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

Report Reference: 202005529

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk

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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SUMMARY

This complaint was about care and treatment the Northern Health and Social Care Trust (the Trust) provided to the patient from 18 December 2021 to 3 February 2022. It was also about information the Consultant provided to the complainant during a telephone call on 18 January 2022.

The investigation identified two failures in the patient's care and treatment. It found the Trust did not fully consider the possibility of nasogastric feeding[1] for the patient. It also found the physiotherapy team did not act in accordance with the HCPC Standards as they did not formulate '*specific and appropriate management plans'* for the patient's leg contracture[2].

The investigation did not identify a failure in relation to information the Consultant provided to the complainant during their telephone call on 18 January 2022.

I recommended the Trust apologise to the complainant for the failures identified. I also recommended actions for the Trust to take to prevent the failures recurring.

[1] Where a narrow feeding tube is placed through the nose into the stomach.
[2] A contracture occurs when the muscles, tendons, joints, or other tissues tighten or shorten, causing a deformity.

THE COMPLAINT

1. This complaint was about the actions of the Northern Health and Social Care Trust (the Trust). The complainant raised concerns about care and treatment the Trust provided to her late husband (the patient) from 18 December 2021 to 3 February 2022. The complainant also raised concerns about information the Consultant provided to her during a telephone call on 18 January 2022.

Background

2. The patient was admitted to Antrim Area Hospital (AAH) on 18 December 2021 following his presentation at the Emergency Department (ED) with general decline. The patient's condition deteriorated during his hospital admission. He developed atrial fibrillation[3] and heart failure. The patient remained in hospital until his discharge on 3 February 2022 when he was transferred to the care of Inver House[4].

Issues of complaint

3. I accepted the following issues of complaint for investigation:

   Issue 1: Whether the care and treatment provided to the patient between 18 December 2021 and 3 February 2022 was appropriate and in accordance with relevant procedures and standards.

   Issue 2: Whether the Trust provided the complainant with the appropriate communication during a telephone call on 18 January 2022.

INVESTIGATION METHODOLOGY

4. 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.

[3] A heart condition that causes irregular/often abnormally fast heart rate.
[4] A community rehabilitation facility which provides care for patients requiring rehabilitation, palliative care or assessment following an acute hospital admission.

Independent Professional Advice Sought

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

    - A nurse with experience across a wide range of clinical settings and specialities (N IPA);
    - A consultant in both acute medicine and geriatrics with experience managing a broad range of acute cases (C IPA);
    - A physiotherapist with experience across a variety of specialties (P IPA).

    I enclose the clinical advice received at Appendix 2 to this report.

6. 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

7. 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[5]:

    - The Principles of Good Administration

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 and guidance relevant to this complaint are:

    - Nursing and Midwifery Council, The Code, Professional standards of practice and behaviour for nurses, midwives and nursing associates, 10 October 2018 (NMC Code).

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

- National Institute for Health and Care Excellence, British National Formulary 82, September 2021 to March 2022, Ramipril, (NICE Ramipril Guidance).
- National Institute for Health and Care Excellence Epilepsies: diagnosis and management, Clinical Guideline, January 2012 (CG137).
- Health and Care Professions Council's Physiotherapist Standards of Proficiency, May 2013 (HCPC Standards).
- National Institute for Health and Care Excellence, Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition, NICE guideline, August 2017 (CG32).

I enclose relevant sections of the guidance considered at Appendix 3 to this report.

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. All of the complainant's comments were carefully considered.

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the patient between 18 December 2021 and 3 February 2022 was appropriate and in accordance with relevant procedures and standards.

In particular this will consider:

- The patient's physical state when he was discharged from hospital;
- The patient's medical history and management of his seizures; and
- Management of the patient's medication.

Detail of Complaint

The patient's physical state when he was discharged from hospital

11. The complainant said the patient physically deteriorated during his hospital stay. In particular, the complainant raised concerns about treatment he received from nursing staff and the patient's legs which were in a bent position upon his hospital discharge. She said the Trust ignored *'the state of his legs'*.

Evidence Considered

Legislation/Policies/Guidance

12. I considered the following standards and guidance:
    - NMC Code.
    - HCPC 2013 Standards.
    - CG32.

The Trust's response to investigation enquiries

13. The Trust stated the patient's prolonged admission and severity of his condition likely *'had an impact and would have continued to have an impact in the medium to long term'*. It recognised the patient was unable to participate with intensive rehabilitation in Inver House and it kept this under review.

Relevant records

14. I considered the patient's clinical records documented during his admission and discharge.

Relevant Independent Professional Advice

N IPA

Deterioration of the patient

15. The N IPA advised the patient's clinical records *'demonstrates that his clinical condition deteriorated during his admission'*. The records suggest staff provided care '*as per assessments, care planning and prescription'*.

Patient's leg condition

16. The N IPA advised the clinical records identify concerns with the patient's flexion[6] from the hips and knees. The records specifically highlight on 30 December 2021 that the patient's posture is *'flexed plus[7]'*.

17. The N IPA advised the nursing care records document that nursing staff provided the patient with assistance, personal care and repositioned him throughout his admission time. The nursing care records *'suggest that relevant clinical assessments were carried out for (the patient) and that associated ongoing care was provided and recorded'*. The records also include assessments in relation to the patient's skin care and condition throughout his admission.

C IPA

Deterioration of the patient

18. The C IPA advised staff prescribed antibiotics and changed administration to an intravenous[8] route when the patient deteriorated. Further investigations and monitoring of the patient's blood results to '*look at response to treatment and CTPA[9] (computed tomography pulmonary angiogram) to rule out a PE[10] (pulmonary embolism)*' as well as a CT scan[11] on the patient's head when he appear drowsy, '*all seem appropriate*'.

[6] Flexion is the bending of a joint so that the bones that form that joint are pulled closer.
[7] Refers to a seated or slumped stance where arms and legs are in front of the torso. It can also involve the spine curving forward.
[8] A way of giving substance through a needle or tube inserted into a vein.
[9] A CT scan that looks for blood clots in the lungs.
[10] A blood clot that develops in a blood vessel which travels to a lung artery blocking blood flow.
[11] Diagnostic imaging procedure using a combination of x-rays and computer technology to produce images of the body.

19. The C IPA advised the early recognition of '*suspected sepsis*[12]' and the initiation of antibiotics was in line with relevant NICE guidance. Also, the monitoring for response and escalation when the patient deteriorated was in line with national guidelines.

20. The C IPA advised that recommendations were made from the Speech and Language team (SALT[13]) to '*consider NG*[14] *(nasogastric) feeding to supplement nutrition as oral intake seems to have been poor for most of the hospital admission*'. Clinicians should have given '*more consideration*' to NG feeding for the patient including holding a '*best interests meeting*' with appropriate members of the multidisciplinary team (MDT) and the complainant. There appeared to be '*a difference of opinion between the medical team and the SALT and Dieticians*'. The teams should have had a formal discussion to resolve these issues. However, it is unlikely that a period of NG feeding would '*have changed the ultimate outcome*'.

P IPA

Patient's leg condition

21. The P IPA referred to the patient's clinical records, which documented the condition of the patient's legs. She summarised this as the patient had '*non blanching erythema on both heels, a healing grade 2 pressure ulcer on the left inner heel which was dry and unable to fully extend hips and knees in standing*'.

22. The P IPA advised the physiotherapy team did not document any '*clear concerns*' about the condition of the patient's legs during their time in hospital. The physiotherapist documented the patient had '*decreased ROM (range of motion) knee extension bilaterally'*, and completed passive knee extension exercises with the patient. Physiotherapy staff also documented the patient had a '*fear of falling'* and this was the reason given for not fully extending at his hips or achieving a full stand.

[12] A condition in which the body responds improperly to an infection, causing the organs to work poorly.
[13] Refers to Speech and Language Therapy.
[14] A type of medical catheter inserted through the nose, into the stomach to deliver food or medication.

23. The P IPA advised it would be '*appropriate clinical practice*' when staff identify a decreased ROM at any joint to assess the patient and document their findings. This is especially where it is '*potentially limiting the patient's standing ability'*. This would have provided '*evidence over the course of rehabilitation whether the range of motion or muscle power is deteriorating or improving or if it is a functional decrease in ROM e.g. due to falling*'. The physiotherapist should have been concerned about the patient's inability to extend fully at the knee and hips.

24. The P IPA referred to the HCPC Standards, Sections 14.9, 14.10 and 14.11. They advised the physiotherapist '*should have been able to use a logical and systematic approach to problem solve the patient's inability to extend fully at the hips and knee*'. They should also have determined the '*appropriate action*' and formulated '*specific and appropriate management plans*' with specified time frames. Other than the one occasion where the physiotherapist performed '*passive range of motion exercises on the knees*', there is '*no evidence*' the physiotherapist addressed '*any concerns limitations*' of the patient's lower limbs.

25. The P IPA advised that between 6 and 21 January 2022, the patient '*was not fit to participate in rehabilitation*'. However, once the patient was moved to community hospital, it is '*unclear whether the position of the patient's legs contributed to the decision*' not to participate in rehabilitation.

26. The P IPA advised that had the contracture and '*what appears to be the worsening of the left leg*' over time been '*identified earlier*', then some of the contracture '*may have been mitigated through positioning and splinting*'. This would have minimised contraction, '*potentially helping*' had it been '*assessed when first documented and subsequently monitored*'. However, it did not affect the patient's cognitive symptoms, *'which is vital to progress with rehab*'. The position of the patient's legs on discharge contributed to the decision that he '*was not fit in latter stages of their inpatient stay*'.

Analysis and Findings

Deterioration of the patient

27. The clinical records clearly evidence that the patient's condition deteriorated while he was in hospital. I considered the complainant's concern that the care and treatment provided to the patient contributed to his deterioration.

28. In relation to nursing care, the N IPA advised that staff appropriately assessed the patient and documented a nursing care plan. She also advised the records evidence that staff provided care in line with the care plan. Based on the evidence available, and advice from the N IPA, I did not identify any failure in the care and treatment nursing staff provided to the patient during his admission.

29. In relation to clinical care, the C IPA advised the investigations carried out on the patient during his admission were appropriate. He also advised the medical team identified and treated the patient's suspected sepsis in line with relevant NICE guidance. I accept this advice.

30. The records evidence that the patient developed dysphagia[15] whilst in hospital and the SALT team recommended the patient begin NG feeding. I note the Consultant disagreed with the recommendation, as he believed it would cause distress for the patient and would not likely have benefitted him. While the records evidence the disagreement, they do not document any formal discussion on the matter between the relevant teams.

31. The C IPA advised the Consultant should have given more consideration to NG feeding. He expected the records to evidence that a formal MDT meeting occurred to fully consider and agree whether NG feeding was appropriate for the patient. However, there is no evidence in the records to suggest this took place or was even considered. I consider the absence of this a failure in the patient's care and treatment. I partly uphold this element of the complaint.

[15] Difficulty swallowing.

32. I note the C IPA's advice that he did not consider introducing NG feeding would have changed the patient's prognosis. However, I am satisfied the patient sustained the injustice of a loss of opportunity to have the matter fully considered and an MDT decision made on whether NG feeding was appropriate. I also consider the patient, and complainant, sustained the injustice of uncertainty.

Patient's leg condition

33. The complainant was concerned the patient's legs were in a '*bent position'* upon discharge from hospital. The records evidence that the patient suffered leg contracture during his admission. I considered if the Trust appropriately managed the contracture.

34. The P IPA advised the patient experienced a decreased ROM that potentially limited his ability to stand. In this case, it was '*appropriate clinical practice*' for physiotherapy staff to assess the patient and document their findings. This is especially where it potentially limited the patient's ability to stand. However, there is no evidence of such an assessment within the records.

35. Sections 14.9, 14.10 and 14.11 of the HCPC Standards require physiotherapists to use their skills to formulate '*specific and appropriate management plans'* to inform their practice. The P IPA identified one occasion when the physiotherapist performed '*passive range of motion exercises on the knees*' for the patient. It is of concern that there is no evidence to suggest the physiotherapist addressed '*any concerns limitations*' of the patient's lower limbs. I consider this a failure in the care and treatment of the patient. I uphold this element of the complaint.

36. I accept the P IPA's advice that we cannot determine if the failure identified led to the patient's later decision not to participate in rehabilitation. However, I also accept their advice that had staff taken appropriate action, it may have minimised contraction. I am therefore satisfied the patient sustained the injustice of a loss of opportunity to have his leg contracture assessed and

treated. I also consider it caused the patient and complainant uncertainty and concern.

Detail of Complaint

The Trust's understanding of the patient's medical history including epilepsy

37. The complainant said medical staff were not aware of the patient's history of epilepsy[16]. She was concerned the patient suffered from '*multiple untreated seizures'* whilst in hospital.

Evidence Considered

Legislation/Policies/Guidance

38. I considered the following guidance and standards:
    - GMC Guidance.
    - NMC Code.
    - NICE CG137.

Trust's response to investigation enquiries

39. The Trust stated the Consultant in charge of the patient's care '*confirmed and offered reassurance'* to the complainant that the patient's past medical diagnoses were '*clearly documented'*. The documentation included the patient's history of epilepsy. Therefore, the medical team '*were aware of the possibility of seizures*[17]'.

Relevant records

40. I considered the patient's clinical records documented during his admission and discharge.

Relevant Independent Professional Advice

C IPA

41. The C IPA advised there were '*multiple and repeated references'* to the patient's history of epilepsy in the ward round notes as well as on the initial

[16] Condition that affects the brain and causes frequent seizures.
[17] Burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone, movements, behaviours, sensations or states of awareness.

assessment documentation. The notes also recorded the patient's prescription history.

42. The C IPA advised the inclusion of the references to the patient's history in his documentation meant the doctors attending the patient '*would have been aware*' of his diagnoses.

43. The C IPA advised there was an episode of unresponsiveness in the patient on 21 December 2021, however this was not attributed to a seizure. Upon his review of the patient's medical records, the C IPA '*could find no record of seizures*'.

44. The C IPA advised the patient was prescribed Sodium Valproate[18] initially in tablet form. Clinicians then changed administration to IV when the patient's swallow began to deteriorate. The change was necessary as it was '*a recognition that the medication was required'* due to the patient's medical history.

N IPA

45. The N IPA advised the patient was prescribed medication for his seizures and the nursing staff administered this medication '*appropriately'*. Where there was an omission, *'the rationale has been provided'*. The N IPA did not identify any evidence in the records to suggest the patient had a seizure during his hospital admission.

Analysis and Findings

46. The complainant said the Trust was unaware of the patient's history of epilepsy during his admission. Standard 16(a) of the GMC Guidance requires clinicians to have '*adequate knowledge of the patient's health'* before they provide treatment.

47. The patient's medical notes and nursing care plans clearly reference his diagnoses, and in particular his history of epilepsy. The C IPA also advised

[18] Medication used to treat epilepsy.

clinicians referenced the patient's epilepsy in their ward round notes and it was included on the problem list in the patient's records. Furthermore, the records evidence the patient was prescribed and administered Sodium Valproate, which NICE CG137 states may be used to treat epilepsy.

48. Based on the evidence available, I have no reason to doubt that the clinicians treating the patient were fully aware of the patient's medical history. I therefore consider the clinicians involved acted in accordance with Standard 16(a) of the GMC Guidance. As such, I have not identified a failure in care and treatment for this issue. I hope this brings an element of reassurance for the complainant.

49. The complainant also said the patient had '*multiple untreated seizures'* during his admission. Having reviewed the records, I accept both the N IPA and C IPA's advice that they do not evidence the patient experienced a seizure at any time during his admission. I also note both IPAs advised the clinicians and nursing staff prescribed and administered appropriate medication to the patient for his epilepsy. I hope this again provides some reassurance for the complainant.

50. I fully appreciate the complainant's concerns given the patient's history of epilepsy. However, upon review of all available information, I have not identified a failure in care and treatment for this issue. As such, I do not uphold this element of the complaint.

Detail of Complaint

Management of the patient's medication

51. The complainant said the Trust did not monitor the patient effectively for side effects from his medication. In particular, she was concerned the medication, Ramipril, could have caused the patient to choke and become drowsy.

Evidence Considered

Legislation/Policies/Guidance

52. I considered the following guidance and standards:

    - NMC Code.

- NICE Ramipril Guidance.

Trust's response to investigation enquiries

53. The Trust stated it informed the complainant during a meeting on 12 May 2023 that the Consultant advised that it was his opinion that the *'medications did not cause these problems for [the patient]'.* In particular, the medication Ramipril *'did not cause swallowing difficulties or drowsiness'*.

Relevant records

54. I considered the patient's clinical records documented during his admission and discharge.

Relevant Independent Professional Advice

C IPA

55. The C IPA advised the patient had a diagnosis of heart failure as well as a background of ischaemic heart disease and stents. Ramipril is a drug '*well recognised to be of benefit in heart failure*'. There was also '*cardiology input*' and Ramipril was '*an appropriate prescription*'. A cough is a '*well recognised side effect*' of drugs such as Ramipril, however choking '*is not listed in the BNF [NICE Ramipril guidance] as a side effect*'.

56. The C IPA advised the patient's cough was '*more likely to have been related to the lower respiratory tract infection and covid*'. Also, the diagnosis of heart failure may have contributed, as heart failure itself can cause a cough.

57. In relation to choking and drowsiness, the C IPA advised there was a '*well documented deterioration in the patient's swallow*', in line with the '*deterioration in his physical health*'. There were no medications prescribed to the patient that are likely to have caused this.

N IPA

58. The N IPA advised that whilst she did not identify any specific reference to monitoring of side effects in the nursing records, *'the ongoing clinical*

assessments, monitoring of vital signs and other indicative signs of clinical stability and wellbeing are detailed'. This was appropriate.

59. The N IPA advised that staff escalated concerns they had to medical staff. She advised that the patient was cared for by a multidisciplinary team '*including nursing, medical and allied health professionals*'. The *'nursing care record suggests that the care provided [to the patient] was appropriate'*.

Analysis and Findings

60. The BNF guide on Ramipril states that 'common or very common' side effects include both cough and drowsiness. It does not list choking as a potential side effect. The C IPA advised the patient's cough may have been a symptom of heart failure or his respiratory condition. I accept his advice and as such, cannot find that the medication caused the patient to choke. While I note Ramipril can cause drowsiness, it is difficult to establish if the patient experienced this because of the medication or the general decline in his health.

61. The complainant believed staff did not monitor the medication to avoid such side effects. I considered the patient's medical records. I did not identify any evidence that nursing staff specifically monitored the patient for his reaction to the medication. However, the N IPA advised she would not expect the records to document this. The N IPA also advised that nursing staff monitored the patient's vital signs in accordance with guidance, which would have highlighted any concerns. I accept this advice. Therefore, I have not identified any failure in the nursing staff's care and treatment of the patient in relation to this element of the complaint.

62. Based on the evidence available, I have not identified a failure in care and treatment for this issue. As such, I do not uphold this element of the complaint.

Issue 2: Whether the Trust provided the complainant with appropriate information during a telephone call on 18 January 2022.

Detail of Complaint

63. The complainant said the consultant was not aware of the patient's full medical history when he spoke with her on the telephone in January 2022. This was because he did not have access to the patient's medical notes during the call.

Evidence Considered

Legislation/Policies/Guidance

64. I considered the following guidance:

- GMC Guidance.

Trust's response to investigation enquiries

65. The Trust stated the consultant confirmed *'he did not have [the patient's] notes to hand´* during his phone call with the patient. The Consultant added*, 'it is not possible to retain full detail of medical information for all patients'*.

Relevant Independent Professional Advice

66. The C IPA advised that there are '*no clear guidelines*' for telephone updates to members of patient's family. It is often best practice to provide updates '*with all of the (patient's) notes to hand*'.

67. The C IPA advised that given the length of the patient's admission, they would have expected the Consultant to be familiar with the case. The Consultant could also have arranged to follow up with the complainant. The C IPA acknowledged that the ward team had also updated the complainant.

Analysis and Findings

68. The complainant was dissatisfied the Consultant did not have full knowledge of the patient's medical history when he spoke to her on 18 January 2022. It has been established that the Consultant did not have the patient's medical records with him when he took the call, which is why he could not provide the relevant information.

69. I am unable to find a note of the call within the patient's medical records. I am also unable to determine if the Consultant arranged the telephone call with the complainant. If he had, I would have expected the Consultant to have the

patient's notes to hand. However, if the call was unexpected, I can appreciate why the Consultant was unable to provide a full update to the complainant.

70. Standard 33 of the GMC Guidance requires clinicians to '*be considerate to those close to the patient and be sensitive and responsive in giving them information and support'*. I acknowledge the C IPA's advice that the Consultant should have been more familiar with the patient's condition given the time he was under his care. However, I cannot comment on the Consultant's ability to recall his patients' information without first reviewing their records. I appreciate the complainant's frustration at not receiving a full and clear update on this occasion. However, there is no evidence that would lead me to find that the Consultant did not act in accordance with the GMC Guidance. Therefore, I do not uphold this issue of complaint.

71. Notwithstanding, I would ask the Trust to remind relevant staff of the importance of retaining a note of their telephone calls with patients' families and to ensure they are in a position to provide full and clear information when providing updates on their condition.

CONCLUSION

72. I received a complaint about care and treatment the Trust provided to the patient from 18 December 2021 to 3 February 2022. The complaint also related to information the Consultant provided to the complainant during a telephone call on 18 January 2022.

73. The investigation identified two failures in the patient's care and treatment. It found the Trust did not fully consider the possibility of NG feeding for the patient. It also found the physiotherapy team did not act in accordance with the HCPC Standards as they did not formulate '*specific and appropriate management plans'* for the patient's leg contracture. I am satisfied the patient sustained the injustice of losses of opportunity to have NG feeding fully considered and an MDT decision made on whether it was appropriate, and to have his leg contracture assessed and treated. I also consider the failures caused the patient and complainant uncertainty and concern.

74. In relation to information the Consultant provided to the complainant on 18 January 2022, the investigation did not identify that the Consultant failed to act in accordance with GMC Guidance.

Recommendations

75. I recommend that the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failures identified (within **one month** of the date of this report).

76. I further recommend, for service improvement and to prevent future recurrence, that the Trust:

    i. Shares this report with the staff involved in the patient's care to allow them to reflect on the failures identified.
    ii. Provides training to relevant staff on the importance of conducting a multidisciplinary review of feeding for those patients who develop dysphagia, especially where there is disagreement between the teams involved.
    iii. Provides training to relevant physiotherapy staff on the importance of conducting appropriate assessments in line with the relevant sections of the HCPC Guidance.

    The Trust should provide evidence to this office to confirm completion of these recommendations within **three months** of the date of this report.

77. Finally, I wish to offer my condolences to the patient's wife on the death of her husband. It is clear the complainant fought to seek answers on the care her husband received. I hope that my report goes some way to address her concerns, allowing her to properly grieve for her sad loss.

Margaret Kelly
Ombudsman **February 2025**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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.