Case 1 - Home Treatment Team: Partially Upheld

Complaint

This was not received as a formal complaint but was investigated as an Serious Incident (SI). The PHSO decided to investigate in 2018, but only concluded their investigation in 2019.

The complainant said the Trust had failed to carry out a proper Mental Health Assessment on their relative when seeing them in Accident and Emergency (A&E) which was two days prior to the patient ending their life.

Failings

The PHSO found that the Trust failed to carry out a full Mental Health Assessment which had caused an injustice to the complainant.

Recommendations

NICE guidance states “within four hours of arriving in an Emergency Department or being referred from a ward it is recommended that a person should have a full Biopsychosocial Assessment. The Trust did not complete a full and thorough assessment in line with the guidance.

The Trust was asked to write to the complainant, acknowledging the failings and apologise for the impact these had caused. In addition, the Trust should carry out a root cause analysis to identify what led to the failing in the assessment and produce an action plan to address these issues.

Learning

The Biopsychosocial Assessment did capture those areas set out in the Trust’s Clinical Risk Assessment and Safety Management Policy; however, this was not highlighted sufficiently within the original Root Cause Analysis. As part of the action plan, the Terms of Reference for a serious incident report should explicitly identify that the requirements have either been met or not met. The Clinical Risk Assessment and Safety Management Policy is being reviewed to ensure that the associated Biopsychosocial Risk Assessment requirements are clearly indicated within the policy.

Case 2 - Poplar Ward, St Margaret's Hospital: Upheld

Complaint

Complainant's relative was discharged from Poplar Ward following a stay of nine days. When complainant gave her personal care the following day, she found a pressure sore on her leg. The patient's GP made a referral to the District Nurses. Complainant felt the sore was caused by a hoist strap used to lift the patient out of bed each day. The complainant was upset when the Trust's response said that the complainant had not alerted the issue of the pressure sore to the Community Nurse who visited. The complaint was re-opened and the response apologised that the patient had not received a pressure area risk assessment at the visit as per guidelines.

Failings

The PHSO found that a pressure ulcer risk assessment and full skin assessment was not carried out by the Community Nurse. Had the Trust conducted a full skin assessment, there is the possibility that any developing pressure sore, or established pressure sore for that matter, could have been appropriately and more efficiently treated and managed. There is also the possibility it may not have deteriorated to the level that it did and may have prevented the further deterioration the wound underwent, in the time leading up to the patient's hospitalisation. The subsequent treatments the patient required in the following months, which were directly related to the pressure sore, could have been avoided, or lessened, had effective and timely treatment been provided in the weeks post discharge.

Recommendations

To write to the patient to acknowledge, and apologise, for the failings. The PHSO said that the impact caused to the patient was significant enough to warrant a financial remedy of £1,000.

Learning

The Service held a meeting with the complainant. The Head of Integrated Community Services & Transformation had met with the family and put forward some improvements they felt addressed the identified failing. A copy of a leaflet 'Preventing Pressure Ulcers,' was shared with the family who agreed that this would have been useful information for them when their relative was discharged from Poplar Ward. It was agreed that the ward would therefore give this leaflet to all patients on discharge. It was also agreed that in future, ward therapists will speak to community colleagues regarding specialist slings that patients might be using at home.

The learning was also shared with staff members to raise awareness; alongside this an audit was carried out of randomly chosen patient's records in order to establish that pressure area assessments were carried out appropriately and in line with guidance. This was undertaken by a senior manager from another locality and the

intention was to understand if shared learning had been understood and put into practice by staff. These were provided to the PHSO who commended the service and were satisfied that the Trust had already taken actions to improve its service.

Case 3 - Thorpe Ward, Basildon Mental Health Unit

Complaint

Complainant's relative was discharged from the ward, having been under section, with all of their medication stopped except Mirtazapine. What followed was a gradual but severe decline resulting in a complete relapse the following week. The clinical decision was to discontinue Quetiapine a week prior to discharge in order to prevent the risk of metabolic changes associated with Quetiapine. A previous discharge had kept the patient on their medication and gradually weaned off over several weeks.

Failings

The PHSO found a failing of stopping Quetiapine instead of slowly decreasing it. They advised at the Assessment stage that this was the only failing and would not issue a report in this case.

Recommendations

The Trust should pay £500 in recognition of the distress caused as a result of the cessation of Quetiapine instead of tapering it off.

Learning

The discharging doctor has reviewed their notes and reflected on the risks associated with the discontinuation of medications. They will consider if medication should be discontinued before a patient is stable in the community.

Case 4 - Integrated Discharge Team (IDT): Partially Upheld

Complaint

This case had not been received as a complaint by EPUT, but as the local authority had responded regarding their involvement, the Local Government Ombudsman (LGO) and the PHSO decided to investigate. The patient had been admitted to Broomfield Hospital following a fall at home, the complaint focussed on the delay in discharging their relative from hospital. As the patient lacked mental capacity, the IDT were involved in the discharge arrangements to determine what was in the patient's best interests. There had been failings in the best interest meeting and representing the complainant's views.

Failings

The PHSO found that there were failings in collaborative working, specifically communication between the multi-agencies involved regarding discharge arrangements.

Recommendations

The PHSO found that the Trust should apologise to the complainant for the distress caused by the failings within the IDT and CHC assessment which led to the patient's discharge being delayed. The Trust should pay £100 for distress and inconvenience caused by the faults leading to the delayed discharge, the other two organisations involved should also pay £100 each. In addition, the Council and EPUT should review their respective responsibilities in the IDT and ensure all relevant staff are aware of their roles and responsibilities within the team to prevent delays in future discharge planning. This should pay particular attention to referral to Social Care, arranging CHC checklists and assessment and best interest decisions.

Learning

Respective staff roles, responsibilities and processes within the IDT have been reviewed. In order to address the issue of unnecessary delay in discharge planning, the new Discharge to Assess model has been fully introduced by Broomfield Hospital IDT, so that a four week care home placement can be accessed via commissioning, whilst the CHC process in completed. Social Care are an integral part of the IDT and are fully involved in the Discharge to Access model, ensuring that there is effective communication during the four week assessment process.