questioned the validity and accuracy of the assessments that led to the decision to discharge her mother from hospital on 12 June 2021.

15. The complainant believed staff had not fully considered her mother's symptoms or listened to concerns regarding her mental capacity or her ability to care for herself while living alone.

16. The complainant said the Trust sent her mother home without fully identifying or explaining her mother's needs to her.

17. The complainant said the Trust's action caused both her mother and her undue suffering and she continues to struggle to accept what happened to her mother.

Evidence Considered

Legislation/Policies/Guidance

18. I considered the following guidance:

    - The GMC Consent Guidelines; and
    - NICE Delirium Guidance.

The Trust's response to investigation enquiries

19. In response to our enquiries, the Trust referenced its response to the complainant on 8 September 2021 and 16 November 2021.

The Pre-discharge Assessments of the Patient

20. The Trust explained the patient's mobility had been declining over the previous six months. She had intermittent confusion. During the patient's admission from 6 June 2021, she was treated with steroids and antibiotics for an acute

exacerbation of her COPD. The Trust explained that during her admission it investigated the patient for possible malignancy and arranged a pancreatic scan.

21. The Trust explained the patient was already known to the Gastroenterology team. It requested outpatient follow-up prior to discharge, and also asked her General Practitioner (GP) to refer her to the Memory Clinic in the community. The Trust explained that the patient was keen to go home, and discharge planning commenced on 9 June 2021.

22. The Trust did not accept it had not fully addressed the patient's symptoms, or that it had failed to listen to concerns regarding her mental capacity and ability to care for herself, particularly as she lived alone.

23. The Trust accepted that nursing and medical staff had noted intermittent confusion during the patient's admission. It explained that the complainant had been present when a Physiotherapist carried out the patient's assessment, but the complainant had raised no concerns to medical or nursing staff at the time.

24. The Trust explained the patient had not been sent home without it having fully identified and / or disclosed her needs to the complainant. It was noted the patient was alert to person, place, and time. The Trust further explained medical staff felt it appropriate to refer the patient via her GP, to the Memory Clinic for further assessment following discharge.

25. The Trust stated the patient was noted to be underweight and had a 'fair appetite' at home. The Trust explained that although the patient had refused supplements, all other medication was administered and not refused, and it had referred the patient to the hospital dietician on admission. The Trust said it was aware of only one occasion the patient had refused dinner. Her fluid intake was recorded on a fluid balance chart. The patient was known to the Community Dietician, and the Hospital Dietician had seen her on admission, but not before discharge.

Multi-Disciplinary Assessment for post-discharge care plan

26. The Trust explained that a multi-disciplinary team conducted assessments of the patient prior to the patient's discharge from hospital. The multi-disciplinary team comprised the HSW, a Physiotherapist, and an Occupational Therapist.

27. The Trust explained that whilst the patient's mobility was noted to be declining, she had expressed a wish to go home, and she was noted as being able to mobilise to the bathroom. Following the assessments, the HWS applied for support in the patient's home, comprising one carer, four times a day, seven days a week. This was to support the patient's living activities and use of a wheeled zimmer frame.

28. The care package provided three calls per day, a 15-minute call at lunchtime to assist with toileting needs and to assist with lunch, a 15-minute call at teatime to assist with toileting needs and to assist with dinner, and a 15-minute call at bedtime to assist with personal care, toileting needs and to assist the patient into bed.

29. The Trust stated that whilst a complete care package could not be confirmed prior to discharge, the complainant agreed to assist with the patient's care until the independent care provider had availability for the initial daily call. The request for an early call to the patient remained on the care provider's waiting list.

Relevant Chronology

30. I enclose a chronology of events at Appendix five to this report.

Relevant Independent Professional Advice

Pre-discharge assessment of the patient

31. The Geriatrician IPA (G IPA) advised when the patient presented to hospital, she was delirious having delusions and hallucinations. He referred to Trust documentation and advised the Respiratory Consultant (the Consultant) made

the decision to discharge the patient from hospital during his ward round at 09:30 on 11 June 2021. He referred to Trust records which indicate on 11 June 2021 the patient was having '*confusion*' although she was noted as '*stable*'. The G IPA advised '*considering that her new onset of confusion was a dominant issue,*' (when the patient was admitted to hospital, as along with her shortness of breath) '*that issue was still unresolved*' on 11 June 2021. It is the G IPA's view therefore at that time, '*she was not quite optimised for discharge.*'

32. The G IPA advised it was '*noteworthy that the confusion was 'new' which means it was acute;*' it was associated with hallucination and delusions which '*clearly represented delirium'*. He noted the complainant referred to her mother's condition deteriorating due to '*troublesome hallucinations, being delusional, and refusing foods and medication'*.

33. The G IPA advised the following in relation to the patient's memory and capacity: '*It was not a long-standing confusion associated with cognitive impairment that the patient had contrary to line of thinking of the clinicians, who planned for the patient to have "memory tests" on discharge. In this case, memory was not really an issue.*'

34. The G IPA noted the clinicians in this case who planned for the patient to have memory tests on discharge, had not considered the patient's condition to be delirium. There is only one mention of delirium in the patient's hospital medical notes and he does not believe that it was fully considered as a diagnosis for the patient's symptoms.

35. The G IPA advised the following in relation to the assessments: there are several potential causes for the onset of delirium, referring to The Royal College of Psychiatrists leaflet on Delirium[3]. The clinicians had delegated "cog ax" (cognitive assessment) to the Physiotherapist, Occupation Therapist, and Social Worker. This was not appropriate in that, '*if the respiratory team could not carry out the cognitive assessment, they could have referred the patient to another physician or even the mental health team for assessment of her delirium, rather than attributing her mental state to cognitive issues.*' The

[3] Royal College of Psychiatrists. https://www.rcpsych.ac.uk/mental-health/problems-disorders/delirium

medical notes indicated the patient had new onset of confusion and was acutely confused, and this patient exhibited a condition recognised diagnostically as delirium[4].

36. The G IPA stated the patient in this case did not require memory testing or cognitive assessment, contrary to the perceptions of the medical team caring for this patient until 12 June 2021. The patient required a test for delirium such as the 4AT[5] or CAM[6], which are bedside tests to establish a diagnosis of delirium. A clinician should perform such tests. When a diagnosis of delirium had been established, the clinician should have proceeded to determine the cause of delirium and treat it, if possible, to reverse the delirium. The cause of the delirium was most likely due to infective exacerbation of the patient's COPD, or a combination of other causes.

37. The medical notes document the clinician requested the patient's GP refer the patient to the Memory Clinic following discharge. A test for mental capacity at this time was irrelevant because it was not the patient's capacity to make a particular decision which was the issue in this case. The patient's diagnosis should have been delirium due to her acute and '*new*' confusion.

38. The G IPA advised a diagnosis of delirium was '*missed in this case*', except for the reference which the Senior House Officer (SHO) made to "? Delirium" in passing on 9 June 2021, the date of the patient's admission to hospital. The patient's delirium remained undiagnosed and unresolved, making her '*not quite ready for discharge'* on 12 June 2021.

39. In relation to the complainant's concerns about the patient's confusion being ignored, the G IPA advised the following: '*Communication with the family appears to have been scanty as per the medical notes. The main issue was that delirium was undiagnosed. It should have been clearly explained to the family that she was delirious, that delirium may not resolve quickly and that she may require appropriate measures to be in place during hospital stay and/or*

[4] NHS. Sudden confusion (delirium). https://www.nhs.uk/conditions/confusion/
[5] 4AT. The rapid clinical test for delirium. https://www.the4at.com/
[6] Inouye SK, et al. Clarifying confusion: the confusion assessment method. A new method for Detection of delirium. Ann Intern Med. 1990 Dec 15;113(12):941-8. doi: 10.7326/0003-4819-113-12-941. PMID: 2240918. https://pubmed.ncbi.nlm.nih.gov/2240918/

following discharge including possibly assessment by the adult mental health team.' On this basis, the Trust did not address the family's concerns regarding the patient's discharge from hospital to her own home with regard to her confusion and delusionary behaviour.

40. The G IPA noted the patient was under the care of the respiratory team while in hospital and advised while it may not have had experience in recognising or treating delirium, opinion should have been sought from the adult mental health team.

41. The G IPA concluded the discharge of the patient on 12 June 2021 was a '*failed discharge'* and was '*premature and inappropriate because the diagnosis of delirium was missed, the cause of her delirium was not elucidated and the delirium itself remained treated.*'

Multi-Disciplinary Assessment for pre-discharge care planning

42. The SW IPA advised that multi-disciplinary assessments were conducted prior to the patient being discharged from hospital on 12 June 2021.

43. The SW IPA advised the following: the Northern Ireland Single Assessment Tool[7] (NISAT) initial assessment notes that '*the OT assessment was that the service user required assistance of one person with personal activities of daily living (PADLS) these being toileting, meals and mobility using zimmer frame and supervision for transfers. Therefore, the OT assessment was that the service-user could safely return home with a care package in place that met those needs.*' Further, the Physiotherapist's assessment recorded on the NISAT was that the patient required the assistance of one person to mobilise. Both assessments referred to agree the patient could safely return home with the provision of one person to assist with the tasks outlined above.

44. There were no concerns highlighted in documentation provided about the patient's welfare and safety regarding the pre-discharge care assessments. It was clear these assessments had been carried out with the patient while on the

[7] The Northern Ireland Single Assessment Tool, Procedural Guidance V4 September 2017 is a tool which optimises inter-disciplinary co-operation and improves the experience for patients and clients by minimising replication of assessment and promoting more consistent practice.

ward in hospital, and their findings were appropriately recorded. The multi-disciplinary assessments agreed the patient would be able to return home with the appropriate support.

45. She also advised there was no record of the HSW having had any concerns regarding the patient's mental capacity or her ability to make her own decisions during the assessment period. The HSW noted the patient was alert and orientated during the assessment, despite having had episodes of confusion both prior to her admission to hospital, and while in hospital.

46. The SW IPA referred to the NISAT Guidance which states that '*Adults are always presumed to be capable of making their own health and social care decisions unless the opposite has been demonstrated.'* However, the responsible doctor would have made the decision as to whether this was medically appropriate. The SW IPA concluded there were no concerns about the assessments. They considered the patient's wishes, her functional abilities, and the support available, or that could be made available to her. The HSW multidisciplinary assessment fulfilled the following requirements as set out in the NISAT Procedural Guidance:

    a. 'Consider the person holistically in the context of their past life and present situation, their preferences, values, and future wishes', and

    b. 'Recognise and capture the person's skills and abilities and consider help and support that will encourage independence and self-care throughout the assessment process.'

47. In relation to the complainant's concerns about the patient's incontinence, there was no clear record indicating the patient was doubly incontinent prior to her discharge from hospital, and as such this would not have formed part of the multi-disciplinary assessment. The patient's clinician would have been responsible for her medical condition and her physical fitness for discharge.

48. The SW IPA advised if there were concerns with a patient's capacity to make a decision regarding being discharged home clinical, nursing, or other

professional staff would have made the HSW aware of it, or they would have become aware of it themselves during their interaction with the patient.

49. The SW IPA further advised that should a patient be assessed as not having capacity to make a decision regarding a return to home following discharge from hospital, the decision can be made on their behalf and in their best interests. The HSW would be the appropriate person to make such an assessment on whether or not a patient could safely return home, in consultation with relevant professionals and family members. There was nothing recorded to indicate this was required for the patient in this case.

50. The SW IPA advised the care package for this patient was '*adequate'* for the needs identified at the point of discharge. Although the package was described as '*minimal at present'*, it met the patient's immediate needs for support with PADLS to enable the patient to return home safely.

51. The SW IPA noted the complainant initially agreed to support the patient at home until the morning carer to complete the package of care could be sourced. Had the patient's daughter been unable to provide this support, it may well have been inappropriate for the patient to return home until a morning call could be sourced.

52. The SW IPA concluded no failings had been identified within the pre-discharge assessment process for this patient, and advised that it was appropriate and reasonable, and was within guidance and standards.

ANALYSIS AND FINDINGS

Pre-discharge Assessment of the Patient, diagnosis of Delirium, and Failed Discharge

53. I note the Trust's comment that the patient had a CT brain scan on 16 June 2021, and that this change in the brain can be indicative of an underlying cause of (vascular) cognitive impairment. The G IPA's advice regarding a failure to recognise and treat the patient's delirium referred to the patient's first admission

to hospital, prior to discharge on 12 June 2021. The Trust's comment refers to her readmission on 15 June 2021.

54. I considered the Trust's response regarding the patient's mobility, and that it had been declining over the previous six-month period, and she had displayed '*intermittent confusion*'. The Trust said the hospital made a referral to the patient's GP to arrange for an appointment for the Memory Clinic. I note the complainant's concerns relating to the patient's capacity; however the G IPA advised this was '*not a longstanding confusion associated with cognitive impairment the patient had…in this case memory was not really an issue*.' He also advised the diagnosis should have been delirium, and other than one entry made on the patient's medical notes on the day of her admission to hospital, the medical team responsible for the patient's pre-discharge assessment did not recognise or diagnose the patient with delirium. He referred to the GMC Guidance on Consent and advised that a *'…test for mental capacity was irrelevant in this situation.'*

55. I note the G IPA also advised the patient was displaying '*obvious'* signs of delirium, having delusions and hallucinations as one of the predominant presentations on her attendance at hospital. She also presented with shortness of breath. I note the patient also had a diagnosis of COPD.

56. I also note the Trust explained the patient had received standard treatment for COPD, and '*had shown stable observations when she was seen by the Consultant on the ward on 11 June 2021... On 11 June 2021 she was not clinically delirious'.* It also said the patient had a brain scan on 16 June 2021 following her readmission to hospital, which '*from which was reported "severe small vessel ischemia" – this change in the brain scan can clearly be indicative of underlying cause of (vascular) cognitive impairment.*'

57. I considered what the Trust said regarding the '*latest recommendation for best treatment for patients with delirium is to be in their own environment, which was ensured.*' I also considered it said that at discharge the patient had capacity to make her own decision and to go home. It also said '*the complainant had the opportunity to refuse discharge or ask for further level of care package.'*

58. In response to the draft report the Trust said the patient was not readmitted within 24 hours, nor with the same symptoms. It stated that these conditions would be what it defines a failed discharge, and as such it did not consider there was a failed discharge in this instance. The Trust also stated it did not observe acute signs of delirium and hence not recorded in the notes, and that on 11 June 2021 the patient was not clinically deemed to be delirious.

59. The Trust stated '*the term 'failed discharge' is not a standard term, as the person who saw this lady on readmission did not have the understanding of the whole episode prior to discharge.'* It said before the clinical discharge, the patient was admitted with exacerbation of COPD, which was '*adequately treated from 6 June 2021 to 12 June 2021.'* The Trust also said the average length of stay for COPD in UK hospitals is seven days, and in this case the patient stayed in hospital for five days.

60. I note however, the G IPA advised the patient was still having unresolved medical issues on 11 June 2021 when the decision to discharge on 12 June 2021 was made. He advised the Consultant's decision to discharge the patient during a ward round at 09:30 on 11 June 2021, '*was not appropriate at that time'* as the medical notes for that date record '*the patient was having "confusion", though "stable".*' He further advised that considering the onset of this confusion was a dominant issue on admission on 6 June 2021, it was still unresolved on 11 June 2021, therefore at that time the patient was *'not quite optimised for discharge.'*

61. The G IPA advised the patient should have had, prior to discharge from hospital, a test for delirium such as the 4AT or CAM which are bedside tests which a clinician can carry out to establish a diagnosis of delirium. If delirium was established, the underlying reason for this should have been established and where possible, treated to reverse the delirium. In this case the delirium may have been due to the infective exacerbation of the patient's COPD, or another combination of causes.

62. He also advised the clinicians had '*not explored'* the diagnosis of delirium prior to the patient being assessed as medically fit for discharge. Consequently the cause of the patient's delirium remained unresolved.

63. As noted above in paragraphs 57 – 59 the Trust disagreed with the G IPA's advice about this matter. I sought further advice from the G IPA, who advised the following: '*There is no definition in the guidance of "failed discharge" based on a chronological period. So, the 24-hour limit referred to by the Trust is not mentioned in the literature or any guidance in this matter. There is therefore no mention in NICE or NHS guidance for a readmission in 24 hours to qualify to be "failed discharge".*

64. The G IPA continued, '*The second objection of the Trust is that the patient was readmitted with different symptoms. This is debatable because the patient was having unrecognized delirium at the first admission, the cause of which had not been explored during that admission. It is likely that the delirium at the first admission represented cerebral ischemia which was reported by the Trust on CT brain and on readmission the patient returned on the third day with a full-blown stroke. Thus, she was readmitted with the same condition (delirium/cerebrovascular ischemia/stroke) – all of which represent the very same clinical paradigm.'* I accept this advice.

65. I also considered the G IPA's advice and the medical records, and I am satisfied the patient's discharge was premature. A diagnosis of delirium was not fully explored, and the patient was subsequently discharged without the underlying symptoms being treated. I note the G IPA concluded this was a '*failed discharge'* as the patient required readmission three days after being discharged, due to her ongoing symptoms of delirium.

66. I accept the G IPA advice in relation to the assessments and discharge. I consider this failure to fully explore the patient's symptoms, which led to a premature discharge, constitutes a failure in the patient's care and treatment. I also consider that, as the Trust failed to fully explore a diagnosis, it was not in a position to adequately communicate the patient's diagnosis with the family.

67. I note the comment of the Trust referring to the latest recommendation for best treatment for patients with delirium is to be in their own environment, which was ensured on this occasion. I asked the Trust which guidance this comment referred to. It responded '*We treated the delirium appropriately by treating COPD exacerbation in accordance to [sic] the British Geriatric society and NICE guidelines. Patient's familiar environment was considered for the care and was agreed upon by her daughter. Referral to diagnose potential dementia in accordance with NICE guidelines was requested*.'

68. However, I consider the Trust has contradicted its initial response, whereby it said it did not consider the patient had delirium, and this is why it was not noted on the patient's clinical record.

69. The Trust referred to the patient having had a CT scan of brain which reported 'severe small vessel ischemia'. The Trust also said the following: *'Therefore delirium can only be an assumptive diagnosis. However, referral was made at the time of discharge for review in the memory clinic. The acute confusion had been treated as the acute exacerbation of COPD to be the potential cause and at the time of the Covid pandemic appropriate discharge was planned with a plan of review in the memory clinic.'*

70. I note the Trust went on to say '*On 16 June 2021 the patient had a CT scan of brain which reported 'severe small vessel ischemia'. This change in the brain scan can be clearly indicative of vascular cognitive impairment. Maybe the G IPA has not considered this and focused on delirium. It is not possible for any geriatrician to give 'bold, confident and definite' diagnosis of delirium in this patient's case. As a professional respect it is to note that people of vascular dementia can be prone to intermittent memory impairment and confusion which can be exacerbated by underlying conditions like COPD. Between 6 June 2021 and 12 June 2021, the COPS exacerbation of the patient was treated with standard treatment and home discharge with package of care was started with the agreement of her daughter. Even if there was an element of acute delirium, this lady was treated fully and appropriately as the NICE and British Geriatric Society Guidelines favour such patients to be treated in their familiar environment (home in this case). Sadly this patient was readmitted more than*

72 hours later with a different problem of being generally unwell, dehydration, and deranged liver function.'

71. Having considered the responses received, together with the complainant's views and a review of the medical notes, I am satisfied the failures identified above led to the patient experiencing a loss of opportunity to receive the correct diagnosis and to receive possible treatment options. I consider the complainant experienced upset and distress about her mother being discharged from hospital too early. The complainant said in her final week, her mother was '*in pain, terrified by things I couldn't see, and had lost every shred of dignity*.'

72. I am satisfied this failure caused the complainant to experience the injustice of upset, distress, and uncertainty. Although I cannot definitively conclude if an extended stay in hospital from 12 June 2021 would have changed the overall outcome for the patient, I recognise that unfortunately this failed discharge means the complainant will always question what difference if any, such a continued stay in hospital may have made to the patient's clinical pathway and experience. I uphold this element of the complaint.

The Post-discharge Care Plan for the patient

73. I note the hospital discharged the patient on 12 June 2021 with a partial care package in place. At the time the patient was being discharged from hospital, the HSW was unable to source a full package at the time the patient was discharged. The complainant agreed to assist with the morning call with the patient. The complainant said the care package was not sufficient given her mother's rapid decline in health. The complainant also said she had raised her concerns about the patient being at home while she was still in hospital, but she felt that her concerns were ignored.

74. I also note the complainant agreed to provide assistance with the morning call until a full care package could be sourced. The SW IPA stated that '*it was not inappropriate for the patient's daughter to assist with supporting her mother until the full plan of care could be implemented.'*

75. I note the SW IPA advised it was evident that the multi-disciplinary assessments were conducted appropriately. An Occupational Therapist, a Physiotherapist, and the HSW conducted assessments with the patient. The SW IPA advised that '*those professionals assessed the service user in person on the ward, and recorded their findings, and that they agreed that with the appropriate support, she would be able to return home.*' The SW IPA had no concerns with the assessments conducted.

76. The SW IPA also advised the patient's own desire to return home was appropriately considered. She advised the multi-disciplinary assessment team spoke to the patient, she had capacity at that time, and her wish was that she wanted to return home. The SW IPA also noted that the patient had good family support.

77. I considered the SW IPA's reference to the (NISAT) Procedural Guidance, September 2017, page 44. This guidance states "*Adults are always presumed to be capable of making their own health and social care decisions unless the opposite has been demonstrated*." A copy of this extract from the guidance document is attached at Appendix four to this report.

78. The complainant said while at home following her discharge from hospital, her mother was doubly incontinent, and she believed this was not taken into account during the post-discharge care plan assessment. The SW IPA advised there was no record in the multi-disciplinary assessment notes to indicate that staff were aware of the patient being doubly incontinent at the time of assessment. I also note the records document commode care and assistance with toileting were needs which were identified and documented in the care plan. The medical notes do not indicate the patient was doubly incontinent on her discharge from hospital. I note the patient's medical notes recorded following her re-admission to hospital on 15 June 2023, document that she was incontinent at the time of readmission.

79. I considered the SW IPA's advice, and in conjunction with the patient's medical records, I accept the medical notes do not indicate the patient was doubly

incontinent on discharge, although this may have become an issue after the patient's discharge from hospital.

80. The SW IPA advised the care package put in place was adequate for the needs of the patient, as they were known at the time the multi-disciplinary care plan assessment took place.

81. In response to the draft report the Trust said the SW IPA felt the patient was allowed to go home on 12 June 2021 with an adequate care plan in place. However I consider the SW IPA would not be the professional responsible for making a clinical decision regarding when a patient is medically fit to be discharged. The SW assessments only took place once the clinicians had decided the patient was medically fit for discharge. In this context, I accept the SW IPA's advice.

82. The SW IPA concluded that the post-discharge care plan assessments were '*appropriate and reasonable and within guidance and standards*.' I accept this advice and do not uphold this element of the complaint.

Communication with family

83. I note the Trust referred to the patient being in a Covid ward, which would have affected communication as there were restrictions in place regarding face to face communication. The complainant's concern was around her belief that concerns she raised to medical staff were not being heard or listened to. I asked the IPA if he believed the Trust took into account the family's concerns regarding the discharge of the patient. His reply was "*on a reading of the notes, no, their concerns do not appear to have been taken into consideration'*. I note the Trust stated that had a specific request been made for face to face communication '*it would have been facilitated*'. It said the Consultant who cared for the patient indicated *'it was not brought to his attention the complainant wished to speak face to face with him'*. The Trust did not provided any evidence regarding this point which would lead me to question the G IPA's advice. I consider the Trust should have listened to the concerns the complainant raised regarding her mother's discharge from hospital, and her ability to cope at home, even with the assistance of a care package.

84. I consider the Covid situation should not have precluded other methods of communication with the patient's daughter. I am satisfied the Trust's lack of communication with the complainant constitutes a failure in this instance, and I have upheld this element of the complaint.

CONCLUSION

85. I received a complaint about the patient's care and treatment while she was a patient at the hospital. The complainant believed the Trust discharged her mother from hospital on 12 June 2021 without undertaking appropriate pre-discharge medical assessments into her ongoing confusion. She also said also the Trust failed to adequately assess care requirements for her post-discharge, which led to the patient being readmitted to hospital three days after her initial discharge on 12 June 2021. The complainant said these failures by the Trust were the reason the patient required to be re-admitted to hospital on 15 June 2021, just prior to her sadly passing away on 19 June 2021.

86. I upheld elements of the complaint for the reasons outlined in this report. I consider the Trust's actions in relation to its decision to discharge the patient constitute a failure in the patient's care and treatment. The Trust did not fully explore a diagnosis of delirium, with the patient requiring re-admission to hospital just three days after being discharged to home. I consider this was a failed discharge and I uphold this element of the complaint.

87. The complainant also said that she did not believe that the post-discharge assessments conducted in hospital had fully addressed her mother's needs following her discharge from hospital. I did not identify any failure in the pre-discharge multi-disciplinary assessments. I do not uphold this element of the complaint.

88. I note the complainant described how the situation had a severe impact on her. I am satisfied the failures in this case caused the complainant an injustice of upset and uncertainty during the period the patient was discharged from hospital, up to her readmission to hospital, and until the subsequent passing of her mother. I also consider the failure led to a loss of opportunity for the patient

to receive a diagnosis of delirium, and appropriate treatment for the underlying cause. I consider the patient also experienced upset.

89. I recognise the loss and grief the complainant has suffered since losing her mother in June 2021. I wish to offer through this report my condolences to the complainant for the sad loss of her mother.

Recommendations

90. I recommend the Trust provides to **this office** a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failure identified within **one month** of the date of this report. The complainant has requested any apology is forwarded to NIPSO for retention on file.

91. I further recommend that, for service improvement and to prevent future recurrence, the Trust:

    (i) brings the contents of this report to the attention of the relevant medical clinicians involved in the patient's care, ensuring they have the opportunity to consider the findings in this report and demonstrate that they have reflected on how they can improve their practice in future;

    (ii) ensures relevant medical clinicians faced with acute and 'new' confusion, are reminded of the importance of considering delirium as a diagnosis, dependent on individual circumstances; and

    (iii) implements an action plan to incorporate these recommendations and should provide me with an update within **six** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

MARGARET KELLY
Ombudsman **March 2024**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.

- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.