

Out of hours: Time to care





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This report is laid before the National Assembly for Wales under paragraph 14 of Schedule 1 of the Public Services Ombudsman (Wales) Act 2005

Foreword



Since being appointed as the Public Services Ombudsman for Wales 18 months ago, I've had to come to grips with the sheer number of public service complaints that my staff deal with on a daily basis.

During the last five years complaints and enquiries have increased 105% while health complaints have escalated 126% during the same period.

Rather than simply accepting this increasing volume as the norm, I would prefer to tackle the problem at its source.

Detailed examination of the office's caseload has revealed patterns of similar complaints and poor practice. While each complaint is different, the failures behind them can be all too familiar.

I have a maximum of five and a half years remaining of my term in office and I intend to use thematic reports such as this to shine a spotlight on these emerging patterns and encourage those public bodies involved to tackle these issues head on.

Earlier this year I conducted an internal reorganisation, and as a result this office now has a new team of improvement officers drawn from our experienced pool of investigators. This places a greater emphasis on best practice, corporate cultural development, and ending cycles of poor service delivery.

My office is in the unique position of being at the end of the complaint journey. The very nature of the job means we deal with events when they have gone wrong, or at least perceived to have gone wrong. However there are emerging examples of good practice and I am keen to share these to contribute to better public services.

I would like to stress I am only too aware that there is an Assembly election in May and the NHS will be a key issue in that campaign. I would like to use this opportunity to remind stakeholders of my office's independence and impartiality, and that the sole purpose of this report is to ensure that lessons are learned from the complaints I have considered. I am therefore highlighting issues for future considerations for public sector bodies which I believe are worthy of deliberation.

Nick Bennett
Public Services Ombudsman for Wales



Introduction

The responsibility and role of the Ombudsman

The Public Services Ombudsman for Wales has legal powers to examine complaints about public services. He also investigates allegations that members of local government bodies have broken their authority's code of conduct. He has a team of people who help him to consider and investigate complaints. He is independent of all government bodies and the service that he provides is impartial and free of charge. The aim of the Ombudsman is to put things right for users of public services and to drive improvement in those services and in standards in public life using the learning from the complaints received.

Introduction

In 2012, Professor Longley produced a report on hospital services in Wales which highlighted that patients admitted to hospital over a weekend, particularly on a Sunday, were more likely to die than those admitted on a week day¹. A year later the Royal College of Physicians (RCP) released the '*Future Hospitals Commission*'² report which, building on previous publications from the National Institute for Health and Care Excellence (NICE) and the RCP, produced a number of recommendations, including that services should be organised so that access to medical care is readily available and that there should be consultant presence on the wards seven days a week.

The RCP in Wales has produced a more recent paper, *Rising to the Challenge*³ to support changes required to meet the changing pressures within hospital medicine caused by an increasing population of more frail and older patients often with cognitive impairment requiring hospital admission. If hospitals are to cope with the increase in hospital admissions, the importance of good quality 24 hour care is more important than ever. Yet it is evident from the cases in this report, and from many of the complaints seen by the Ombudsman, that there is still much to be done to achieve the standards required.

Poor quality care out of hours and including weekends, often related to inadequate consultant supervision, is a regular characteristic in health complaints, even if it is not the main failing being investigated. In this report, we present a sample of 12 cases which all demonstrate significant clinical failings outside usual working hours including weekends. It can be difficult to determine whether an increase in the number of patient reviews, the presence

¹ The Best Configuration of Hospital Services for Wales: A Review of the evidence, Professor Marcus Longley Welsh Institute for Health and Social Care, 2012

² Future Hospitals Commission, Royal College of Physicians, 2013

³ Rising to the Challenge: Improving acute care, meeting patients' needs in Wales, Royal College of Physicians in Wales, 2015



Introduction

of a senior clinician or appropriate supervision of a junior member of staff would have changed the outcome in these cases. However, it is clear that these factors would have contributed to a better standard of care for the patients concerned and reduced the distress caused to their families, which in itself is an injustice. This report emphasises the need for more effective and equitable clinical care to be provided seven days a week with greater consultant supervision, as well as the requirement for health boards to ensure their staff are adhering to the guidelines that are already established and accepted as good practice.

More often than not, particularly when it comes to health complaints, individuals who have suffered as a result of poor medical care or their families simply want to ensure the same mistake does not affect someone else. The Ombudsman aims to ensure that their complaints make a difference, and this report strives to achieve this.

These 12 cases are a snapshot of Ombudsman investigations. While there are many more cases involving out of hours care that continue to be brought to this office, this report does not suggest that the inadequate standards highlighted are typical of that given to the majority of people who have been admitted to Welsh hospitals over the past five years. However there is no doubt that the pattern of failings identified suggests that these cases are not “one-off” or isolated incidents and the failings in some areas may be more widespread.

“The aim of the Ombudsman is to put things right for users of public services”

It is recognised that a number of initiatives have been introduced within NHS Wales to secure more effective out of hours care, and future measurable outcomes will need to be assessed to see whether these have been successful. Nevertheless, the learning derived from the Ombudsman’s investigations remains important and NHS Wales along with individual health boards and hospitals are urged to give consideration to it to sustain the impetus for improvement.



Analysis

Weekend and out of hours care is not a new source of concern for the NHS. Since the Francis report⁴ of the Mid Staffordshire NHS Foundation Trust Public Inquiry in 2013 and the subsequent Welsh Government response ‘Delivering Safe Care, Compassionate Care’⁵, the topic of avoidable deaths has become a major issue within the NHS. Understanding hospital mortality is very complex and subject to considerable debate.

An analysis by Professor Marcus Longley, commissioned by Wales’ Local Health Boards, commented that in both England and Wales, “there is now worrying evidence that patients admitted at the weekend – and especially on Sundays – are more likely to die than those admitted Monday to Friday.”⁶

Despite this, there is currently a debate about the usefulness of mortality statistics, and their association with weekend hospital admissions. In any case, the focus should be on reducing avoidable deaths and harm in hospitals.

Reduction in the quality and availability of care outside of ‘normal’ working hours is a recurring feature of the complaints referred to the Ombudsman. The provision of clinical care to patients varies considerably across the NHS both between hospitals and between departments within the same hospital, and this disparity in the quality and efficiency of care as seen by our casework more generally is both surprising and puzzling.

Why are hospitals failing to maintain the quality of care they provide outside of ‘normal’ hours? We can see from the case studies outlined in this report that the same themes arise:

- inadequate consultant cover across seven days
- delays in medical review and lack of consultant review
- lack of senior supervision for junior medical staff
- junior nurses and doctors unaware of, or reluctant to use, escalation procedures to contact consultants or specialist services (e.g. haematology/stroke) for support
- failure to meet standards of care and follow nationally agreed guidelines
- poor communication between members of staff and between staff and patients or their families
- inadequate medical record keeping.

⁴ Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC, 2013

⁵ Delivering Safe Care, Compassionate Care, Welsh Government, August 2013

⁶ The Best Configuration of Hospital Services for Wales: A Review of the evidence, Professor Marcus Longley Welsh Institute for Health and Social Care, 2012



Analysis

Lack of consultant cover/review

A National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Report (2007)⁷ proposed several recommendations for emergency admissions including that the initial assessment of patients should include a doctor of sufficient experience and authority to implement a management plan, and that emergency admissions should be seen by a consultant within 12 hours. In 2012 a report '*Seven Day Consultant Present Care*'⁸ from the Academy of Medical Royal Colleges (AoMRC) made several recommendations including:

1. hospitals' inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week unless it has been determined this would not affect the patient's care pathway
2. consultant-supervised interventions and investigations along with reports should be provided seven days a week.

These recommendations have been reiterated by the RCP's Future Hospital Commission report in 2013⁹.

The case studies in this report demonstrate the need for timely reviews of patients, whether as an emergency admission or a current inpatient. Delays or failure to review ill patients often contributes to premature or avoidable death.

In **Mrs K's story**, the consultant who originally reviewed her then went on leave without apparently leaving any care plan or discharge instructions. He did not review her on his return, which led to Mrs K being incorrectly discharged by a junior doctor, whilst **Mr T** spent over 40 hours in hospital without a medical review.

Mr Y's story is another example of a lack of medical reviews over a weekend leading to a possible avoidable death.

Evidence of a consultant-led service and even of a consultant-delivered service out of hours and at weekends in the case studies in this report is at best patchy.

In **Mr P's** story in particular, the lack of senior physicians over the weekend plays a key factor. Despite the Health Board's claim that a consultant was available from 8am to 12pm and again from 4pm until 7pm, this is well below the national guidelines. A single consultant responsible for acute admissions across a hospital site is insufficient. Inpatients need the availability of seven days a week consultant-led review.

⁷ Emergency Admission: A journey in the right direction?, NCEPOD, 2007

⁸ http://www.aomrc.org.uk/index.php/doc_download/9532-seven-day-consultant-present-care

⁹ Future Hospital Commission, Royal College of Physicians, 2013



Analysis

The stories of **Mr P** and **Mr K** demonstrate that national guidelines for the management of stroke patients and consultant-led reviews are not being followed.

In **Mr P's** case the Health Board argued it was not possible to have 24 hour stroke specialist cover. Guidance does not stipulate that this is necessary, but it does advise that stroke patients must be admitted to a specialist stroke unit¹⁰. In 2007, the Welsh Government produced the *All Wales Stroke Guide*¹¹ following a critical audit report from the Royal College of Physicians stating that urgent attention was required, and it is incumbent on health boards to meet these standards.

Failure to recruit

The number of medical students qualifying for junior doctors jobs exceeds the available places, but each year there are always vacancies across the UK¹². In addition hospitals in Wales, particularly those operating in geographical, professional or academic isolation, have difficulty recruiting sufficient numbers of high quality senior doctors and there is a worrying over-reliance on locums and agency staff. Whilst England suffers a similar problem this may be a greater issue in Wales¹³, and this perhaps indicates that hospitals need to work more closely together with 'buddy' arrangements¹⁴. The Welsh Government is trying to tackle the problem of recruiting junior doctors by launching its 'Make Your Future Part of Our Future' campaign to attract doctors from across the border to undergo their training in Wales. Health Boards need to create attractive posts for junior doctors to encourage them to stay after their training at medical school is completed. Improved consultant supervision and greater team working may make making a career in Wales more attractive.

Cultural changes

A failure to escalate concerns about deteriorating patients to senior clinical decision makers characterises many of these cases, despite national guidance and local policies, and in disregard of well-established good practice. This problem is not easily explained. From many of the case studies it is evident that during weekends and out of hours, too often, junior doctors are left to run wards without adequate consultant supervision despite the GMC's guidance which states that '*trainees must be appropriately supervised according to their experience and competence (...) and must never be put in a situation where they are asked to*

¹⁰ National Institute of Health and Clinical Excellence Stroke Guidance, 2008

¹¹ All Wales Stroke Guide, Welsh Government, 2007

¹² Source: UK Foundation Programme Office

¹³ Rising to the Challenge: Improving acute care, meeting patients' needs in Wales, RCP, 2014

¹⁴ Pooling specialist workforce and facilities to increase standard of services available



Analysis

work beyond the limits of their competence without appropriate support.¹⁵ Even where consultant advice is available – either in person or via the telephone - there is often an apparent reluctance amongst both junior medical and nursing staff to escalate concerns and seek assistance from seniors. This suggests that a culture change is needed to create an effective consultant-led service.

Consultants are more likely to be contacted if present on the hospital premises, hence recommendations for consultants to be present and available in hospital 12 hours a day 7 days a week¹⁶. In 2005 NCEPOD reported delayed recognition of acutely unwell patients in hospital and inappropriate care leading to delayed referral to critical care as contributing factors to increased mortality and avoidable deaths¹⁷. As a result the Royal College of Physicians addressed this issue with a number of recommendations including improved access to senior physicians¹⁸.

Improved out of hours care

A more consistent service for inpatients is feasible, and has been demonstrated in a number of hospitals¹⁹. Whilst the exact figures regarding increased deaths at weekends are disputed there is evidence that the mortality rate is higher for ill patients admitted at weekends.²⁰

An emergency medical admission remains the responsibility of the admitting consultant clinician even after the post-take ward round and the possible transfer of the patient to another ward, until the patient's care is accepted by another consultant physician or surgeon. At weekends this becomes more complicated which is why carefully planned and documented handover policies and pathways are required.

A seven day working week for emergency medical and surgical admissions is accepted. However, this clinical supervision should not be confined to emergency admissions only, but should include inpatients. **Consistent seven day care requires a systems-wide approach with multi-disciplinary teams including diagnostics, pharmacists and both community and social care.**

The variation between hospitals' practice is both interesting and worrying. Even within a hospital the quality and efficiency of wards and departments can vary considerably often dependent on the leadership skills of individual senior nurses or consultants. This report has highlighted various failings that continue to be reported to the Ombudsman, with the importance of good record keeping and good communication repeatedly emphasised.

¹⁵ The Trainee Doctor, GMC, 2011

¹⁶ Seven Day Consultant Present Care, Academy of Medical Royal College, 2012

¹⁷ An Acute Problem?, NCEPOD, 2005

¹⁸ Acute Medical Care, RCP, 2007

¹⁹ Case study, page 10, Rising to the Challenge, RCP in Wales, 2014

²⁰ The Best Configuration of Hospital Services for Wales: A Review of the evidence, Professor Marcus Longley Welsh Institute for Health and Social Care, 2012



Future considerations

The case studies contained in this report highlight a number of key areas where patients have not received acceptable care out of hours.

It could be argued that the lack of consistent out of hours cover illustrates some of the wider problems faced by the NHS in Wales as outlined in a 2014 Nuffield Trust research report²¹ – pressure from an ageing population and continuing strain on resources, both human and financial.

This report also puts a human face on what the Longley Report describes as the ‘perfect storm’ of reducing availability and increasing demand of medical staff. European Working Time Directive and consultant contract changes, together with the decision by some doctors to not work full-time, have resulted in a shortage of available cover.

There are a number of areas which could be examined to improve out of hours care in our hospitals.

1. An independent systemic review

While our case studies have highlighted poor standards of out of hours care, it is not possible for this office to conduct a comprehensive systemic review, as the Ombudsman’s jurisdiction currently only permits him to look at complaints submitted to him by the public.

A wider independent review focussing on out of hours care would ensure that if there are any confirmed emerging patterns or inconsistencies in quality of care, they are recognised and addressed appropriately. A review could look at the areas outlined below.

2. Improved supervision of junior staff

In too many cases, the burden placed on junior staff is too great. There needs to be a cultural shift to encourage junior medical staff to escalate concerns to senior consultants, regardless of what time of day or day of the week it is.

There is also an argument for increased support for junior doctors. They should not solely shoulder the blame after being put in situations they are clearly not experienced enough to be in.

²¹ A decade of Austerity in Wales? The funding pressures facing the NHS in Wales, Nuffield Trust Research Report, Roberts, A. and Charlesworth, 2014



Future considerations

3. Prioritisation of inpatient care

Inpatient care for acute admissions requires increasing prioritisation. Completing a post-take ward round in itself is insufficient if subsequently there is a lack of continuity in clinical care and management. This becomes more important in relation to weekends and bank holidays.

Each medical and surgical ward should receive a consultant 'visit' seven days a week. Patients at risk of clinical deterioration, or who might be discharged, should be reviewed as a matter of urgency.

4. Improved handovers

Formal electronic handovers should be available for each inpatient before the weekend highlighting the individual patient's action plan.

The cases in this report have highlighted gross inconsistencies in handover quality and moving to a universal electronic system would help address that. At the heart of this is the issue of good communication and leadership. The handover should include at the very least:

Who is responsible for each patient?

What plan has been put in place while they are under care?

Who is in charge of seeing that care plan is implemented?

When is the next review and whose responsibility is it to implement?

While these may seem like basic fundamental questions, the Ombudsman's caseload shows that in some instances leadership is lacking and clinical guidance is not being followed, leaving these questions unanswered.

“ Patients at risk of clinical deterioration, or who might be discharged should be reviewed as a matter of urgency. ”



Case studies

Mr T's story

Clinical presentation

Mr T had a history of motor neurone disease (MND) and Pick's disease (a type of dementia). He attended the Emergency Department at his local hospital on Thursday 4 August 2011 following a fall at home. He was subsequently transferred to a medical ward in the early hours of the following morning. A consultant physician reviewed him that Friday morning, and there was a further assessment by a speech and language therapist (SALT) later on that afternoon. It was considered Mr T was at risk of drawing food into his lungs due to an inability to swallow correctly and therefore should be nil by mouth. The SALT indicated that feeding should be via a nasogastric tube (NGT). The medical registrar recorded the SALT assessment and advice in the patient's medical records the same Friday afternoon. However, there was no attempt to insert a NGT until Sunday 7th August.

The initial attempt failed, but following discussion with Mr T and his family a further, successful attempt was made at approximately 5.00pm on the Sunday. At 08.25am on 8 August, 72 hours after the previous consultant review, a consultant physician considered that Mr T had pneumonia in his right lung possibly as a result of aspiration. The SALT and dietician reviewed Mr T later the same day. Following a discussion with Mr T's family a 'do not attempt resuscitation' (DNAR) decision was made. In the early hours of the morning of Tuesday 9 August Mr T further deteriorated, and he sadly died later that morning.

The investigation

The Ombudsman found that it was entirely unacceptable that an elderly, nutritionally deficient patient had to wait more than 40 hours over a weekend until an attempt was made to insert a NGT in order to provide him with appropriate nutrition. The Ombudsman also had concerns about the lack of any medical review during a 40 hour period and upheld this part of the complaint. The medical adviser concluded that had the medical team reviewed the patient during this 40 hour period it would have, at least, brought the lack of NG feeding to the attention of medical and nursing staff.

The Ombudsman's recommendations

The Ombudsman recommended that the Health Board provide a fulsome apology to Mr T's family and pay financial redress for the distress and worry Mr T's family experienced while he was in hospital over the weekend of 5-7 August 2011. The Ombudsman



Case studies

issued a number of recommendations to the Health Board, including reviewing its guidance on timescales for the insertion of NGTs, and carrying out an audit of its performance. The Ombudsman noted that there were recommendations he issued in a previous report regarding the lack of medical review. Since the Health Board had recently agreed to take forward these actions, no further recommendation was given.

References

- 1) Royal College of Physicians, 2007, *Acute Medical Care*
- 2) Royal College of Physicians, 2013, *Future hospitals: Caring for medical patients*
- 3) NICE CG32, 2006 – *Nutritional support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition*

Mr M's Story

Clinical presentation

Following referral from his GP in the early hours of Friday 29 October 2010, Mr M was admitted to hospital suffering with diarrhoea, vomiting and abdominal pain. He was admitted to the Medical Assessment Unit (MAU) under the care of physicians where he remained for the duration of his admission. On review by a consultant physician, gastroenteritis or peritonitis was suspected and a surgical opinion was requested, which was provided by a junior doctor at 9.30am. Gastroenteritis was diagnosed and the patient remained under the care of the medical team. In the afternoon, concerns were raised with the surgical team about the patient's increasingly distended abdomen. An X-ray was carried out which showed a markedly dilated large intestine with signs of colitis.²² The patient was dehydrated and inflammatory markers were very high.

A surgical registrar reviewed Mr M at 5.00pm and advised that he continue with the current treatment plan but did not comment on his X-ray or blood tests. It is unclear if the consultant physician was still in the hospital at this time. Later Mr M's abdominal pain worsened and a medical registrar reviewed the patient at 1.00am. On Saturday there was no improvement in his condition but there was no medical or surgical review. Mr M's urine output was reduced on the Sunday morning when a consultant surgeon diagnosed severe infection and shock and requested an abdominal CT scan, which identified fulminant colitis.²³ A referral to the critical care team led to acceptance for admission to the Intense Trauma Unit (ITU), but Mr M died before transfer to the ITU could be arranged.

²²Inflammation of the lining of the colon

²³A severe form of ulcerative colitis which usually requires urgent surgery



Case studies

The investigation

Our investigation concluded that if a consultant surgeon review had taken place on the day he was admitted to hospital, emergency surgery would have been carried out and Mr M's death could have been prevented. There was a lack of consultant-led, and certainly no evidence of a consultant-delivered, service. Acutely ill patients on the MAU should receive consultant physician reviews at least daily. There was no effective referral (consultant to consultant) to the surgical team before or during the weekend and communication between the surgical and medical teams was poor. Similarly communication with the patient's family was inadequate, bordering on non-existent, such that Mr M's relatives were only aware of the seriousness of his condition when sadly it was too late.

The Ombudsman's recommendations

We asked the Health Board to apologise to Mr M's family particularly regarding the failure to carry out an urgent operation, and offer the family redress in light of their continuing distress due to the uncertainty about whether the sad outcome of Mr M's death could have been avoided. A review of weekend working practices was advised in addition to consultant availability at weekends, to ensure patients' clinical needs are met at all times. The Health Board was also asked to undertake a review of Mr M's case to establish why there was such a lack of senior consultant care and what would be done to ensure this did not happen again. Further recommendations included establishing an effective referral system between the medical and surgical teams, and providing training to staff on effective communication with both patients and their families, and between hospital teams. Training on the importance of good record keeping was also advised.

References

- 1) Acute Medical Care, Royal College of Physicians, 2007
- 2) NICE CG 50, 2007 - Acutely ill patients in hospital / Recognition of, and responses, to acute illness in adults in hospital
- 3) Good Medical Practice, GMC, 2006, Supervising juniors / Referring a patient to another practitioner



Case studies

Mr Y's Story

Clinical background

Mr Y was admitted to hospital on Friday 21 September 2012 following a referral by his GP. His symptoms included confusion, vomiting and abdominal pain, with an unexplained rash. He had underlying ischaemic heart disease, hypertension (high blood pressure) and had recently been diagnosed with diabetes. In addition Mr Y had liver cirrhosis with portal hypertension.

An initial clinical assessment diagnosed sepsis, and antibiotics were administered in response. Septicaemia was later confirmed with positive blood cultures for staphylococcus aureus.

On Friday 5 October Mr Y was diagnosed with discitis²⁴ and he was prescribed six weeks of antibiotic therapy and bed rest. Throughout his hospital admission, Mr Y showed symptoms of dehydration which were not addressed and despite repeatedly vomiting from 10 October onwards there was an occasion when he was not provided with a suitable receptacle, instead he was given a black bin liner. Mr Y was also found to be shivering from the cold because there was a shortage of hospital blankets and he had to sleep under his sister's coat in order to keep warm.

Mr Y's blood test results dated 15 October indicated that he had impaired kidney function. However, these results were not checked until 17 October, and not repeated until Monday 23 October. The responsible doctor said that he was not aware of the decline in Mr Y's kidney function until he received the blood test results on 23 October. Mr Y was subsequently transferred to the HDU (High Dependency Unit) for treatment and then to the ITU (Intensive Therapy Unit) at a different hospital five days later. Mr Y remained on the ITU until he sadly died on 9 November. According to Mr Y's sister she fully expected him to return home as he appeared to be getting better and *'it was a shock when he deteriorated so quickly and died'*.

The investigation

As a result of a lack of weekend reviews Mr Y's clinical journey was seriously delayed. Due to several missed opportunities to diagnose renal impairment between 15 and 22 October as well as the lack of weekend cover, Mr Y's severe acute kidney failure was not identified until 23 October. There were repeated failures to maintain Mr Y's hydration levels, which contributed to the severity of his renal failure, and there was also a failure to provide a reasonable standard of nursing care while he was on the ward. During the investigation the consultant physician commented *"In my view*

²⁴Infection in a disc between vertebrae in the spine



Case studies

Mr Y had appeared to have deteriorated over the weekend period and into the Monday. I have studied that period of time in more detail to see if there was anything that I believe could have been done different. I do not recall whether any junior doctors were called during that weekend period. Unfortunately during the weekend there is a shortage of doctors at the Hospital, this is an issue for all hospitals, and as a result patients do tend to deteriorate over the weekend period”.

The Ombudsman’s recommendations

The Ombudsman recommended that the Health Board apologise to Mr Y’s family and offer them redress for the failings identified and the trouble of complaining to the Ombudsman. It was also recommended that hospital staff be reminded of the importance of good record keeping and fully documented reviews and assessments, as well as to provide them with training on dehydration and fluid balance monitoring. Finally it was recommended that the Health Board consider weekend working arrangements for consultants, and how this can impact on patient care.

References

- 1) Acute Kidney Injury (AKI) Study – Adding insult to injury, NCEPOD, 2009
- 2) Acute Medical Care, Royal College of Physicians, 2007
- 3) Future hospital – Caring for medical patients, Royal College of Physicians, 2013

“ Unfortunately during the weekend there is a shortage of doctors at the Hospital ”



Case studies

Mr P's Story

Clinical presentation

Mr P was 77 years old when he was referred by his GP and admitted to hospital on Friday 23 March 2012 with a suspected stroke manifested by a left facial droop and weakness of his left arm. The GP did not administer aspirin due to Mr P's low platelet count. He was at the time under the care of Haematology with ITP²⁵.

The duty physician on the Admission Unit requested a CT scan at 2.40pm (a working diagnosis of a stroke was made as the scan lacked clarity on any acute bleed), but did not then further review the patient who was admitted to a hospital ward at 9.50pm. Mr P was not transferred to a specialist stroke ward within the hospital, or transferred to the Acute Stroke Unit at a neighbouring hospital. Initially this was due to a lack of beds; however there were opportunities over the weekend when appropriate beds did become available but these opportunities were missed, most likely because of limited staffing levels at the weekend. Over the course of this weekend (23 March – 25 March) Mr P was assessed on the ward by two trainee doctors, but not by a Consultant until Monday 26 March.

Despite repeated requests from Mr P's family for him to see both a haematologist (for his blood disorder ITP) and a stroke physician for specialist advice, they were told 'they are not available at the weekend'. A specialist stroke physician eventually reviewed Mr P on Tuesday afternoon, five days after his original hospital admission, and he was finally transferred to the stroke ward.

The investigation

Acute medical patients should be reviewed by a Consultant within 24 hours of admission as recommended by guidance from the Royal College of Physicians, but this did not happen for Mr P. Medical staff cover over the weekend was predominantly junior grade, and it would appear that the junior doctors were unaware of the availability of, or unwilling to contact, on-call consultants. However, limited therapeutic options were available and therefore the lack of input from relevant consultant medical staff did not necessarily contribute to Mr P's decline.

Following professional advice, the Ombudsman found that haematology advice should have been sought much earlier, particularly as the medication Mr P was taking for his blood disorder is restricted by NICE guidelines for use only by a haematologist and Mr P had suffered a possible bleed (the stroke)

²⁵ Immune thrombocytopenia is a blood disorder characterised by an increased destruction of platelets



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whilst taking it. A haematology service should be available at weekends for advice. Additionally, a specialist stroke Consultant should have been available to offer advice on any management of Mr P. Evidence suggested that acute stroke patients benefit greatly from being under the care of a specialist in the first 72 hours after a stroke. Although the Health Board claimed Consultants were available, junior doctors were not aware of this. In addition to these failings, there were further issues in relation to communication with the family involving both the lack of information provided and the manner in which one doctor spoke to the family. The Health Board was also criticised for the length of time it took to respond to the complaint from Mr P's family (eight months).

The Ombudsman's recommendations

The Ombudsman asked the Health Board to apologise to Mr P's family for the identified failings. The Health Board was also asked to remind senior clinicians of the requirement to assess acutely ill patients within 24 hours, including on weekends. Junior doctors should be made aware of escalation procedures to seek advice from appropriate specialist consultants, and be able to request attendance and review by consultant clinicians. The Health Board has indicated there are insufficient specialist stroke physicians to provide 24 hour care at the hospital and it was hoping to introduce a seven day working week for stroke specialist nurses to improve the care available for stroke patients at weekends.

References

- 1) NICE CG 68, *Stroke*, July 2008
- 2) NICE CG 50, 2007 – Acute illness in adults in hospital: recognising and responding to deterioration
- 3) Acute Medical Care, Royal College of Physicians, 2007
- 4) Welsh Government 'Circulars' 2007 No 058 & 082 and the resulting "All Wales Stroke Services Improvement Collaborative- How to Guide – Improving the Reliability of Acute Stroke Care"
- 5) National Framework for Older People, Welsh Government, 2007

“ Although the Health Board claimed Consultants were available, junior doctors were not aware of this. ”



Case studies

Mr F's story

Clinical presentation

On Thursday 29 September 2012, Mr F was admitted to the hospital emergency admissions unit (EAU) following a 10 day period of diarrhoea and vomiting. A junior doctor diagnosed gastroenteritis with associated dehydration and complicating impaired kidney function (AKI), and the duty consultant physician later confirmed this assessment. Four litres of intravenous fluids were due to be administered over 24 hours, but this plan was not completed. The next day (Friday) another junior doctor documented the patient could be discharged once he had stopped vomiting. However, over the course of Saturday Mr F's condition deteriorated rapidly. His MEWS²⁶ score, which had been recorded as being surprisingly low, increased but he suffered a respiratory arrest at 8.30am on Sunday morning. He was initially resuscitated, but suffered a further 'arrest' and sadly died.

The investigation

The Ombudsman upheld aspects of the family's complaint regarding the hospital staff failing to adequately rehydrate Mr F, or identify and respond appropriately to his acute kidney failure, which developed during his brief hospital admission. He found that doctors failed to monitor Mr F adequately, or to ensure his care plan was appropriately communicated during staff handovers. His intravenous fluid rehydration was discontinued overnight without explanation. He did not receive preventive treatment for the risk of deep vein thrombosis and complicating pulmonary thrombosis, which was the suggested explanation for the patient's respiratory arrest.

Overall the nursing care Mr F received during his admission was substandard. There was no further consultant physician review after Thursday evening and therefore a concerning lack of senior clinician input and consultant review, which was unacceptable. The Ombudsman could not be sure that if Mr F was provided with adequate care his untimely death could have been avoided. However, had his care been of an acceptable standard his family might not have suffered the distress and uncertainty of wondering whether the outcome would have been different.

²⁶MEWS: Modified Early Warning System
- Designed to give health professionals an indication of the severity of a patient's condition. As a patient's condition deteriorates, the MEWS score increases.



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The Ombudsman's recommendations

As in Mr F's case above, the Health Board was asked to apologise for the serious failings in Mr F's clinical care, and conduct an urgent review of the EAU, focussing on the ratio of senior to junior physicians and the level of senior medical review available at weekends and bank holidays. In addition, the Health Board should ensure that junior doctors on the EAU are sufficiently competent in diagnosing and treating, amongst other things, dehydration and renal/kidney failure. Nursing staff should be provided with training on the monitoring of patients with clinical deterioration. The Health Board agreed to implement these recommendations and in September 2014 informed the Ombudsman that various new working practices were being trialled to ensure there was always weekend consultant cover. However to date, no progress has been made.

References

- 1) AKI (Acute Kidney Injury) Study, NCEPOD, – Adding insult to injury, 2009
- 2) Future Hospital: Caring for medical patients, Royal College of Physicians, 2013

Mrs Y's Story

Clinical presentation

Mrs Y aged 67 years was admitted to the Emergency Department in her local hospital on 1 June 2011 complaining of increased breathlessness, and promptly transferred to the CDU (clinical decisions unit). The initial diagnosis was chest infection with underlying chronic obstructive pulmonary disease. She received antibiotics, steroids, nebulizers and oxygen, and it is reported that she responded to this treatment.

On Friday 3 June Mrs Y was transferred to a medical ward. On Monday morning her blood pressure was so low it could not be measured. Her antibiotics were adjusted and intravenous fluids administered. Her condition had deteriorated at some time over the weekend of 4 and 5 June, however it was not possible to determine exactly when because there were no medical reviews, and no documentation by medical staff throughout the course of the weekend. On Monday Mrs Y did not respond to escalated medical intervention. Her condition continued to deteriorate and she sadly died on 10 June 2011.



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The investigation

The Ombudsman's adviser found that Mrs Y had 'collapsed' at some time over the weekend, possibly as late as Sunday evening, but this could not be verified. The Patient at Risk scores²⁷ had been deteriorating over the weekend. On Monday morning Mrs Y was unwell and her blood pressure was unreadable. She was sufficiently ill that morning to require a substantial quantity of fluids rapidly, and a change in antibiotics to cover aspiration pneumonia. The adviser stated that in view of the above there was a probability that Mrs Y had been detrimentally affected by the lack of a weekend medical review. However, because of a complete lack of documentation, he said that he could not be certain whether the lack of a medical review (and therefore possible medical intervention) over the weekend was likely to have detrimentally affected Mrs Y. The Ombudsman could not conclude whether the failure to medically review Mrs Y over the weekend was likely to have caused her any detriment or to have been clinically significant. However, the uncertainty whether a medical review over the weekend in question might have made a difference to Mrs Y's condition was an injustice in itself, and the Ombudsman upheld the complaint.

The Ombudsman's recommendations

The Health Board had already apologised to Mrs Y's daughter for failing to follow the escalation process over the weekend and had taken appropriate steps to address this failing. The Ombudsman also recommended the Health Board make a financial redress payment to Mrs Y's daughter to reflect the distress caused by the uncertainty as to whether the lack of a medical review over the weekend in question might have detrimentally affected her mother. The Health Board agreed to the recommendation.

References

- 1) **Acute Medical Care, The right person, in the right setting – first time, Royal College of Physicians, 2007**

²⁷Patient at Risk Score: designed to enable health care professionals to recognise "at risk" patients and to trigger early referral to medical staff, so that early intervention can help to prevent deterioration.



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Mrs X's story

Clinical presentation

Mrs X, aged 74 years, was admitted to hospital on Monday 30 April 2012 complaining of a persistent cough and breathlessness. Her GP had diagnosed a chest infection, but she had not responded to antibiotics. She was receiving nutrition, albeit not exclusively, through a PEG tube (per-cutaneous enteric gastrostomy) due to swallowing problems.

She had previously suffered a debilitating stroke following a surgical operation in 2000. The duty consultant physician suspected inhalation of food or fluid into her lung causing aspiration pneumonia, and produced a care plan. Initial blood tests included high blood sodium (168 - normal 135-145mmol/l) and urea (10.8 – normal 2.5 to 7.1 mmol/l) levels indicating dehydration. Mrs X was moved from the Medical Assessment Unit to a medical ward under the care of a different consultant physician.

Mrs X's condition was reported the next day to have improved, and consideration was made for her discharge the following Friday. However, on Friday 4 May her blood glucose level was markedly elevated at 27.8 (normal 4.0-6.0mmol/l), and her blood sodium level was dangerously high at 171. However, on this same day a second consultant physician did not comment on the high blood sodium and glucose levels, and prescribed an additional medication for her elevated blood pressure. According to the Health Board, the patient's condition began to deteriorate on the Friday but there was no weekend action plan implemented or even documented.

The following day Mrs X was noted to have sluggish reactions and slurred speech. Her sodium measured 172mmol/l. The next day (Sunday) at 10.45pm a junior doctor suggested she had an infection and prescribed intravenous fluids although her inflammatory marker (CRP) was only slightly elevated. The doctor documented 'quite likely to have infection' and experiencing 'profound hypernatraemia (high sodium) and hyperglycaemic (high blood glucose) polyuria (increased urine output) for six days'. On Monday 7 May a doctor reported the previous day's chest x-ray was normal, and later a further chest x-ray was requested. The following day a consultant physician considered either hospital-acquired pneumonia or left ventricular (heart) failure. Mrs X failed to improve and her condition further deteriorated and she sadly died on Wednesday 9 May. An investigation by the Health Board commented that patients



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do not usually die from high blood glucose levels, and which consultant was on duty over the bank holiday was not an issue. It was implied that junior doctors on duty at the weekend were at fault.

The investigation

The Ombudsman found that the standard of medical review and supervision during Mrs X's admission, and in particular over the bank holiday weekend was poor, infrequent and lacking in coherence. There was no consultant physician review over the bank holiday weekend including 5, 6 and 7 May. The absence of middle-grade or consultant (competent clinical decision makers) supervision resulted in a failure to adequately manage the patient's elevated blood sugar levels, a failure to adequately respond to and manage Mrs X's dehydrated condition and a failure to formulate and then implement a weekend care plan. Such high sodium levels will cause confusion, drowsiness and deteriorating health. Fluid charts were inadequate and incomplete.

The Ombudsman, guided by his adviser, concluded that the poor quality of care was unlikely to have been a causal factor in Mrs X's deterioration and her subsequent death. However the absence of senior clinical supervision, and cover, resulted in a flawed standard of care and that this, in turn, left Mrs X's family with an element of doubt about the nature of the impact of these findings on Mrs X's sad outcome. The distress and uncertainty arising from this element of doubt was an injustice, and had Mrs X's care been of a higher standard, could have very well been avoided.

The Ombudsman's recommendations

The Ombudsman recommended the Health Board make a payment to Mrs X's daughter in recognition of the failings, and the distress caused to the family in pursuing a complaint at a time of bereavement. The Health Board agreed to provide a fulsome apology to Mrs X's daughter recognising its failings, and to conduct an urgent review of how medical cover could be assured over weekends and bank holidays.

References

- 1) Good Medical Practice, GMC, 2006

“ the absence of senior clinical supervision and cover resulted in a flawed standard of care ”



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Mrs K's story

Clinical presentation

Mrs K was admitted to hospital through the Emergency Department (ED) following a fall at home on Sunday 12 January 2014, where she was found to have a bruised, swollen leg. She was transferred to a second hospital the next day. A first consultant review occurred on 14 January, and antibiotics were prescribed. There was no evidence of a further review by the consultant who was on leave from 16 to 24 January, and a specialist registrar discharged the patient on 27 January. The discharge letter did not mention the patient's swollen leg and no follow-up was arranged.

The following day (28 January), Mrs K's GP arranged her readmission because of her badly swollen and inflamed leg, which was 7cm in circumference larger than the other calf. The GP questioned DVT (deep vein thrombosis). The patient was acutely unwell and the leg was red and swollen. A second consultant physician review the morning after her readmission also questioned a DVT and prescribed antibiotics and pain relief. An ultrasound confirmed extensive thrombosis of the proximal leg veins extending into the pelvis (iliac veins). The patient was discharged later the same day with warfarin and low molecular weight heparin. The decision to discharge was not discussed with the responsible consultant.

Four days later Mrs K was re-admitted as her condition had deteriorated, and she was again transferred to the same hospital where over the next two days she was reviewed by a third consultant physician who attributed her deterioration to one of three possible causes: DVT leading to a pulmonary embolus, sepsis and intra-abdominal bleeding. A DNAR (do not attempt resuscitation) decision was made. Later on the second day of her third admission, Mrs K suffered a cardiac arrest and sadly died. No autopsy to establish the cause of death took place.

The Health Board asked the first consultant to provide a response to the complainant on their behalf. This response claimed there was no link between the DVT and the patient's final illness.

The investigation

The Ombudsman's clinical adviser found that the patient was not further physically examined after her transfer from ED during the first admission, and the unequal size of her legs was not commented upon again. The patient had extensive thrombosis (clot) within the large thigh veins of her leg with a significantly



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increased risk of embolisation²⁸. The quality of documentation was inadequate. The patient was not medically safe to be discharged on either occasion. The Health Board's response was considered inaccurate and not supported by the available information in the medical records. The response relied entirely on input from the consultant who had responsibility for the matters subject to the complaint, without verification, which may have contributed to its inaccuracy.

The Ombudsman's recommendations

Recommendations were made to the Health Board including an apology and financial redress. The first consultant was requested to reflect on his statement. The Ombudsman recommended that the Health Board should review its processes for investigating complaints and audit failed discharges.

Additionally, it was recommended that the HB should review the instigation of anticoagulation in the presence of unexplained iron deficiency anaemia, which should require careful consideration.

References

- 1) Good Medical Practice, GMC, 2006

Mr K's story

Clinical background

On the evening of 24 November 2011, after collapsing at home, Mr K was admitted to hospital where he was found to have suffered a stroke. He was assessed by a dietician and a speech and language therapist (SALT), and given intravenous fluids. He needed to be fed via a nasogastric tube (NG) because he was unable to swallow properly. The NG was inserted the following day which according to his records was with Mr K's consent, but he was seen pulling at the NG during the early hours of the following morning, and so a mitt was applied to Mr K's right hand.

Mr K deteriorated over the next few days but there was no consultant review over the weekend. Mr K was finally seen by a consultant physician on Monday 28 November, four days after his admission. Mr K's GCS score²⁹ was low but his condition appeared to improve and he became more alert. He was seen by the consultant again on 8 December who noted that he was stable. Another review by the SALT the next day noted that Mr K had limited levels of alertness and that he should continue to be fed via the NG tube.

²⁸The clot breaking loose and travelling to the lung causing an embolism

²⁹Glasgow Coma Scale – objective measurement (out of 15) of the state of consciousness and responsiveness of a person who has suffered a trauma.



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A few days later Mr K pulled out the NG tube on two occasions having removed the restraining mitt from his hand. On 5 January Mr K was spoken to about the possibility of inserting a PEG tube and to decide whether he was able to understand and consent to the procedure. It was recorded that he 'categorically agreed' to having the PEG inserted and was considered to have the capacity to make this decision. Mr K's daughter questioned this as in conversations she had with her father later that day he seemed confused. An MCA (Mental Capacity Act 2005) assessment was finally conducted on Mr K on 25 January and he was considered to have capacity. In early February Mr K spoke to a different consultant, expressing his wishes to not have the NG tube reinserted again, and that he understood this would likely result in him dying, which was what he wanted. He was discharged home and sadly died a couple of weeks later.

The investigation

This case raised a number of ethical and legal issues regarding the treatment of patients whose capacity to give treatment consent is poor or absent, and the importance of formal documented mental capacity assessments. The Ombudsman sought advice from his medical adviser, who expressed concerns over the lack of weekend medical review, particularly on 26/27 November shortly after Mr K was admitted. There were also concerns with the level of consultant input throughout his admission, which seemed weekly at best. In a consultant-led and consultant-delivered service it is expected there would be a minimum of two consultant reviews each week, if not daily as is increasingly recommended.

More recently the RCP has recommended daily consultant review of all medical wards including those inpatients who would gain benefit. Communication between the responsible consultant and the patient's family was inadequate. The investigation found that consultant and weekend cover at the hospital did not meet professional guidance.

The Ombudsman's recommendations

As well as apologise to Mr K's family, the Ombudsman recommended that the Health Board consider whether additional training for staff on the Mental Capacity Act, restraint and consent was required. He also recommended that the Health Board review its current level of consultant supervision for the stroke service and weekend medical cover to ensure that patient care is not



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compromised outside of normal hours. The Health Board agreed to implement the recommendations, and in addition acknowledged that its Stroke Service at the hospital was not meeting RCP guidelines in terms of consultant cover, but it was working towards achieving the required standard.

References

- 1) NICE CG 68, Stroke, July 2008
- 2) RCP and NICE, 2007

Mrs D's story

Clinical presentation

Mrs D was 86 years old with a history of osteoarthritis, osteoporosis, diabetes and atrial fibrillation (irregular heart rate) for which she was receiving warfarin anticoagulation. She was admitted to hospital on Saturday 24 March 2012 with diarrhoea and vomiting. Mrs D's recovery was satisfactory and she was due to be discharged home on 5 April. However, at 5.00pm the day before her discharge Mrs D suffered a stroke, but, despite repeated requests from her son, was not seen by a doctor for over six hours.

When the doctor reviewed Mrs D at 11.20pm, he considered the patient had suffered a minor (cerebellar) stroke, and planned a CT scan for the next morning. Approximately 12 hours later a second medical review took place at which time Mrs D had severe right-sided weakness and an urgent CT scan was arranged which showed that Mrs D had suffered a more severe stroke overnight with a large left cerebral infarct (ischaemic stroke). However, Mrs D was not transferred to the stroke unit until eight days later where she remained for almost a year before being discharged to a nursing home. Her recovery was sadly very limited due to the severity of the stroke along with her other medical conditions.

The investigation

The Ombudsman was assisted during this investigation by three specialist advisers including a nurse with stroke experience, a consultant in health care of the elderly and a specialist stroke consultant. Despite the Health Board's claim that Mrs D had suffered a TIA (transient ischaemic attack), the Ombudsman's stroke adviser confirmed that Mrs D had in fact suffered a mini stroke and should have been admitted directly to the Acute Stroke Unit where her chances of staying independent would have been significantly improved. However there was a nine day delay before she received



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specialist care. The investigation found that the Health Board did not have an adequate stroke care protocol, and clinical decisions were left to junior grade doctors both in and out of hours.

The Ombudsman's recommendations

The Ombudsman recommended that the Health Board apologise to Mrs D's family and offer them a redress amount. The Health Board also agreed to ensure that staff training on stroke management was up to date as well as implement a stroke recognition tool such as NIHSS.³⁰ It also agreed to review its processes for identifying and treating acute stroke patients including ensuring any patient suspected of suffering a stroke is immediately assessed by a suitably trained physician; that all stroke patients undergo CT scanning within a maximum of one hour; all stroke patients should be immediately assessed for admission to a specialist stroke unit and all suspected stroke patients should undergo a swallowing screening test within four hours.

References

- 1) NICE CG 68, Stroke Rapid recognition and diagnosis of symptoms followed by specialist care

Mrs L's Story

Clinical presentation

Mrs L was admitted to hospital on Thursday 2 December 2010 with extensive cellulitis of her right leg extending to her groin, and antibiotics were prescribed for sepsis. At 03.30am the next morning a specialist registrar reviewed Mrs L and recommended an orthopaedic review. A Do Not Attempt Resuscitation (DNAR) decision was agreed by telephone with the on-call consultant due to Mrs L's poor clinical condition and it was agreed she would receive palliative care on the ward. Her family were to be updated if her condition deteriorated.

A review by a second specialist registrar later that morning found Mrs L had a 'leaky' heart valve. Mrs L was put on a plan of IV fluids every 4-6 hours and she was put under the care of a consultant. However, Mrs L was not reviewed by the senior doctor until 11.30pm that night, over 24 hours after her original admission, apparently because at the time she was transferred to the ward he had already completed his ward rounds and was on his way to another hospital. Despite the consultant finding Mrs L 'comfortable', her condition

³⁰National Institute of Health Stroke Scale



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remained unstable, and progressively deteriorated over the next couple of days until sadly she died in the early hours of the morning of Tuesday 7 December.

The investigation

The Ombudsman's investigation acknowledged the fact that if the care offered to Mrs L had been different the outcome was unlikely to have been changed. However, the case did highlight issues around the lack of consultant-led supervision, which meant there was disjointed care with no weekend care plan arranged. As part of the Health Board's investigation, the consultant physician reviewed Mrs L's care and confirmed that this was a typical example of many cases where multiple junior doctors, shift changes and ward transfers necessitated complex handovers, which as a result leaves patients and their families unsure of which consultant is in charge of their care. A decision was made not to resuscitate Mrs L due to her poor health. The Ombudsman's investigation concluded that whilst the decision to not resuscitate Mrs L was reasonable, he was critical that there was no record that this was discussed with Mrs L. Although it was discussed with Mrs L's son the timing was not documented.

The Ombudsman's recommendations

The Ombudsman recommended an apology was made to Mrs L's son. He also recommended that clinicians should be reminded of the RCP Acute Medical Care guidelines which state that consultant-led post-take ward rounds for emergency medical admissions should take place within 12 hours of a patient's admission. Communication with patients and their relatives should be improved and recorded properly, and any DNAR decisions should be first reviewed by and then communicated to families by the consultant, and not a junior doctor.

References

- 1) Royal College of Physicians, 2007
Acute Medical Care – 12 hourly ward rounds for acute medical admissions
- 2) Decisions related to cardiopulmonary resuscitation, British Medical Association Resuscitation Council/Royal College of Nursing, October 2007



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Mrs C's story

Clinical presentation

Mrs C had epilepsy and type-2 diabetes. She was admitted to hospital on Thursday 12 July 2012 for elective knee surgery the following day, but was not placed on the elective surgery ward because she had tested positive for MRSA, and instead was admitted to the trauma ward. However Mrs C's operation was cancelled on the Friday due to a trauma case requiring priority. The patient remained nil-by-mouth over the weekend, from 14 to 16 July due to the possibility of a re-arranged operation, but the operation did not take place.

The Health Board apologised for the patient's unnecessary stay in hospital over the weekend. The nurses had thought she could have the operation during the weekend, but the consultant surgeon was not on duty and had gone home.

The investigation

The investigation found the consultant surgeon was not on duty over the weekend so there was no possibility of Mrs C's surgery taking place once it had been cancelled on the Friday. However due to a breakdown in communication which meant no clear plan was left by surgical staff that Mrs C could be discharged, along with a misapprehension that Mrs C was a trauma patient and not an elective surgery patient, nursing staff believed there was a possibility that the operation would go ahead and that Mrs C should remain in hospital until then.

The Ombudsman's recommendations

The Health Board had already apologised to Mrs C for the poor communication and unnecessary stay in hospital, and yet the Ombudsman considered Mrs C's injustice to be unremedied and therefore recommended a redress payment to be paid to Mrs C for the inconvenience of being kept in hospital over the weekend.

References

- 1) Good Medical Practice, GMC, 2006



References

A decade of Austerity in Wales? The funding pressures facing the NHS in Wales, Nuffield Trust Research Report, Roberts, A. and Charlesworth, A, 2014

Acute Medical Care, Royal College of Physicians, 2007

Acutely ill patients in hospital, National Institute for Health and Clinical Excellence, NICE CG 50, July 2007

- Recognition of and response to acute illness in adults in hospital
- Physiological track and trigger warning systems (M/NEWS scores) should be widely used within acute hospitals in the NHS to identify patients on general wards at risk of clinical deterioration and the need for escalation of care.
- Clearly defined contact pathways for named senior clinical opinions. Patients need access to acute medical care throughout the 24 hours period and not just in traditional office hours.

AKI Study (Acute kidney injury) – Adding insult to injury, National Confidential Enquiry into Patient Outcome and Death 2009

- Good clinical assessment is the bedrock of competent and focussed clinical practice and should be a uniform skill amongst clinicians

All Wales Stroke Services Improvement Collaborative- How to Guide – Improving the Reliability of Acute Stroke Care”, Welsh Government Circulars 2007 No 058 & 082

Berwick report, August 2013

- ‘Patient safety should be the ever-present concern of every person working in or affecting NHS-funded care. The quality of patient care should come before all other considerations in leadership and conduct of the NHS, and patient safety is the keystone dimension of quality.’
- Transparency must be complete, timely and unequivocal.
- Complaints systems need to be continuously reviewed and improved.

British Medical Journal, BMJ, September 2015

Increased mortality associated with weekend hospital admission: a case for expanded seven days services?



References

Decisions relating to Cardiopulmonary Resuscitation (3rd edition), British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing, 2014

Delivering Safe Care, Compassionate Care: Learning for Wales from the Report of Mid Staffordshire NHS Foundation Trust Public Inquiry, Welsh Government, July 2013

Emergency admissions: A journey in the right direction? National Confidential Enquiry into Patient Outcome and Death, 2007

- Patients should be seen by a consultant within 12 hours of admission and this must be clearly and recognisably documented in the medical notes.
- Access to conventional radiology and CT scanning 24 hours a day, with immediate reporting.
- Excessive transfers should be avoided, since may be detrimental to patient care.
- Robust systems need to be in place for handover of patients between clinical teams with readily identifiable and agreed protocol-based handover procedures.

Future Hospitals Commission, Royal College of Physicians, 2013
General medical record keeping standards, Royal College of Physicians, 2015

Good Medical Practice for Physicians, Royal College of Physicians, 2004

Providing a good standard and practice of care

The physician's first responsibility must be to the patient and their safety. At the heart of a physician's practice is the consultation. The patient's history must be carefully elicited and recorded, physical examination and investigations must be thorough, but appropriate, therapy prompt and suitable.

Good medical practice: Providing good clinical care, General Medical Council, 2006

Good clinical care must include:

- a) Adequately assessing the patients' conditions, taking account of the history (including the symptoms, and psychological and social factors), the patients' views, and where necessary examining the patient.



References

- b) Providing or arranging advice, investigations or treatment where necessary.
- c) Referring a patient to another practitioner, when this is in the patient's best interest.

Domain 2: safety and quality

Respond to risks to safety

25. You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.

- a) If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.
- b) If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.

Domain 3: communication, partnership and teamwork

Teaching, training, supporting and assessing

40. You must make sure that all staff you manage have appropriate supervision.

Domain 4: maintaining trust

Treating patients and colleagues fairly and without discrimination

56. You must give priority to patients on the basis of their clinical need if these decisions are within your power. If inadequate resources, policies or systems prevent you from doing this, and patient safety, dignity or comfort may be seriously compromised, you must follow the guidance in paragraph 25b.

Keogh Report: Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, Professor Sir Bruce Keogh, 2013

National Framework for Older People, Welsh Government, 2007

Each local health area should have in place a pathway for stroke care including a mechanism for specialist assessment and treatment for suspected stroke, and prompt access to specialist acute stroke services, by March 2007. The Welsh Government also required that, by March 2009, all patients suspected of having a stroke should be assessed and treated in specialist stroke units with direct admission from A&E.



References

Nutritional support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition, National Institute for Health and Clinical Excellence, CG32, 2006

Report of the Acute Task Force - The right person, in the right setting-first time, Royal College of Physicians, 2007

- We recommend that modern acute hospitals will require daily clinical review of the entire bed base by a competent clinical decision maker to ensure efficient patient flows and reduced length of stay. AMU should be the hub for coordinating acute medical outreach care undertaking activities of out-of-hours medical cover arrangements for the hospital.
- There should be appropriate handover of care between junior medical staff.
- Clearly defined contact pathways for named senior clinical opinion.
- Patients need access to acute medical care throughout the 24 hours period and not just within traditional office hours.
- Senior (consultant) review of patients must be available at all times. This should occur immediately for the acutely ill patients.
- For trainees taking part in 'Hospital at Night' or 'Out of Hours' services and acute medical outreach – they should have ready access to the senior physicians working within the AMU for support and educational feedback.
- Patients should not be moved off AMU without diagnosis and without review of investigations and an action plan.
- The quality of the first 48 hours of acute medical care is an important determinant of clinical outcome and we recognise the need to guarantee the quality of this care and access to this care, 24 hours a day 7 days a week (24/7).
- Patients suffering severe illness should be seen by the consultant on-call at the earliest opportunity and there should be clear mechanisms in place to involve the consultant at an early stage in the care of the patients who are particularly unwell.
- In planning workforce arrangements a consultant physician should be expected to spend one 4 hours session of programmed activity (PA) in direct clinical care on a PTWR. This should allow for the consultant on call to assess each new patient on the PTWR, review of the case and relevant documentation, and talk to relatives...



References

Report of the Mid Staffordshire NHSFT Public Enquiry, Chaired by Robert Francis QC, February 2013

‘The patient must be the first priority in all of what the NHS does. Within acceptable resources they must receive effective services from caring compassionate and committed staff working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights’.

Rising to the Challenge: Improving acute care, meeting patients’ needs in Wales, Royal College of Physicians in Wales, 2015

Review of concerns (complaints) handling within NHS Wales – ‘Using the gift of complaints’, Keith Evans, June 2014

Safer care for the acutely ill patient: learning from serious incidents, National Patient Safety Agency - NPSA, 2007 and 2010

- A report that outlines and identifies some of the areas of risk, as well as actions that NHS organisations can take immediately to ensure that acutely ill patients are monitored and managed effectively.
- Definition of a serious incident requiring investigation includes unexpected or avoidable death, and serious harm causing shortened life expectancy, prolonged pain or psychological harm.

Stroke and transient ischaemic attack in over 16s: diagnosis and initial management, National Institute for Health and Clinical Excellence, CG68, 2008

The Best Configuration of Hospital Services for Wales: A Review of the evidence, Professor Marcus Longley Welsh Institute for Health and Social Care, 2012

The Trainee Doctor, General Medical Council 2011

Together for Health, Welsh Government, 2011

