Enw'r Pwyllgor: Name of Sub-Committee:	Exception Report from Listening and Learning Sub-Committee
Cadeirydd y Pwyllgor: Chair of Sub-Committee:	Mr Paul Newman, Independent Member, Chair
Cyfnod Adrodd: Reporting Period:	May 2021
Materion Ansawdd, Diogelwch a Phrofiad: Quality, Safety & Experience Matters:	

The Sub-Committee reviewed a number of presentations and individual cases from across the concerns and safeguarding portfolio, relating to discharge arrangements.

The public services ombudsman final reports received during the relevant period were also reviewed.

Patient Experience/Complaints

The Sub-Committee reviewed two complaints. One case involved a lack of suitable transport which caused difficulty for the patient in accessing/exiting the vehicle both at the hospital and at home. It was upheld that staff should have waited for an appropriate vehicle to attend. Staff had also received updated training on manual handling procedures. The second complaint related to communication with the family who felt the discharge was unsafe and felt unprepared to care for the patient at home. It was upheld that the standard of communication had fallen below the expected standard as consideration had not been given to how the family would manage at home.

A presentation was received from the Patient Experience team on the theme of discharge arrangements and feedback from patients and their families. The common themes and concerns received included:

- Communication – poor communication and planning with the family;
- Lack of full consideration of home environment;
- Not contacting the family on discharge resulting in the patient arriving home unexpectedly;
- Unsuitable transport or lack of transport to facilitate discharge;
- Unsafe discharge, patients requiring ongoing medical treatment or readmission;
- Falls, patients suffering falls at home soon after discharge;
- Timing of discharge – such as early hours of the morning from A&E;
- Dignity – state of dress on leaving hospital.

Incidents

The Sub-Committee received a summary of the incidents received during 1st September 2021 and 22nd February 2022 via the Datix system. A total of 72 incidents relating to discharge had been raised, 14 related to moderate harm and two as severe harm. Of the 14 incidents relating to moderate harm, the main theme arising related to the lack of a care package in place, or that the patient's individual circumstances may not have been taken into account at the point of discharge from acute care. Other themes included self-discharge against medical advice and deterioration in the patient's condition after discharge.

The incidents relating to severe harm related to a declined package of care or self-discharge against medical advice, leading to poorer outcomes for the patient.

It was also noted that appropriate care and treatment had been provided to patients in the majority of cases, however not all of the patient's conditions or limitations in their conditions had been shared appropriately with relatives or third parties at the point of discharge.

Safeguarding

A thematic review of discharge related reports had been undertaken in 2019, the cases for 2020 and 2021 had also been reviewed. It was noted that the number of cases had increased from 27 in a 12 month period in 2019 to 55 in 2021. Forty one of the reports were generated for patients who were returning to their own home, most of whom were dependent upon others for support. Particular challenges were noted for patients who were living alone, when delays in identification of problems and seeking solutions was identified.

Communication was central to most of the reports, including communication regarding clinical needs, care, equipment/consumables not supplied and package of care not restarted. Seven of the reports related to care needs in excess of family expectations.

Legal Cases

A summary report was presented by the Legal Team discussing 12 claims and 7 redress cases for the period, which had an aspect of discharge within the particulars of the claim/case.

In response to the issues identified, it was noted that a number of actions were being taken across the organisation, including a review of the discharge policy. It was agreed to hold a meeting outside of the sub-committee meeting to ensure coordination across the various pieces of work and consider options for a quality improvement approach to a fundamental review of the discharge process, involving patient, family and carer engagement.

Public Services Ombudsman Reports

Four final (non-public interest) reports were received by the Sub-Committee.

Case 16044 reviewed related to care and treatment under Mental Health services. Specifically, the complainant said that the Health Board had failed to arrange for a Section 12

approved doctor to visit and conduct a mental health assessment which resulted the patient's mother having to take the patient by car to hospital, when the patient was in severe distress. The complaint was partly upheld. Whilst clinicians had reasonably attempted to secure a Section 12 doctor, the Ombudsman found that attempts lacked any systemic escalation process and upheld this element of the complaint, also acknowledging the shortage of Section 12 doctors NHS-wide. A number of recommendations were made, including within 3 months from issue of the report, evidence is supplied of the measures, initiatives, and improvements to service that have been implemented in respect of identifying appropriate environments for patients with mental health conditions waiting for admission, and implementing strategies to address the shortages of trained psychiatrists, Section 12 doctors, psychotherapists and other mental health clinicians.

Also within 6 months, provide evidence of the development of an escalation policy in relation to managing contacts with Section 12 approved doctors (ie an explicit stepwise system that clarifies the actions to be taken).

Case 15627 - involved attendance at Minor Injury Unit with a finger injury. The complaint said the Health Board failed to diagnose an avulsion injury to a tendon and that there was a failure to promptly refer him to another specialist outside of the Health Board. The Ombudsman found that there had been an inadequate assessment of the patient's finger by the orthopaedic doctor, also that there had been an unreasonable delay in making the referral to a specialist. A number of recommendations were made, including within 12 weeks of the issue of the report, the Health Board takes action to ensure that hand injury referrals are made to the other Health Body or another health agency for specialist hand trauma related input, promptly and efficiently.

Case 18213 – involved a patient who had been admitted for surgery during 2020 and said that the Health Board failed to monitor and treat her blood glucose levels whilst she was an inpatient and that it failed to appropriately manage the discharge from hospital. The Ombudsman found that the diabetes management had been appropriate and this was not upheld. However, the discharge had not been managed appropriately regarding pain management and more should have been done to engage with pain services before the patient was discharged. The Ombudsman recommended that within 6 months of the final version of the report's issue, the Health Board should undertake a review of the mechanisms in place to ensure patients admitted to an emergency department setting have timely access to pain reviews prior to discharge.

Case 18853 – the complainant said that the Health Board had failed to provide the patient with appropriate care during her hospital admission in relation to fluid, nutritional needs, symptoms of nausea, skin care needs and low potassium levels. The complainant also said there was inadequate communication and that her complaint had not been fully investigated. The Ombudsman upheld the complaint about nutritional care. The complaint about communication was partly upheld on the basis that poor communication within the nursing team impacted on continuity of care. The Ombudsman also upheld the concerns about the investigation into the complaint. A number of recommendations were made including, within 3 months of the report's issue the Health Board should review the availability of nutritional supplements across relevant wards, to ensure that commonly used supplements are readily available and remind staff about the mechanism for ordering and obtaining these.

Risgiau:
Risks (include Reference to Risk Register reference):

Risk of patient harm/increase in readmission rates as a result of non-compliance with the discharge process set by the Health Board.

Gwella Ansawdd:
Quality Improvement:

The identified actions for quality improvement from review of cases that remain on the Sub-Committee action log are as follows:

- Follow up, monitoring and action of all test results.
- Improvements in relation to communication.
- Medical records management and record keeping.
- Review of the discharge process.

Argymhelliad:
Recommendation:

- Discuss whether the assurance and actions taken by the Sub-Committee to mitigate the risks are adequate.

Dyddiad y Cyfarfod Pwyllgor Nesaf:
Date of Next Sub- Committee Meeting:

July 2022