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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint by Mr and Mrs Q against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201201275

Contents

	Page
Introduction	3
Summary	4
The complaint	5
Related ombudsman investigations	5
Investigation	6
The background events	7
The UHB's evidence	13
Professional advice	20
Analysis and conclusions	24
Recommendations	28

Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005. This report considers safe discharge and record keeping within Betsi Cadwaladr University Health Board, two issues that I have reported on previously and found failings on the part of the Health Board.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainants as Mr and Mrs Q.

Summary

Mr and Mrs Q complained about the care and treatment Mr Q had received as a patient at Glan Clwyd Hospital and Wrexham Maelor Hospital.

Having reviewed the evidence I found that during Mr Q's admission to Glan Clwyd Hospital on 17 and 18 May 2011 the "In-Patient Medication Administration Record" had not been appropriately completed. As a result, it was unclear whether Mr Q had received any of his Parkinson's disease medication.

With respect to Mr Q's discharge from Wrexham Maelor Hospital on 22 May 2011, I found that the medical records for this period failed to fully reflect Mr Q's anxious and difficult behaviour, the actions taken by staff to reassure him, any medical reviews undertaken by doctors or need to call a security officer. As a result Mr Q was discharged from hospital without assessment, placing Mr and Mrs Q in a vulnerable position.

I recommended that the UHB apologise to Mr and Mrs Q for the failings identified in the report and pay them £750 in recognition of the service failure and the time and trouble in bringing their complaint to this office. I also recommended that the UHB:

- Review Mr Q's "In-patients Medication Administration Record" for the period 17-18 May 2011, and where appropriate instigate the UHB's "Medicines Management Assessment Workbook and Competencies" document, in accordance with the UHB's procedure.
- Review Mr Q's medical records for the period 19-22 May 2011 and where appropriate take action in accordance with the UHB's procedures.
- Remind the relevant staff that in the event that a security officer is called an "Incident Recording Form" should be completed.
- Bring the updated discharge protocol to the attention of the relevant staff and introduce discharge drop in sessions at the Second Hospital.
- Produce a training plan ensuring that within 12 months all relevant staff at the Hospital receives training on record keeping.

The complaint

1. Mr and Mrs Q complained about the care and treatment Mr Q had received at Glan Clwyd Hospital ("the First Hospital"), specifically, the administration of Mr Q's Parkinson's disease[1] medication during his admission and the safety of his discharge from hospital on 18 May **2011**.

2. Mr and Mrs Q also complained about the care and treatment Mr Q received at Wrexham Maelor Hospital ("the Second Hospital"), specifically the events leading up to and including Mr Q's discharge from hospital on 22 May, the quality of the catheter care advice Mrs Q was given following Mr Q's discharge from hospital on 14 June and the treatment he received as an in-patient on Ward A from 9 to 18 July.

Related ombudsman investigations

3. The detail of these cases has been set out below:

4. In August 2012 I issued a public report relating to the care of a patient in 2009. In that case I found evidence of poor record keeping, specifically a failure to make adequate timed notes in the medical records. (case reference: 201101271)

5. I also issued a report in August 2012 relating the care of a patient in 2011. In that case I found evidence of unacceptable failings in record keeping and the discharge of a patient that was contrary to the UHB's own Discharge Policy (case reference: 201101609).

6. In November 2012 I issued a letter report relating the care of a patient in 2010. In that case I found evidence of poor record keeping and poor discharge planning (case reference: 201103032).

7. In November 2012 I issued a letter report relating to the care of a patient in 2011. In that case I had concerns about the failure of medical staff to sign clinical records (case reference: 201200659).

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[1] This is where part of the brain becomes progressively more damaged over time. The three main symptoms of Parkinson's Disease are tremors, muscle stiffness and physical movement becoming very slow.

8. In November 2012 I issued a letter report relating to the care of a patient in 2011. In that case I raised concerns about the failure of medical staff to make full and accurate notes in the medical records (case reference: 201200819).

9. In each case appropriate recommendations relating to training and review were made by this office and agreed by the UHB. This has resulted in the introduction of an up to date Discharge Protocol[2], and discharge drop in sessions[3]. The UHB has also indicated that it would provide training on record keeping for some of its staff.

10. In view of the number of reports that I have issued against Betsi Cadwaladr University Health Board ("the UHB") in the last 12 months about discharge from hospital and record keeping, I have decided to issue this report as a public report. Given the pattern of concerns I consider it appropriate to bring this matter to the attention of the public and Healthcare Inspectorate Wales.

Investigation

11. My investigator obtained comments and copies of relevant documents from the UHB and interviewed three members of staff[4]. This information was considered in conjunction with the evidence provided by Mr and Mrs Q. Advice was also taken from two of my professional advisers. The Consultant Adviser, Mr Richard McGonigle, has over 20 years experience as a Consultant General and Renal Physician. The Nursing Adviser, Ms Elizabeth Onslow, is a senior nurse with a particular expertise in the care of older people gained in ward sister nurse specialist roles. The Nursing Adviser currently works as a nurse specialist in an older person's outreach team based in an acute care setting.

12. The legislation, policy and guidance considered to be relevant to the complaint have been fully considered.

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[2] July 2012.
[3] These sessions are open to student nurses, trained nurses, healthcare support workers, MDT members, junior doctors, ward clerks in secondary, prim
ary and community care and voluntary services. The aim of the session is to raise awareness and provide knowledge, updates and expert support on discharge planning and related issues.
[4] The Senior Sister, Staff Nurse and Healthcare Support Worker on duty on 22 May 2011

13. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

14. Both Mr and Mrs Q and the UHB were given the opportunity to see and comment on a draft of this report before the final version was issued.

The background events

Background

15. Mr Q was diagnosed with Parkinson Disease in 1996, the condition was controlled with medication. Between 2009 and 2011 Mr Q also suffered with bladder stones[5], which had resulted in urinary tract infections ("UTI")[6].

16. On 17 May 2012 Mr Q collapsed whilst on holiday and was taken to the First Hospital where he was seen in the Emergency Department before being transferred to the Medical Assessment Unit. Mr and Mrs Q said that they informed the ward staff at the First Hospital of Mr Q's medical history.

17. Mrs Q said that she was not aware of the nurses giving Mr Q his Parkinson's disease medication during his admission. However an entry in the medical records stated that at 10:00pm on 17 May "wife has given [patient] meds for today". There was no explanation in the medical record of the medication administered by Mrs Q. Furthermore, whilst it was documented on the medication chart that on 18 May a nurse had signed for Mr Q's Parkinson's disease medication, there was nothing to show that it had been administered. Finally it was recorded that Mr Q was given a single dose of trimethroprim[7] however there was no prescription for further antibiotics following his discharge.

18. On 18 May Mr Q was reviewed on two separate occasions. Mr Q's observations were stable and he was found fit for discharge. Mr Q was told

[5] These are small stones that develop inside the bladder, they may irritate the bladder wall or affect the flow of urine. They can cause pain in the abdomen, and when urinating. They may also cause blood in the urine and may affect the frequency a person needs to urinate.
[6] This is a bacterial infection of the urinary tract, which consists of the kidneys, ureters, bladder and urethra.
[7] An antibiotic used to cure bacterial infections including urine infections.

that his collapse was thought to have been caused by postural hypotension[8]. Mr Q was also told that he had Hyperparathyroidism[9], and that was the likely cause of his bladder stones. The "Acute Medicine Discharge Letter" to Mr Q's GP stated that he had also been diagnosed with Hypercalcaemia[10] due to high parathyroid hormone levels. However it was noted that Mr Q's levels at that stage were 9.7 which was considered to be low. As well as a scan of his parathyroid[11], which Mr Q requested be undertaken at his local hospital, it was also recommended that Mr Q be referred to a local endocrinologist[12].

19. Mr Q returned home from his holiday but remained unwell. At 12:22pm on 19 May Mr Q was admitted to the Emergency Department of the Wrexham Maelor Hospital with urinary retention. Mr Q was catheterised at 1:30pm and provided with an analgesic. Mr Q underwent a scan and at 6:40pm he was transferred to the Surgical Admission Unit ("SAU") where he was diagnosed with a UTI.

20. An untimed entry in the medical records stated that on 20 May Mr Q was settled and that all regular medication had been administered by Mrs Q, again the record does not specify exactly what medication was given and when. At 4:00pm Mr Q was transferred from the SAU to Ward B. An untimed entry in the medical record states that whilst on Ward B Mr Q became agitated and was climbing out of bed. It was noted that Mrs Q was contacted by the ward staff and during the conversation Mrs Q said that Mr Q's behaviour on the ward was uncharacteristic. Mrs Q contacted the Parkinson's disease helpline for advice. The Parkinson's disease helpline in turn contacted the ward and suggested that Mr Q be prescribed Quetiapine[13].

21. At 8:00pm Mr Q was reviewed by the on-call doctor at the request of the ward staff. The Doctor noted in the medical records that the reason for

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[8] This is where a person's systolic blood pressure falls by 20mmHg or more after standing for one minute.
[9] A rare hormone disorder caused by the parathyroid gland in the neck producing too much parathyroid hormone. This hormone helps control the levels of calcium, phosphorus and Vitamin D within the bones and blood.
[10] This is an elevated level of calcium in the blood.
[11] This gland controls the level of calcium in the blood and bones.
[12] A doctor that specialises in hormone related disorders.
[13] Anti-psychotic medication

the request was because Mr Q was displaying increased movement and restlessness. The Doctor also noted his discussion with Mrs Q about Mr Q's behaviour, specifically that Mrs Q had said that Mr Q's movements were no worse on the ward than at home, although he added that that was contrary to what Mrs Q had told a nurse. The Doctor recorded that Mr Q was alert and not confused, and that he reassured Mr Q. The Doctor prescribed Quetiapine should it be necessary, but added that Mr Q did not need it at that point.

22. Mr Q was transferred back to the SAU at 9:00pm because of his agitated behavior whilst on Ward B. Once back on the SAU Mr Q settled for the night. The SAU discussed Mr Q's restlessness and agitation with Mrs Q and was informed that it was uncharacteristic behaviour.

23. The entry in the medical records shows that on 21 May Mr Q was settled all day.

24. An entry in the medical records at 4:30am on 22 May stated that Mr Q had not expressed any anxiety and had slept well until approximately 3:00am. At that point Mr Q's behavior had become agitated and he got out of bed and walked around the ward expressing a wish to go home. The UHB said that Mr Q was reviewed by the on-call doctor in an attempt to establish a reason for the agitation, but no external trigger was found. There was no entry in Mr Q's medical records relating to that examination.

25. The medical records note that at 10:10am Mr Q remained anxious to go home. A later untimed entry also noted that Mr Q had become very unsettled and agitated and was wanting to go home. It was also recorded that Mr Q had tried to leave the ward and whilst he was able to run he seemed unstable on his feet and security was called.

26. An untimed entry in the medical records note that Mr Q was seen by a consultant during the ward round. The Consultant noted that Mr Q was well with no "acute urological problems". He also noted that whilst Mr Q had been "aggressive overnight" he found him "calm and lucid enough to have a conversation". Mr Q was found fit for discharge and was to be discharged into the care of the district nursing service.

27. A further untimed entry in the medical records refer to the presence of the security officer in order to calm Mr Q down and stop him leaving the SAU whilst he was waiting to be collected by his wife. The UHB said that in attempting to leave the SAU Mr Q's arms were bruised, there was no reference to these injuries in the medical records. The UHB also said that Mr Q was examined by a doctor who found that no course of treatment was necessary, again there was no reference to this examination in the medical records.

28. Mrs Q said that when she arrived to collect Mr Q he was "corralled" behind the nursing station with the Security Officer stood over him. Mrs Q said that she was informed by a nurse that Mr Q had been restrained and that there may be bruising on his upper arms as a result. Mrs Q said that Mr Q was visibly agitated and distressed and looked to be in a very similar state to the day he was admitted.

29. Mr and Mrs Q returned home, however Mr Q's condition worsened and the hallucinations were such that he broke the spindle from the banister of his stairs and threatened his wife. An ambulance was called and Mr Q was found with a strip of Mrs Q's tablets in his mouth. Mr Q was returned to the Second Hospital where he remained until after his cystoscopy[14] and bladder stone lithotripsy[15] on 6 June 2012.

30. Mr Q appeared to improve daily following the operation and catheterisation, and he was discharged under the care of the Intermediate Care Team on 14 June. Whilst at home Mr Q had increased trouble passing urine due to his catheter blocking. Mrs Q contacted the District Nurse Service who referred her back to Ward C. Having contacted the ward she was told that they could not help as Mr Q was no longer an in-patient and she was advised to contact the Out Of Hours GP service or go to the Emergency Department. Mrs Q contacted her GP who arranged for the District Nurse to

[14] This procedure involves the insertion of a light and camera (cystoscope) through the urethra and into the bladder.
[15] This procedure uses shockwaves to break up stones in the bladder.

attend. Mr Q's catheter was removed, and following a failure to re-catheterise him Mr Q decided to use urinary sheath[16].

31. Mr Q's condition gradually deteriorated and on 5 July he was readmitted to the Second Hospital. Mr Q's medication was altered in an attempt to combat his changing behaviour and deterioration and a decision was made to keep him in hospital for rehabilitation.

32. On 9 July Mr Q was transferred to Ward A. Mrs Q had some concern over the care that her husband received on the ward. Mrs Q said that whilst on the ward Mr Q had incontinence issues, his pads were not regularly changed, he was left lying in wet clothes and he also developed a red rash on his inside thighs and genitals. There was no entry in Mr Q's medical records of Mrs Q raising any of these issues with the staff on duty at the time. The only entry that may be related to these concerns was a request by Mrs Q on 13 July that Mr Q have a bath or shower the following day.

33. Mr Q was moved to Ward D for rehabilitation on 18 July before being discharged on 24 August.

34. Mr and Mrs Q submitted a complaint to the UHB on 19 September. The UHB responded to the complaint on 21 December. The response was based on the statements taken from the Consultant responsible for Mr Q's discharge from the Second Hospital on 22 May, the SAU's Senior Sister, the Staff Nurse on duty during the night shift on 21-22 May and the Ward Sister for Ward C regarding Mr Q's discharge from the Second Hospital on 14 June.

35. The Consultant's statement dated 17 November stated that on 20 May it had been concluded that Mr Q was not suffering from an acute medical emergency needing treatment. The Consultant said that Mr Q was not confused clinically, and following a conversation with Mrs Q it appeared that Mr Q was no worse in hospital than he was at home. The Consultant said that he saw Mr Q on 21 and 22 May and following a calm and lucid

[16] This is a device that is similar to a condom which facilitates the drainage of urine away from the body and into a drainage bag.

conversation the decision was made to discharge him. The Consultant said that it had been noted that Mr Q had been aggressive overnight but no medical records were seen to suggest that discharge would have been inappropriate.

36. In her statement dated 9 November the Senior Sister stated that on his return to the SAU on 20 May Mr Q said that he did not like it on Ward B and was glad that he was back on the SAU. The Senior Sister said that having been told that he was fit for discharge on 22 May Mr Q became agitated, wanting to go home and tried to leave via the fire exit door. The Senior Sister said that the nurses on the SAU were busy and felt that they needed the support and assistance of a security officer to keep an eye on Mr Q and stop him leaving the ward. The Senior Sister said that Mr Q became aggressive and kept thumping the wall with his fists and shouting that he wanted to go home. The Senior Sister said that the security officer gently made sure that Mr Q did not come to any harm and protected the other patients and relatives on the SAU from Mr Q's actions.

37. The Senior Sister said that the other patients on the ward had been frightened and distressed by Mr Q's behaviour. The Senior Sister said that Mrs Q was contacted and asked to collect Mr Q, however she sounded as if she did not want to take him home. The Senior Sister said that the doctors felt that Mr Q would settle quicker at home and he was at risk of harming himself and others on the ward. The Senior Sister said that when Mrs Q left the ward she gave her a tin of chocolates for the staff and apologised for Mr Q's behaviour.

38. The Staff Nurse's statement dated 9 November stated that on the morning of 22 May Mr Q was encouraged to return to his bed for safety and comfort and to have his catheter flushed. The on-call doctor was informed of the change in Mr Q's behaviour and reviewed him but no instructions were given. The Staff Nurse said that as Mr Q's behaviour became more troublesome a security officer was called for support to nursing staff and to protect fellow patients, although no intervention was required. The Staff Nurse said that Mr Q settled following reassurance and the following morning he apologised for his behaviour.

39. With respect to the catheter care advice Mr and Mrs Q received prior to Mr Q's discharge on 14 June, the Ward Sister for Ward C said that Mr Q's catheter had not blocked whilst he was on the ward, therefore the blockage that had occurred following his discharge could not have been foreseen. The Ward Sister said that Mr Q had been safely discharged home with home care services in place and that the advice Mrs Q had been given by the ward was correct.

The UHB's evidence

40. The following members of staff were interviewed by my investigator on 1 May 2013 in relation to Mr Q's discharge from the Second Hospital on 22 May 2011.

The Senior Sister

41. The Senior Sister said that the SAU was a very busy ward with 13 beds. At that time patients would normally stay on the SAU for 24 – 48 hours before being discharged or moved to another ward. The process for discharging a patient from the SAU involved a decision taken by the relevant doctor and the discharge nurse on duty at that time. The Senior Sister said that she was not the discharge nurse responsible for discharging Mr Q.

42. The Senior Sister said that she arrived on the SAU at approximately 12:00pm on 22 May 2011 in preparation for starting her shift at 12:30pm. Upon arrival the Senior Sister saw the Security Officer stood by the nurse's station. The Security Officer informed her that he had been called to keep an eye on Mr Q. The Senior Sister said that at that time Mr Q was laughing and joking with his family and getting ready to leave the SAU. The Senior Sister said that on the way out of the SAU Mrs Q stopped and gave her a box of chocolates and thanked her for looking after Mr Q. The Senior Sister said that at no point did Mrs Q express any concern about taking Mr Q home. The Senior Sister said that in her view the discharge was safe and had there been any suggestion that it was not, she would have stopped it.

43. The Senior Sister said that at the time of the incident in question, she was unaware of any Hospital or UHB policy in place for calling a security officer to the SAU. She said that it was unusual for a security officer to be called to the SAU because the staff were used to dealing with people in a state of agitation, particularly when unwell. The Senior Sister said that on the rare occasion that a security officer was called it was unusual for them to take any action because the presence of an officer in a uniform was usually sufficient to settle a patient down. The Senior Sister said that in Mr Q's case the decision to call the Security Officer was based on staffing levels in the SAU, there were no staff available to sit with him and as such there was no need to complete an incident reporting form.

44. The Senior Sister said that she had drafted a statement in response to Mr and Mrs Q's complaint to the UHB. The content of the statement was based on her recollection of the discussions she had had with staff on the day of the incident and subsequent discussions with them following the letter of complaint from Mrs Q in November 2011.

45. The Senior Sister said that everything relating to this incident should be recorded in Mr Q's medical records, and whilst she recognised that there was not a lot of information written in the records she said that they did accurately reflect the incident and show that not a lot actually happened.

The Staff Nurse

46. The Staff Nurse said that she was on duty between 8:45pm and 7:45am on 20 May 2011. The Staff Nurse said that she was on duty when the SAU received a telephone call from Ward B saying that Mr Q was agitated and would not settle down. The Staff Nurse said that a decision was made to return Mr Q to the SAU because he knew the staff and it was easier to keep an eye on him there because there was always someone in the room with the patients. The Staff Nurse said that it was unusual to have a patient returned to the SAU. The Staff Nurse said that upon being transferred back to the SAU Mr Q settled and slept all night.

47. The Staff Nurse said that there were no complaints from the day staff about Mr Q when she started her shift at 8:45pm on 21 May. The Staff Nurse said that Mr Q was settled until the early hours of the morning. At that time a number of very sick patients had been admitted onto the ward so the lights had been switched on. The Staff Nurse said that having returned to the SAU after her break she found Mr Q quite agitated and he was pacing the ward looking for an exit. The Staff Nurse said that at no point did Mr Q display any signs of aggression.

48. The Staff Nurse said that members of staff walked with Mr Q in order to calm him down, and an attempt was made to find out what had triggered the agitation. The Staff Nurse said that having no success in discovering the cause of Mr Q's agitation an on-call doctor was asked to carry out a review. Mr Q agreed to the examination and for a short while afterwards stayed on the bed.

49. Mr Q then resumed pacing the SAU stating that he wanted to go home. The Staff Nurse said that the staff on duty continued to reassure Mr Q and explained that he could not go home as it was the middle of the night. Again attempts were made to determine the cause of the agitation. The Staff Nurse said that she was not aware of any external factors that may have triggered Mr Q's agitation, his observations were fine, his catheter was fine and there was no complaint of pain. The Staff Nurse said that Mr Q was given lots of reassurance and plenty of tea and biscuits. The Staff Nurse said that at no point did Mr Q appear confused, and there was no evidence of delirium or acute confusional state[17] and he was able to appropriately answer any questions that he was asked. The Staff Nurse said that there was some concern about Mr Q's safety because his Parkinson's Disease made him unsteady on his feet.

50. The Staff Nurse said that there were only two nurses on duty during the night shift on 21-22 May and Mr Q's behaviour was making it difficult to keep him safe and look after a very sick patient. The decision was therefore made

[17] This term is used to describe a change in a person's mental state or consciousness. This change may be shown as confusion, difficulty understanding, personality changes or agitation and restlessness.

to call the Security Officer to sit with Mr Q. The Security Officer came onto the SAU and sat and chatted with Mr Q over a cup of tea and biscuits which allowed staff time to look after the other patients on the SAU that night. The Staff Nurse said that the presence of a security officer on the SAU was unusual, but it had been used previously as a means to settle an agitated patient who could not be reassured. This was because the presence of a person in uniform was usually enough to calm a person down.

51. The Staff Nurse said that she was not aware of any UHB or Hospital policies on restraint in place at the time of the incident and did not record the decision to call security because the Security Officer had not taken any action other than chatting and having a cup of tea with Mr Q. The Staff Nurse said that the Security Officer was only there for about half an hour and did not return to the SAU.

52. The Staff Nurse said that Mr Q's agitation lasted for approximately one and a half hours, once daylight broke Mr Q settled down, apologised for being naughty and went to sleep.

53. The Staff Nurse said that she discussed Mr Q's behaviour with the Senior Sister at the time of the incident, then in November 2011 she made a statement in response to Mr and Mrs Q's complaint to the UHB.

The Healthcare Support Worker

54. The Healthcare Support Worker ("HCSW") said that on the occasions that sitting, talking and reassuring an agitated or distressed patient had not worked a security officer had been called, however that was a last resort and was rarely done. The HCSW said that she was not aware of a Hospital or UHB procedure in place at the time for requesting the presence of a security officer at the SAU, and the decision was based on the circumstances at the time. The HCSW said that security officers rarely had to take action because the presence of an officer in uniform was usually enough to calm a patient down and reassure the other patients on the SAU who may be distressed and frightened by the behaviour of one patient. The HCSW said that usually the

security officer would either stand by the nurse's station or sit with the patient and have a chat with them.

55. The HCSW said that she had been working the shift from 7:30am to 9:00pm on the weekend of 20-22 May 2011. The HCSW said that Mr Q had arrived onto the SAU on 20 May 2011, where he was assessed by the on-call doctor and identified for transfer to the available bed on Ward B. The HCSW said that at that point Mr Q was the only patient in a position to be transferred. The HCSW said that she had built up a very good rapport Mr and Mrs Q, and after the visiting hours had finished at 8:00pm she took him to Ward B and settled him in.

56. The HCSW said that just before she finished her shift, the SAU received an irate telephone call from the Sister on Ward B. The Sister said that Mr Q had started to become very agitated and did not want to stay on the bed or the ward. A request was made for one of the SAU's night staff to go to Ward B and sit with him. As the SAU could not spare a member of staff at that time, it was agreed that Mr Q would be transferred from Ward B back to the SAU. The HCSW said that staff felt that by transferring Mr Q back to the SAU he could be watched along with the other patients.

57. The HCSW said when she started her shift on 21 May Mr Q was sat in his bed with a smile on his face. The HCSW said that she asked Mr Q what he was doing back and he said "I didn't like it on [Ward B], I wanted to be back here with you because you give me biscuits, so I was naughty for them". The HCSW said that she commented that Mr Q's actions were not very nice and he laughed. The HCSW said that she gave Mr Q his breakfast in bed that morning and he read his paper. Then when the tea round came Mr Q had a hot drink and a biscuit. The HCSW said that Mrs Q came to see Mr Q that day and everything seemed fine.

58. The HCSW said that the Security Officer was present when she started her shift on 22 May. The Security Officer had been coming in and out of the SAU in order to keep an eye on Mr Q. The HCSW said that when she arrived on the ward Mr Q was in bed, laughing and joking and she commented to him "You have been naughty for them in the night". The HCSW said that Mr Q

approached the Staff Nurse from the night shift, shook her hand and apologised for his behaviour the night before.

59. The HCSW said that Mr Q had breakfast in bed and was sat happily with his newspapers. Mr Q had a cup of tea and a biscuit at approximately 10:00am before he was seen by his Doctor at approximately 10:30am. The Doctor examined Mr Q and said that he could be discharged. The HCSW said that as soon as the Doctor left the SAU Mr Q's attitude and demeanour changed, he wanted to go home there and then. Mr Q insisted on getting out of bed and walked all the way down to Ward E looking for a way out. The HCSW said that she told Mr Q that his wife had been contacted and was on her way to collect him. Mr Q was asked whether he wanted to put his clothes on as he was in his pyjamas, he declined. The HCSW said that she asked Mr Q to wait as he could not leave on his own as he had no means of getting home. The HCSW said that Mr Q paced the SAU and she accompanied him because he was unsteady on his feet and upset because he wanted to go home.

60. The HCSW said that the Security Officer entered the SAU through the fire exit door at the top of the room, which, unlike the main door into the SAU was always unlocked. The HCSW said that Mr Q realised that the door was unlocked and that he could leave through it. The HCSW said that the Security Officer stood in Mr Q's way and jammed the door with his foot in order to stop Mr Q leaving the SAU. The HCSW said that Mr Q made several attempts to open the door, and in doing so knocked his arm, at no point did Mr Q hit or punch a wall.

61. The HCSW said that Mr Q decided that he wanted to telephone his wife so he went behind the nurse's station to use the telephone. The HCSW said that she sat on the edge of the nurse's station talking to Mr Q whilst everyone else was out of the way except the Security Officer who was on the other side of the nurse's station. The HCSW said that she reassured Mr Q that his wife was on her way and suggested that he not telephone his wife because it may upset her and she had to drive to collect him. The HCSW said that the Security Officer also asked Mr Q to sit down and wait for his wife. The HCSW said that during that discussion Mrs Q and her son walked into the SAU with a

wheelchair. The HCSW said that whilst she appreciated that from their perspective it may have looked like Mr Q was barricaded in the area, he was not, he went behind the nurse's station of his own volition in order to use the telephone. The HCSW said that Mr Q's behaviour and demeanour changed again when he saw his family.

62. The HCSW said that as she assisted Mr Q in putting his coat on Mrs Q noticed the bruise on his arm. The HCSW said that she told Mrs Q what had happened and explained that as Mr Q pulled at the door in an attempt to leave he may have knocked and bruised his arm. The HCSW said that Mrs Q confirmed that Mr Q's frailty meant that he bruised easily.

63. The HCSW said that Mr Q was happy as he got into the wheelchair to leave and as they left Mrs Q gave the Senior Sister a tin of chocolates and said thank you for all that had been done for them. Additionally, Mrs Q made Mr Q thank and apologise to the staff for the problems he had caused that morning. Then following a discussion about aftercare with the Senior Sister Mrs Q took Mr Q home.

64. The HCSW said that there was no indication as to what triggered Mr Q's agitated behaviour. The HCSW said that Mr Q could be very determined once his mind was set and on that morning he wanted to go home. The HCSW said that she had spent over half an hour chatting with Mr and Mrs Q on 20 May and spoke to them again on 21 May and at no point did Mrs Q raise any concerns about Mr Q's behaviour or state that she had concerns about violence or coping with his behaviour. The HCSW said that when Mrs Q had been notified of Mr Q's behaviour, she did not comment on it she just asked Mr Q whether he had been naughty. The HCSW said that Mrs Q seemed happy when she left the SAU and did not mention any concerns about taking Mr Q home.

65. The HCSW said that at no point was Mr Q considered to be in an acute confusional state, and in her opinion Mr Q knew what he was doing, just the same as when he was on Ward B.

66. The HCSW said that she discussed Mr Q's behaviour that morning with the Senior Sister and provided her with a drafted note of events.

Professional advice

The Consultant Adviser

67. With respect to the care Mr Q received at the First Hospital, the Consultant Adviser said that whilst it appeared that Mr Q had been prescribed the appropriate Parkinson's Disease medication during his stay, it was not possible to determine whether the medication had been administered at the correct time.

68. The Consultant Adviser also said that Mr Q had been appropriately assessed and reviewed on a post-take ward round and was found to have a raised calcium level in the blood and a slightly elevated parathyroid hormone. The Consultant Adviser said that that level of calcium would not cause bladder stones. The Consultant Adviser said that the discharge summary detailed the appropriate advice for Mr Q's GP along with recommendations for further investigations and an onward referral.

69. The Consultant Adviser said that there was evidence that Mr Q had a UTI and a single dose of trimethoprim was prescribed. However it was unclear whether Mr Q was discharged home with more antibiotics. The Consultant Adviser said that Mr Q should have been discharged from the First Hospital with a prescription for trimethoprim, and whilst the discharge was not dangerous, it was likely that Mr Q was in urinary retention.

70. With respect Mr Q's admission to the Second Hospital on 19 May, the Consultant Adviser said that it was unclear from the medical records whether Mr Q's calcium levels had been measured to ensure they had not increased. It was also unclear from the medical records whether the cause of Mr Q's urinary retention had been established and he had been prescribed antibiotics.

71. The Consultant Adviser also considered Mr Q's discharge from the Second Hospital on 22 May. He said that itt would not be usual or good practice to discharge an elderly, confused male patient with Parkinson's disease, who had been admitted with urinary retention requiring catheterisation and evidence of a urinary infection. The Consultant Adviser said that the medical notes were insufficient to comment further.

72. The Consultant Adviser said that there was no documented attempt to establish the cause for Mr Q's confusion, and no consideration that this might be related to infection. In view of the evidence available the Consultant Adviser said that Mr Q's discharge was not appropriate and could be considered unsafe.

The Nursing Adviser

73. With respect to Mr Q's admission to the First Hospital, the Nursing Adviser said that Mr Q was prescribed the appropriate Parkinson's disease medication during his admission to the First Hospital on 17 May. The records show Mr Q's medications documented on the medical clerking form and transcribed onto the Trust in-patient medication prescription chart. Furthermore, there was evidence that the ward pharmacist confirmed Mr Q's usual medications. However it was not clear from the evidence that Mr Q received his medication on time that day, nor was it clear whether Mr Q received any of his Parkinson's disease medication on 18 May.

74. The Nursing Adviser also considered Mr Q's discharge from the First Hospital. She said that from a nursing perspective there were no concerns about Mr Q's fitness for discharge. There was clear evidence of appropriate assessment and discharge planning which had included involvement from Mr and Mrs Q. Additionally, Mr Q's physiological observations were within normal parameters and the medical records stated that Mr Q's activities of daily living abilities reflected his usual status.

75. With respect to Mr Q's admission to the Second Hospital for the period 19-22 May, the Nursing Adviser said that there was no indication in the medical records that there had been an investigation into the reason for Mr

Q's agitation and aggression on 22 May. This should have documented along with details of the actions taken to address Mr Q's changed behaviour. The Nursing Adviser said that if staff had to call security for intervention an incident form should have been completed to provide a detailed account of what actually happened.

76. The Nursing Adviser expressed concern that Mrs Q was expected to collect Mr Q and take him home, despite the fact that security officers were necessary to assist in keeping him calm on the SAU. The Nursing Adviser said that there was no indication of any discussion with Mrs Q concerning her ability to manage Mr Q at home nor was there an evaluation of Mr Q's behaviour when she arrived to collect him. The Nursing Adviser said that she would have expected to have seen an assessment of Mr Q's level of agitation and distress once he knew he was going home.

77. Having considered the evidence available, the Nursing Adviser said that Mr Q's discharge from hospital on 22 May was inappropriate and unsafe. Furthermore, the reason for his fluctuating state of agitation and aggression had not been investigated. It was apparent that both Mr and Mrs Q were at risk following his discharge home.

78. With respect to Mr Q's discharge from the Second Hospital on 14th June, the Nursing Adviser said that an appropriate referral had been made to the District Nursing Service requesting district nursing input for on-going catheter care in the community. Mr Q was to be visited by the district nurse the day after his discharge. Mrs Q had also been given advice on "day to day" catheter care. However, there was no indication that Mrs Q was given either verbal or written information on the action to be taken, in the event of the catheter becoming blocked.

79. The Nursing Adviser said that there was some confusion about the advice given to Mrs Q when she contacted the district nurse services on 15 June about problems with her husband's catheter. The Nursing Adviser said that it was unclear why Mrs Q was advised to contact Ward C rather than Mr Q's GP or the Emergency Department, because Mr Q had been discharged and the ward staff would be committed to the care of inpatients on the ward.

80. With respect to the concerns raised about the care Mr Q received as an inpatient on Ward A the Nursing Adviser said that overall, the standard of nursing documentation for that period of the care was very good. There was clear evidence of comprehensive and person centered assessment and a number of care plans were generated in response to identified problems, including personal care. The Nursing Adviser said that the evaluation of care delivery was of a reasonable standard and reflected Mr Q's changing needs and abilities.

81. The Nursing Adviser said that from a personal hygiene perspective it was evident that Mr Q had a wash, bath or shower at least daily, and when his urinary sheath came off or he was incontinent he was appropriately washed and changed. However the frequency of the change of incontinence pads was not documented and should have been, although it is important to note that incontinence pads do not need to be changed each time a person is incontinent. Pad changes are determined by the absorbency of the pad being used with most having a change indicator line identifying when the pad has reached its level of absorbency and requires changing. The Nursing Adviser added that it would have been entirely inappropriate for Mr Q to have been left in a wet bed or for his urinal to be placed out of reach. However, it was difficult to establish when Mr Q was in a wet bed, because there was no indication that Mrs Q raised concerns on those occasions. The Nursing Adviser said that there was sufficient evidence in the nursing notes to indicate that attention was paid to Q's personal hygiene and continence needs.

82. The Nursing Adviser said that Mr Q had a red rash inside his thighs and on his genitals, which had been recorded in his medical records. The Nursing Adviser said that entries in the medical records show that and as well as washing and drying the area, appropriate skin protectants were applied. The Nursing Adviser said that the most likely cause of the redness was incontinence associated dermatitis which was a clinical manifestation of moisture associated skin damage, a common problem in patients with urinary incontinence.

Analysis and conclusions

83. Mr and Mrs Q raised concerns about the administration of Mr Q's Parkinson's disease medication during his admission to the First Hospital on 17-18 May. The "In-Patient Medication Administration Record" shows that Mr Q's Parkinson's disease medication had been prescribed on 17 May and the prescription appeared to have been filled on 18 May. There is also an entry in the medical records stating that Mrs Q gave Mr Q his medication that day. However there is no entry in either Mr Q's "In-Patient Medication Administration Record" or his medical record of him receiving any Parkinson's disease medication on 18 May.

84. In view of the information available to me I **uphold** this element of the complaint. The medication, dosage and regime for an individual patient with Parkinson's disease are carefully prescribed in order to maximise the benefit to the patient and it is essential that medication is administered as prescribed. Therefore, it was reasonable for Mrs Q to have administered Mr Q's Parkinson's disease medication on 17 May to ensure that he had the correct dose at the right time. However there is no record that Mr Q had received any of his Parkinson's disease medication whilst he was an in-patient at the First Hospital on 18 May.

85. Mr and Mrs Q also raised concerns about the safety of Mr Q's discharge from the First Hospital on 18 May. The medical records show that following his admission to the First Hospital Mr Q was appropriately assessed, his observations were monitored and he was found to be stable. Mr Q was also eating and drinking independently. Whilst the discharge was planned with input from Mr and Mrs Q and the "Acute Medicine Discharge Letter" detailed appropriate follow up actions for Mr Q's GP, Mr Q should have been discharged with a prescription for antibiotics for his UTI and it was likely that he was retaining urine at that point. However there was nothing to suggest that the discharge was unsafe. Having considered the evidence available I **do not uphold** this element of the complaint.

86. Mr and Mrs Q raised a concern about the safety of Mr Q's discharge from the Second Hospital on 22 May. Mr Q was discharged following a review by his Consultant and the staff nurse on duty. The Consultant had recognised that Mr Q had been aggressive overnight, but said that there was nothing in the medical records to suggest that discharge would be inappropriate (see paragraphs 26 and 35).

87. The medical records for the period leading up to Mr Q's discharge from the Second Hospital on 22 May are not comprehensive. Many of the entries for this period are untimed, making it difficult to establish an accurate chronology. The content of the entries in the medical records fail to provide enough detail to establish what actually happened on 22 May and as a result the full extent of Mr Q's agitation was not clear. The medical records also fail to show any assessment undertaken by the medical staff of Mr Q's behaviour, the two examinations by doctors, what action was taken to identify a trigger for Mr Q's behaviour and resolve the problem and what effect that action had on Mr Q. This meant that the Consultant who discharged Mr Q on 22 May did not have all of the information available to him when he made the decision to discharge Mr Q. Furthermore the UHB had to rely on recall and hearsay when responding to Mr and Mrs Q's complaint, and in doing so provided two different versions of events (see paragraphs 36 and 38) with neither being corroborated by the contemporaneous records.

88. The medical records only make one reference to the Security Officer being called to assist with Mr Q, however the evidence suggests that he was called on two separate occasions (see paragraphs 42, 50, 51 and 58). It is clear from the evidence that the need for a security officer's presence on the SAU was unusual yet despite the security officer being called on two separate occasions the staff on duty felt that it would not be necessary to complete an incident reporting form. Furthermore the entry in the medical record states "Security present to calm [patient] and to stop [patient] leaving the ward whilst he was waiting for his wife as we were concerned about his safety", it fails to state why and when the Security Officer was called, what, if any, action he undertook whilst on the SAU, what effect that had on Mr Q, any injuries sustained by Mr Q and the cause thereof, and how long the Security Officer was there. As a result there was no effective incident report on this

matter. The record keeping for this period is not appropriate and well below what was expected[18].

89. The medical records did show however that in a period of less than 12 hours Mr Q had displayed signs of agitation and upset on two separate occasions (see paragraphs 24, 25 and 27). The medical records also show that on one occasion a security officer was needed to assist ward staff in keeping Mr Q calm (see paragraph 25), although it is clear from the evidence that a security officer was called on two occasions. Additionally the final entry in the medical records for that admission states that a security officer was present to keep Mr Q calm. There was no evidence in the medical records that the clinicians had established what had triggered the change in Mr Q's behaviour, including whether it had been caused by a UTI or some other infection. There was no evidence that the ward staff had considered whether Mr Q was in a state of delirium or acute confusional state. There was no evidence of an assessment of Mr Q's level of agitation and distress before and after Mrs Q had arrived to collect him. Finally there was no evidence that ward staff had discussed Mr Q's behaviour that day with Mrs Q, conducted any evaluation of Mrs Q's ability to manage Mr Q at home or considered whether discharging Mr Q would put Mrs Q at serious harm. The evidence does suggest however that the staff had taken into account Mr Q's comments following his return from Ward B to the SAU (see paragraph 57) and had presumed that Mr Q's behaviour had been intentional. Subsequent events following Mr Q's discharge prove this was incorrect. The failing place Mr and Mrs Q who was herself elderly in a vulnerable position. In view of the information available to me I **uphold** this element of the complaint.

90. Mr and Mrs Q have raised concerns about the catheter care advice given prior to Mr Q's discharge from the Second Hospital on 14 June. Mr Q underwent an operation on his bladder and catheterisation on 6 June, and there was no evidence of any concerns about Mr Q's catheter for the period

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[18] GMC, Good Medical Practice: Providing good clinical care. (2006)
Generic Medical Record Keeping Standards, Royal College of Physicians first published in 2007 in Clinical Medicine
NMC, Record Keeping Guidance for Nurses and Midwives (2009)
NMC, The Code Standards of Conduct Performance and Ethics for Nurses and Midwives (2008)

leading up to his discharge on 14 June. Prior to Mr Q's discharge, Mrs Q was given advice on "day to day" catheter care and a referral was made to the District Nursing Service for a first visit on 15 June. There was no evidence that Mrs Q had been advised what to do in the event that Mr Q's catheter should block.

91. Mr and Mrs Q said that following Mr Q's return home, he found that he was having increased difficulty passing urine due to blockages in his catheter. Mrs Q contacted the District Nursing Service who advised Mrs Q to contact Ward C. Ward C in turn advised Mrs Q to contact Mr Q's GP, the Out Of Hours Service or the Emergency Department.

92. In its response to Mr and Mrs Q's complaint the UHB confirmed that the District Nursing Service should have advised them to contact Mr Q's GP, the Out Of Hours Service or the Emergency Department, as Mr Q had been discharged from Ward C and they were no longer responsible for his care at that time.

93. Having considered the information available to me I **do not uphold** this element of the complaint. Whilst it would have been good practice to have advised Mr and Mrs Q on the action that should be taken when a catheter blocks, there was nothing to suggest to the ward staff prior to discharge that a blockage was likely to occur. Additionally, Mr Q had been appropriately referred to the District Nursing Service who should have provided the correct advice when Mrs Q contacted them on 14 June.

94. Mr and Mrs Q raised concerns about the standard of care Mr Q received as an in-patient on Ward A from 9 to 18 July. It is noted that the UHB failed to comment on this issue in its response to Mr and Mrs Q's complaint[19]. Mr Q's medical records for this period are of a good standard, and there is evidence of comprehensive and person-centred assessment. Care plans have been generated in response to specific problems and the care reflects Mr Q's changing needs.

[19] 21 December 2011

95. With respect to Mr Q's personal care, it is clear from the medical records that Mr Q received a daily wash, bath or shower. Mr Q was also appropriately washed following any episodes of incontinence. There is no evidence in the medical records to suggest that Mr Q's personal hygiene needs had not been adequately met. With respect to Mrs Q's concerns that Mr Q had been left in a wet bed, there is no evidence in the medical records supporting Mrs Q's concern, nor is there evidence that Mrs Q raised this matter at the time.

96. With respect to the rash on Mr Q's inner thigh and genitals, it is likely that the cause of the rash was incontinence-associated dermatitis, a common problem with patients with urinary incontinence. The evidence in the medical records shows that the nurses appropriately attended to the rash and applied skin protectants. Having considered all of the information available to me I **do not uphold** this element of the complaint.

Recommendations

97. I recommend that within one month of the date of this report the UHB:

- Apologise to Mr and Mrs Q for the failings identified in the report.
- Pay Mr and Mrs Q £750 in recognition of the service failure and the time and trouble in bringing their complaint to this office.
- Review Mr Q's "In-patients Medication Administration Record" for the period 17-18 May 2011, and where appropriate instigate the UHB's "Medicines Management Assessment Workbook and Competencies" document, in accordance with the UHB's procedure.
- Review Mr Q's medical records for the period 19-22 May 2011 and where appropriate take action in accordance with the UHB's procedures.
- Remind the relevant staff that in the event that a security officer is called an "Incident Recording Form" should be completed.
- Bring the updated Discharge protocol to the attention of the relevant staff.

98. I recommend that within three months of the date of this report the UHB:

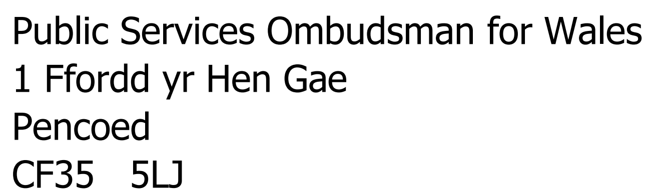
- Introduce discharge drop in sessions at Wrexham Maelor Hospital.
- Produce a training plan ensuring that within 12 months all relevant staff at Wrexham Maelor Hospital receive training on record keeping.

99. As a matter of good practice, I would also ask that the UHB consider:

- Introducing the discharge drop in sessions to all hospitals across the health board.
- Extending the training on record keeping across the health board.
- Including information on what to do should a catheter become blocked as part of the standard advice provided to catheterised patients on discharge from hospital.

100. I am pleased to note that in commenting on the draft report the UHB has informed me that a number of these recommendations have already been implemented and that work has already started on those outstanding.

Peter Tyndall
Ombudsman 18 July 2013



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