

Home Safe and Sound

Effective Hospital Discharge





Contents

Foreword	3
Introduction	4
Analysis	5
Future considerations	9
Cases	10
Glossary	29
References	30

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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 Ombudsman in 2014, health services have generated the largest number of complaints across public services in Wales. This year, whilst we've seen a welcome 2% reduction in the total number of complaints, complaints about health boards increased by 11% from 676 in 2016/17 to 747 in 2017/18.

It will, therefore, be of no surprise that two of the three thematic reports I have issued during my tenure have been specifically health-related. My office's vision is of a public service culture that values complaints and learns from them to improve public service delivery; I very much see thematic reports as a mechanism to promote that learning.

The Public Services Ombudsman (Wales) Bill continues to progress through the legislative process and I am hopeful that we will have a new Act in place in 2019. This will create innovative avenues to drive up standards of complaints handling and service delivery. One of these is the use of own initiative investigations - a more proactive tool for investigation of systemic issues. This will not replace thematic reporting, but rather complement it.

My first thematic report, *Out of Hours: Time to Care*, highlighted a number of themes, including inadequate consultant cover, lack of senior supervision and failure to meet required standards of care. As a consequence, the Welsh Government agreed to instigate a peer review programme into care for acutely ill and deteriorating patients across Wales. That work is continuing.

This report looks at another crucial issue within the healthcare system – patient discharge from hospital. I hope, in the year that marks the 70th anniversary of the National Health Service, that this is an area where the lessons from complaints can provide some insight into where things have gone wrong, and where public services can do better.

The great Chinese philosopher Confucius once said there are three ways of learning wisdom – by reflection, by imitation and by experience. I hope that, in some small part, this thematic report offers an opportunity to do all three!

Nick Bennett
Public Services Ombudsman for Wales



Introduction

It is natural for a patient to want to go home and regain some independence following their stay in hospital. Leaving hospital can be a difficult and emotional process and, for many, it is an opportunity to return to normal life and to loved ones or carers following a traumatic period.

In Wales, there are approximately 750,000 admissions to and discharges from hospital every year.¹ Most patients will not require any further care and support once they leave hospital. However, 20% of patients being discharged will have ongoing health and/or social care needs.² Such patients trust medical professionals to ensure their discharge is well-planned and safe.

There are clear national guidelines to support the safe and timely discharge of patients from hospital.³ These promote a multi-agency and multi-professional approach to planning and management alongside effective communication that puts the patient at the centre of the discharge process. Health Boards and Trusts are called upon to ensure that all hospitals have clear procedures and policies in place regarding patient discharge to secure a 'smooth transition from one stage of care to the next.'⁴

It is evident from the Ombudsman's caseload that these guidelines are, in some cases, being ignored or not followed by hospital staff. This can compromise patient safety and lead to hospital readmission and failures in meeting patient needs.

We have conducted a thematic analysis, of 16 cases investigated by the Ombudsman's office, to provide a snapshot identifying a number of concerns about patient discharge from hospital. The cases considered are not representative of the everyday service provided by the NHS in Wales, nor are they specific to Wales – similar concerns have been identified in other health services across the UK.⁵

The cases in this analysis identify areas where improvements can be made to the benefit of patients and it is important that we learn the lessons from them to ensure patients receive the highest quality of care during and after their discharge from hospital.

¹ Wales Audit Office (2017) Discharge Planning – Cardiff and Vale University Health Board; Wales Audit Office (2018) Discharge Planning – Abertawe Bro Morgannwg University Health Board.

² Ibid.

³ Welsh Government (2016) NHS Planning Framework 2017/20; NICE Guideline (2015) Transition between inpatient hospital settings and community or care home settings for adults with social care needs; Welsh Government (2013) Integrated Assessment, Planning and Review Arrangements for Older People; Welsh Government, (2011) Supplementary Guidance to WHC 2005 Procedures when discharging patients from hospital to a care setting; National Leadership and Innovation Agency for Healthcare (2008) Passing the Baton – A Practical Guide to Effective Discharge Planning; Welsh Health Circular (2005) Hospital Discharge and Planning Guidance. National Assembly for Wales; Welsh Health Circular (2002) Intermediate Care Guidance. National Assembly for Wales Circular.

⁴ Welsh Health Circular (2005) *ibid*, p.15

⁵ Parliamentary and Health Services Ombudsman, (2016) A report of investigations into unsafe discharge from hospital; Healthwatch England, (2015) Safely home: What happens when people leave hospital and care settings? Special inquiry findings.



Analysis

Five primary themes are identified from the analysis of the 16 cases and discussed below. These themes show the areas in which service providers fall short when conducting patient discharge procedures. They are:

1. Inadequate senior doctor and consultant involvement in the discharge process
2. Lack of effective communication in and between hospitals and with community services
3. Lack of effective planning of patient discharge
4. Lack of effective organisation in the care and discharge of patients
5. Failure to include and involve appropriate family members and/or carers in the discharge process

It is identified that failings in one or more of these areas may result in, or increase the likelihood of, the following outcomes: distress and/or discomfort to patients and/or family, prolonged patient suffering, early discharge of patients where it is not clinically safe to do so, hospital readmission and deficiencies in providing continuity of care after hospital discharge.

1. Involvement from senior doctors and consultants in discharge process.

We identify in a number of cases that patient discharge takes place without appropriate assessment and monitoring from consultants. In our cases, a senior doctor had not taken adequate care to review the patient fully, had not reviewed the patient within an appropriate time frame or had not been present at any stage during the patient's admission to hospital.

In these cases, patients have been discharged early with incorrect diagnoses and have not received the appropriate treatment until they have been readmitted to hospital. This puts pressure on emergency services and junior doctors, increasing the likelihood of mistakes and creating serious risks to the health and safety of patients.

This is evident in both Mrs K and Mr L's cases, where prolonged suffering and readmission to hospital could have been mitigated if periods of observation had taken place and if they had received reviews or further clinical examinations by senior doctors prior to, and after, being discharged.



Analysis

It is recognised that prevailing workforce shortages in medical specialities are having a significant impact on the health care system in Wales.⁶ Challenges in medical recruitment, while more prevalent in rural areas, can affect professional support and service delivery more widely.⁷ Nonetheless, it is necessary to ensure, when appropriate, that senior doctors are involved in the discharge process. Furthermore, that medical staff receive appropriate training to fully understand discharge procedures and that they are familiar with the relevant policies.

2. Effective communication in and between hospitals and with community services

Effective communication promotes collaborative and co-ordinated working. It is essential that communication flows efficiently at all levels and across all organisations and that assessments, plans and the patient's health status are available at both hospital and community levels.⁸

In our cases, communication between the hospital and community services was sometimes inadequate or non-existent. There are examples of failures to communicate appropriate instructions for use of medication and for end of life treatment.

For Mr M, failings in communication between hospital staff, community nursing staff and social workers meant that the home care package he received was insufficient in level and frequency to meet his needs.

Shortcomings in communication between hospital staff and community services can lead to disjointed or discontinuous care, or to a failure to ensure specialised care is delivered by community services following a patient's discharge from hospital.

Communication and information sharing is at the centre of Welsh Government guidelines.⁹ Effective and efficient communication between and within primary and secondary care organisations is pivotal in bridging the care gap between hospital and the community settings. Having a clear understanding of the patient's health and care needs when leaving hospital can better prepare community services and can safeguard patients from inadequate care.

Continued support for the development and use of e-communications systems, such as Welsh Clinical Communications Gateway (WCCG) and Welsh Community Care Information System (WCCIS), will greatly enhance communication efficiency between hospitals and community services and will promote the sharing of good practice and innovative ways of working.¹⁰

⁶ National Assembly for Wales (2017) Medical Recruitment, Health, Social Care and Sport Committee, p.30.

⁷ The Welsh NHS Confederation (2018) Rural Health and Care Services in Wales, p.4.

⁸ Welsh Health Circular (2005) op cit n.3, s.21; NICE Guideline (2015) op cit, n.3, s. 1.5.5.

⁹ Welsh Government (2013) op cit, n.3.

¹⁰ These are pilot projects introducing e-discharges which are instantaneous and eliminate the worry of being lost in the post.



Analysis

3. Effective planning of patient discharge

Effective discharge planning helps health and social care systems to run smoothly and to meet patient needs. Planned discharges facilitate efficient use of resources, whilst securing support for individuals and their families and/or carers when they return home or transfer to another health or social care setting.

Ineffective planning can leave patients without the appropriate care they need. This is particularly evident where the patient is vulnerable or receiving end-of-life care. Mr T was receiving palliative care, but planning failures meant that he and his family went without the appropriate support services, such as a Community Palliative Care Team, over the Christmas period. This resulted in Mr T suffering unnecessarily in the days leading to his death and in increased pressure and anguish on his family.

Furthermore, when discharges are effectively planned it is possible to foresee where patient treatment may be difficult to provide once they leave the hospital. Arrangements can then be made proactively to accommodate this. Mrs E was transferred to a community hospital but was unable to receive the appropriate treatment because staff there had not received adequate training. This left Mrs E vulnerable to further health complications and put increased pressure on another hospital when her condition deteriorated. Health boards should ensure that there are defined discharge pathways, setting out the process and actions needed for the continuity of patient care once they have left the hospital. Planning should involve appropriate care and support assessments so that patients receive the services that are right for them. Increasing the accessibility of staff training, through the use of technology and developing e-learning packages, will help increase and maintain knowledge of discharge planning, supporting appropriate discharge arrangements even during busy periods.

4. Effective organisation of the care and discharge of patients

Ineffective organisation impacts on communication between hospital staff and community services and can lead to failures to share information. Failings in efficient record keeping and provision of timely discharge notifications and medical handover notes can damage the continuity of patient care following their hospital discharge.

Ineffective organisation in the hospital setting is prevalent in Mr B's case. When discharged back to the care home, the hospital failed to



Analysis

provide any medical handover notes or advice to care home staff about his treatment. It failed to complete a discharge notification until two weeks after his discharge.

5. Patient, family and/or carer inclusivity in the discharge process.

Patients, families and carers should be involved appropriately at each stage of the discharge process. Adequately preparing relatives or carers is essential so that they are equipped to cope with the care of the patient following discharge and so they are aware of the potential risks of further deterioration.

Mr P's and Mr D's wives were not included in discussions about their husbands' care. This meant they were not given the opportunity to voice their concerns and identify their needs and they were left uninformed about their husbands' conditions. Mrs D was denied the opportunity to make choices about the care and treatment of her husband. Both were ill-prepared to cope with their husbands' deteriorating health.

The discharge process should be patient-centred, and the care and support plan should take account of family and carers. Sharing information about the discharge process, through guidance and easy read leaflets available to all patients and families, helps increase their understanding of risk, management of care and expectations.

Continued support for the development and use of e-communications systems, such as Welsh Clinical Communications Gateway (WCCG) and Welsh Community Care Information System (WCCIS), will greatly enhance communication efficiency between hospitals and community services and will promote the sharing of good practice and innovative ways of working.



Future considerations

Following this thematic analysis, there are a number of areas for future improvement. Health boards, GPs and local authorities should ensure that:

1. When appropriate, senior doctors are involved in the discharge process
2. Medical staff receive appropriate training so that they fully understand discharge policies and procedures
3. Appropriate assessments are undertaken before discharge and planning for discharge puts the patient at the centre of the process
4. There is effective communication between and within primary and secondary care organisations, and with social services
5. The patient and appropriate carers/family members are involved in the discharge process and that relevant information is shared with them during the discharge process



Cases

Mr A's story

Mr A was born with spina bifida and had a long history of recurrent kidney infections with only one kidney functioning, and therefore had been under the care of the Urology department for a number of years. He catheterised himself to empty his bladder about three times daily.

Mr A was admitted to hospital on 11 September 2011 with a suspected kidney infection, for which he received antibiotics and was rehydrated with intravenous fluids. His medical records stated he was anaemic with weight loss and poor appetite. An ultrasound two days later found his left kidney was obstructed (hydronephrosis) and non-functioning and had suspected pyonephrosis (infected hydronephrosis). A CT scan and nephrostomy¹¹ were considered but not undertaken.

The only consultant review took place four days after Mr A's admission. The consultant concluded that Mr A could be discharged if he did not suffer a fever or raised temperature for the next 48 hours. However, he was discharged the following day without any further review.

An appointment should have been made for Mr A to be reviewed three weeks later but this was never booked. After an urgent GP request he was seen in clinic by a registrar on 15 November. Despite persisting abdominal discomfort and worsening anaemia, no blood tests were undertaken during this appointment. According to his father Mr A continued to complain of abdominal pains, fatigue and weight loss.

Referrals were made by his GP to Haematology, Gastroenterology and, again, Urology, but no reviews took place. He was admitted to a different hospital on 27 February 2012 with severe sepsis and sadly died the following day. The post-mortem confirmed 'acute or chronic kidney infection' as the cause of Mr A's death.

Investigation

The Ombudsman found that there was no information provided to Mr A or his family about plans for on-going care, or about the continued risk of chronic infection and, indeed, acute sepsis. There was no plan in place to address Mr A's weight loss and no record that antibiotics were prescribed on discharge.

There was only one consultant review in nine days, with no senior review before Mr A was discharged. Communication between

¹¹ Drainage of the obstructed kidney



Cases

consultant colleagues was inadequate, at best, which led to disjointed care. The radiology report, suggesting pyonephrosis with its consequent risk of overwhelming sepsis, appeared to have been ignored.

The Ombudsman identified shortcomings in the management of Mr A's condition, particularly a lack of urgency in arranging an early outpatient appointment and further follow up appointments. There was a failure to properly assess and monitor his chronic kidney infection and was denied the opportunity for treatment that could have altered his sad outcome. Further investigations should have taken place before Mr A was discharged - his discharge was without doubt premature, inappropriate and unsafe.

Recommendations

The Ombudsman recommended that the Health Board should provide an apology for the identified shortcomings and make a payment of £5000 in recognition of Mr A's family's on-going distress. Confirmation was requested that a review of the case had been undertaken and that actions had been taken to address the identified shortcomings including Mr A's premature discharge

Mr B's story

Following referral from his care home, Mr B was admitted to hospital on 19 September 2013 because of deteriorating renal function, raised potassium levels and an extensive skin rash. He had a history of chronic kidney disease, hypertension and prostate cancer with a long-term indwelling urinary catheter.

Despite no significant improvement in his blood results Mr B was discharged back to the care home the following day. Mr B was visited at his nursing home by his GP on the day of his discharge, who admitted him to a different hospital because of the persisting rash, severely impaired kidney function and 'general deterioration'. Over the next few weeks Mr B received treatment from the Renal Team and was eventually discharged on 5 November. Mr B sadly died a few months later at his care home. A discharge notification from his first admission was not completed until 3 October – two weeks after he was discharged.

Investigation

Mr B's initial discharge was considered clinically unsafe in view of the seriousness of his renal condition at that time. His blood results



Cases

were discussed between Emergency Department doctors, but there was no consultant involvement.

There was no action taken to address Mr B's potentially dangerously high potassium levels, though he should have been referred to an expert renal clinician. In addition, a possible urinary infection was not treated.

The Health Board admitted that it did not provide a timely discharge notification, and therefore failed to provide any medical handover notes or advice to the care home staff about Mr B's treatment at the time of his discharge.

While there was no evidence to suggest Mr B had suffered harm following his initial discharge, it is possible that significant harm could have occurred had his GP not intervened and arranged admission to a second hospital.

Recommendations

The Ombudsman made a number of recommendations including that the Health Board ensure discharge summaries are promptly prepared and shared with partner organisations when patients are discharged. The Health Board was also asked to remind staff of the importance of effective communication with patients, and their families or carers, in relation to their discharge.

Mr D's story

Mrs D complained about the care of her late husband between 24 December 2014 and 30 January 2015. Mr D had dementia with impaired speech and cognition and was resident in an Elderly Mentally Infirm (EMI) care home. He attended the SAU (Surgical Assessment Unit) on 24 December 2014 due to visible blood in his urine and was fitted with a urinary catheter. He was later moved to the Urology ward where a cystoscopy and bladder biopsy took place. He remained frequently agitated during his hospital stay. His bladder catheter was removed on the 31 December and he was discharged soon afterwards.

He was readmitted the following day with worsening agitation and abdominal pain due to urine retention causing a distended bladder, and he required the insertion of another catheter. During this second admission, he developed pneumonia. He was discharged to another nursing home on 30th January.



Cases

Histology from the bladder biopsy confirmed that cancer was present from 8 January, however, the family was not informed of this until 20 February by the family's GP after Mr D had died on 13 February.

Investigation

The Health Board was unable to say whether Mr D passed urine before his discharge, but there is no evidence he did, and he was discharged shortly after the removal of his catheter. Most guidance recommends a six-hour observation period, usually with a bladder scan after urination, to ensure the bladder is emptying. This is even more important for a patient with dementia. It is unclear from Mr D's records why he was discharged without a catheter; however, if it had been considered medically unsafe to insert one then his discharge should have been delayed.

There were no specific discharge documentation or care plans included in Mr D's medical records. There was no indication of any communication with the residential home about the discharge. In addition, there was a poor standard of record keeping regarding completion of daily fluid charts.

Recommendations

The Health Board was asked to apologise to Mrs D for the poor management of her husband's discharge.

The Ombudsman asked the Health Board to remind all staff members involved in Mr D's discharge of the importance of good record keeping, and to provide training on relevant policies and procedures for appropriate discharge planning for catheterised patients.

Mr F's story

Mrs F made a complaint about her husband's care and discharge three days after having had an appendectomy¹² on 27 July 2015.

Mr F was admitted to hospital with abdominal pain. He had developed appendicitis and was operated on later the same day. During the operation keyhole surgery was converted to an open procedure due to complications. His operation was recorded as a 'deep, difficult procedure'. It is unclear if he was reviewed by the responsible consultant after his operation because he was not in his bed during the ward round the following day.

¹² Surgical removal of the appendix



Cases

On 30 July, an infection was identified in the wound for which Mr F was prescribed antibiotics, he still required oxygen and had a raised heart rate which meant he had a NEWS¹³ score was 3 ('Threat, Acute illness or unstable chronic disease?'). Despite this he was discharged the same day.

Mr F was readmitted the next day feeling hot and sweaty and with abdominal pain around the surgical wound. On examination Mr F's abdomen was distended and tender with evidence of cellulitis¹⁴ around the wound. He later required a further operation on 3 August when the wound was re-opened and the infection washed out. He was discharged a second time on 5 August.

Investigation

It is likely the surgical wound infection was present at the time of discharge, and it would have been acceptable clinical practice to discharge the Mrs F with this knowledge if she was to be followed up in the community.

However, on the 30 July the Mrs F's NEWS was elevated at 3 indicating the nurse in charge should be alerted and the observations repeated within one hour. This did not happen. Mr F's observations were not stable and showed a raised heart rate, and he was still receiving oxygen. Consequently, the discharge was not appropriate.

Recommendations

The Health Board was asked to apologise to Mrs F for the distress and uncertainty arising from his inappropriate discharge.

The Ombudsman asked the Health Board to share the report with the staff involved for them to reflect on the findings.

Mr J's story

Mr J, 84, was diagnosed with dementia in 2013. In 2014, he started losing weight and following review by his GP was diagnosed with prostate cancer and commenced a course of hormone therapy. He was complaining about pain in his back and hips and suffered a fall at home. He was admitted to hospital as an emergency on Sunday 13 April 2014 with shortness of breath, and a chest infection. He was diagnosed and treated. A brief medical entry completed by a junior doctor during a ward round on 15 April stated Mr J could "return home when safe".

¹³ See Glossary for meaning

¹⁴ A common bacterial skin infection of the deeper layers of the skin causing infected areas to look red and swollen, and to feel hot and painful.



Cases

When Mr J's son visited on the same day he was informed his father was to be discharged home. Mr J was said to be moving around the ward and feeling better, with less breathlessness. However, at home Mr J was not eating or taking in adequate fluids. He remained in severe pain and had to be assisted to the toilet by his son who was an amputee. The GP was asked to attend but district nurses who should also have attended Mr J's home did not. Mr J remained unwell at home, unable to mobilise and restricted to his bed. His son discovered pressure bedsores on the same day he was discharged.

Mr J was readmitted to hospital on 19 April when it was noted he had been bed bound for two days and had undergone considerable weight loss (22 lbs) in 4 weeks. He sadly died on just 10 days later. A post mortem identified community acquired pneumonia, urinary tract infection, prostate cancer and ischaemic heart disease.

Investigation

On admission Mr J's CRP¹⁵ was significantly elevated which was suspected to be related to a chest infection. The CRP test was not repeated. There were several moves to different wards, but Mr J was not reviewed by a consultant within 24 hours of his admission.

Mr J was transferred to a medical ward from the Medical Assessment Unit without transfer documentation during the night of 14/15 April and discharged home a few hours later. There were no falls, dementia or safety assessments undertaken and no discharge paperwork was completed. No individual care plans were completed.

The Health Board acknowledged several shortcomings in Mr J's discharge, including a failure to assess his social situation before he returned home. Community support was not arranged, and the carers needs were not considered or addressed.

Recommendations

The Ombudsman recommended that the Health Board apologise and make a payment of £500 to Mr J's son for the failings in his father's discharge.

The Health Board was also asked to provide evidence of the improvements in its discharge processes that were put in place following Mr J's sad death.

¹⁵ See Glossary for meaning



Cases

Mr L's story

Mr L attended A&E at 11.30pm on a Saturday. He had been drinking, and was unconscious following an assault resulting in a head injury. He vomited twice in the Emergency Department, and at 04:35am he remained intoxicated. A junior doctor discharged Mr L and it was agreed that his girlfriend would take him to a second hospital later that morning for attention to a facial injury. Following treatment of his facial injury, Mr L was sent home. He was drowsy over the remainder of the weekend and was feeling too unwell to go to work on the Monday. He called emergency services later that morning before collapsing. The police had to break into his home, and he was returned to the emergency department by ambulance.

A CT scan identified bleeding on the brain. Mr L was transferred to a regional Neurosurgery Unit where, after initial conservative (non-surgical) care, he underwent surgery on 1 July to release pressure on the brain. He was discharged from hospital on 9 July.

Investigation

The Ombudsman's investigation found that Mr L should not have been discharged without a period of observation, particularly under these circumstances. Mr L should have been reviewed by a consultant before discharge was considered. If Mr L had been reviewed in this way this was likely to have resulted in a CT scan of his head being undertaken.

Mr L's premature discharge meant that he suffered unnecessary difficulties when he returned home, including his collapse at home, which warranted further involvement of the emergency services. This was a serious service failure which under other circumstances could have resulted in a tragic outcome.

Recommendations

The Health Board acknowledged the failings and breach of duty of care in this case, and subsequently conducted a serious incident review. In addition, the Ombudsman recommended that following this serious incident review it take action to address the errors that took place in Mr L's care.



Cases

Mr M's story

Mr B's 37-year-old son (Mr M) had myotonic muscular dystrophy and lived at home with his family, with support from social services. He was admitted to hospital on 10 December 2012 with a chest infection, which was initially resistant to antibiotics. He was temporarily moved to the High Dependency Unit with respiratory problems. Mr M was reviewed by a consultant on 18 December and was considered fit for discharge the following day. On his discharge, a plan was put in place for Mr M to be reviewed six weeks later, although Mr B was advised to contact his GP if his son's condition worsened.

Mr M was readmitted on 22 December unwell and frail, suffering with jaundice and anaemia. Various specialists reviewed him, and a further chest infection improved in response to antibiotic treatment. A discharge was agreed by the consultant on 2 January, and he was discharged home two days later.

There were several home visits carried out following his discharge although only one was recorded. During a visit on 29 January, it was recorded retrospectively that Mr M was secreting excess saliva. This was removed manually; no plan was made for suction and no risk of aspiration (inhaling fluid) was recorded.

Mr M's third admission occurred on 11 February because of increasing oedema¹⁶ and urine retention. Two days later, following a conversation with a consultant about Mr M's deterioration over the previous six months, a DNAR¹⁷ was made. Mr M sadly died the same day.

Investigation

Whilst the social worker was contacted for the first discharge, the district nurses were not. The Health Board's statement that there was a transfer of care letter, and that the district nurses were contacted, was not supported by any documented evidence.

Despite a structured transfer of care process, carers and the social worker were unaware of the second discharge; physiotherapy was not arranged, and Mr M's father did not receive any information about follow up. Suction for bronchial secretions was needed, but not provided. Following the second discharge, district nurses visited on three occasions starting on the 11 January over a period of 19 days with a 13 days gap preceding the 29 January visit.

District nurses failed to adequately support Mr M's father after each of the discharges, with the frequency and level of intensity of

¹⁶ a condition characterized by an excess of watery fluid collecting in the cavities or tissues of the body

¹⁷ See Glossary for meaning



Cases

care insufficient to meet Mr M's needs. The transfer of care from hospital to community, in order to recommence Mr M's home care package, was not adequate. Communication between the hospital ward and the community nurses in the December was poor. There was no plan for pain monitoring in the care plan package, and no discussion with the Mr M's father or GP about pain control. In summary, the discharge in December was poor with no evidence of communication between ward staff and community nursing staff, who were contacted by the social worker rather than ward staff.

Recommendations

Amongst other recommendations, it was recommended that Mr B should be allowed to share his experiences, in an appropriate forum within the Health Board, to support learning from this case.

Mr P's story

In 1992 Mr P, aged 37, was diagnosed with skin cancer and had undergone numerous treatments including surgery and chemotherapy over the subsequent 20 years.

In early 2014, Mr P was experiencing worsening headaches, as well as nausea, vomiting and dehydration. He suffered a series of 'mini-strokes' in the subsequent weeks and was admitted to hospital on 22 April and underwent a number of investigations, including an MRI brain scan which did not identify any metastases.¹⁸

Mr P was anxious to return home despite his headaches continuing. However, the pain was noted to be more in control and on 16 May he was allowed home on weekend leave, in preparation for arrangements for advanced home care when he was fully discharged. His wife stated that the weekend leave was unsuccessful because of her husband's agitation and confusion, unsteadiness and risk of falls. Mr P returned to hospital, and on 19 May his wife attended the hospital to participate in a multi-disciplinary meeting to plan her husband's further care. However, the meeting was cancelled without notification, and she was informed her husband had been discharged and could be taken home. She was handed prescription medication for him.

Following his discharge, Mr P continued to fall and required 24-hour supervision before he was admitted to the local hospice on 27 May. He sadly died on 10 June.

¹⁸ Spread of cancer from the original tumour to other parts of the body



Cases

Investigation

There were no care plans generated for Mr P's pain relief or nutrition, either on his admission to or on his discharge from hospital. Mrs P was given a 'bag of medicines' including morphine ampoules (which are a controlled drug and should only be administered by a registered nurse) and steroids, without instruction about frequency, or method, of administration. The district nurse had not been contacted about the morphine ampoules, and there were no instructions about the time intervals for changing the slow release opioid patches.

The Ombudsman's adviser noted that 'the potential for serious medication error, because of these failings, cannot be underestimated'.

The discharge letter dated 14 May was incorrectly addressed to a hospice, and there was no evidence that Mr P's increased dizziness and difficulties with his balance were discussed with Mr P and his wife, leaving them ill-prepared to cope with his increased falls. Whilst Mr P wanted to return home, his wife had no opportunity to discuss or voice her concerns about her husband's home care as the meeting was cancelled. This case demonstrates the importance of carer involvement in the discharge planning process, particularly in situations where a patient is likely to continue to deteriorate at home.

Recommendations

The Health Board was asked to apologise to Mrs P and provide her with a £3000 payment for the delay in her husband's admission to hospital, failings in his clinical treatment, the lack of effective planning and communication regarding his hospital discharge, and deficiencies by the Health Board's handling of the complaint.

The Ombudsman also requested that the Health Board provide him with an action plan to demonstrate how it would deal with the nursing care failings identified in this case.

Mr T's story

Mrs T complained on behalf of her late husband that his discharge was not properly planned, leaving him without adequate services over the Christmas period.

Mr T was diagnosed with a rare high grade, aggressive lung cancer in May 2012, which was found to have spread to his brain in November of the same year. He was admitted to hospital on 6 December for



Cases

further investigations and assessment. It was noted he was at high risk of pressure sores and malnutrition. A DNAR¹⁹ form was completed on 7 December and he was referred to the palliative care team. Whole brain radiotherapy was planned and administered from 12 December onwards. A decision was made by a consultant oncologist to discharge Mr T on 18 December. The following day a planned MDT (multi-disciplinary team) meeting took place to discuss Mr T's future treatment and it was noted that he had been discharged earlier than expected.

Mrs T made several requests for various support services, including from the community palliative care team, but she was informed that Mr T had never been referred to them.

Mr T was readmitted to hospital on 26 December after his wife became worried that she could not rouse him. He died shortly after his arrival.

Investigation

There was no discussion about the potential rapid deterioration of Mr T's condition. Community services and GPs were unaware of the DNAR decision. The hospital discharge was not properly planned, leaving Mr T without adequate services over the Christmas period and resulting in unnecessary suffering in his final days. Whilst the district nursing team was contacted, there is no record of an appropriate exchange of information to ensure continuity of care. Mr G was in receipt of palliative care in hospital with a syringe driver to control pain, but an intravenous cannula had been mistakenly left in place. There were no arrangements for Occupational Therapy. There was no end-of-life pathway and no contact was made with the Community Palliative Care Team (whose early intervention was likely to be needed), even though the MDT had acknowledged this would be required. The DNAR form was not sent home with the Mr T. The Health Board acknowledged there was no documented formal discharge plan.

Recommendations

An apology and a payment of £1500 for identified failings was to be made to Mrs T. The Health Board was recommended to review both its pain management procedures and cannula care systems. Clinicians were further recommended to reflect on the issues surrounding communication and for training to be made available on such issues as maintaining patient dignity, completion and updating of care plans and the importance of referrals to appropriate specialists when preparing patient discharge. An audit of discharges from this ward was recommended.

¹⁹ See Glossary for meaning



Cases

Mr X's story

Mr X was admitted to A&E on 25 March 2015 with abdominal and sudden onset chest pain, shortness of breath and productive cough. He had a long history of heart disease with significantly impaired cardiac function. He had suffered intermittent diarrhoea and vomiting for the previous seven days. Following a chest X-ray, it was suspected that Mr X had suffered a heart attack and he was transferred to the coronary care unit (CCU). However, the following morning, the duty consultant reviewed Mr X's test results and ruled out any problems with his heart. He suspected chronic bowel ischaemia²⁰ but tests did not show any abnormalities, so Mr X was deemed fit for discharge with a follow up CT scan planned for three to four weeks later.

Mr X's wife informed nurses he was too ill to go home, and at 4:00pm a registrar was asked to review him and confirmed his discharge. In the early hours of the following day, Mr X was readmitted with severe abdominal pain, which had worsened over the hours since his discharge. An urgent abdominal CT scan was arranged but the Mr X became unresponsive during the scan and sadly died later the same morning. The post-mortem revealed Mr X died of ischaemic heart disease and pneumonia.

Investigation

The consultant ignored the junior doctor's findings, which included shortness of breath, productive cough, crackly chest noises and a persistent fever overnight, and consequently a CRP²¹ test was not ordered. The consultant obtained a different diagnosis to the junior doctor and did not review Mr X's initial chest X-ray. He apologised for not administering antibiotics earlier, and the Health Board acknowledged a breach of care but claimed this did not cause harm to Mr X. This assertion does not sit easily with guidelines for the detection of early sepsis and the focus on early intervention.

The consultant's notes were inadequate and included no detail of time, clinical signature or the clinicians involved. Consequently, there was discrepancy between what was recorded and the consultant's later statement during the case review.

Recommendations

The Ombudsman found that Mr X should not have been discharged on 26 March. He recommended that the Health Board apologise to Mr X's family and provide a payment of £1500. The clinicians involved were to be reminded of the need to follow relevant record keeping guidance and asked to review the Ombudsman's report and reflect on its findings.

²⁰ inflammation of the large intestine due to inadequate blood supply

²¹ See Glossary for meaning



Cases

Mrs C's story

Mrs C, 75, had been experiencing worsening breathlessness for a number of days before her GP admitted her to hospital on 11 January 2013, where she was placed on a Cardiology ward. She was known to have a heart condition, chronic obstructive pulmonary disease (COPD), severely impaired kidney function and had had two previous appointments to discuss future dialysis.

On admission to hospital, she had severe fluid retention with consequent heart failure. Specialist renal advice was requested on 23 January and a formal referral requested which was not made.

Mrs C was discharged the following afternoon but approximately 12 hours after her discharge she was readmitted. She had become increasingly breathless since the previous afternoon and had worsened overnight. Mrs C's daughters stated that she had 'started filling up with water before discharge', with clinical evidence of fluid retention including pulmonary oedema (fluid in the lungs). On the night of 26 January, a registrar instructed nursing staff to ignore the Mrs C's low oxygen levels thus reducing the NEWS²² from 10 to 5. Sadly, Mrs C died the following day after proving resistant to further aggressive diuretic therapy, and attempted dialysis in the HDU/ITU setting.

Investigation

There was a failure to keep adequate fluid charts and therefore no means to accurately assess the effectiveness of diuretic therapy. There was no detailed assessment or medical examination of Mrs C before her discharge, and an inadequate length of time to assess the efficacy of the change to oral diuretics. Advice from the local renal department was not adequate, and availability of consultant renal advice appeared limited. There was no discussion at a senior (consultant) level between the renal and cardiology departments, and deficiencies in interdepartmental communication were apparent.

From the Health Board's response, it did not appear any lessons had been learnt, and the involved clinicians continued to justify the care provided to Mrs C. It was accepted however that the discharge was inappropriate and a failing.

There were shortcomings in the care provided to Mrs C, including the failure to consider earlier dialysis, which reduced the likelihood of a better outcome.

²² See Glossary for meaning



Cases

Recommendations

The Ombudsman asked the Health Board to provide evidence that it had addressed the failings in Mrs C's case, including the decision not to commence dialysis earlier, the poor communication between departments and the failings in the referral system.

Mrs E's story

On 23 November 2014 Mrs E underwent surgery for an incarcerated incisional hernia through a scar from previous hernia surgery.²³ Mrs E suffered from diabetes and COPD.²⁴ The operation was complicated, and she later required further abdominal surgery which resulted in an open wound and stoma bag. A third operation on 9 December closed the abdominal wound. Mrs E remained in the High Dependency Unit for several weeks before her return to the surgical ward on 31 December. A VAC (Vacuum Assisted Closure therapy) was required to assist drainage from the wound.

Mrs E's condition deteriorated, and on 21 February she was suspected of having a urinary infection, but it is unclear if this was ever confirmed or treated. Mrs E was reviewed again three days later when it was documented that she did not require acute care. On 24 February, she was transferred to a community hospital, but staff had had no training in the use of a VAC and the necessary complicated wound dressings. They were dependent on nursing staff from a busy acute ward at the main hospital attending when there was a problem. Furthermore, there was evidence of infection on the left side of the wound, which resulted in Mrs E returning to the main hospital on 26 February for a single day because she was feeling generally unwell. She was formally readmitted to the main hospital on 2 March, following signs of infection and deterioration. Mrs E was diagnosed with sepsis and sadly died on 13 March.

Investigation

There were no medical records for Mrs E's hospital attendance on 26 February. No record of any discussion about her discharge was made, and no Multi-Disciplinary Team (MDT) meeting was held to discuss or plan her care.

Whilst Mrs E's fragility meant that transfer to another hospital was normal procedure, her transfer to the community hospital was not reasonable or planned appropriately and was only in response to a bed becoming available. The community hospital was unable to meet Mrs E's specific needs particularly as nursing staff were not trained in the use of VAC. In addition, there is no evidence to suggest

²³ Where a loop of intestine is trapped within the incisional hernia and at risk of ischaemia

²⁴ See Glossary for meaning



Cases

that the indication of urinary sepsis was considered or that adequate treatment was available at the community hospital.

There was no evidence of any discussion with Mrs E or her family regarding the appropriate setting for her ongoing care and rehabilitation.

Recommendations

The Ombudsman found that the manner in which Mrs E was transferred between hospitals was inappropriate. He recommended that the Health Board apologise to Mrs E's family and make a payment of £250.

In addition, the responsible MDT was asked to meet and discuss the poor discharge planning, especially the decision to transfer Mrs E to a hospital that could not adequately meet her needs.

Mrs Y's story

Mrs Y was admitted to the Emergency Department (ED) at 11:15pm on 17 January 2014 complaining of chest pain. A junior doctor did not pick up on Mrs Y's neck pain and treatment with warfarin and therefore failed to diagnose her dissecting aortic aneurysm. Mrs Y was discharged only four hours later and sadly died the same morning.

Investigation

Mrs Y attended A&E with highly suspicious non-traumatic chest pain. There were several diagnoses that could have been made - acute coronary syndrome/heart attack, blood clot in the lungs or aortic dissection. Any one of these diagnoses would have required admission to hospital and further investigations by a senior doctor. However, Mrs Y was discharged, depriving her of a nine-hour period when she could have received additional tests and treatment.

Recommendations

Whilst, sadly, it is unlikely that Mrs Y's death could have been prevented even if she was admitted, the Health Board fully acknowledged the shortcomings in Mrs Y's care and discharge. It agreed to update the junior doctors' handbook as part of the learning process. This handbook should include the principles that junior doctors should not discharge patients with non-traumatic chest pain before discussing this with a senior clinician.



Cases

Mrs W's story

Mrs W was admitted to the Emergency Department at approximately midnight on 3 February 2015 having waited three hours in an ambulance. Her speech was slurred, she was vomiting and feeling cold, with worsening pain in her legs from chronic lower limb venous ulcers. She suffered from hypertension and was receiving treatment with beta-blockers. Her blood pressure was low.

On reviewing Mrs W, a junior doctor noted that she was feeling nauseous and felt 'light headed and shivery'. Her legs were covered in dressings, but some redness could be seen above the dressings. Although the family recalled the dressings being removed for examination, there was no record of this nor of the decision to send her home. Mrs W was prescribed oral antibiotics and discharged at 04:00.

Following a routine visit from the district nurse the day after she was discharged, Mrs W was readmitted to hospital. She arrived at 11:48am when her NEWS²⁵ measured 9, and she was diagnosed with acute kidney injury and intravenous fluids and antibiotics were administered.

Unfortunately, Mrs W did not respond to these measures, and she further deteriorated until doctors decided that she should receive palliative care only. Mrs W was transferred to the hospice where her husband was resident, and she sadly died from sepsis, just a week after her original admission to hospital.

Investigation

No blood tests were undertaken during Mrs W's first A&E attendance and there is no formal record that the dressings were removed to examine her legs, even though previous hospital records noted she had had severe infections on her ulcerated legs. Blood tests taken on Mrs W's second admission to A&E showed severe sepsis and impaired kidney function. Both these results would have been significantly abnormal if measured the day before.

Medical records and note keeping were inadequate. It was unsafe to leave Mrs W for three hours in an ambulance, although this did not affect the sad outcome because the subsequent action taken in A&E was neither adequate or appropriate. If antibiotics and fluids had been administered earlier, Mrs W's ability to overcome the sepsis would have been improved. Disappointingly, the Health Board's own investigation into this case failed to identify any failings in Mrs W's care and treatment.

²⁵ See Glossary for meaning



Cases

Recommendations

The Health Board was instructed to provide an apology to the family and make a payment of £2500. The Emergency Department was requested to review its management of sepsis including effective triage for sepsis and ensuring adequate documentation of Emergency Department assessments.

Ms B's story

Ms B was 43 years old with a history of self-harm and alcohol misuse. On 27 April 2013, she was reported as 'missing' by an unknown person and found more than 12 hours later in an outdoor area. She was suspected of taking a methadone overdose and admitted to hospital.

Ms B's initial GCS score measured 3 (normal 15)²⁶ and paramedics had administered two doses of naloxone to reverse the sedative effects of the methadone before reaching hospital. She was hypothermic and required intravenous fluids, oxygen and warming. Her chest was reportedly clear. Her CRP²⁷ was normal but white cell count significantly elevated. Further naloxone was required in A&E before her move to the Clinical Decisions Unit at 07:55pm. A consultant review which took place the following morning considered her medically fit for discharge, although she was still being administered oxygen.

A Community Psychiatric Nurse considered Ms B's 'apparent' self-harm risk as low, and she was discharged later that day. The time of the discharge was not recorded. Ms B was sadly found dead in her bedroom at home at approximately 8:00am the following day. An inquest found the cause of death to be pneumonia combined with taking citalopram and methadone.

Investigation

Ms B required oxygen and repeated infusions of naloxone and should have been cared for in a closely monitored environment such as High Dependency Unit. An assessment and decision to discharge should not have been made whilst she still required oxygen. There were no further observations after the consultant review. The consultant failed to physically examine Ms B's chest, and the Health Board subsequently admitted that her chest X-ray results were not normal.

Furthermore, there was a risk that Ms B could suffer further respiratory depression and medical staff should have considered observing Ms B for longer. It is likely early pneumonia was missed and

²⁶ Glasgow Coma Scale - tool used to rate the severity of a coma following an assessment of an individual's ability to open his/her eyes, move and speak. Generally, GCS scores of 3 – 8 (you cannot score lower than 3), 9 – 12 and 13 – 15 indicate severe, moderate and mild losses of consciousness respectively

²⁷ See Glossary for meaning



Cases

longer observation, and therefore delayed discharge, would on the balance of probability have led to a different outcome.

The Ombudsman concluded the discharge was unreasonable. Worryingly, at the time of this case, the hospital had no discharge policy in place.

Recommendations

The Ombudsman made several recommendations including that the Health Board should draw up an action plan to address the clinical failings in Ms B's care. One of the key actions was to complete its discharge policy.

Mrs K's story

On 12 January 2014, Mrs K was admitted to hospital following a fall at home. She had long-standing anaemia with some impairment of kidney function and presented with a bruised and swollen leg. Antibiotics were administered for an unconfirmed infection from an unidentified source.

Mrs K was discharged two weeks later, apparently without any further physical examination, and with no follow up arranged. However, her GP readmitted her to hospital the next day with a badly swollen and inflamed leg, which he suspected indicated Deep Vein Thrombosis. The GP described terrible pain, a swollen left leg that was barely weight bearing and commented that 'the left leg has been somewhat overlooked'. Scans showed extensive thrombosis within the proximal leg veins, and treatment was started. Mrs K was discharged home on the same day.

Four days later Mrs K's condition had further worsened, and she was once again admitted to hospital, but sadly died shortly afterwards. The differential diagnoses included overwhelming severe sepsis, intra-abdominal bleeding and pulmonary embolus, but a post-mortem was not carried out.

Investigation

Apart from the initial assessment in A&E by a junior doctor, the Ombudsman found no documentary evidence of a further clinical examination during the two weeks of Mrs K's first hospital admission.

A junior doctor arranged the first discharge with no comment regarding Mrs K's swollen leg and no further follow up was arranged. The responsible consultant was on leave from 16 to 24 January, but consultant cover appeared absent, or inadequate.



Cases

During the second admission, Mrs K's anaemia was ignored when heparin treatment was initiated. In addition, the venous thrombosis was incorrectly described as below the knee and therefore ignoring the much greater risks of pulmonary embolism associated with femoral vein thrombosis. This discharge was not sanctioned by the responsible consultant. The reasons for the second admission were not addressed before discharge. Instigation of therapeutic heparin in the presence of unexplained iron deficiency anaemia creates further risk of complications for bleeding in the gastrointestinal tract (GIT).

Mrs K was very ill at the time of the third admission four days later with a differential diagnosis made by a third consultant including sepsis, GIT bleeding and pulmonary embolus. Inexplicably a post mortem was not requested.

The Health Board's initial response was based on the opinion of the first consultant, who had been on leave. The response proved inaccurate and was later withdrawn with an accompanying apology.

Recommendations

The Ombudsman made a number of recommendations to the Health Board including that it should conduct an audit of failed discharges, at the hospital Mrs K attended, over the 18 months preceding the investigation and that it should report its findings and the course of action it planned to take. Following this audit, the Health Board identified areas for improvement including documentation of discharge planning in patients' clinical notes.



Glossary

Term	Meaning
National Early Warning Score (NEWS)	This is a tool used in hospitals across the UK to improve the detection and response to clinical deterioration in adult patients. There are three trigger points for low, medium and high risk set at a NEWS score of 3, 6 and 9 respectively. For more information see: 1000 Lives (2013) The Good NEWS for Wales. Implementation by NHS Wales of the National Early Warning Score (NEWS), Welsh Government.
C-reactive protein (CRP)	This is a blood test marker for inflammation in the body. The levels of CRP in the body will rise in response to inflammation.
Do Not Attempt Resuscitation (DNAR)	This is a clinical decision not to attempt cardio-pulmonary resuscitation.
Chronic Obstructive Pulmonary Disease (COPD)	The name for a group of lung conditions that cause breathing difficulties.

The responsibility and role of the Ombudsman

The Public Services Ombudsman for Wales has legal powers to investigate complaints about public services. He also considers complaints 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 of public life, using the learning from the complaints received.



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