Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 201916951

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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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Case Reference: 201916951

Listed Authority: South Eastern Health and Social Care Trust

SUMMARY

This complaint is about care and treatment staff of the Ulster Hospital provided to the complainant's late mother (the patient) during her admission from 3 to 11 August 2019. The complainant said staff did not identify the patient suffered a stroke days before she experienced an acute Cerebral Vascular Accident[1] (CVA). She raised further concerns about staff's prescription and administration of insulin, the administration of potassium injections, staff's refusal to give the patient a drink, and their communication of the patient's prognosis.

The investigation found a number of failings in both the care and treatment provided to the patient as well as a number of service failures. Overall, it found that failures by the Trust denied the patient the opportunity to receive appropriate medication for stroke, as early as possible and to receive that treatment by specialist staff on a stroke ward. This has created the continuing uncertainty for the patient's family of not knowing whether or not such treatment may have made a difference to the patient's survival.

It further found that the patient remained in the ED for more than 24 hours before admission to a ward despite the Ministerial target that no patient should wait more than 12 hours

The failings identified in relation to the patient's care and treatment were:-

- Medical staff failed to determine an earlier diagnosis and treatment of the patient's stoke and should not have ruled out a stroke diagnosis based solely on the patient's normal CT scan;
- Sufficient urgency was not demonstrated by staff to test, or rule out, the patient's infection diagnosis and to consider alternatives to account for her symptoms;
- Incomplete ED nursing assessments and care plans, including the non documentation of pain scores, which led to information not being available to or taken into account by other clinicians treating the patient;

[1] The medical term for a stroke. A stroke is when blood flow to a part of your brain is stopped either by a blockage or the rupture of a blood vessel.

- Failure to the record relevant information about the patient's glucose levels when in the ED;
- Absence of an oral assessment or mouth care plan; and
- Inadequate provision of mouthcare.

The investigation found a number of service failures in relation to the poor standard of record keeping these included:-

- The failure to record the time of the ED medical assessment;
- The inaccurate recording of the patient's systolic blood pressure in the ED; and
- The incomplete recording of observations on Neely Ward and Ward 20.

The investigation found that the service failures identified did not impact on the patient's care and treatment.

The investigation could not find any evidence to suggest staff administered potassium injections to the patient. Furthermore, there was no evidence to suggest medical staff inappropriately communicated the patient's prognosis to the complainant. I recommended the Trust apologise to the complainant for the failures identified. I also recommended actions for the Trust to undertake to prevent the failures recurring.

THE COMPLAINT

1. This complaint is about the actions of the South Eastern Health and Social Care Trust (the Trust). It concerns care and treatment staff of the Ulster Hospital (UH) provided to the complainant's late mother (the patient) during her admission from 3 to 11 August 2019.

Background

2. The patient had a history of chronic kidney disease[2], secondary to chronic pyelonephritis[3]. She regularly attended the renal unit in the UH. She also had Type 2 diabetes and chronic obstructive pulmonary disease[4] (COPD). The patient

[2] A reduction in kidney function or structural damage (or both) present for more than 3 months, with associated health implications.
[3] A continuing pyogenic infection of the kidney.
[4] A long-term condition that causes inflammation in the lungs, damaged lung tissue and narrowing of the airways, making breathing difficult.

attended the emergency department (ED) on 3 August 2019. She presented with pain in her left leg that caused her difficulty walking. She also started to experience a headache while in the ED, which she reported to nursing staff. The patient remained in the ED until the early hours of 5 August 2019 when staff admitted her to the Neely Ward as a medical outlier[5].

3. The patient's condition deteriorated over the next few days. Tests showed she experienced a dense left hemiparesis[6] in keeping with an acute Cerebral Vascular Accident[7] (CVA). Staff transferred the patient to Ward 20 where her condition continued to decline and she sadly passed away on 11 August 2019.

Issue of complaint

4. I accepted the following issue of complaint for investigation:

Whether the patient received appropriate care and treatment in the Ulster Hospital from 3 August 2019 to 11 August 2019?

INVESTIGATION METHODOLOGY

5. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

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

- **Consultant in Emergency Medicine**, FRCEM, FRCSEd(A&E), MBBS, LLM (Medical Law), RCPathME, with 14 years' experience in attending acutely unwell or injured patients, in addition to providing supervision for doctors in training (ED IPA);

[5] Those patients placed in an area which is not normally designated to their particular clinical condition e.g. a medical patient being admitted to a surgical ward.

[6] Weakness to the left side of the body.

[7] The medical term for a stroke. A stroke is when blood flow to a part of your brain is stopped either by a blockage or the rupture of a blood vessel.

- **Consultant in Acute Internal Medicine**, MBiochem(Oxon), BM BCh(Oxon), FRCP(Edin), MMedSci (ClinEd), with experience in treating patients presenting with medical problems to hospital including those with renal complaints, diabetes, and those presenting with strokes (AC IPA);
- **Registered Nurse**, BSc in Nursing Practice, Diploma in Adult Nursing, MSc in Advanced Clinical Practice, with 18 years nursing and managerial experience across both emergency and critical care areas (EN IPA); and
- **Registered Nurse**, Diploma in Adult Nursing, with over 16 years' experience as a senior sister in general surgery and acute medicine (GN IPA).

7. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

8. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[8]:

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

9. 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 and guidance relevant to this complaint are:

- The General Medical Council's (GMC) Good Medical Practice, updated

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

April 2014 (GMC Guidance);

- The Nursing and Midwifery Council's (NMC) Code: Professional standards of practice and behaviour for nurses and midwives, March 2015 (NMC Code);
- Royal College of Physicians (RCP) National Early Warning Score (NEWS) 2. Standardising the assessment of acute illness severity in the NHS, 2017 (NEWS guidance);
- The National Institute for Health and Care Excellence's (NICE) Stroke and transient ischaemic attack in over 16s: diagnosis and initial management, NICE Guideline 128, May 2019 (NICE NG128); and
- The South Eastern Health and Social Care Trust (Trust), Hospital Admissions Policy, March 2014 (the Trust's Admissions Policy).

10. 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.

11. 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.

THE INVESTIGATION

Issue 1: **Whether the patient received appropriate care and treatment in the Ulster Hospital from 3 August 2019 to 11 August 2019?**

Detail of Complaint

12. The complainant raised the following concerns:

- Staff '*ignored*' the family's concerns about her symptoms. They also '*ignored*' signs the patient suffered a mini stroke;
- Staff did not appropriately prescribe and administer insulin for the patient;

- Staff administered to the patient three large injections of potassium on 7 August 2019, and asked family members to time the injections on their phones;
- Staff refused the patient's request for a drink; and
- Doctors informed her on 10 August 2019 that due to the patient's renal history, they did not consider it necessary to continue treatment. She considered the communication of this message inappropriate.

13. The complainant explained the events leading to her mother's death affected her own health at a time when she was already grieving. She said she wants the Trust to provide answers to her concerns.

Evidence Considered

Policies/Guidance

14. I considered the following policies/guidance:
    - GMC Guidance;
    - NMC Code;
    - NEWS guidance;
    - NICE NG128; and
    - The Trust's Admissions Policy.

The Trust's response to investigation enquiries

General care and treatment including diagnosis of stroke

15. The Trust explained staff appropriately escalated any concerns they had about the patient's presentation during her admission. It said staff consulted with the renal team and the critical care outreach team (CCOT) about the patient.

16. The Trust said staff raised concerns about the patient's deterioration on 8 August 2019 and performed a CT scan of her brain. They confirmed the patient experienced a stroke and transferred her to Ward 20.

Prescription and administration of insulin

17. The Trust provided details of the insulin staff prescribed and administered to the patient during her admission. It explained an ED nurse was due to recheck the

patient's blood sugar level on 4 August 2018. However, they did not perform this check. It also explained staff did not administer insulin for the patient at the correct time on 4 August 2019 (22:00). However, staff administered it later at 00:45 on 5 August 2019.

Administration of potassium injections

18. The Trust explained the clinical records did not provide evidence that staff administered potassium injections to the patient.

The refusal to provide the patient a drink

19. The Trust explained staff on ward 20 told the patient she could not have a drink as she was '*nil by mouth*[9]' (NBM) at that time due to the risk of aspiration[10]. It said staff explained this to the patient's family. It also said staff provided regular mouth care for the patient.

Prognosis communicated to the complainant on 10 August 2019

20. The Trust explained that following the patient experiencing an acute CVA, the renal team undertook a review on Friday 9 August 2019. It said the CCOT also reviewed the patient. The Trust explained that after consultation with the intensive care unit (ICU), medical staff concluded the patient '*was not a suitable candidate for ICU'.* It also said the renal team excluded long term dialysis for the patient due to the acute CVA. Staff communicated this information to the complainant on 10 August 2019.

Clinical records

21. Relevant extracts from the clinical records were studied for this report.

Relevant Independent Professional Advice

Advice obtained from the ED IPA

22. A Consultant of emergency medicine (ED IPA) provided me with advice on the care and treatment ED medical staff provided to the patient from 3 to 5 August 2019.

[9] Patients are restricted from eating and drinking.
[10] When something swallowed enters the airway or lungs.

Advice obtained from the AC IPA

23. A Consultant of acute internal medicine (AC IPA) provided me with advice on the care and treatment ward medical staff provided to the patient from 5 to 11 August 2019.

Advice obtained from the EN IPA

24. A nurse with experience working in emergency departments (EN IPA) provided me with advice on the care and treatment ED nursing staff provided to the patient from 3 to 5 August 2019.

Advice obtained from the GN IPA

25. A nurse with experience of acute care (GN IPA) provided me with advice on the care and treatment ward nursing staff provided to the patient from 5 to 11 August 2019.

26. **Complainant's response to draft report**

In response to the draft report the complainant said she did not agree with notes that stated that the patient's calls for help were answered. She believed the patient's symptoms and, concerns raised by the patient's partner, were not addressed. She further believed that had symptoms and concerns been addressed that the patient would still be here. The complainant also reiterated her concerns that potassium injections were given to the patient.

Analysis and Findings

27. The patient remained in the ED from 3 August 2019 (following admission) until the early hours of 5 August 2019 when staff transferred her to the Neely ward. Following diagnosis of the acute CVA, staff transferred the patient to ward 20. For this investigation I considered care and treatment the patient received while in the ED, the Neely ward and Ward 20 (where relevant).

General care and treatment including diagnosis of stroke

The complainant said staff '*ignored*' the family's concerns about her symptoms.

i. The ED

28. I note the ED IPA's advice that staff triaged the patient, assigning the triage category of very urgent[11] in accordance with relevant guidelines. However, I am unable to determine when medical staff assessed the patient, as the records are not time stamped.

29. In accordance with standard 21 of the GMC Guidance, doctors are required to document when they complete a record. I do not consider the failure to time stamp the record affected the patient's care and treatment. However, the absence of a complete record prevents me from establishing whether staff treated the patient in accordance with relevant guidance. Therefore, I consider this a service failure.

30. The patient remained within the ED for more than 24 hours before staff transferred her to the Neely ward. I note the ED IPA's advice that the time taken to complete admission was '*significantly over what would be considered the reasonable expected standard'*. I note that in Northern Ireland The Ministerial targets for emergency care waiting times during 2018/19 stated that '*From April 2019, 95% of patients attending any Type 1, 2 or 3 Emergency Department should be either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours'.* I acknowledge the UH experienced increased demand at that time and recognise the pressure staff must have been under. However, I note the ED IPA's advice that the records do not document staff provided the patient (or her family) an explanation or apology for the delay. While I did not identify any failure in the care and treatment ED medical staff provided to the patient, I do not consider it acceptable that a patient has to wait more than 24 hours to be transferred to a ward. While understanding that the Trust may take steps to make patients and their families awaiting admission comfortable the ED is not an environment suitable for such a prolonged stay. I acknowledge the extended time spent in the ED is likely to have caused the patient (and her family) a degree of uncertainty regarding her admission. I would ask the Trust to remind staff to be mindful of the impact this has

[11] Triage standards would generally expect a very urgent patient to be attended within 10 minutes of the initial assessment. *(ref. Manchester triage system/ UK national triage system).*

on patients and families, and to provide appropriate explanations and support in similar circumstances.

31. I also considered care and treatment ED nursing staff provided to the patient. I note concerns the EN IPA raised regarding information staff recorded in the patient's clinical records. One such concern was the inaccurate recording of the patient's systolic blood pressure[12] on two occasions resulting in an inaccurate recording of the patient's NEWS. I note the EN IPA advised this error *'… would not have changed the frequency of monitoring or required escalation to the medical team'.* Therefore, I do not consider it impacted the patient's care and treatment. However, in accordance with standard 10 of the NMC Code, nurses are required to complete records accurately. I consider this a service failure.

32. I also note the EN IPA's advice that nursing staff did not document the patient's pain score or complete the ED nursing assessment and plan of care. I again acknowledge the ED was particularly busy and the pressure this must have caused the nursing team. However, I consider an incomplete ED nursing assessment and recording of pain scores would have limited the availability of clinical information for ward staff involved in the patient's ongoing care. It would also have denied the patient the opportunity for staff to consider this information when deciding on her future care and treatment. I consider this a failure in the patient's care and treatment. I uphold this element of the complaint in relation to the incomplete nursing documentation.

ii. The Neely Ward

33. Staff transferred the patient on 5 August 2019 to the Neely Ward, which was a Gynaecology[13] ward, but the patient was a medical patient. Such arrangements for a patient leads to them being referred to as 'outliers'. I note the AC IPA's advice that the medical team attended to the patient at least twice daily. This is in accordance with the Trust's Admission Policy. However, I also note his general observation that on the ward, '…*medical staffing appears to be ad hoc, inconsistent'.* I would ask the Trust to reflect on his comment and consider how it can improve staffing on outlying

[12] This measures the force the heart exerts on the walls of the arteries each time it beats (also known as the top number in blood pressure readings).

[13] The area of medicine that involves the treatment of women's diseases especially those of the reproductive organs.

wards to ensure continuity of care. I would further ask the Trust to consider reviewing the patient's journey to ensure that the delay in transfer to the Neely Ward, as well her being placed in an outlying ward, did not impact on the care offered to the patient.

34. The complainant said staff failed to identify the patient suffered a '*mini stroke*'. The AC IPA advised the patient presented with symptoms of stroke from her arrival at the ED and throughout her admission. I note the patient's CT brain scan performed at admission provided a '*normal*' result. However, the AC IPA advised this does not necessarily rule out stroke. He said it can indicate the stroke happened recently and '*no acute damage is visible yet*' on the scan.

35. I note from the admission records medical staff did not record a diagnosis of stroke. Instead, they reached a possible diagnosis of infection (either chest or urinary tract). I considered if staff performed appropriate tests to check this diagnosis.

36. The records document the ED doctor asked staff to obtain a mid-stream sample of urine (MSSU) on 3 August 2019 (presumably to confirm or rule out a urine tract infection [UTI]). I note ED staff attempted to obtain a sample on 4 August 2019, which was unsuccessful. However, the records do not contain any further attempt to obtain a sample until the afternoon of 5 August 2019. I note from the laboratory records this sample did not confirm infection. I cannot identify from the records that medical staff considered this result and used it to rule out a UTI.

37. The records document the ED doctor also requested a chest x-ray on 3 August 2019 (presumably to confirm or rule out chest infection). While the notes for 5 August 2019 refer to an x-ray, the records evidence staff did not successfully perform an x-ray and produce a formal report until 8 August 2019. Therefore, it was five days following the patient's admission that staff performed tests to enable them to rule out infection. Based on the information contained in the clinical records, I cannot be satisfied staff demonstrated sufficient urgency to test the infection diagnosis and to consider alternatives to account for the patients symptoms.

38. I note the AC IPA's advice that the normal CT '*falsely reassured*' medical staff. Therefore, they did not investigate further the possibility of stroke until after the patient experienced an acute CVA. I also note his advice that had staff performed the MSSU and chest x-ray, and had they obtained normal results earlier, they would likely have considered other reasons for the patient's symptoms. The AC IPA considers it likely this would have elicited an earlier diagnosis and treatment for stroke. I accept his advice and uphold this element of the complaint.

39. The AC IPA advised that even if the patient received earlier treatment, there was only a '*very small*' chance it would have prevented the second stroke. He advised that '*on the balance of probabilities this would have made no difference to this individual patient and she would still have suffered the fatal larger second stroke even had things gone right*'. The AC IPA further advised *'it is likely that the patient would have been on an acute stroke ward if and when the second stroke occurred which may have been picked up sooner and more amenable to acute treatment*'. I acknowledge the complainant's view that if the patient's symptoms and concerns of her partner had been addressed sooner the patient would still be here. Based on the available evidence, I cannot determine that earlier diagnosis and treatment would have prevented the patient from suffering an acute CVA. However, I consider the failures by the Trust, denied the patient the opportunity to receive appropriate medication for stroke, as early as possible and to receive that treatment by specialist staff on a stroke ward.

40. I acknowledge the frustration, upset and anxiety the complainant and her family must have felt during the patient's admission. This is especially as they believed the patient experienced a stroke yet medical staff were not in a position to confirm the diagnosis. I also acknowledge the uncertainty they experienced, and will continue to experience, not knowing what difference (if any) earlier diagnosis and treatment on a specialist ward may have made.

41. In relation to nursing care, I note the GN IPA advised there is no evidence in the records to suggest staff did not appropriately respond to concerns and escalate to medical staff when necessary. I acknowledge that the complainant disagreed with this advice. The GN IPA identified several record keeping concerns with staff's

NEWS and GCS monitoring of the patient. However, I note she did not consider the failings impacted the care provided to the patient. I again refer to standard 10 of the NMC Code, which provides that nurses are required to complete records accurately. While I do not consider this a failure in the patient's care and treatment, I do consider it a service failure.

Prescription and administration of insulin

42. The complainant said staff did not appropriately prescribe and administer insulin to the patient.

i. ED department

43. I note from the triage records that staff did not check the patient's blood sugar when she arrived at the ED. The ED IPA advised staff should have considered this a '*baseline observation*' for a diabetic patient. I acknowledge ED staff performed a venous blood gas[14] (VBG), which produced a reading slightly above normal. However, the ED IPA advised staff did not comment on the result within the patient's records. I also note that following a normal reading on 4 August 2019, staff were due to check the patient's blood sugar again later that evening. The records evidence staff did not take the second reading.

44. In relation to the administration of insulin, I note the EN IPA advised nursing staff did not administer the prescribed dose at 18:30 on 4 August 2019. She further advised that while this was likely because the blood glucose reading was '*at the lower end of range',* nursing staff should have documented the reason and escalated it to medical staff. However, the records do not evidence they did this.

45. I note both the ED and EN IPAs did not consider the missed readings or missed dose on 4 August 2019 impacted the patient's care. However, I am concerned that the failure to record information regarding the patient's blood glucose levels and administration of insulin would have denied the patient the opportunity for staff to consider this information when deciding on her future care and treatment. Therefore, I consider this a failure in the patient's care and treatment. I uphold the

[14] A venous blood gas sample can be used to evaluate carbon dioxide, pH and bicarbonate. They can be used to indicate the presence of certain medical conditions including diabetes.

element of the complaint relating to the recording of relevant information about the patient's glucose levels.

ii. Neely Ward and Ward 20

46. The records evidence several occasions when staff did not administer insulin to the patient on both wards. The GN IPA advised this was either at the patient's request or because it was not required due to her blood glucose level, which she considered appropriate. However, I also note her observation that '*some further discussion with the medical team would have been beneficial'.* I ask the Trust to reflect on her comment and consider reminding nursing staff in future to discuss similar requests with their medical colleagues. They should also document their discussions in the clinical record.

47. I note the GN IPA's advice that ward staff appropriately monitored the patient's blood glucose levels. The records evidence that staff ceased monitoring after 9 August 2019. However, this was due to the patient's deterioration, which the GN IPA considered appropriate.

48. I did not identify any failure in the patient's care and treatment regarding the prescription and administration of insulin while she was on the wards. It is my experience that many diabetic patients with the help of their families take great care in monitoring blood glucose levels and administering insulin, it is therefore important that staff engage with patients and their families' and explain the reasons why they have decided to vary the approach. I have no doubt this would have eased the complainant's concerns about this issue at an already worrying time.

Administration of potassium injections

49. The complainant said family members witnessed the patient receiving three large injections of potassium on 7 August 2019. She also said staff asked them to time the injections on their phones.

50. I note the AC and GN IPAs' advice that the records do not provide evidence staff prescribed or administered potassium injections for the patient at any time during

her admission. I also note the records do not provide evidence that staff asked family members to time any injections. While I have no reason to doubt the complainant's concern, I cannot find any evidence that would allow me to conclude on this element of the complaint.

The refusal to provide a drink to the patient

51. The complainant raised concerns that staff refused to give the patient a drink during her time on Ward 20. The clinical records document the patient requested a drink of water at 04:05 on 10 August 2019.

52. I note the GN IPA considered staff's refusal to provide the drink reasonable given she was NBM at that time. I also note that had staff provided a drink, there was an increased risk the patient would aspirate given her presentation after experiencing an acute CVA. Therefore, I consider staff's refusal of a drink in this instance appropriate and in the patient's best interests.

53. In these circumstances, nursing staff normally provide regular mouth care to patients. I note in her advice, the GN IPA identified only six occasions between 8 and 11 August 2019 when staff provided the patient mouth care. She considered this inadequate. I accept her advice and consider this a failure in the patient's care and treatment.

54. The GN IPA also identified the patient's clinical records do not contain an oral assessment or mouth care plan. Such assessments and plans inform staff how often they should provide mouth care to patients. Therefore, it is likely the absence of these led to the failure to provide adequate mouth care. I also consider this a failure in the patient's care and treatment, denying her the opportunity to receive adequate assessment and mouth care provision.

55. Appropriate mouth care is especially important for those patients who are NBM. I have no doubt the absence of adequate mouth care caused the patient discomfort. This is especially evident from her request for water. I also consider that if staff had carried out an oral assessment, devised a mouth care plan and communicated the plan to the patient's family, these alongside the patient being NBM, would have

helped ease the family's concern following staff's refusal to provide a drink. I uphold the element of the complaint in relation to the management of mouth care for the patient and communication with the family but I consider it was in the patient's best interests not to provide a drink at the time requested.

Prognosis communicated to the complainant on 10 August 2019

56. The complainant raised concerns about doctors' communication of the patient's prognosis to her on 10 August 2019. I note the GN IPA's advice that it is difficult to comment on whether doctors appropriately communicated the prognosis from the written record alone. However, based on the record, he considered the information provided to the complainant reasonable and appropriate.

57. I recognise this was a difficult conversation for the complainant at an already traumatic time. I would hope that in this situation, doctors convey this type of message sensitively and sympathetically. From the information available to me, I cannot conclude the doctors' communication was inappropriate or that they failed to act in accordance with GMC Guidance. While I do not uphold this element of the complaint, I do not doubt the upset the complainant would have felt having received the distressing news about her mother's prognosis particularly if this was not managed in line with professional standards.

CONCLUSION

58. This complaint is about care and treatment staff provided to the patient between 3 and 11 August 2019 during her time in the UH. I have upheld elements of the complaint for the reasons outlined in this report. I also found the record keeping for this case of a poor standard and identified service failures relating to the creation and maintenance of clinical records.

59. I recognise the impact the failures had on the patient, the complainant, and their family. I especially recognise that there was most likely a delay in the identification of a stroke and as a result, the patient was denied the opportunity to receive appropriate medication for stroke, and receive treatment on a stroke ward. I

acknowledge this also leaves the complainant and her family in a position of uncertainty regarding the patient's clinical pathway. I offer my condolences for their loss.

Recommendations

60. I recommend within one month of the date of this report:

    i. The Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused to her as a result of the failures identified;

    ii. Provide evidence it shared and discussed this report with staff involved in the patient's care; and

    iii. Provide evidence the Trust use the findings outlined in this report as a training tool for staff.

61. I further recommend the Trust implements an action plan to incorporate the following recommendations and should provide me with an update within **three months** of the date of my final report. It should provide evidence to confirm completion of the actions (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies):

    i. Provide training to relevant staff regarding the importance of creating and retaining contemporaneous records in accordance with Standard 10 of the NMC Code and Standard 21 of the GMC Guidance;

    ii. Provide training to relevant medical staff regarding recognition of stroke in patients and the provision of appropriate treatment; and

    iii. Undertake an audit using a random sample of nursing records. The audit should assess if the records contain completed oral assessments and mouth care plans. The Trust should report its findings to my office.

62. I would ask the Trust to reflect on the comments of the AC IPA, and consider how it can improve staffing on outlying wards to ensure continuity of care. I would further ask the Trust, to consider reviewing the patient's journey to ensure that the delay in transfer to the Neely Ward, and the fact the patient was placed on an outlying ward, did not impact on the care offered to the patient.

63. Throughout my examination of this complaint, I recognised the pain and trauma the complainant and her family experienced over the patient's sudden and unexpected death. The effect of losing a much loved mother in such circumstances is very evident in the correspondence I received. It is clear from my reading of the records how involved the family were in the patient's care. I hope this report goes some way to address the complainant's concerns. I recognise the complainant may not totally agree with all of my conclusions. However, I wish to assure her I reached them only after my full consideration of the facts of this case.

64. The Trust accepted my findings and recommendations.

MARGARET KELLY
OMBUDSMAN **15 March 2022**

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.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT 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.