Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the South Eastern Health and Social Care Trust

NIPSO Reference: 22259

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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, and 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.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

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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Listed Authority: South Eastern Health and Social Care Trust

SUMMARY

I received a complaint about the South Eastern Health and Social Care Trust's (the Trust) care and treatment of the complainant's mother (the patient) while she was at the Ulster Hospital (UH) in April 2018. The complainant raised concerns about the medication administered to the patient while she was in the UH. She also said nursing staff failed to escalate concerns about the patient's care to a doctor.

The investigation examined the details of the complaint, the Trust's response, and relevant guidelines. I sought independent professional advice from an ED Consultant, a Geriatric Consultant, and a Nurse. The investigation established that the medical care and treatment of the patient was appropriate. However, it identified that nursing staff failed to record a reason for late administration of medication. This was considered a service failure. It also identified failures in nursing staff's creation and retention of records, which could potentially have impacted the patient's ongoing care and treatment.

The complaint was also about staff's communication with the complainant as the patient's next of kin (NOK). The investigation identified further record keeping failures relating to ED and nursing staff's communication with the complainant. The absence of these records was considered a service failure.

I recommended actions for the Trust to take to prevent the identified failures from reoccurring. The Trust accepted my findings and recommendations.

THE COMPLAINT

1. I received a complaint about the South Eastern Health and Social Care Trust's (the Trust) care and treatment of the patient while she was at the Ulster Hospital (UH) in April 2018. The complaint was also about staff's communication with the complainant during the patient's stay on the ward.

Background

2. The patient became unwell at home on 20 April 2018. An ambulance transported the patient to the emergency department (ED) of the UH, arriving at 14:00. While in the ED, the patient received a presumptive diagnosis[1] of acute ischaemic stroke[2]. The ED staff prescribed the patient a daily dose of 300mg of aspirin[3]. This was first administered at 19:55 on 20 April 2018. The patient was admitted to Ward 3C on the evening of 20 April 2018, and was treated there until 29 April 2018. She received the prescribed dose of aspirin until it was held on 24 April 2018 then stopped on 25 April 2018. The patient was transferred to another ward before being discharged to the complainant's home on 8 May 2018. She sadly passed away in November 2018.

Issues of complaint

3. The issues of complaint accepted for investigation were:

   Issue 1: Whether the care and treatment the Ulster Hospital provided to the patient between 20 and 29 April 2018 was in accordance with good medical practice.

   Issue 2: Whether the communication between Ulster Hospital staff and the patient's daughter was appropriate and in accordance with relevant guidelines.

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the

[1] Identifies the likely condition of a patient.

[2] A sudden loss of blood circulation to an area of the brain resulting in a corresponding loss of neurologic function.

[3] A medication that thins the blood and thereby prevents clots. It is commonly used to reduce the long-term risks of a second stroke in patients who've had an ischemic stroke

issues raised. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):
    - A consultant within emergency and critical medicine for over 10 years;
    - A consultant physician for over 30 years and an accredited geriatrician for 19 years; and
    - A senior Registered General Nurse (RGN) with 19 years nursing and managerial experience across both primary and secondary care.

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

Relevant Standards

7. 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. I also make reference to relevant regulatory, professional and statutory guidance.

    The general standards are the Ombudsman's Principles[4]:

    - The Principles of Good Administration
    - The Principles of Good Complaint Handling

8. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

    The specific standards relevant to this complaint are:

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

- The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
- The Nursing and Midwifery Council's (NMC) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, March 2015 (the NMC Code);
- The Royal College of Physician's (RCP) National clinical guideline for stroke, 5th edition, 2016 (the RCP's stroke guideline);
- The British National Formulary (BNF), 75th edition, March to September 2018 (the BNF);
- The Royal Marsden's (RM) Manual of Clinical and Cancer Nursing Procedures, 2008 (the RM Manual);
- The Royal College of Physician's (RCP) National Early Warning Score (NEWS) 2, December 2017 (RCP's NEWS guidance);
- The General Medical Council's (GMC) Consent: patients and doctors making decisions together, 2008 (GMC guidance on consent); and
- The General Medical Council's (GMC) Confidentiality: Good practice in handling patient information, as updated October 2017 (GMC guidance on confidentiality).

9. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

10. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy, and the reasonableness of the findings and recommendations.

INVESTIGATION

Issue 1: Whether the care and treatment the Ulster Hospital provided to the patient between 20 and 29 April 2018 was in accordance with good medical practice.

Detail of Complaint

11. This issue of complaint is about the care and treatment the patient received at

the UH between 20 and 29 April 2019. The complainant said staff gave the patient '*large doses of aspirin'* despite their awareness of her history of gastric ulcer. She also said nursing staff failed to identify the patient was '*very unwell'* and had vomited on her nightdress. The complainant said the patient was dehydrated due to being given furosemide[5]. She also said she had to ask a nurse to call a Registrar, who only made the decision to stop the furosemide following her request.

Evidence Considered

Legislation/Policies/Guidance

12. I referred to the following policies and guidance, which were considered as part of investigation enquiries:
    i. The GMC Guidance;
    ii. The NMC Code;
    iii. The RCP's stroke guideline;
    iv. The BNF;
    v. The RM Manual; and
    vi. The RCP's NEWS guidance.

The Trust's response to investigation enquiries

13. The Trust explained that ED medical staff prescribed aspirin 300mg once daily for the patient, which is a '*standard dose accepted for use in acute ischaemic stroke'*. The Trust said that Consultant A believed the aspirin was started appropriately, as the patient did not have a history of intolerance or allergy, and was taking esomeprazole[6] prior to and during her admission. It explained that Consultant A believed the aspirin could have been discontinued from 21 April 2018 rather than on 24 April 2018.

14. The Trust explained the records for 21 April 2018 at 01:20 documented that the patient *'was probably suffering from delirium[7] secondary to sepsis[8]'.* It further explained that at 11:30, Consultant B documented '*not a definite vascular*

[5] Diuretic medication used to treat fluid build-up.
[6] A proton pump inhibitor that decreases the amount of acid produced in the stomach.
[7] An acutely disturbed state of mind characterised by restlessness, illusions, and incoherence.
[8] Sepsis is the body's extreme response to an infection.

event[9]' and his differential diagnosis[10] was decompensation secondary to intercurrent illness[11]. It said '*this would have been the first time that the Aspirin could have been discontinued, but…[he] still was not certain whether [the patient] had suffered an acute stroke or had decompensation of an old stroke due to sepsis'*. The Trust said Consultant A reviewed the patient on 22 April 2018 and '*agreed that decompensation of an old stroke due to sepsis was more likely than an acute stroke'*. It said Consultant A '*should, in retrospect, have discontinued the Aspirin at this stage'*.

15. The Trust explained that esomeprazole 40mg once daily was administered on 22, 23, 24, 25 and 26 April 2018. It further explained there was an omitted dose on 21 April 2018 due to the drug not being available. The Trust said the dose was increased to 40mg twice daily on 27 April 2018. However, only one dose was administered that day. The Trust explained it was not clear why the dose on 27 April 2018 was not administered. It apologised for the omitted doses.

16. The Trust explained that on 28 April 2018, the complainant asked for a doctor to review the patient. The Trust said a Registrar attended at 20:05 and confirmed the presence of pulmonary oedema[12]. It explained that because the complainant raised concerns about dehydration, the Registrar stopped her Furosemide[13] and encouraged oral intake.

17. The Trust was referred to the absence of notes in the patient's medical records on 22 April 2018 between 11:28 and 22:35, and also on 23 April 2018 between 16:46 and 05:08 on 24 April 2018. The Trust explained '*regrettably, the Trust is unable to identify why there was a gap in the clinical records for the periods and dates listed above'*.

18. In summary, the Trust explained that Consultant A '*does not feel that [the patient's] condition was harmed by her medical treatment. Although it is difficult to be certain about the issue of Aspirin and Aspirin sensitivity, [the Consultant]*

[9] Concerning the arteries and veins of the circulatory system of the body.
[10] More than one possibility for the diagnosis.
[11] Worsening of symptoms due to the patient developing a secondary illness, such as sepsis or pneumonia.
[12] A condition caused by excess fluid in the lungs, making it difficult to breathe.
[13] A type of diuretic used to treat swelling / increased fluid.

feels on balance that [the patient's] immediate problem related to her acute illness from sepsis and subsequently left ventricular failure[14], and possibly aspiration pneumonia[15], as a result of poor swallow'. The Trust further explained the Consultant '*is not convinced that the Aspirin given for such a short time significantly contributed to these issues. Also, although staff knew that there was a history of gastro ulcer, [the patient] was already on a gastro-protective agent and there was no history documented of Aspirin intolerance'*.

Clinical Records

19. A summary of the relevant clinical records is enclosed at Appendix five to this report.

Relevant Independent Professional Advice

Emergency medicine IPA (ED IPA)

20. The E IPA advised that while in the ED, *'bloods tests, an ECG and a CT scan of the brain were requested [for the patient]. A capillary blood glucose[16] was recorded at approximately 1845hr'*. The E IPA advised that the patient's '*symptoms and signs are consistent with a stroke and this was the working diagnosis in the emergency department'*. The E IPA also advised that there was *'no record of symptoms, signs or tests from the emergency department that would indicate an infection'*.

21. The E IPA advised that the ED medical staff sought advice from a stroke registrar or consultant and prescribed '*a dose of 300mg aspirin…at 1940hr'*. He further advised that this decision and the dosage was '*appropriate*'. The E IPA advised that '*the indication was for acute stroke….NICE advise that treatment with aspirin should be initiated as soon as possible within 24 hours of symptom onset and that a proton pump inhibitor should be considered for patients with a history of dyspepsia[17] associated with aspirin. There are other antiplatelets agents in use but none have the evidence base that aspirin does'*.

[14] Dysfunction of the left ventricle causing insufficient delivery of blood to vital body organs.
[15] A lung infection that develops when a person inhales food, liquid, or vomit into the lungs.
[16] A way of monitoring blood glucose levels and guiding treatment changes in patients.
[17] Also known as indigestion - discomfort or pain that occurs in the upper abdomen, often after eating or drinking.

22. The E IPA advised that '*the information that the ED team had was that the patient had previously had a gastric ulcer…these ulcers can have an association with aspirin administration. Subsequent to a diagnosis of gastric ulcers the use of aspirin should be considered on an individual risk/benefit basis'*. He advised that the patient was on a regular dose of esomeprazole, and her '*dose of 40mg is higher than typically prescribed for ulcers alone...'*

23. The E IPA advised that he did not consider there were any concerns '*with the clinical management of [the patient's] acute presentation…on the basis of the information provided…the balance of risk/benefit was clearly in favour of aspirin administration'*.

Geriatric medicine IPA (G IPA)

24. The G IPA advised that the patient did not show signs of an infection at the time of her admission to the ward. The G IPA advised that he agreed with Consultant B's finding on 21 April 2018 that it was '*not a definite vascular event'*, as bloods had become abnormal and *'there was no progression of clinical features to suggest a stroke'.* The G IPA advised that Consultant B's further note in the records, which stated, '*decompensation due to inter-current illness'* was '*a reasonable explanation of her presentation and clinical findings'*.

G IPA - Prescription of aspirin

25. The G IPA referred to the RCP's stroke guideline and advised that '*In a patient with ischaemic stroke, aspirin 300 mg should be administered "as soon as possible within 24 hours" and continued for two weeks…With a diagnosis of stroke the administration of aspirin is mandatory'*. He further advised that it was appropriate to '*continue aspirin in a patient with possible stroke who did not qualify for thrombolysis*[18]*'*. The G IPA advised that the patient '*did NOT [his emphasis] have active gastric ulceration*[19] *at the time of admission. There was no overt bleeding from the stomach at any point during her hospital stay…she was on esomeprazole 40 mg which is the specific treatment for gastric ulcer and it was providing her with "gastric protection*"'.

[18] A treatment to dissolve dangerous clots in blood vessels, improve blood flow, and prevent damage to tissues and organs.
[19] Ulcers that occur on the inside of the stomach.

26. The G IPA advised that '*giving [the patient] only 300 mg, even with past history of peptic ulcer[20], was NOT [his emphasis] contraindicated[21] especially as [the patient] was…concurrently getting esomeprazole'*. He referred to the RCP Guidance and advised that the patient received aspirin with esomeprazole as the PPI [proton pump inhibitor]. The G IPA advised that the patient's '*management was exactly as per the recommendations in the extant national clinical guideline for stroke'*.

27. The G IPA advised that in the early hours of 21 April 2018, '*the doctors ordered blood and urine cultures and treated the patient as having sepsis. This was an example of good medical practice and the correct approach was followed…the Sepsis Six protocol was correctly initiated'*. The G IPA advised that aspirin could not have caused these symptoms. He further advised that '*sepsis was proven when urine culture done at the time grew the organism Proteus[22]'*. He further advised that '*at that point, the possibility of a stroke had not been ruled out. She had by then received probably a single 300 mg tablet. Hence it was right to continue aspirin'*.

28. The G IPA advised that the aspirin prescription '*could have been discontinued when it was established by [Consultant B] that the diagnosis was not ischaemic stroke [on 21 April 2018]*'. He further advised that '*Aspirin was not really contraindicated as there was no active peptic ulceration or a bleeding disorder. There was no evidence of aspirin hypersensitivity which would have been manifested by asthma and angioedema[23]. So in the absence of dyspepsia or gastric bleeding, [the patient] did not suffer from specific side effects of aspirin...Esomeprazole would have neutralised any harmful side effects of aspirin, of which in the case of [the patient], there was no evidence'*. The G IPA advised that '*there is no evidence to believe that four tablets of aspirin impacted [the patient's] long term health'.*

[20] Open sores that develop on the inside lining of the stomach and the upper portion of the small intestine.
[21] A condition or factor that serves as a reason to withhold a certain medical treatment due to the harm that it would cause.
[22] A type of bacteria.
[23] An area of swelling of the lower layer of skin and tissue just under the skin or mucous membranes.

29. The G IPA was asked if the aspirin medication could have caused the patient to vomit. He advised '*the vomiting could not be attributed to aspirin because it was not associated with bleeding. It is more probable the result of sepsis'*. He further advised that *'vomiting is a rare or very rare side effect of aspirin'*.

30. The G IPA advised that '*it is possible for vomiting [sic] to be aspirated into the lungs through the windpipe. This may occur if the patient is not fully conscious or when the normal cough reflexes do not function as they normally should. In those circumstances, aspiration and following that, pneumonia is inevitable. Aspiration can also occur due to saliva and secretions (in addition to food) tracking the wrong way in to the windpipe rather than the gullet. This can also happen when consciousness is obtunded*[24] *and is often unavoidable in such a situation'*.

31. The G IPA was asked what impact the missed esomeprazole doses may have had on the patient. The G IPA advised that the patient '*had been on long term PPI [esomeprazole]. Omitting a single dose will NOT [his emphasis] cause harmful effects…unless she had dyspepsia or indigestion'*.

G IPA - Events on 28 April 2018

32. The G IPA was asked if he believed the patient was dehydrated on 28 April 2018. He advised that '*the notes say that her mucus membranes*[25] *were moist and blood tests did not show evidence of dehydration'*. He advised, '*no action was required because she was in heart failure and furosemide was clinically indicated'*.

33. The G IPA advised '*there was no requirement or reason to stop the diuretic because there was radiological evidence of heart failure and therefore the prescription of frusemide [sic] was correct and appropriate'*. He further advised that '*intravenous fluids would be contraindicated in the presence of heart failure and would have caused [the patient] to become increasingly breathless and poorly. It would definitely worsen the heart failure and it would be irrational to do so'*.

[24] Altered level of consciousness.

[25] A membrane that lines various cavities in the body and covers the surface of internal organs.

G IPA - Record Keeping

34. In relation to the gaps in the medical records, the GP IPA advised that '*on the wards, medical notes are often recorded at ward rounds, a clinical event or medical intervention, or when the patient is deemed to be critically ill…On the regular medical wards if nothing was happening, there is no requirement to record anything other than standard medical observations/NEWS etc. which would give a clue to anything being amiss'*. In relation to the potential impact on the patient, the G IPA advised, '*I do not believe there was any impact or significance except that it is evidence that no medical intervention occurred during those hours. Regular observations and NEWS was being recorded by the nurses'*.

35. In summary, the G IPA advised that he did not find any failings in the ward medical staff's care and treatment of the patient.

Nursing IPA (N IPA) - Medication

36. In relation to the missed dose of medication on 21 April 2018, the N IPA advised that '*the Medicine Prescription and Administration Record…shows that Esomeprazole was not administered'*. She further advised that '*the reason documented is…'drug not available*''. The N IPA advised that '*the documentation shows that this did not impact on the patient as 'Patient comfortable. No abdominal pain' is documented at 17:00'*.

37. In relation to the missed dose of medication on 27 April 2018, the N IPA advised that the medication chart documents that the patient '*was only administered one dose [of esomeprazole] at 10:00 which was in line with the prescription instructions at the time. However, the dose of Esomeprazole was increased at some point during 27th April to BD (twice a day at 10:00 and 22:00*)'. The N IPA further advised that '*the 22:00 dose has not been given and there is no corresponding code to identify why. In line with standards applicable at the time of these events [NMC Code], there should be a clear indication of any medication omitted and the reason why'*.

38. The N IPA advised that she '*could not conclude that this was communicated to nursing staff by the prescriber'*. The N IPA further advised that '*the nursing records state that medications were given as prescribed. I was not able therefore to conclude why this medication was omitted'*. I asked the N IPA what impact she considered the missed dose had on the patient. She advised that she '*could not identify any impact on the patient for this omission. It is noted that she vomited the next day at 14:00 but that cannot clearly be linked to a missed dose of Esomeprazole the night before'*.

N IPA - Events on 28 April 2018

39. The N IPA referred to the vomiting episode recorded on 28 April 2018 and advised that *'the SKIN bundle / Care rounding[26] had been completed at 13:20 and again at 14:00. At 13:20 the patient was repositioned on to a right sided tilt, she had not vomited at this time. At 14:00 she was attended to again because she had vomited. The clinical records do not document when [the complainant] attended the ward'*.

40. The N IPA advised that *'the patient was cleaned…Her physiological observations were taken and documented on NEWS at 14:20...The staff nurse was informed which is in line with NEWS guidance…A request for medical review was documented by the staff nurse at 14:39, after a discussion with the [complainant]...An anti-emetic[27]…was administered at 17:00'*. The N IPA further advised that '*it is not clear if nursing staff attended after being informed by the [complainant], however it is clear that the patient was not left unattended for a long period of time'*.

41. The N IPA advised that the position the patient was in at the time of the event '*is recognised in national standards as an appropriate position that is both safe and comfortable for the patient…this position is comfortable for the patient and should not increase the risk of vomiting'*. The N IPA further advised that '*the NEWS charts indicate that nausea was not generally a problem for this patient. This appears to have been an isolated episode'*.

[26] Health professionals carrying out regular checks with individual patients at set intervals.
[27] A drug that is effective against vomiting and nausea.

42. The N IPA advised that *'Nursing staff were…only able to identify episodes of need through intentional rounding…planned interventions and by being alerted by family or other patients. The patient was therefore on four hourly care rounds'.* The N IPA further advised that '*it is appropriate that nursing staff would be alerted to the patient's vomiting by her daughter. It is clear that she was attended to a maximum of 40 minutes before the vomiting episode'*. The N IPA advised that *'the actions taken were in line with national standards [the NMC Code]'.*

43. The N IPA advised that the recording of the incident was in accordance with the NMC Code. She further advised that '*as the patient was on a fluid balance chart, the vomiting episode should also have been documented on these charts under 'output' with the approximate volume of vomitus documented…this is in line with nursing guidelines and should be including in local fluid balance policy…I do not think that this would have impacted on the patient as she was reviewed medically at 20:05 and diuretics were stopped to reduce fluid losses anyway'*.

N IPA - Record keeping

44. I asked the N IPA if it is usual for there to be a gap of up to 12 hours in the progress notes. She advised that '*national standards do not specify how often within a 24 hour period nursing evaluations should be written. In line with national standards, nurses should make clear and accurate records relevant to their practice…it is usual therefore to see at least three nursing entries within a 24 hour period, written at the end of the nurses' shift. If there have been any "risks or problems" that have arisen, these should also be documented in line with national standards'*.

45. The N IPA advised that on 22 April 2018, there are entries in the SKIN/ Care rounding charts, and it is recorded that medication was administered. She also advised that she '*cannot see NEWS covering this date, although it is referred to within the records at 22:35 on 22.04.2018. There are no…food and fluid charts covering 22.04.2018…it is not possible to know if there was any impact on the patient from the lack of nursing progress notes...I cannot say that she was assisted with food and drink on 22nd [April] between 11:28 and 22:35'*.

46. The N IPA advised that on 23 April 2018, '*there is sufficient documentation within the progress notes up to 16:46…to show that the patient received 'all cares'.* She further advised that *'there was no impact therefore from the lack of a nursing progress note between 16:46 on 23rd to 05:06 on 24th April 2018'*.

Other information considered

The complainant's response to the draft report

47. The complainant referred to the G IPA's advice that there '*was no evidence of hypersensitivity*' to aspirin. She said the patient was well when she was in the ED. She explained the patient was given Aspirin at 19:55 and at 00:50 she '*began sweating profusely was crying out and had a fast heart rate*'. The complainant said the '*only thing that had happened from when she was well to when she became unwell was the administration of aspirin*'.

48. The complainant said that when she visited her mother on 23 April 2018, she appeared '*very unwell*'. She said the patient had '*apparently*' developed pulmonary oedema and was very short of breath. The complainant explained that this was not how her mother appeared on 20 April 2018 while in the ED. She said she was '*smiling and her usual self*'. She also said the ED doctor informed her that the patient's CT scan did not indicate a stroke and her bloods and x-ray '*did not give cause for concern*'.

49. The complainant said vomiting may be a "rare or very rare" side effect of aspirin *'but it is still a side effect*'. She explained the patient had a '*very sensitive stomach*' and was '*very nauseated*' when she took 75 mgs of aspirin in 2000. The complainant said she has *'no doubt*' that 300mgs of aspirin caused the patient to vomit.

50. The complainant said she concluded that although the G IPA advised there is no evidence that aspirin caused her mother to become ill and to hasten her death, she considers it '*very evident*' that the first medical interventions '*set in motion further reactions which harmed her*'.

Analysis and Findings

Prescription of aspirin

51. The complainant said medical staff prescribed the patient with '*large doses' of aspirin'* despite her history of gastric ulcer. She said this caused the patient to deteriorate. I note the patient received a presumptive diagnosis of an ischaemic stroke in the ED. I considered the RCP's stroke guideline, which states that '*patients with acute ischaemic stroke should be given aspirin 300mg as soon as possible within 24 hours'*. It also states that patients *'reporting previous dyspepsia with an antiplatelet agent should be given a proton pump inhibitor in addition to aspirin'*. I note that at the time, the patient was taking a regular dose of PPI (esomeprazole). I accept the E IPA's advice that '*the balance of risk/benefit was clearly in favour of aspirin administration'*. I consider that the decision to prescribe and administer aspirin for the patient while she was in the ED was appropriate and in accordance with relevant guidelines.

52. I note medical staff continued the aspirin prescription when the patient was admitted to the ward in the early hours of 21 April 2018. I also note that at the time of her admission, the presumptive diagnosis of stroke still stood, and the patient continued to take esomeprazole. Therefore, I accept the G IPA's advice that, *'it was right to continue aspirin'* when she was admitted to the ward.

53. I note the G IPA's advice that the aspirin '*could have been discontinued when it was established by [Consultant B] that the diagnosis was not ischaemic stroke'* on 21 April 2018. I considered the impact the decision to continue the aspirin had on the patient. I note the complainant believed the aspirin caused the patient to vomit, which then led to her contracting aspiration pneumonia. I note the G IPA's advice that in certain circumstances, vomiting can cause aspiration pneumonia. However, the BNF categorises vomiting as a '*rare or very rare'* side effect of aspirin. I also note the G IPA's advice that this reaction '*could not be attributed to aspirin because it was not associated with bleeding*'. While I note the complainant's views on this issue, I do not consider there is sufficient evidence to suggest that the patient's aspirin intake at that time caused her to vomit. Therefore, I do not consider there is a link between the aspirin and the patient's later diagnosis of aspiration pneumonia.

54. The complainant also said the patient's intake of aspirin caused her to deteriorate. I note the G IPA's advice that the patient '*did not suffer from specific side effects of aspirin…there is no evidence to believe that four tablets of aspirin impacted [the patient's] long term health'.* While I note the complainant's views on this issue, I do not consider there is sufficient evidence to suggest the patient's intake of aspirin caused her condition to deteriorate.

55. I note and accept the E IPA's and the G IPA's advice. I consider the decision to prescribe aspirin for the patient was appropriate and made in accordance with the RCP stroke guidance. I also consider that the prescription could have been stopped from 21 April 2018 when the ischaemic stroke diagnosis was no longer a consideration. However, I do not consider there is any evidence to suggest that the continuation of the medication until 24 April 2018 negatively impacted the patient either imminently or long term. I am satisfied that the decision to prescribe and administer aspirin to the patient did not amount to a failure in her care and treatment.

56. I note the patient was taking esomeprazole prior to and during her admission. The G IPA advised that this provided the patient with '*gastric protection'*. The records provide evidence that the prescribed dose of this medication was not administered on 21 April 2018 due to it being unavailable. I also note the prescription was increased to two doses on 27 April 2018 with the second to be administered at 22:00. However, the second dose was not administered until 02:30 on 28 April 2018.

57. I note the N IPA's advice that she '*could not conclude that this [change of prescription] was communicated to nursing staff by the prescriber'*. I reviewed the records relating to this date. I note the Kardex does not document what time the prescription changed (there is no space to do so on the form). However, the progress notes for this date document the medical decision to change the prescription at 14:06 on 27 April 2018. I have no reason to doubt that medical staff updated the Kardex at this time.

58. I note the records do not document a reason why the dose was not administered until 02:30 the following day rather than at 22:00 on 27 April 2018. I accept the N IPA's advice that '*In line with standards applicable at the time of these events [NMC Code], there should be a clear indication of any medication omitted and the reason why'*. I refer to the NMC Code, Standard 10, which provides that nurses are required to '*complete all records at the time or as soon as possible after an event, and to identify any risks or problems… and steps taken to deal with them, so that colleagues who use the records have all the information they need'.* I consider a failure in maintaining accurate and contemporaneous records impedes the thorough, independent assessment of care provided to patients. I also consider that maintaining accurate and appropriate records affords protection to staff involved in providing patient care by providing a clear record of their actions and the treatment provided. I note the G IPA and N IPA's advice that the late administration of esomeprazole did not negatively impact the patient. Therefore, I do not consider this caused the patient to experience any adverse side effects of the aspirin. I consider the absence of this record a service failure.

Events on 28 April 2018 – nursing care

59. The complainant said that on 28 April 2018, nursing staff failed to identify that the patient was '*very unwell'* and failed to escalate her deterioration to a doctor. The RCP's NEWS guidance states that nurses ought to report to the medical team if a patient's observations score three in one of the parameters, and/or their total NEWS is five or above. I note that on 28 April 2018, the patient's NEWS did not reach these levels. Therefore, I do not consider, in accordance with the guidelines, that nursing staff were required to report the patient's condition to the medical team. I accept the N IPA's advice that '*actions taken were in line with national standards'*.

60. The complainant said she reported to nursing staff that the patient had vomit on her nightdress, and she was concerned this was not discovered sooner. I note there was some confusion around the date this occurred. However, I note the records from 28 April 2018 document that the complainant reported to nursing staff at 14:00 that the patient was lying on her back and had vomit on her

nightdress. I note that on that afternoon, the patient was repositioned onto a right sided tilt at 13:20. I accept the N IPA's advice that this was an '*appropriate position that is both safe and comfortable for the patient… and should not increase the risk of vomiting'*.

61. I consider it unfortunate it was the complainant and not staff who discovered the patient had vomited. However, I acknowledge that nursing staff attended to the patient 40 minutes before it was reported, and straight away when they were notified of the situation. I accept the N IPA's advice that '*it is clear that the patient was not left unattended for a long period of time',* and that '*actions taken were in line with national standards'*. I did not identify a failure in the care and treatment nursing staff provided to the patient on 28 April 2018. I do not uphold this element of the complaint.

62. I note that while the N IPA advised that staff recorded the vomiting incident in accordance with the NMC Code, the volume of vomitus was not recorded on the fluid chart. I accept the N IPA's advice that she did not consider this impacted negatively on the patient. However, I would ask the Trust to ensure that in future, staff document all output fluids on the chart in accordance with relevant guidelines.

Events on 28 April 2018 – medical care

63. The complainant said the patient was dehydrated following administration of furosemide. However, I note the G IPA's advice that medical tests undertaken at the time '*did not show evidence of dehydration'*. I also note the complainant said a Registrar made the decision to stop the furosemide, but only following her request. I note the G IPA's advice that there was no reason to stop the furosemide as '*there was radiological evidence of heart failure'*. Furthermore, he advised that '*intravenous fluids would be contraindicated in the presence of heart failure and would have caused [the patient] to become increasingly breathless and poorly'*. I consider there was no reason for medical staff to stop administration of furosemide prior to the complainant's request. Furthermore, I do not consider there was a requirement to prescribe and administer IV fluids for the patient at that time. I did not identify a failure in the medical care and

treatment of the patient on 28 April 2018. I do not uphold this element of the complaint.

Record Keeping

64. In the course of my investigation, I noted gaps of up to 12 hours in the patient's multidisciplinary progress notes on 22 April 2018, and between 23 and 24 April 2018. I note the Trust said it was unable to identify reasons for the gaps in the records.

65. I note the G IPA's advice that as there was no evidence of medical intervention required during these times, there would have been '*no requirement to record anything other than standard medical observations'*. Therefore, I am satisfied there was no requirement for medical staff to update the notes during the stated times.

66. I note the N IPA's advice that while guidelines do not specify how often nursing evaluations ought to be written, it is standard for records to have '*at least three nursing entries within a 24 hour period, written at the end of the nurses' shift*'. I consider, therefore, there is at least one entry missing for the shift completed on 22 April 2018. I also note the N IPA advised that a food and fluid chart covering this date was not recorded. I again refer to Standard 10 of the NMC Code. A lack of appropriate records will limit the availability of clinical information for staff who become involved in the patient's ongoing care and treatment. Therefore, I partially uphold this element of the complaint. I will refer to the injustice to the patient later in this report.

67. I note there is also at least one entry missing for the shift covering 23 April 2018. However, I note the N IPA's advice that additional records provide evidence that the patient received '*all cares'* during this shift. While these records demonstrate that the patient received appropriate care and treatment for that period, I would ask the Trust to ensure that nursing records are completed in accordance with the NMC Code.

Summary of Issue One

68. I established that the medical care and treatment of the patient was appropriate. However, I identified that nursing staff failed to create and retain appropriate records relating to the administration of medication on 27 April 2018. I am satisfied that this did not negatively impact the patient and considered it a service failure. I also identified that nursing staff failed to create and retain appropriate records relating to the care provided to the patient on 22 April 2018. I consider that in this respect, nursing staff failed to act in accordance with Standard 10 of the NMC Code. Therefore, I partially uphold this issue of complaint. I note that in relation to the absence of records on 22 April 2018, the N IPA advised that '*it is not possible to know if there was any impact on the patient from the lack of nursing progress notes'*. However, I am satisfied that the failure identified would have caused the patient to experience the injustice of the loss of opportunity for staff to consider these records when deciding on her future care and treatment.

Issue 2: Whether the communication between Ulster Hospital staff and the patient's daughter was appropriate and in accordance with relevant guidelines.

Detail of complaint

69. This issue of complaint is about staff's communication with the complainant between 20 and 29 April 2018. The complainant said staff did not inform her that the patient's condition deteriorated. She said that instead, when she called on 21 April 2018 to ask how the patient was, the complainant was told she was '*well'*. The complainant was also concerned that medical staff provided her with '*contradictory information'* regarding the patient's condition. She said ED staff informed her the patient did not have a stroke. However, the complainant said that when the patient was admitted to the ward, medical staff initially informed her that the patient did have a stroke. She said the patient's diagnosis later changed to an infection.

Evidence Considered

Legislation/Policies/Guidance

70. I referred to the following legislation, policies and guidance which were considered as part of investigation enquiries:

- The GMC Guidance;
- The GMC Guidance on Consent;
- The GMC Guidance on Confidentiality; and
- The NMC Code.

The Trust's response to investigation enquiries

71. The Trust explained that records document a *'collateral history'* was obtained from the patient's daughter while she was in the ED. It further explained that a '*retrospective note'*, dated 21 April 2018, refers to a conversation between a staff nurse and the complainant regarding the patient's *'medical history and baseline'.* However, it said there is no record of what was discussed. It explained that '*Contemporaneous records should be maintained to include any documented conversation with family members or next of kin'*.

72. The Trust said it accepted doctors gave two different interpretations on the same chest X-ray performed on 26 April 2018*.* It explained that the '*Junior doctors gave both opinions with no Radiology training, so they were giving their non-specialist views before the X-ray had been officially reported on by the Radiology Specialist. Such practice can sometimes lead to different interpretations of the same X-ray by different non specialist doctors before the official report is available on ECR[28] [electronic care record]'*. The Trust said this was '*unfortunate'.* It further explained that *'staff need to ensure that they try to remain as consistent as possible in how they communicate such information. Staff should check what opinion (if any) has already been given and explain why opinions could potentially differ as non-specialists'*.

73. The Trust said it believed the information medical staff gave the complainant was '*as accurate as possible'*. It explained that the only contradictory information that Consultant A would suggest was given to the complainant was that *'she was initially told that her mother had suffered an acute stroke, which was probably reasonable in the fairly early stages of her illness'*. It said this changed '*once [the patient's] condition had deteriorated and she was showing signs of sepsis'.* The Trust explained that '*this information may seem*

[28] A system that holds an electronic record for each patient.

contradictory but as more information became available and more clinical signs became available, it was appropriate that the medical staff moved from a diagnosis of acute stroke, to one of acute sepsis with decompensation of her old stroke'.

74. In relation to learning taken from the complaint, the Trust said '*the team in Ward 3C have reflected both individually and collectively on the concerns raised, specifically in relation to medicines administration and communication'*.

Clinical records

75. A summary of the relevant clinical records is enclosed at Appendix five to this report.

Relevant Independent Professional Advice

Emergency medicine IPA

76. The E IPA advised that the patient's daughter provided a collateral history to medical staff in the ED. However, he advised that there is no evidence in the records to suggest that the ED staff informed the complainant (or any other family) of her mother's diagnosis. He advised that '*in the emergency department typically, we should communicate the problems, a primary and maybe differential diagnosis, the tests requested and how they will help in either making a diagnosis or guide treatment. This is usually to the patient although if this is not possible, next of kin are usually told. In this case it is not documented what information was given'*. In relation to communicating the diagnosis when a family member is not present, the E IPA advised '*it would be good practice to contact them. It is not necessary to have them physically there. There is documented communication from the daughter to the staff, there wasn't anything documented about any [communication] from the staff to the daughter'*.

77. The E IPA advised that '*the key learning here is about communication. It is unclear whether/what verbal communication was made to the [patient's] daughter. This is because there is no record of it. I do not know whether this is an isolated finding and it would be useful to conduct an audit of complaint themes and/or clinical notes to understand how prevalent this is. Beyond that*

the ED staff should be reminded of the importance of documenting conversations with patients and their next of kin. This can be in the medical record although some hospitals use communication sheets'. The E IPA advised that he did not consider this failure had any impact on the patient.

Geriatrician IPA

78. The G IPA advised that '*there is an entry on 24/4/18 at 1245 hrs that [Consultant A] spoke by telephone to the daughter who lived abroad and said that he felt her mother could be discharged after assessment by the physiotherapy'.* He further advised that *'the information that a clinician provides to the relatives about their patient is based on the picture as it was at that point in time. The clinical signs are subject to change and [Consultant A] cannot be said to have provided misinformation or contrary information, when subsequent medical events caused him to change his clinical plans'*.

79. The G IPA was asked if Consultant A initially informed the patient's family that she had not had a stroke and he was hoping to discharge her. He advised that '*there is no record in the…notes that [Consultant A] said so. However…on subsequent review a stroke was ruled out. [The patient] could have been discharged but for the fact that she developed sepsis and urine and chest infection'*.

80. The G IPA advised that '*it is not unreasonable for a clinician to first say what he thinks is wrong based on his impression at the time. When the situation changes or when there are new developments, his impression and reports may alter. That does not mean that [Consultant A] was deliberately plying the complainant with wrong information. Often that is the nature and course of human illness'*.

X-Ray Results

81. The G IPA advised that '*the doctors have recorded their own interpretation of the chest x-ray…I agree with the Trust that the formal report had not been issued at that stage and…the junior doctors gave their own interpretation, which was not of course the specialist opinion'*.

Nursing IPA

82. The N IPA advised that '*staff did not contact NOK in the early hours of 21.04.2018. The patient was admitted to the ward alone with no family member present…and thus a full assessment could not be completed by ward staff. Within such an assessment, nursing staff can document who the first contact should be (this is not always the NOK and this should never be assumed) and if they consent to being contacted late at night or in the early hours. In the absence of this information; and given that the patient whilst unwell, was not at the end of life; it was not appropriate for staff to attempt to contact NOK'*.

83. I asked the N IPA if nursing staff ought to have obtained this information from the NOK. She advised that '*at the time that the assessment was completed, the patient was alone…this could not have been documented prior to the incident occurring in the early hours of 21.04.2018 and it is therefore not a failing that it was omitted'*.

84. The N IPA advised that '*there is no record of a phone call from the complainant on 21.02.2018 [or on] 22.02.18'.* She referred to the NMC Code and advised that '*It is not necessary…to document whenever family phone for an update. It would be necessary and in line with NMC standards however to document if important information was imparted during the update…on this occasion it appears that this was not the case and thus there is no reason to document that an update has been given. Of course any documentation relating to patient care helps to give a full picture of care and communication provision and accordingly it would be 'best practice' to document routine family updates'*.

85. The N IPA advised that '*if the complainant said that she called for an update on 21.04.2018 and 22.04.2018, nursing staff should have updated her at these times. Aside from this, nursing staff would not phone family unless there was a significant change in the patients' condition, if the patient moved wards or if discharge was considered imminent'*.

Analysis and Findings

86. The complainant raised concern with staff's communication with her as the patient's next of kin (NOK). For this issue of complaint, I considered Standard

38 of the GMC's Guidance on Confidentiality, which states, '*If a patient lacks capacity to make the decision, it is reasonable to assume the patient would want those closest to them to be kept informed of their general condition and prognosis, unless they indicate (or have previously indicated) otherwise'*. I note the records do not go as far to establish that the patient lacked capacity. However, I note the clinical records document the patient was '*confused*' and had difficulties communicating when she was admitted to the ward. I also note the record in which the patient normally provides consent for information to be shared with their NOK is blank. This may be due to the patient's difficulties with communicating.

87. While I cannot determine the patient lacked capacity, I consider it clear from the records that the complainant was involved in the patient's care throughout her time in hospital. There is also no suggestion in the records that the patient indicated at any time that she objected to information being shared with the complainant. Therefore, I consider it was appropriate for staff to share information with the complainant as the patient's NOK.

Nursing communication

88. The complainant said nursing staff did not inform her the patient's condition deteriorated in the early hours of 21 April 2018. I note that as the patient was admitted in the early hours, and a family member did not accompany her, staff were unable to confirm if the NOK (or other family member) consented to being contacted at night. I accept the N IPA's advice that this cannot be assumed. I also accept the N IPA's advice that *'in the absence of this information; and given that the patient whilst unwell, was not at the end of life; it was not appropriate for staff to attempt to contact NOK'*. I do not consider there was any requirement for nursing staff to contact the complainant in the early hours of 21 April 2018.

89. The complainant also said that when she made enquiries on 21 and 22 April 2018, nursing staff informed her that the patient was '*well* and she was not informed of the patient's deterioration. I note there is no record of these telephone calls in the patient's clinical records. In the absence of these records,

I cannot conclude if the information provided to the complainant accurately reflected the patient's condition at that time.

90. Nevertheless, I note the N IPA advised that the NMC Code does not require nursing staff to document when relatives call for an update on patients. However, I note the NMC Code requires nurses to '*keep clear and accurate records relevant to your Practice'*. Furthermore, I note the Trust said it expects staff to document *'contemporaneous records…to include any documented conversation with family members or next of kin'*. I consider the absence of these records a service failure. I appreciate the complainant was unable to visit her mother that weekend. While I cannot determine what information was shared with the complainant, I would have expected nursing staff to have provided the complainant with clear and accurate information about the patient's condition.

Communication with medical staff

91. The complainant said medical staff provided her with '*contradictory information'*. I note this partly related to information about the patient's diagnosis. The clinical records document that the patient received a presumptive diagnosis of stroke in the ED. I note the E IPA's advice that information including the diagnosis is usually provided to the patient. However, if this is not possible, *'next of kin are usually told'*. Given the patient's difficulties with communicating, I consider it was necessary to have some form of communication with her next of kin in this instance. The records document the patient was unaccompanied when she was in the ED. However, I note the E IPA's advice that '*it is not necessary to have them physically there'* to communicate this information.

92. The complainant said ED staff informed her the patient did not have a stroke. I note there is no record to suggest that ED staff informed the complainant of any presumptive diagnosis. I consider the information the complainant said she received is contrary to the presumptive diagnosis documented in the ED records. I note the E IPA's advice that diagnoses can change. However, if this is the case, there is no evidence to suggest that staff updated the complainant with a revised diagnosis. In the absence of a record of ED staff's communication with the complainant, I cannot conclude what information was

shared with her in relation to the patient's presumptive diagnosis. I consider the absence of these records a service failure.

93. I note that while on the ward, the patient's diagnosis changed from stroke to sepsis. I note the G IPA's advice that information provided to patients' families '*is based on the picture as it was at that point in time'*. I acknowledge diagnoses can change based on the patient's symptoms and test results. I accept the G IPA's advice that this '*does not mean that [Consultant A] was deliberately plying the complainant with wrong information'*. I acknowledge the information Consultant A provided to the complainant changed during the patient's stay in Ward 3C. However, I consider it was based on the patient's condition at those particular times. I do not uphold this element of the complaint.

94. The complainant also said two doctors provided her with different opinions on the patient's x-ray results on 26 April 2018. Having reviewed the relevant records, I acknowledge the Trust's comment that both doctors gave their '*non-specialist views'* on the x-ray. I do not consider it was made clear to the complainant that these were their individual views, or that the results could change after radiologist review. As the differing opinions did not alter her treatment, I do not consider the miscommunication had any impact on the patient's care and treatment. However, I acknowledge the confusion this would have caused the patient and the complainant. I would ask the Trust to ensure that if medical staff are communicating this type of information in future, it is made clear it is a non-specialist view, and that the patient should await the outcome of the formal report. I note the Trust said that '*staff should check what opinion (if any) has already been given and explain why opinions could potentially differ as non-specialists'*. I welcome this learning.

CONCLUSION

95. I received a complaint about the Trust's care and treatment of the patient during her admission to the UH in April 2018. The investigation established that the medical care and treatment of the patient was appropriate. However, it identified that nursing staff failed to document the reason for the late administration of esomeprazole on 27 April 2018. I consider this a service

failure. It also established that nursing staff failed to create and retain appropriate records relating to the care provided to the patient on 22 April 2018. I am satisfied this failure caused the patient to experience the injustice of the loss of opportunity for staff to consider these records when deciding on her future care and treatment.

96. The complaint was also about staff's communication with the complainant as the patient's NOK. I am unable to determine what information ED staff communicated to the complainant regarding the patient's presumptive diagnosis and subsequent plan of care. This is because there is no record of it. I consider the absence of this record a service failure. In relation to communication with ward medical staff, the investigation identified that information Consultant A communicated to the complainant reflected the patient's condition at those particular times.

97. The investigation was unable to establish if nursing staff communicated to the complainant that the patient was '*well*' following a deterioration in her condition on 21 April 2018. This was due to a lack of records. I consider the absence of this record a service failure.

Recommendations

98. I recommend the Trust discusses the findings of this report with the staff involved in the patient's care within **one month** of the date of this report.

99. I further recommend the Trust provides training to relevant nursing staff to incorporate the following. The Trust should provide me with evidence of this training within **three months** of the date of my final report:
    i. The importance of creating and retaining contemporaneous records of care and treatment provided to patients, in accordance with Standard 10 of the NMC Code.

100. While not a formal recommendation, I would ask the Trust to reflect on its staff's communication with patients' families and/or next of kin and the importance of documenting such conversations in the relevant records.

101. The Trust accepted my findings and recommendations.

MARGARET KELLY
Ombudsman **June 2021**

Appendix 1

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.