Investigation Report

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

NIPSO Reference: 201916987

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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.

TABLE OF CONTENTS

Page

SUMMARY ………………………………………………………… 3

THE COMPLAINT ……………………………………………… 4

INVESTIGATION METHODOLOGY ………………………… 5

THE INVESTIGATION ………………………………………….. 7

CONCLUSION …………………………………………………... 16

APPENDICES ……………………………………………………. 19

Appendix 1 – The Principles of Good Administration

Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 201916987

Listed Authority: Western Health & Social Care Trust

SUMMARY

I received a complaint about the actions of the Western Health & Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to the patient. In particular, the complainant was concerned that the Trust failed to identify indicators of sepsis while the patient was recuperating on a ward after surgery to her ankle, leading to the patient spending 95 days in ICU and the amputation of her lower right leg.

The investigation examined the details of the complaint, the Trust's response and relevant local and national guidance. I also obtained independent professional advice from an experienced Registered General Nurse and a Consultant Orthopaedic Surgeon.

The investigation established that the care and treatment the patient received until 6 February was reasonable and appropriate. However, the investigation found that the Trust failed to take a blood culture to test for infection and to escalate the patient for a review by a senior doctor when she was presenting with several moderate to high-risk indicators of sepsis and high infection markers on 6 February 2018. I concluded that the patient was denied the opportunity to be reviewed by senior doctor and to have her blood tested for infection in a timely manner. While I recognise and sympathise that the experience of witnessing the patient's deterioration would have been very distressing for the complainant, I was unable to reach a definitive conclusion on how the Trust's actions affected the patient's outcome. I also concluded that these failings amounted to uncertainty and upset for the complainant.

I recommended that the Trust provide the complainant with a written apology for the injustice caused as a result of the failures in care and treatment I identified. I also made recommendations for service improvements in relation to record keeping and staff training.

THE COMPLAINT

1. The complainant raised concerns about the actions of the Western Health and Social Care Trust (the Trust) in relation to the care and treatment provided to his wife (the patient) at Altnagelvin Area Hospital (the hospital) between 26 January 2018 and 7 February 2018

Background

2. The patient attended the hospital on 26 January 2018 with a swollen and tender right ankle. The ankle joint was a prosthetic replacement inserted over fifteen years previously. Investigations indicated that the ankle joint was infected and on 28 January, the patient underwent surgery to have the infected area washed out. Surgeons subsequently removed the ankle joint on 31 January.

3. On 3 February, tests indicated that there was a problem with the patient's kidney function. On 6 February, the complainant said that he reported to a nurse that the patient was slurring her speech and was confused. The patient's blood results indicated an acute kidney injury (AKI[1]). In addition, the patient's blood pressure and temperature were low.

4. On 7 February the patient's condition deteriorated and she was admitted to the Intensive Care Unit (ICU) with sepsis[2]. She remained in the ICU for 95 days. While in the ICU, surgeons removed her right hip femoral head[3] and amputated her lower right leg.

Issue(s) of complaint

5. The issue of complaint accepted for investigation was:

Issue 1: **Was the Care and Treatment provided to the patient between 26 January 2018 and 7 February 2018 in Altnagelvin Hospital, appropriate and reasonable and in accordance with good medical practice?**

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[1] an abrupt (within hours) decrease in **kidney** function, which encompasses both **injury** (structural damage) and impairment (loss of function)

[2] An infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever

[3] the highest part of the thigh bone

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

- **Registered General Nurse (RGN)**: Diploma in Asthma, Diploma in Chronic Obstructive Pulmonary Disease, BSc (Hons) Nurse Practitioner, MA Health Service Management, V300 Non-medical prescriber Association for Respiratory Technology & Physiology. Spirometry. A senior nurse with eighteen years nursing and managerial experience across both primary and secondary care (N IPA); and
- **Consultant Orthopaedic Surgeon**: MD, FRCSEd(T&O) who has worked in the NHS since 2007 (O IPA).

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

Relevant Standards and Guidance

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

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

- The Principles of Good Complaints Handling

10. 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, as updated April 2014 (the GMC Guidance);
    - The National Institute for Health and Care Excellence (NICE) Guidelines:CG50 Acutely ill Adults in hospital - recognising and responding to deterioration July 2007 (NICE CG50);
    - The National Institute for Health and Care Excellence (NICE) Guidelines: NG51 Sepsis, recognition, diagnosis and early management September 2017 (NICE NG51);
    - Nursing & Midwifery Council (NMC) The Code – Standards of Conduct, performance and ethics for nurses and midwives, March 2015 (NMC Code);
    - Parliamentary and Health Service Ombudsman (PHSO): TIME TO ACT Severe sepsis: rapid diagnosis and treatment saves lives, September 2013 (PHSO, Time to Act); and
    - Royal College of Physicians (RCP) National Early Warning Score (NEWS[5])2 Standardising the assessment of acute-illness severity in the NHS December 2017 (RCP NEWS Guidance).

11. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

12. 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.

[5] A guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs

THE INVESTIGATION

Issue 1: Was the Care and Treatment provided to the patient between 26 January 2018 and 7 February 2018 in Altnagelvin Hospital, appropriate and reasonable and in accordance with good medical practice?

Detail of Complaint

13. The complainant was concerned that while treating the patient on Ward 2, clinical staff overlooked several indicators of sepsis. The claimant said that on 6 February he informed a nurse that the patient was jaundiced, slurring her speech and appeared confused. He said that the nurse told him that this was because the patient's kidneys were not processing her pain relief and she was experiencing symptoms similar to a mild overdose.

14. The complainant said that in addition to these visible symptoms, the patient's blood pressure and temperature were low and her blood results indicated the presence of an AKI. He said that as she had been admitted to the hospital with an infection and was taking steroids for rheumatoid arthritis[6], she was a high-risk patient.

15. The complainant questioned why clinical staff did not take blood cultures from the patient, despite plans in her medical notes to do so. He believed that by not testing her blood for infection the Trust did not follow the relevant guidelines. The complainant said that the experience had left him feeling angry and he wanted to know if the patient's outcome would have been different if ward staff had identified the signs of sepsis earlier.

Evidence Considered

Legislation/Policies/Guidance

16. I considered the following guidance:
    - the GMC Guidance;
    - NICE NG51; and
    - PHSO, Time to Act.

[6] A chronic inflammatory disease that affects the joints. This results in painful joints, swelling and stiffness in the joints.

The Trust's response to investigation enquiries

17. In its response to investigation enquiries the Trust referred to the responses it gave to the complainant following his initial complaint and during a subsequent meeting between the complainant and the team responsible for the patient's care. In relation to the care the patient received following the operation to remove the ankle replacement, the Trust stated that it '*was of the view that the initial care involving washout and removal of metalwork in theatre was appropriate as the infection was not going to resolve while the ankle implant was still in place. This was evidenced in the daily review by the Orthopaedic Team, ongoing blood and observation monitoring and involvement of the …Microbiology staff.'*

18. In response to the complainant's concern that the patient was at high risk of developing sepsis, the Trust stated that *'sepsis was diagnosed and managed by surgical incision and debridement[7] of the considered source. Repeat surgery, with more extensive debridement, indicates appropriate intervention to further reduce the infective components and tissue. Antibiotics continued with evidence of discussion with the Microbiology Team.'*

19. In response to the complainant's enquiry as to why clinical staff did not take blood cultures as planned when the patient was showing several markers consistent with sepsis, the Trust stated '*a blood culture test may not have made any difference. [The patient] was already on antibiotics and the infection had been treated. At the time there was more concern for liver and kidney problems, infection was on the list of things to monitor but it was not the main concern….the infection had been treated and as such it was not the number one priority.* In addition, in response to investigation enquiries, the Trust stated '*Considering that tissue from [the patient's] ankle had been sent to the laboratory for culture and she was on antibiotics, blood cultures could have been considered inappropriate*.'

Clinical records

20. I carefully considered the patient's clinical records.

Relevant Independent Professional Advice

[7] the removal of damaged tissue or foreign objects from a wound

21. The N IPA was asked if the nursing care the patient received while on Ward 2 was reasonable. The N IPA advised '*the patients* (sic) *nursing care was in line with national guidance because it was assessed, planned, and evaluated from admission up until HDU transfer*.'

22. The N IPA further advised '*[a]t 00:15 on 06/02/2018 the doctor was bleeped due to blood tests showing AKI (acute kidney injury). Prior to this time, given that the patient was reviewed on daily ward rounds, there was no indication from NEWS or nursing documentation that the patient should have been escalated to a doctor'*

23. Enquiries were made of the N IPA if nursing staff ought to have considered the possibility that the patient was suffering from sepsis prior to 7 February. The N IPA advised '*[t]he patient was at high risk of sepsis due to the long term steroids (prednisolone) that she was taking for her rheumatoid arthritis. On admission a 'septic right ankle' was suspected...She was therefore already being treated with IV antibiotics and had had a senior review, as recommended within NICE guidelines*'.

24. The O IPA was asked if the actions taken by the Trust to treat the patient's ankle were reasonable; he advised '*Overall the operations performed are reasonable, although there was an unexplained delay from 27 – 28 January*. *There is no evidence that the patient had the opportunity to meet with the consultant or the operating surgeon prior to the procedures. This is poor.'*

25. The O IPA advised '*Following surgery the patient was managed on antibiotics (IV flucloxacillin). She was seen daily on ward rounds, and was seen by tissue viability. Microbiology input is also documented. This represents good post op care but again there is no evidence of consultant involvement in this lady's review.'* The O IPA further advised that the '*[c]hoice of antibiotic was appropriate, and supported by microbiology advice***.'**

26. Enquiries were made of the O IPA if the patient's treatment was reasonable during the period between her return to the ward after surgery and her admission to the ICU on 7 February. The O IPA advised '*[o]verall, while there is little evidence of consultant orthopaedic surgeon input into this patient's care, there is regular review and in my opinion her management over this period is reasonable*'. The O IPA

further advised that '*[t]he patient was diagnosed with an infected ankle joint at the time of admission. This was treated appropriately with surgery, and antibiotics. She was seen daily, and when her condition deteriorated she was referred to ITU. Orthopaedic consultant input was somewhat lacking, but I do not think this would have altered management.'*

27. Enquiries were made of the O IPA that given her symptoms, if clinical staff ought to have considered the possibility that the patient was suffering from sepsis prior to 7 February. The O IPA advised '*on 6/2 the CRP*[8] *had increased to 272. This is documented by the FY1*[9]*'.* The O IPA further advised, '*there was an opportunity for senior review following FY1 review at 19:55. There were clearly signs of active infection at that point, and as per the complaints correspondence, blood cultures as part of Sepsis 6 would have been appropriate. This may not however have altered the patient's outcome, however a diagnosis of sepsis at that point may have triggered active fluid balance, oxygen therapy and active management of potential sources of infection* ' The O IPA further advised '*given a CRP of 272, in my opinion a sepsis screen*[10] *should have been undertaken'.*

28. Further enquiries were made of the O IPA if it would have been appropriate for the Trust to undertake a sepsis screen, given that on 6 February, the patient's blood pressure and temperature were low, and that her blood tests indicated that she had an AKI. The O IPA said that while he understood the actions that the Trust took to treat the patient, a sepsis screen would have been appropriate and that he considered that her care was '*poor*'.

The complainant's response to the draft report

29. The complainant raised a concern about the O IPA's advice that an escalation for senior review and additional blood cultures '*may not however have altered the patient's outcome'.* The complainant said that '*I think it fair to ask that the possibility that it "may have" altered the outcome also be included and explored.*' The

[8] **C-reactive protein (CRP)** is an acute phase reactant, a protein made by the liver that is released into the blood within a few hours after tissue injury, the start of an infection or other inflammation
[9] Foundation Year 1 junior doctor: the first level of clinical training for qualified doctors that bridges the gap between medical school and specialty training
[10] Also known as Sepsis 6: components of the sepsis 6 are: blood cultures, check full blood count and lactate, IV fluid challenge, IV antibiotics, monitor urine output and give oxygen

complainant said that he wanted the issue looked at in the context of the time critical nature of sepsis management.

30. The complainant asked if the failures in care and treatment identified had denied the patient '*the opportunity to have a better outcome'.*

31. In order to address the complainant's concern that earlier intervention by the Trust '*may have*' altered the patient's outcome, I obtained additional advice from the O IPA. The O IPA advised that while there was an opportunity for the Trust to take blood cultures and to escalate the patient for senior review, it was impossible to know definitively what would have happened if the Trust had taken these actions.

The Trust's response to the draft report

32. In its response, the Trust stated that a consultant saw the patient on 29 January and informed her that a further operation was required to remove the infected ankle joint. The consultant warned the patient that an amputation might be necessary at a later date if the procedure was unsuccessful.

33. In relation to the failure to escalate the patient for senior review on the evening of 6 February, the Trust stated that services were stretched due to a lack of cover from clinicians. The Trust advised that the FY2 who led the ward round covered 55 beds, as well as dealing with the Emergency Department and a variety of other duties. The Trust stated that there was no consultant on site and that the FY2 escalated the patient to a senior clinician early in the morning of 7 February when her NEWS[11] reached 7.

34. In relation to the complainant's claim that the patient was confused and slurring her speech on 6 February, the Trust stated that the '*patient's clinical observations are not reflective of what was described in the draft report.'* It stated that the patient appeared drowsy after returning to the ward following a cigarette break on the morning of 7 February, but there was no record of slurring or confusion in her notes.

35. In relation to the failure to take a blood culture, the Trust stated that it was aware

[11] National early warning score: A guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs

that the patient was septic and it had prescribed antibiotics to treat the infection. It questioned if further blood cultures would have been effective.

36. The Trust advised that the patient was 'very well' following the operation to remove her ankle joint and that her deterioration was sudden and unexpected. It also emphasised that the treatment it provided to the patient in the ICU had saved her life.

Analysis and Findings

37. I note the N IPA's advice that '*the patients nursing care was 'in line with national guidance because it was assessed, planned, and evaluated from admission up until HDU transfer*.' I note further the O IPA's advice that'*[t]he patient was diagnosed with an infected ankle joint at the time of admission. This was treated appropriately with surgery, and antibiotics. She was seen daily, and when her condition deteriorated she was referred to ITU.* I note that the O IPA highlighted the lack of consultant review in the patient's post-operative care, but advised that despite this; in general the patient's management was reasonable. I accept both IPAs' advice and I am satisfied that the care and treatment the patient received until 6 February was reasonable and appropriate.

38. I note the complainant said that on 6 February he alerted a nurse on two occasions that the patient was confused and slurring her speech. He said the nurse told him that the patient's kidneys were not processing her pain relief medication well. He said that the nurse told him the patient was no longer receiving the medication and that her system would flush out any excess. I note further that the complainant said the patient's mother later informed a nurse that the patient was very lethargic.

39. I carefully examined the patient's clinical records. There is no indication in the records that she was confused and slurring her speech on 6 February. In addition, there is no record of a discussion between the complainant and clinical staff regarding these symptoms. I consider that the complainant's recall of the incident is very clear and consistent. I also note that he recounted this incident during his meeting with the Trust on 21 0ctober 2019. I note that during the meeting, the Trust's representatives did not challenge, or dispute the complainant's recollection

of events.

40. The Trust stated in a meeting with this office that there is no record in the patient's clinical observations that she was confused, or slurring her speech on 6 February. The complainant feels this was a clear indicator that the patient was septic, however I have been unable to verify this as nothing is contained in the contemporaneous records made by Trust staff and I must base my findings on the evidence. However, I note there were a number of other indicators of sepsis in the patient's clinical observations on 6 February.

41. The complainant raised concerns that on 6 February, the patient's medical records showed that her temperature and blood pressure were low and that her blood tests indicated an AKI. I note that NICE NG51 Sepsis risk stratification tool advises that a patient aged 18 and over in hospital '*assessed as having acute kidney injury'* should be escalated to high risk and to '*[a]rrange immediate review by senior clinical decision maker'*. I note further the risk stratification tool advises that when a patient's blood pressure is measured at 91-100mmHg, a venous blood test should be carried out for a blood culture.

42. The patient's nursing notes record that on 6 February a '*JHO'*[12] doctor reviewed the patient and felt that her kidney injury was '*due to* (sic) *high amount of analgesia and to get same reviewed in AM'.* I note further that during a subsequent review at 06.39, a '*SHO'*[13] doctor was '*not concerned'* by the patient's continuing low blood pressure

43. On 6 February at 19.55 a FY1 doctor assessed the patient in relation to raised CRP levels of 272. I note that the patient's records indicate the doctor's plan to carry out a chest x-ray in relation to the elevated CRP levels, with no indication of any further action.

44. I note that in response to the complainant's concern that ward staff did not take a blood culture from the patient, the Trust stated '*[a]t the time there was more*

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[12] (Junior) House Officer. a grade of junior doctor that was, until 2005, the only job open to medical graduates in the United Kingdom who had just passed their final examinations at medical school and had received their medical degrees. Now more commonly referred to as FY1 (see footnote 9)
[13] Senior House Officer: a junior level role. Some hospitals use the term in an unofficial capacity for doctors in FY2 (foundation year 2) and CT1/2 year (core trainee year 1 & year 2) and in some "CT3"

concern for liver and kidney problems, infection was on the list of things to monitor but it was not the main concern….the infection had been treated and as such it was not the number one priority'.

45. I note the O IPA's advice that the overall care and treatment on 6 February was '*poor*' and that it would have been appropriate to undertake a sepsis screen given that the patient was exhibiting several symptoms indicative of moderate to high risk of sepsis. I note further the O IPA advised that **'***on 6/2 there was an opportunity for senior review following FY1 review at 19:55… blood cultures as part of Sepsis 6 would have been appropriate… a diagnosis of sepsis at that point may have triggered active fluid balance, oxygen therapy and active management of potential sources of infection'***.** I note that in response to the O IPA's advice, the complainant said that a diagnosis of sepsis '*should have*' triggered active fluid balance, oxygen therapy and active management of potential sources of infection. I agree with the complainant. I note that the next senior review occurred at 07.40 on 7 February.

46. I refer to the GMC Guidance, and in particular standard 15, which states that good clinical care must *'adequately assess the patient's conditions''* and that medical staff must *'promptly provide or arrange suitable advice, investigations or treatment where necessary.*' While I acknowledge that the Trust considered that it had successfully treated the patient's ankle infection by means of intravenous antibiotics, I note the IPA's advice that by 6 February there 'w*ere clearly signs of active infection at that point'.*

47. I accept the O IPA's advice that it would have been appropriate to refer the patient for senior review and to take a blood culture to test for infection on 6 February following the FY1 review at 19.55. The Trust explained the pressures it faced on the wards due to a lack of available medical staff. I acknowledge the difficulties that this can cause for the Trust and the burden it places on those clinicians who must manage competing pressures on their time. The Trust also explained that as it was actively treating the patient for an infection it was unclear if a blood culture would have revealed anything. This may have been the case, however; I do not consider it sufficient reason not to have undertaken a blood culture. The early detection and appropriate management of sepsis is fundamental in a hospital setting. Therefore, I find that this was a failure in care and treatment and I uphold this element of the

complaint.

48. I note the O IPA's advice that a more timely review and blood culture '*may not…have altered the patient's outcome';* therefore, it is impossible to be certain if the failings identified led to the patient's deterioration and admission to the ICU. It is understandable for the complainant to ask if a more timely review and blood culture 'may' have altered the patient's outcome. The PHSO Time to Act report found that in sepsis management, '*rapid diagnosis and simple treatment can be critical*'. However, I consider that the O IPA's advice is reasonable in the circumstances and I agree that it is uncertain whether the additional actions listed by the IPA would have prevented deterioration in the patient's condition and escalation of care to the ICU. The complainant makes the point that the actions listed by the IPA may have prevented deterioration. I acknowledge the complainant's view and agree that these actions ought to have been implemented. I will address the injustice to the patient and complainant in paragraphs 52 and 53.

49. Early detection of sepsis in hospital settings is an ongoing concern. I note that the PHSO Time to Act report identified shortcomings in clinical care such as: '(doing) *the necessary tests to quickly identify the source of infection*', having '*adequate staff education and training*' and '*ensuring appropriate and timely senior input*'. I am critical that all of these issues identified by the PHSO appear to be features in the patient's care and treatment on 6 February. However, I acknowledge the efforts made by the treating clinicians in the ICU to turn the patient's situation around and I commend their actions.

50. While not part of the issues of complaint, I note the O IPA advised that there was no evidence that the patient had the opportunity to meet with the consultant or the operating surgeon prior to the operations on 28 and 31 January. The O IPA advised that this was '*poor'.* The O IPA further advised that there was '*no documentation in the clinical record that these procedures were discussed with the patient other than the consent form. It would be good practice that discussions of this type, in particular the risks benefits and alternatives to surgery are discussed and documented'.*

51. The investigating officer spoke with the complainant who recalled that a clinician

advised the patient it was possible that it might become necessary to amputate the patient's leg depending on the outcome of the operation. The complainant could not recall if this discussion took place before or after the procedures on 27 and 30 January. I note the Trust subsequently provided the Investigating Officer with evidence that a consultant met with the patient on 29 January and discussed the potential issues in relation to the second operation.

Injustice

52. I considered whether the failings I identified caused an injustice to the patient and the complainant. I found that the Trust failed to take a blood culture and refer the patient for a review by a senior clinician when she was exhibiting several moderate to high-risk criteria of sepsis and her CRP levels were elevated. I consider the patient suffered the injustice of a loss of opportunity for review by a senior clinician and to have her blood tested for infection in a timely fashion. However, I am unable to determine what the patient's outcome may have been if clinicians had reviewed her, or tested for infection at an earlier stage.

53. I accept the the O IPA's advice in this instance that the failures identified '*may not … have altered the patient's outcome'.* While it is not possible to be certain that appropriate care and treatment would have changed the outcome, I also acknowledge the complainant's point that it might have. I consider there was uncertainty and upset for the complainant at a stressful time. This is because there will always be an element of doubt, as he will always question whether things could have been different if better care and treatment had been provided.

CONCLUSION

54. I received a complaint about the actions of the Trust. The complainant raised concerns about the care and treatment the hospital staff provided to his wife, the patient.

55. The investigation was unable to establish if the patient's admission to ICU was attributable to the failure of clinicians to take a blood culture and to refer the patient for a review by a senior clinician in a timely fashion. The investigation established failures in the care and treatment in relation to the following matter.

- The failure to take a blood culture and refer the patient for a review by a senior clinician when she was exhibiting several medium to high risk indicators of sepsis and her infection markers were raised.

56. I am satisfied that the failure in care and treatment identified caused the patient to experience the injustice of the loss of opportunity for a review by a senior clinician and to have her blood tested for infection. In addition, I am satisfied that the complainant experienced the injustice of upset and uncertainty.

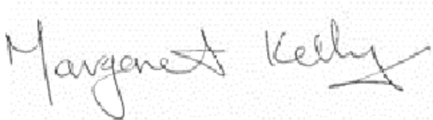
57. I recognise that this report may be distressing for the complainant to read. It must have been very difficult for the complainant to witness his wife's deterioration during the time she was in hospital and particularly in ICU. I offer my sincere condolences to the complainant.

Recommendations

58. I recommend that within **one month** of the date of this report:
    - The Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures identified

59. I also recommend for service improvement and to prevent future recurrence, the Trust:
    - Carry out a random sampling audit of patients' records in Ward 2 to ensure that clinical records contain relevant information in accordance with GMC guidance;
    - Raises awareness of the recognition and management of sepsis among junior doctors joining on placements in accordance with NICE NG51 guidance; and
    - Arrange for a copy of this report to be shared and discussed with the doctors involved in the patient's care. They should also be reminded that concerns in relation to sepsis management are escalated without delay to senior clinical staff for appropriate action.

60. I recommend that the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (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).



MARGARET KELLY
Ombudsman **1 April 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.