Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Western Health and Social Care Trust

NIPSO Reference: 17045

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities. She may also investigate and report on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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EXECUTIVE SUMMARY

I received a complaint regarding the actions of the Western Health & Social Care Trust (the Trust) concerning the care and treatment received by the complainant's late father at Altnagelvin Hospital during November 2013. I also received a complaint about the Trust's subsequent handling of the complaint.

Issues of Complaint

I accepted the following issues of complaint for investigation:

- Was the care and treatment provided to the patient appropriate?
- Was there appropriate communication between medical staff and the patient's family during his time in hospital?
- Was the Trust's handling of the complaint attended by maladministration?

Findings and Conclusion

The investigation identified the following failures in the care and treatment provided:

- The Trust's failure to check the PICC and peripheral lines in accordance with procedure
- The Trust's failures in record keeping identified in this report.

The investigation also identified maladministration in respect of the following matters:

- The Trust's failure to thoroughly investigate the incident involving the PICC line.
- The delays in the Trust providing a response to the complaint.
- The failure to record the patient's property.

I am satisfied that the maladministration I identified caused the complainant to experience the injustice of upset, uncertainty, frustration and the time and trouble in pursuing her complaint to my Office.

Recommendations for Remedy

The complainant indicated that she wanted a proper apology and an explanation of the lessons learned by the Trust in this case. Having considered all relevant facts and evidence in this case and the nature and extent of the injustice sustained in consequence of the maladministration I have identified, I recommended the following:

- The Trust should apologise for the failures identified in this report in accordance with the Ombudsman's Guidance on issuing an apology (see Appendix). This apology should include a clear indication of lessons learned by the Trust in this case.
- The complainant should receive a payment of £750 by way of solatium for the injustice I have identified.

I recommended that the Trust should provide the apology and a payment within one month of the date of my final report.

In order to improve the service delivery of the Trust I also recommended the following:

- The Trust should establish internal performance indicators in its complaints procedure to ensure that information is provided to the complaints department in a timely manner.

I recommended that the Trust should provide me with evidence that this recommendation has been actioned within three months of the date of my final report.

THE COMPLAINT

1. The complainant's father received radiotherapy treatment for nasopharyngeal cancer at Belfast City Hospital from 16 September to 1 November 2013. On 2 November 2013 he was taken by ambulance from his home address to the Emergency Department (ED) at Altnagelvin hospital. He remained in hospital where he passed away on 27 November 2013. The recorded cause of death was pneumonia, aspiration and nasopharyngeal cancer.

2. The patient's daughter complained about the actions of the Trust in relation to the care and treatment provided to her father during his stay in Altnagelvin hospital. She also complained about the level of communication between her family and medical staff, and the Trust's handling of her complaint.

Issues of complaint

3. The issues which I accepted for investigation were:

Issue 1: Was the care and treatment provided to the patient appropriate?

Issue 2: Was there appropriate communication between medical staff and the family during the patient's time in hospital?

Issue 3: Was the Trust's handling of the complaint attended by maladministration?

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised. This documentation included the patient's medical records and information relating to the Trust's handling of the complaint.

5. The complainant outlined in writing her issues of complaint and submitted

copies of all correspondence with the Trust in relation to the complaint.

6. As part of my process I shared a draft report with the complainant and the Trust. I considered responses from both parties before arriving at my conclusion.

Independent Professional Advice Sought

7. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

- Senior Respiratory Nurse IPA (N IPA)
- Consultant in Emergency Medicine IPA (ED IPA)
- Consultant Respiratory Physician IPA (R IPA)

8. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs have provided me with advice; however how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

9. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

10. The general standards are the Ombudsman's Principles[1]:

- The Principles of Good Administration
- The Principles of Good Complaints Handling

11. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions of the Trust

[1] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

and the decisions of the clinicians whose actions are the subject of this complaint.

12. The specific clinical and operational standards relevant to this complaint are:

- United Kingdom Oral Mucositis in Cancer Care Group (2012 and 2015 editions)
- Complaints in Health and Social Care – Standards and Guidelines for Resolution & Learning (Updated October 2013)
- Guidelines and Audit Implementation Network (GAIN) General Palliative Care Guidelines for the Management Of Pain At The End Of Life In Adult Patients February 2011 (The GAIN guidelines)
- Western Health and Social Care Trust Guidance on Infection Prevention and Control Protocol for Peripheral Intravenous Cannulation and Access (November 2013)
- Health and Social Care Board (HSC) Procedure for the Reporting and Follow up of Serious Adverse Incidents (October 2013)
- Western Health and Social Care Trust Incident Reporting Policy and Procedures October 2012 (The 2012 Policy)
- Western Health and Social Care Trust's Patients Property Procedures March 2012 (The Property Procedures)
- Health and Social Care Standards and Guidelines for Resolution and Learning October 2013 (The HSC Standards and Guidelines)
- Nursing & Midwifery Council (NMC) The Code – Standards of conduct, performance and ethics for nurses and midwives 2008 (The NMC Code)
- General Medical Council (GMC) Good Medical Practice 2013 (The GMC Practice).

13. I have not included all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

MY INVESTIGATION

Issue 1: Was the care and treatment provided to the patient appropriate?

Detail of the Complaint

14. The complainant raised the following issues relating to the care and treatment provided to her father from 2 to 27 November 2013:

i. That he was unwell following his radiotherapy treatment and on admission at the ED he showed signs of sepsis. The complainant stated that it was obvious that his immune system was compromised. His family therefore requested that he be moved to either the oncology ward or the high dependency unit (HDU), where he could receive appropriate care. This request 'was ignored by medical staff'. The complainant believes that her father may not have acquired further infections had he been placed in the appropriate ward. She also complained that it took four weeks to move her father into a side room in the respiratory ward (Ward 3).

ii. That he did not receive appropriate care and treatment for his mucositis[2].

iii. That his pain relief did not work and was therefore inadequate. The complainant stated that her family had to continually ask for pain relief instead of the Trust being proactive in providing it.

iv. That he was unable to feed himself. She feels the attempts to feed/hydrate her father were insufficient and staff did not encourage or help him to eat and drink.

v. That he was being fed Total Parenteral Nutrition[3] (TPN) via a peripheral inserted central catheter (PICC) line[4] to aid nutrition. This was placed in his left upper arm. At a time unknown the TPN feed was connected to a peripheral line[5] in error, which had been inserted into his left hand. The complainant complained that it took the Trust too long to identify this error. She also complained that this incident was not properly investigated by the Trust.

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[2] Mucositis is the painful inflammation and ulceration of the mucous membranes lining the digestive tract, usually as an adverse effect of chemotherapy and radiotherapy treatment for cancer.
[3] The feeding of a person intravenously bypassing the usual process of eating and digestion.
[4] A PICC line is a centrally placed intravenous device which can be used to administer a range of fluids and normally goes to a larger central vein in the upper arm.
[5] A peripheral line is a catheter (a small, flexible tube) placed into a peripheral vein in order to administer medication or fluids.

vi. That he had a mobile phone on admission to hospital and during his time in hospital but at some point this went missing. She did not want to complain about this but she stated that the Trust has no record of her father having this phone during his stay in hospital.

Evidence Considered

i. Admission to respiratory Ward (Ward 3)

15. In response to enquiries regarding the decision to admit and keep the patient in Ward 3, the Trust stated:

- He was assessed in the ED and at that time his position was unstable. He was admitted with symptoms suggestive of a chest (respiratory) infection, mucositis and sepsis. He received initial treatment and responded well to this.
- Consideration was given to admitting him to the oncology ward and a side room of the Ward prior to his placement there, but it was deemed not necessary.
- His radiotherapy treatment compromised his immune system. However, given that his condition was stabilising and antibiotics were working, it was appropriate to move him to the Ward.
- He remained in Ward 3. He was not neutropenic[6]. A patient would only be considered for transfer to the oncology department if (s)he became neutropenic.
- The availability of single rooms is discussed daily and normally the decisions regarding allocation of side rooms is taken by the nurse in charge of the ward with the bed management team. Single rooms are allocated as a priority for infection control issues and those requiring end of life care. The delay in moving the patient to a side room was due to unavailability of same.
- The Trust provided the Investigating Officer with a synopsis detailing the condition of those patients who occupied the side rooms in the Ward at the time of the patient's admission.
- He was moved to a side room of the Ward on 26 November 2013 due to the

[6] the presence of abnormally few neutrophils in the blood, leading to increased susceptibility to infection.

deterioration of his condition.

Independent Professional Advice

16. The Investigating Officer requested advice from the ED IPA regarding the decision to admit the patient to the Ward. In response the ED IPA advised that:

- '*After initial assessment and investigations, [the patient] was diagnosed as having sepsis secondary to a respiratory tract infection and was admitted to the hospital's respiratory ward for further treatment*.'
- '*The important finding with the initial investigations was that he was not suffering from neutropenic sepsis which is a recognised complication for patients who have recently received chemotherapy or radiotherapy and results from the individual's immune response being reduced because of the therapy they had received.'*
- '*I would consider that his condition was stable at the time he was admitted to Ward 3.*'
- '*Whilst there is no clear record of the decision to admit the patient to the Ward it would appear to be consistent with standard practice to admit a patient with an acute respiratory problem to the respiratory ward when admission to critical care is not indicated, the patient did not require isolation as [he] was not neutropenic and the preferred choice of ward of the patient and his family was full on the day of admission (and he did not have any specific medical requirements at that time that would have been better delivered on the oncology ward).'*
- '*Given his condition it was reasonable to admit him to the respiratory ward from the ED.'*
- '*Similarly there is nothing in the history, examination or investigation results that would have prompted the need for a side room at the time of admission.'*
- *'From the ED assessment in relation to the severity of the sepsis episode there appears to be no clinical indication to require immediate admission to HDU.'*
- *'I consider the initial assessment and care delivered to the patient to be of an appropriate standard for patients with this type of condition.'*

17. The Investigating Officer requested advice from the R IPA regarding the decision to keep the patient in an open bay in the respiratory Ward until 26 November 2013. In response the R IPA advised that:

- On admission '*it was reasonable not to admit the patient to a side room*.'
- '*Although there are no definitive guidelines as to who to admit to a side room, in my experience the two main indications for nursing a patient in a side room are for infection isolation purposes or for end of life care*.'
- '*The majority of isolation nursing is performed to prevent the infection spreading from the patient to other patients on the ward eg. gastroenteritis, MRSA. This is known as source isolation. The patients that were occupying the side rooms on the Ward at the time all fell into this category.*'
- '*Although [the patient's] immune system was reduced following his illness, he was not severely immunosuppressed as evidenced by a normal neutrophil count though out (sic) his admission. This is the most important white blood cell for fighting infection. His lymphocyte count was reduced; however this was a result of his infection and is not an indication to nurse a patient in a side room.'*
- *'There was no medical indication that he should have been nursed in a side room in terms of protective isolation. Therefore a specific review relating to this was not indicated. The patient was appropriately moved to a side room for end of life care on the 26 November.'*
- *'The patient had two further infective episodes whilst on Ward 3. The second episode on the 17 November could have been a (sic) due to a recurrence of the infection with which he presented to hospital. The third episode was almost certainly due to aspiration of oral-pharyngeal secretions into his lungs.'*
- *'The recurrent respiratory infection he experienced was almost certainly due to ongoing micro-aspiration of oropharyngeal secretions which would not have been prevented by isolation nursing.'*
- '*I do not consider that he acquired infection through staying in an open ward'.*
- *'It was appropriate that he was not moved to the oncology department, the HDU or a side room (except for end of life care) during his stay in the open bay*

in the Ward.'

- '*In general, admissions to the oncology ward are reserved for chemotherapy patients with neutropenic sepsis or with cancer patients with acute oncology emergencies such as spinal cord compression.'*
- *'I do not consider that it was necessary for the patient to be nursed in a side room for protective isolation as he was not at significant risk of acquiring infection from other patients on the ward as evidenced by his normal neutrophil count.'*
- The IPA explained the national early warning score (NEWS) system which determines the degree of illness of a patient and whether an escalation of care is required. '*The patient's NEW scores were consistently 6 or below from his admission to the ward until the 26 November. Therefore a critical care outreach review and transfer to HDU care was not indicated at this time. His NEW score went up to 9 on the 26 [November] at which point the decision was made in conjunction with the family that further escalation of care was not in his best interests.'*

Analysis and Findings

18. I note the concerns raised by the complainant in relation to her father's admission to Ward 3. I also note the comments of the Trust in this regard. The ED adviser is a consultant physician. I note his clear advice that it was reasonable that the patient was admitted to a respiratory ward from the ED. Further, in his conclusions, the Consultant ED Physician confirms that the decision to admit him to a medical ward rather than an oncology unit or HDU was based on the results of a clinical assessment which would be in line with normal practice.

19. I have carefully reviewed and considered the ED IPA's advice regarding this decision. I accept his advice. I have therefore not identified any failings in relation to the clinical decision to admit the patient to the Ward. **I therefore do not uphold this element of the complaint.**

20. I note the concerns raised by the complainant regarding the appropriateness of her father being kept in an open ward until 26 November 2013. I also note the Trust's policy and also the rationale provided by the Trust for keeping the patient in an open ward. I note that the Trust's bed management team decide on the choice of ward once the clinical requirements are known, applying Trust policy. The bed management team have difficult decisions to make in applying the policy on a daily basis based on the patient's condition and the availability of beds.

21. I have considered the R IPA's advice on this issue. In particular I note his comment that it was '*appropriate that the patient was not moved to the oncology department, the HDU or a side room (except for end of life care) during his stay in the open bay in Ward 3.*' I also note the R IPA's comment that he does 'not consider that [the patient] acquired infection through staying in an open ward'.

22. I accept the advice of the R IPA and I am satisfied that the clinical decision to keep the patient in an open bay in Ward 3 until 26 November 2013 was reasonable. **I therefore do not uphold this element of the complaint.**

ii. The Trust's treatment for mucositis

23. I have considered the United Kingdom Oral Mucositis in Cancer Care Group (2012 and 2015 editions) guidance on treatment for mucositis.

The Trust's response to investigation enquiries

24. In response to enquiries regarding the treatment of the patient's mucositis, the Trust responded as follows:

- The patient had radiation induced mucositis of the mouth.
- This was 'picked up quite early' as he was in pain and was unable to tolerate swallowing.

- He was first seen by the Palliative Care Team on 4 November 2013 and following this was seen by the team on a regular basis.
- In order to minimise the side effects of painkillers, they were carefully administered in the 'stepwise' fashion[7].

Independent Professional Advice

25. The Investigating Officer requested advice from the R IPA regarding the treatment of the patient's mucositis. In response the R IPA advised that:

- He '*experienced severe mucositis'*.
- '*As a result he had significant problems eating and drinking and became significantly debilitated*.'
- The R IPA referred to recommendations made by the United Kingdom Oral Mucositis in Cancer Care Group (2015 edition) in relation to treatment for oral mucositis.
- The treatments received '*map almost exactly to the guideline recommendations documented*' in the above guidance. '*Therefore I consider that the patient did receive appropriate care and treatment for his mucositis whilst on Ward 3*.'
- '*The oral mucositis was treated according to published guidelines and appropriate input was sought from the ENT and oncology teams.'*
- *'The input from the palliative care team was of the highest standard with very frequent reviews and a pro-active approach to symptom management, including pain.'*

26. I note that the R IPA referred to the 2015 edition of the United Kingdom Oral Mucositis in Cancer Care Group publication of treatment for oral mucositis. I obtained the 2012 edition of this publication which was in place at the time of the patient's period in hospital. I am satisfied that the recommended treatments outlined in the 2012 edition are reflected in the 2015 edition.

[7] where medication is either 'stepped up' or 'stepped down' to ensure the best balance is found for the patient.

Analysis and Findings

27. I note the Trust's comments on its treatment of the patient's mucositis. I have reviewed and carefully considered the R IPA's advice on this issue and I note his opinion that the patient '*did receive appropriate care and treatment for his mucositis whilst on Ward 3*.' I accept the advice of the R IPA and I am satisfied that the care and treatment provided was reasonable.

28. **While I have not upheld this element of the complaint, I can fully understand her concerns for her father in the circumstances. I hope she will be reassured that the care and treatment of her late father was reasonable.**

iii. The Trust's administration of pain relief

29. I note the complainant's concerns about the pain relief provided to her father by the Trust. In investigating this issue, I have considered the patient's medical notes and also the content of the GAIN Guidelines 2011. I have also made enquiries of the Trust in relation to this issue of the complaint as part of my investigation.

The Trust's response to investigation enquiries

30. In response to enquiries regarding the pain relief provided, the Trust confirmed as follows:

- The patient was provided with pain relief to help with his symptoms of pain.
- The patient was given breakthrough pain relief[8] as requested by the family.

[8] The pain that occurs between regularly scheduled doses of pain medication.

Independent Professional Advice

31. The Investigating Officer requested advice from the R IPA regarding the pain relief provided. In response the R IPA referred to a summary of the GAIN guidelines (2011) used by the Trust for pain management. The R IPA summarised the pain relief, assessment of pain control and palliative care input provided to the complainant.

32. In response to a request for advice from the Investigating Officer regarding the pain relief provided, the R IPA advised that:

- '*I consider that the use of morphine, with regular reviews and palliative care input is fully compliant with the hospital guideline and therefore the pain relief provided in Ward 3 was reasonable*.'
- '*An assessment of the patient's pain control was made on a number of occasions on every day that he was on Ward 3 by either the medical staff, nursing staff or the palliative care team. I consider this to be a reflection of a proactive approach to pain relief.'*
- '*The input from the palliative care team was of the highest standard with very frequent reviews and a pro-active approach to symptom management, including pain.*'

Analysis and Findings

33. I note and understand the complainant's concerns in relation to the provision of pain relief to her father. I also note the comments of the Trust with regard to the same issue. I have reviewed the GAIN Guidelines and carefully considered the R IPA's advice on this issue. I note in particular his comments that there was evidence of a 'proactive approach to pain relief' and 'the pain relief provided in Ward 3 was reasonable.'

34. In light of the available evidence and the GAIN guidelines, I accept the advice of the R IPA and I am satisfied that the care and treatment provided to the patient for his pain relief was reasonable. **While I do not uphold this element**

of the complaint, I can fully appreciate the complainants concerns about her father having appropriate pain relief in the circumstances. I hope the investigation of this issue and my conclusion provides reassurance to her.

iv. The Trust's feeding and hydration of the patient

35. I have reviewed the Trust's Policy for the Recording of Fluid Balance/Intake Output (2008). The policy states that 'accuracy in recording fluid intake and output is vital in the overall management of certain patient groups and to facilitate correct prescribing of intravenous and subcutaneous fluids.'

36. I have also considered the content of the NMC Code (the Code). In particular the Code states that 'You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.'

The Trust's response to investigation enquiries

37. In response to investigation enquiries regarding the attempts made by staff to encourage the patient to eat and drink, the Trust responded as follows:

- On admission to Ward 3 the patient was '*only able to tolerate sips of water due to painful mouth (sic) and throat following 35 fractions of radiotherapy until 9 November 2013.*'
- '*Throughout his admission to Ward 3 his nutritional intake orally would not have been adequate as it was too painful for him to eat and drink.*'
- The patient was encouraged by nursing staff to eat and drink and he was provided with the products he was more likely to eat, for example milk/custard/yoghurts.
- The Malnutrition Universal Screening Tool (MUST) assessment[9] was not completed on 2 November 2013 as he was too unwell.

[9] 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan including whether the adult requires referral to a dietician.

- The Trust acknowledged that '*there are gaps regarding completion of the oral intake on the fluid balance sheets. Whether it was an omission due to the fact that there was no oral intake or possibly that the staff forgot to record is impossible to determine, however with the introduction of the new fluid balance charts more training has taken place with focus directed towards the accurate completion of the fluid balance charts and food charts as this is an ongoing challenge.*' The Trust also acknowledged that the patient's food charts 'were not completed on occasions.'

Independent Professional Advice

38. The Investigating Officer requested advice from the N IPA regarding the attempts made by nursing staff to encourage the patient to eat and drink. In response the N IPA outlined the methods employed by nursing staff to ensure he received adequate nutrition and was hydrated.

39. The N IPA advised that:

- The entries made by nursing staff on the fluid balance charts and food intake charts were 'scanty and infrequent.'
- '*Documentation initially suggests that the patient is too unwell [for his MUST assessment] however the pre-MUST questions could have been answered from the patient's medical history and clinical presentation'.*
- *'Nursing staff carried out adequate interventions to address the patient's nutritional needs. His underlying medical condition and other risk factors made oral intake difficult. A multidisciplinary approach addressed this and ensured adequate nutrition was given.'*

Analysis and Findings

40. I note the complainant's concerns in relation to the attempts made by medical staff to ensure her father received adequate nutrition and was hydrated. I also note the Trust's comments on this issue. I have considered the N IPA's advice

on this matter and I accept her view that 'nursing staff carried out adequate interventions to address the patient's nutritional needs.' **I therefore do not uphold this element of the complaint.**

41. I note the comments of the Trust and the N IPA in relation to the lack of a MUST assessment on the patient's admission to Ward 3. I have examined his nursing assessment and plan of care booklet which states that this assessment should be completed within twenty four hours of admission. The booklet also documents that he was unable to have an assessment on admission to Ward 3 as he was unwell. Having examined the medical notes I am satisfied that the need for a dietician was identified on the morning of 3 November 2013 following medical review. I am therefore satisfied that although in this case the assessment was not conducted early intervention from a dietician was still identified in a timely fashion.

42. I note the N IPA's comments on the poor completion of the patient's food and fluid record charts by nursing staff. I also note the Code which requires at section 42 that nursing staff keep 'clear and accurate records.' I consider that accurate recording of medical charts plays an important role in the care and treatment provided to patients. I also consider that accurate and contemporaneous record keeping allows for thorough independent assessment of the care provided and helps ensure transparency. I find that the poor completion of the flood and fluid records amounts to a serious failure in the clinical practice of those involved in the patient's care.

43. I note that in this case the Trust has acknowledged the poor recording of these charts and has provided further training to staff to ensure that the charts are completed accurately. I welcome this initiative and am therefore satisfied that the Trust has taken the necessary steps to address this failure in general. There is no evidence that the Trust's failings caused distress or discomfort to the patient and I hope his daughter is reassured by this.

v. The PICC line incident

44. The complainant complained about an incident when her father's Total Parental Nutrition feed was connected to a peripheral line in error. In investigating this issue I have reviewed the Trust's Infection Prevention & Control Protocol for peripheral intravenous cannulation and access (November 2013). The protocol defines a peripheral intravenous cannula as a 'flexible tube containing a needle (stylus), which can be inserted into a blood vessel.' The protocol outlines the following:

- An inspection of a non-infused cannula should take place 'every 12 hours', whilst inspection of an infused cannula site should take place 'every 4 hours, or more frequently depending on [the] infusion type.'
- 'All observations must be documented on the WHSCT Cannula and Infusion Checking Chart.'
- 'Accurate and timely documentation is essential for the safe care of the patient with a peripheral venous cannula.'

45. The Trust's policy on Peripherally Inserted Central Catheter's (PICC) states that exit sites should be observed 'daily for signs of infection.'

46. The Trust's Incident Reporting Policy and Procedures (the 2012 Policy) defines an incident as 'any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation.'

47. The 2012 Policy explains that an incident can either be reported by Trust staff completing an incident report form or online by completing a datix incident form.

48. The 2012 Policy provides the following criteria for determining whether or not an incident should be treated as a serious adverse incident:

- 'Serious injury to, or the unexpected/unexplained death…of:
    - a service user

- a service user known to Mental Health services…
- a staff member in the course of their work
- A member of the public whilst visiting an HSC facility
- Unexpected serious risk to a service user and/or staff member and/or member of the public

- Unexpected or significant threat to provide service and/or maintain business continuity
- Serious assault (including homicide and sexual assaults) by a service user…
- Serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.'

49. The 2012 Policy states that managers should:
    - 'Review all incident reports and ensure remedial action is implemented where necessary
    - Be involved in carrying out incident investigations within their area of responsibility
    - Maintain appropriate records including recording of follow-up action, lessons learned and appropriate closure of incidents'.

50. The 2012 Policy also states the following:
    - All staff should 'record appropriate details in the patient/client notes'.
    - The Risk Management Department should be contacted if staff are in any doubt about whether an incident is a SAI.
    - All incidents must be graded at the time of reporting the incident.
    - The handler attached to each incident has responsibility for ensuring that an appropriate level of investigation is carried out. The level of investigation required is determined by the grading of the incident.
    - 'The investigation of incidents and near misses must be thorough and comprehensive to ensure causes are identified and remedial action taken.'

51. The 2012 Policy states that incidents provided with a green (low) or medium

(yellow) grading ‘generally require minimum investigation that can be undertaken adequately by the ward/departmental manager’.

52. I have reviewed the Health and Social Care Board procedure for the reporting and follow up of serious adverse incidents (SAI) (October 2013). It provides the same criteria and definition of an SAI as the 2012 Policy.

The Trust’s response to investigation enquiries

53. In response to enquiries about the time taken to identify the incorrect insertion of the TPN feed to the peripheral line, the Trust responded as follows:

- TPN was prescribed to be given to the patient via a PICC line. Due to human error it was administered for a period of time via the peripheral line. The Trust cannot say exactly when this occurred but the likelihood is that it may have been connected to the peripheral line whilst he was getting changed/washed around 09.00 or 10.00 hours on 16 November 2013.
- ‘*This was reported as an incident as the concentration is different for PICC line and peripheral line usage.’*
- The infusion via the peripheral line was checked at 23.45 hours on 15 November and at this time infusion was near complete. Infusion would have been completed at approximately 01.00 hours on 16 November. As the line was not in use it should have been checked every twelve hours in accordance with the policy at the time. The Trust accepted that this did not happen.
- The PICC line was checked at midnight and at 03.00 hours on 16 November. The line was not checked again until 17.00 hours which is not in keeping with Trust policy at that time which said that infused PICC lines should be checked every four hours.
- It is clear that the Visual Infusion Phlebitis (VIP) charts used to monitor the peripheral and PICC lines and observation of the sites were ‘well below the standard expected by the Trust’. Staff have since attended relevant training since the incident and the VIP chart has also been updated since then.

54. In response to enquiries regarding the investigation into the PICC line incident, the Trust responded as follows:

- The patient was assessed by a doctor and monitored following the incident.
- The Trust informed the complainant that '*No thrombophlebitis*[10] *occurred due to the use of the peripheral line for the administration of TPN so could not be seen to have any relation to your father's death.*'
- A clinical incident form (datix) was completed by the then Ward Manager on 16 November 2013 to initiate an investigation. The grading for the incident was initially low/green, which is classified as insignificant/minor, but on 19 November 2013 this was changed to medium/yellow, which is minor/moderate.
- A statement was obtained from the nurse (Nurse A) who erected the TPN feed using a PICC line. She used the PICC line as there was already another infusion running via the peripheral line.
- A statement was also obtained from the nurse (Nurse B) who assisted the patient with his personal hygiene, in which she describes disconnecting the TPN feed and reconnecting it quickly. Nurse B denied that she reconnected the TPN feed to the peripheral line instead of the PICC line.
- An investigation was conducted but no staff member accepted responsibility for the incident. However, since the incident ward staff have attended central venous access devices (CVAD) and PICC line training. Learning from this incident has also been shared with all ward staff.
- The Trust initially informed the Investigating Officer that both senior management and the Risk Management Department were involved in considering whether this incident was a serious adverse incident (SAI) but decided that it did not meet the criteria. However, the Trust clarified at a later date that the Risk Management Department were not consulted following the incident.
- There are no contemporaneous records to show the decision making process regarding whether the incident should have been treated as an SAI.
- The Trust apologised to the complainant for any 'distress caused' as a result of the incident.

[10] inflammation of a vein.

Independent Professional Advice

55. The Investigating Officer requested advice from the N IPA regarding the time taken to identify the PICC line incident. In response the N IPA advised that 'there was a lack of compliance with peripheral cannula checks'.

56. The Investigating Officer requested advice from the N IPA regarding the standard of the Trust investigation into the PICC line incident. In response the N IPA advised that:

- '*The nursing staff identified and reported the error with the PICC line at 17.00 on 16/11/2013. The nursing staff document that they have informed the medical staff but there is no documentation by the medical staff in the medical notes.'*
- *'The immediate actions following identification of the incident were adequate'.*
- *'The incident was graded at medium therefore the policy states these incidents can be investigated and undertaken by the ward/departmental manager.'*
- *'The ward Sister who completed the datix did not feel that the incident met the criteria for an SAI. There is no documentation regarding the rationale for this.*'
- The advisor highlighted that if the TPN had been running at a higher rate or had been running for a longer period of time and the potential harm to the patient would have been 'severe'. The IPA commented that therefore 'an internal investigation following the methods and structure of an SAI would have been beneficial to clarify events surrounding the incident, minimise further risk of this occurrence and facilitate shared learning and service improvement.'
- The NIPA stated that the Trust should have been able to identify who incorrectly inserted the TPN feed.
- The N IPA noted that the two nurses who were caring for the patient that day had differing roles and responsibilities. '*Robust timelines of actions by both nurses and discussions/interviews held to establish their actions and sequence of events could have led to the identification of the nurse responsible for the incident. Statements from other staff who were present on the day could have been gathered to assist with this. There does not seem to have been a discussion regarding whether it was appropriate to ask the patient his*

recollection of events.'

- '*The advisor would have expected there to have been a documented discussion or guidance sought from a senior colleague or risk management at the time of the incident as to whether it should be considered as an SAI or whether any further actions were needed at the time.'*

57. The Investigating Officer requested advice from the R IPA regarding the action taken by Trust staff following identification of the incident. In response the R IPA summarised the steps taken by medical staff to assess whether the incident impacted on the patient's condition. The R IPA concluded that:

- '*The incident was managed appropriately and there is no evidence that this caused any harm. The only potential harm was thrombophlebitis which is a mild self-limiting condition.'*
- The Investigating Officer asked the R IPA whether the absence of contemporaneous medical notes on 16 and 17 November 2013 in relation to the PICC line incident had any impact on the care and treatment provided to the patient. The R IPA stated that it had no impact.
- The Investigating Officer asked the R IPA whether an entry relating to the incident should have been made in the medical notes on 16 or 17 November 2013. The R IPA stated that 'If the doctor decided to review the patient then the outcome of the review should have been documented in the notes'. I note the failure to record the review as a further incident of the Trust's inadequate record keeping.

The Trust's response to IPA comments

58. As part of this investigation, in response to the IPAs comments in relation to the PICC line incident, the Trust responded as follows:

- Appropriate actions were taken following identification of the incident.
- It was the Ward Manager's responsibility to investigate the incident.
- It was the responsibility of the person who reported the incident and the Ward

Manager to grade the incident.

- As the incident was graded medium there was no requirement to contact the Risk Management Department. The Risk Management Department was therefore not contacted in relation to the incident.
- Given the nature of the incident it would not have been treated as an SAI.
- The Trust described the incident as 'very unfortunate' and accepted that the Doctor who reviewed the patient after the incident should have documented this in the medical notes.
- The Trust reiterated that it could not say for sure who incorrectly inserted the TPN feed but both nurses who provided statements in relation to the incident were provided with relevant training.
- The Trust said that discussions between senior management and the Ward Manager would have taken place following the incident.

Examination of Relevant Documents

59. The nursing notes document that following identification of the incident nursing staff called the senior house officer (SHO). However, there is no contemporaneous note made by the SHO in the medical notes on either 16 or 17 November 2013.

60. The Datix incident investigation report for the incident provides a description of the incident and immediate action taken. It measures the consequence as moderate and grades the incident as medium (yellow). The report highlighted the need for staff training and lessons learned from the incident.

61. Statements were recorded from Nurse A and Nurse B. A statement was also recorded from Nurse C who monitored both the PICC and peripheral lines from the evening of 15 November 2013 until the morning of 16 November 2013 (this statement was only provided by the Trust after the comments of the N IPA had been shared with the Trust).

Analysis and Findings

Checks on PICC/Peripheral Lines

62. I note the N IPA's comments that in this case 'there was a lack of compliance with peripheral cannula checks'. I have considered and I accept the R IPA's advice that 'the incident was managed appropriately and there is no evidence that this caused any harm to the patient.'

63. I welcome the Trust's acknowledgement that the peripheral and PICC lines in this case were not checked in accordance with policy. I note that the Trust has apologised to the complainant for the 'distress caused' by the incident. However, the complainant does not consider the Trust's apology is appropriate.

64. I consider that the failure to check these lines in accordance with procedure constituted a failure in the care and treatment provided to the patient. However I have not identified any evidence of harm or pain suffered by him as a result of the failure to carry out appropriate checks of the PICC and peripheral lines.

65. I note and welcome that since the incident the Trust has provided further training to staff on the management of PICC and peripheral lines and learning from this incident has been shared with all ward staff. I also acknowledge that the Trust has produced updated VIP charts since the incident which reminds staff of the need for timely checks of infused or non-infused cannulas. I am therefore satisfied that the Trust has taken the necessary steps to address this issue generally.

66. I note the comment made by the N IPA when she referred to the 'confusion' she identified when trying to interpret the VIP chart records. I also note the NMC Code which requires nursing staff to keep 'clear and accurate records.' I consider that accurate recording of medical charts plays an important role in the overall care and treatment provided to patients.

67. I also consider that accurate and contemporaneous record keeping allows for thorough independent assessment of the care provided and helps ensure

transparency. I consider that this issue amounts to a failure in the clinical practice of those involved in the patient's care. However I have not identified any injustice suffered by him as a result of this failure in record keeping.

68. I welcome the acknowledgement by the Trust that the completion of the VIP charts was 'well below the standard expected by the Trust'. I am pleased to note that Trust staff have attended training since this incident and have been reminded of the importance of recording VIP charts in the correct manner. I am therefore satisfied that the Trust has taken the necessary steps to address this issue generally.

The Trust's Investigation of the PICC Line Incident

69. The complainant was understandably concerned about the PICC line incident and its impact on her father. I have considered and I accept the advice of both the R IPA and N IPA that following identification of the incident it was 'managed appropriately' and actions taken were 'adequate'. I am therefore satisfied that medical staff responded to the incident in the appropriate manner.

70. I note the Trust's view that the PICC line incident did not meet the criteria to be considered and treated as a SAI. I note the content of the 2012 Policy which outlines the criteria for an incident to be considered a SAI. I am satisfied, following review of the 2012 policy that there was no requirement for the Trust to treat this incident as an SAI and therefore there was no requirement for the Trust to engage with the Risk Management Department.

71. I have considered the 2012 Policy in relation to the Trust's investigation of incidents, particularly the need for the investigation of all incidents to be 'thorough'. I note the steps taken by the Ward Manager to investigate the incident at the time. I also note the comments of the N IPA in relation to the steps both taken and not taken by the Trust to investigate the matter. I find that although the Ward Manager recorded several statements following the incident she failed to conduct a thorough investigation and further investigative actions should have taken place.

72. For example, I note the content of the accounts provided by Nurse A and Nurse B in relation to the PICC line incident. I consider that both accounts identified several other members of staff who ought to have been interviewed as part of the Trust investigation. I also find that no consideration was given to consulting with the patient as part of the investigation. I therefore consider that the Trust has failed to conduct an adequate investigation into the incident in accordance with the 2012 Policy.

73. I find that the failure to thoroughly investigate the incident is contrary to the first principle of Good Administration 'Getting it Right' which requires a public body to act in accordance with its policies and guidance**. I consider that this failure constitutes maladministration. I therefore uphold this element of the complaint.**

74. As a consequence of the maladministration, I am satisfied that the complainant suffered the injustice of uncertainty about events surrounding this incident, and experienced the time and trouble in pursuing the complaint to my office.

vi. The issue of the mobile phone record

75. I have reviewed The Property Procedures. They state that 'property books should always be fully completed on admission.'

76. In response to enquiries about the patient's mobile phone the Trust confirmed that 'there is no documented evidence that he had a mobile phone' during his stay in hospital. However, the Trust confirmed that it did not dispute that he had a mobile phone in hospital as staff helped family members look for the phone when they were informed it had been lost.

77. The patient's Nursing Assessment and Plan of Care booklet contains a section in relation to his property. This section was completed by nursing staff on 2 November 2013 following his admission to Ward 3. This section contains no reference to a mobile phone.

Analysis and Findings

78. I have considered the comments of the complainant regarding her father's mobile phone and the lack of contemporaneous records made by the Trust in this regard. I also note the Trust's policy on patient property. I also note that the Trust has not disputed that the patient had a mobile phone when in hospital.

79. Having examined the available evidence I find that, on the balance of probabilities, the patient had his mobile phone on admission to Ward 3 and nursing staff were aware that he was in possession of the phone. I therefore consider that nursing staff failed to record the presence of the phone in the patient's property book, in accordance with the Property Procedures.

80. I find that the failure to record the presence of the mobile phone is contrary to the first principle of Good Administration 'Getting it Right' which requires a public body to act in accordance with its policies and guidance. I also find that the failure is contrary to the third principle of Good Administration which requires a public body to keep full and accurate records.

81. **I consider that this failure constitutes maladministration. I therefore uphold this element of the complaint. However I have not identified any injustice suffered by the patient as a result of this failure in record keeping**.

The complainant's response to the draft report

82. In her response to the draft report the complainant reiterated her concerns with the decision to admit her father to Ward 3, the provision of pain relief to him, his feeding and hydration, the investigation into the PICC line incident and the loss of her father's mobile phone in Ward 3. I considered her comments in relation to these issues but found no new evidence that would cause me to reconsider my findings and conclusions in this case.

The Trust's response to the draft report

83. In its response to the draft report the Trust referred to its investigation into the PICC line incident. The Trust asked me to consider guidance from its Incident Reporting Policy and Procedures (2012). I note that this guidance was considered in my draft report. I have carefully considered the comments of the Trust and its guidance in relation to this issue but found no evidence that would cause me to reconsider my findings and conclusions in this case.

Issue 2: <u>Was there appropriate communication between medical staff and the family during the patient's time in hospital?</u>

Detail of Complaint

84. The complainant stated that her family only had one meeting with medical staff during her father's stay in Altnagelvin hospital. She also complained that there were no meetings with the Oncology or Ear Nose and Throat (ENT) departments despite repeated requests to communicate with them.

Evidence Considered

85. I have considered the relevant guidance from the GMC Practice (2013). This guidance is referred to by the R IPA in his advice. It stipulates that:
'You must listen to patients, take account of their views, and respond honestly to their questions.
You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.
You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.
When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.'

86. The IPA also advised that 'it is generally accepted that clinical staff will update

patients and their families (with the patient’s permission) at the following time points:

- on admission to update on diagnosis and treatment plan
- if the patient’s clinical condition significantly deteriorates
- if the patient experiences a clinical incident or unexpected complication of treatment
- if a significant test result becomes available eg. CT scan suggesting cancer
- if the patient or relatives request an update or express concern over the patient’s condition or the care given.’

87. In response to enquiries regarding the level of communication between the family and medical staff, the Trust responded as follows:

- ‘In instances where meetings with a consultant are requested, these are usually facilitated.’ The Trust ‘regrets that this opportunity was not available or forthcoming at the time of the patient’s admission.’

Independent Professional Advice

88. The Investigating Officer requested advice from the R IPA regarding the level of communication between the family and medical staff. The R IPA reviewed the patient’s medical notes and summarised the recorded instances of communication in Ward 3 between medical staff and the family. The R IPA also referred to the relevant GMC guidelines and accepted standards. The R IPA concluded that:

- The instances of ‘*documented communication met GMC guidelines and accepted standards in all areas with the exception of the requests from [the complainant] for a medical update on the 5/11 and to speak to a doctor on the 17/11. There is no documentation that the doctor spoke to [the complainant]. It is not clear if [the complainant] did phone the doctor’s secretary to request a phone call discussion or if the nursing staff passed the message on to the doctor.’*
- ‘*Assuming it is confirmed that the doctor did not respond this (sic) request*

then I consider this to be inappropriate.'

- *'I do not consider that it was necessary for the Oncology or ENT department to contact the family directly.'*
- *'Communication between the clinical staff and the patient and his family was generally satisfactory, although there were two occasions where the patient's daughter requested to speak to the consultant which does not appear to have been met.'*

The Trust's response to IPA comments

89. In response to the R IPA's comments in relation to the level of communication between medical staff and the family, the Trust stated:

- The Trust encourages relatives to have meetings with the Consultant for regular updates but nurses also can give updates to family members.
- There is no evidence in the medical notes that the doctor spoke to the complainant following the requests to speak with him on 5 and 17 November 2013.

Additional information provided by the complainant

90. Following receipt of the R IPA's comments the Investigating Officer contacted the complainant for any further information she could provide in relation to her communication with the doctor. She stated that on one occasion (date unknown) she contacted his secretary to speak with him about her father's condition. The complainant recalled that he returned her call.

The patient's medical records

91. I have reviewed the patient's medical records in order to investigate the level of communication between the family and medical staff. I have also considered the content of these records following the comments of the R IPA. I note the following entries of relevance in the patient's medical records:

November 5 - Nursing notes record that the complainant phoned Ward 3. She was advised to phone the doctor's secretary for an update. The notes record that nursing staff provided two updates to the complainant on her father's condition by phone later that day.

November 6 – Nursing notes record that nursing staff spoke to the patient, his wife and son in relation to his treatment.

November 17 - Nursing notes record that the complainant phoned and requested to speak to the doctor as soon as possible. The notes evidence that the complainant phoned Ward 3 that evening and nursing staff provided her with an update.

November 18 – Nursing notes record that nursing staff provided the complainant with an update by phone and made the following entry: *'keen to speak to Dr – son arranged appointment to be updated via secretary'.*

November 20 – The doctor met with members of the family.

Analysis and Findings on the issue of communication with the family

92. I note the comments provided by both the Trust and The complainant in relation to the level of communication between medical staff and the patient's family. I note and accept the advice of the R IPA that it was not 'necessary for the Oncology or ENT department to contact the family directly.'

93. I also note that although the R IPA found the level of communication between the family and medical staff 'generally satisfactory', he highlighted instances on 5 and 17 November 2013 where he was concerned with the lack of documented communication from medical staff.

94. In relation to the telephone call of 5 November 2013 I note that the nursing records document that no undertaking was given by nursing staff to contact the complainant following her call and she was provided with two updates later that day by nursing staff.

95. I also note the complainant's recollection that she contacted the doctor's secretary by telephone and he subsequently returned her call. Although the

complainant could not recall the exact date of this interaction I am satisfied, on the balance of probabilities, that this occurred following the complainant's telephone call to Ward 3 on 5 November 2013.

96. In relation to the telephone call of 17 November 2013 I note from the nursing records that the complainant was provided with an update later that day and also on 18 November 2013. I also note that arrangements were being made around this time for other members of the family to speak with the doctor, which resulted in a meeting on 20 November 2013.

97. Having considered all available evidence, including the patient's medical records and taking into account GMC guidelines and the R IPA advice, I am satisfied that the level of communication between the complainant and medical staff was reasonable. **I therefore do not uphold this issue of complaint.**

The complainant's response to the draft report

98. In her response to the draft report the complainant reiterated her concerns that the ENT department failed to provide her with updates on her father's care. She also stated that many of her phone calls to Ward 3 were not recorded in the medical notes. I have carefully considered these comments regarding this issue but found no new evidence that would cause me to reconsider my findings and conclusions in this case.

Issue 3: Was the Trust's handling of the complaint attended by maladministration?

Detail of Complaint

99. The complainant complained that there were significant delays in the Trust's responses to her complaint about her father's care, treatment and stay in Altnagelvin Hospital.

Evidence Considered

Policies/Guidance

100. The HSC Complaints Procedure is the relevant statutory procedure for all health and social care complaints in Northern Ireland. I have reviewed the HSC Standards and Guidelines which also applied to the Trust's handling of the complaint. I note the following extracts in relation to the timeframe for responding to complaints:

- 'Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required. Others may be delayed as a result of circumstance, for example, the unavailability of a member of staff or a complainant as a result of holidays, personal or domestic arrangements or bereavement.'
- A response must be sent to the complainant within 20 working days of receipt of the complaint or, where that is not possible, the complainant must be advised of the delay and keep them informed of progress.

101. I note the following HSC standards for complaint handling:

Receiving Complaints – 'All complaints, however or wherever received, will be recorded, treated confidentially, taken seriously and dealt with in a timely manner.'

Investigation of Complaints – 'All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.'

Responding to Complaints – 'All complaints will be responded to as promptly as possible and all issues raised will be addressed.'

The Trust's response to investigation enquiries

102. In response to enquiries regarding the delay in replying to the complainant's letters of complaint, the Trust confirmed to the Investigating Officer as follows:

- The Trust acknowledged that there were significant delays in providing the complainant with the responses to her complaint and they apologised for this.
- In relation to the letter of 24 October 2014 the delay occurred due to a delay in receiving a response from a member of the clinical care team.
- In relation to the letter of 28 May 2015 the delay occurred 'mainly' due to a member of the clinical team being on leave and another member leaving the Trust whilst the investigation was ongoing.
- The Complaints Officer maintained regular contact with the complainant during this period and also continually followed up on outstanding information from the investigation team in line with the complaints procedure.

103. I have examined the Trust's documentation relating to the complaint. On 23 June 2013 the Trust received the complaint. It was not until 24 October 2014 that the Trust issued its response to that letter. In its response the Trust apologised to the complainant for the 'extensive delay'. On 22 December 2014 the Trust received a second letter from the complainant. It was not until 28 May 2015 (five months later) that the Trust issued a written response to this letter. In that response, the Trust apologised for the 'extensive delay' in providing a reply.

104. I have reviewed the complaints chronology and associated emails provided by the Trust. This documentation records the instances of communication between the Trust Complaints Department and medical staff who were contacted as part of the investigation. The records evidence that the delays were largely caused by delays in receiving responses from several members of medical staff, one of whom had left the Trust.

Analysis and Findings

105. I note the Trust's acknowledgement that there was an excessive delay in providing responses to the complainant as part of the HSC complaints procedure. I consider that the failure of the Trust to provide timely responses is contrary to the first principle of Good Administration 'Getting it Right' which

requires a public body to act in accordance with its policies and guidance. I also find that this failure is contrary to the second principle of Good Administration 'Being Customer Focused' which requires a public body to deal with people promptly and sensitively.

106. **I consider that the Trust's failure to provide timely responses to the complainant did not meet the standards required by those Principles and these failings constitute maladministration.** As a consequence of the maladministration, I am satisfied that the complainant suffered the injustice of uncertainty and frustration due to the excessive delays in the Trust responding to her correspondence. I note that the Trust has provided the complainant with an apology for these delays and I am satisfied that this represented in part an appropriate remedy for the injustice. I will deal with the issue of remedy in the conclusion of this report.

107. In my role I also, when appropriate, should highlight instances of good practice. In this particular case I find that the Trust Complaints Officer made numerous attempts to obtain the required information from medical staff in a timely manner. **I note the Complaints Officer kept the complainant updated throughout the process**.

108. However I consider the time taken by the respondents to assist in the Trust's investigation of the complaint was unacceptable. I recommend that the Trust establish internal performance indicators in its complaints procedure to ensure that information is provided to the complaints department in a timely manner. These performance indicators would help ensure that the HSC complaint timescales for responding to complaints are met.

CONCLUSION

109. The complainant submitted a complaint to me about the actions of the Trust in relation to a number of issues concerning the care and treatment of her late father in Altnagelvin Hospital. These issues were:

- The decision to admit her father to Ward 3
- The Trust's treatment of her father's mucositis
- The Trust's feeding and hydration of her father
- The checks conducted on the PICC/peripheral lines
- The Trust investigation of the PICC line incident
- The issue of the mobile phone record.

110. She also complained about the level of communication with medical staff, and the Trust's handling of her complaint.

111. The investigation of the complaint identified the following failures in the care and treatment provided to the patient:

- The Trust's failure to check the PICC and peripheral lines in accordance with procedure
- The Trust's failures in record keeping identified in this report.

112. The investigation of the complaint identified maladministration in respect of the following matters:

- The Trust's failure to thoroughly investigate the PICC line incident involving the PICC line
- The delays in the Trust providing a response to the complaint
- The failure to record the patient's property.

I am satisfied that the maladministration I identified caused the complainant to experience the injustice of upset, uncertainty, frustration and the time and trouble in

pursuing her complaint to my office.

Recommendations for Remedy

The complainant indicated she wanted a proper apology and an explanation of the lessons learned by the Trust in this case. Having considered all relevant facts and evidence in this case and the nature and extent of the injustice sustained by the complainant in consequence of the maladministration I have identified, I recommend the following:

- The Trust should apologise to the complainant for the failures identified in this report in accordance with the Ombudsman's Guidance on Apology (see Appendix). This apology should include a clear indication of lessons learned by the Trust in this case.
- The complainant should receive a payment of £750 by way of solatium for the injustice I have identified.

I recommend that the Trust should provide the apology and a payment within one month of the date of my final report.

In order to improve the service delivery of the Trust I also recommend the following:

- The Trust should establish internal performance indicators in its complaints procedure to ensure that information is provided to the complaints department in a timely manner.

I recommend that the Trust should provide me with evidence that this recommendation has been actioned within three months of the date of my final report.

Both the complainant and the Trust raised a number of points and questions in response to my draft report. I have carefully considered these comments but I am satisfied that this additional information would not lead me to alter the content of my report.

Marie Anderson

MARIE ANDERSON
Ombudsman **May 2018**

Appendix One

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix Two

PRINCIPLES OF GOOD COMPLAINTS HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being Customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.

Appendix Three

GUIDANCE ON ISSUING AN APOLOGY

Introduction
When my office investigates a complaint and finds that a problem has not been resolved I often recommend that the organisation offers an apology. In these circumstances the complainant has very often been waiting a considerable period of time for someone to provide a full explanation as to what went wrong and to apologise for the mistakes that have been made.
This guidance note sets out what an apology is and what you need to do for an apology to be meaningful.

What is an apology?
An apology means accepting that you have done wrong and accepting responsibility for it. It can be defined as a 'regretful acknowledgement of an offence or failure'. Mistakes can be made by one member of staff, a whole team or there may be systemic failures within an organisation. When things do go wrong most people who have had a bad experience may want no more than to be listened to, understood, respected and, if appropriate, given an explanation and an apology.

Why apologise?
In many cases an apology and explanation may be a sufficient and appropriate response to a complaint. The value of this approach should not be underestimated. A prompt acknowledgement and apology, where appropriate, can often prevent the complaint escalating. It can help restore dignity and trust and can be the first step in putting things right.

What are the implications of an apology?
Although there is no legislation in this area of law which applies specifically to Northern Ireland, the Compensation Act 2006 governing England and Wales states that 'an apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or statutory duty.' The timely provision of a full apology may in fact reduce the chances of legal action being taken against public bodies.
An apology should not be regarded as a sign of organisational weakness and can benefit the public authority as well as the complainant by showing a willingness to:

- Acknowledge when things have gone wrong
- Accept responsibility
- Learn from the maladministration or poor service
- Put things right

What is a meaningful apology?
The most appropriate form and method of communicating an apology will depend on the circumstances of a particular case. To make your apology meaningful you should do the following:

• Accept you have done wrong. You should include identifying the failure along with a description of the relevant action or omission to which the apology applies. This should include the failings that I have identified in my investigation that warrant an apology. Your description must be specific to show that you understand the effect your act or omission has had on the complainant. It must also acknowledge that the affected person has suffered embarrassment, hurt, anxiety, pain, damage or loss.

• Accept responsibility for the failure and the harm done.

• Clearly explain why the failure happened and include that the failure was not intentional or personal. If there is no explanation however one should not be offered. Care should be taken to provide explanation rather than excuses.

• Demonstrate that you are sincerely sorry. An apology should be an expression of sorrow or at the very least an expression of regret. The nature of the harm done will determine whether the expression of regret should be made in person as well as being reinforced in writing.

• Assure the complainant that you will not repeat the failure. This may include a statement of the steps that have been taken or will be taken to address the complaint, and, if possible, to prevent a reoccurrence of the problem.

• Provide the complainant with a statement of the action taken or specific steps proposed to address the grievance or problem, by mitigating the harm or offering restitution or compensation.

How should I make an apology?

Each complaint is unique so your apology will need to be based on the individual circumstances. It is important that when you are making an apology, you understand how and why the person making the complaint believes they were wronged and what they want in order to put things right. An apology therefore should express regret and sympathy as well as acknowledgment of fault, shortcoming or failing. Failing to acknowledge the complainant's whole experience is only a partial apology and much less powerful that a complete apology.

There is no 'one size fits all' apology but I would include the following points as reflecting some general good practice:

1. The timing of an apology is very important. Once you establish that you have done wrong, apologise. If you delay you may lose your opportunity to apologise.

2. The language you use should be clear, plain and direct.

3. Your apology should not be conditional by qualifying the apology by saying for example: 'I apologise if you feel that the service provided to you was not acceptable' or 'if mistakes have been made, I apologise'.
4. To make an apology meaningful do not distance yourself from the apology. Generalised apologies such as 'I am sorry for what occurred' or 'mistakes were made' do not sound natural or sincere. It is much better to accept responsibility and say 'It was my fault'.

5. Avoid enforced apologies such as 'I have received the Investigation report from the Commissioner and am therefore carrying out his recommendations by apologising to you for the shortcomings identified in his report'.

6. It is also very important to apologise to the right person or the right people.

Who should apologise?
If, in my Investigation Report I have made a recommendation that an apology should be provided to the complainant, then I would expect to see the Chief Executive or Director or Head of Department of the Body involved making the apology.

Who should receive the apology?
The apology should be sent directly to the complainant who is named in the Investigation Report. I will not, as a matter of course, review apologies prior to them being issued. However in order that I am able to monitor compliance with the recommendations that I have made, I would expect to receive a copy of the apology letter within the timeframe stated in my report.

The benefits to organisations of apologising
It is important to remember that an apology is not a sign of weakness or an invitation to be sued. It can be a sign of confidence and competence and it can demonstrate that you are willing to learn when something has gone wrong. It can also show that you are committed to putting things right. To apologise is good practice and is an important part of effectively managing complaints where an organisation has failed.

Marie Anderson
Ombudsman