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

Report Reference: 202004744

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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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SUMMARY

I received a complaint about the care and treatment the Western Health and Social Care Trust (the Trust) provided to the complainant's late sister, who is referred to in this report as 'the Patient'.

On 18 September 2021, the Patient was transferred to a general medical ward in the Trust's Altnagelvin Area Hospital (Altnagelvin) from the Belfast Health and Social Care Trust's Roval Victoria Hospital (RVH) where, during the previous three weeks, she had received care and treatment from the RVH Neurosurgical Team. Sadly, the Patient passed away in Altnagelvin on 23 September 2021.

The complainant said the Patient *'died unexpectedly'* and that her death was *'avoidable'.* She said she, and other members of the Patient's family, were *'not convinced … that [the Patient had] received the appropriate level of clinical care'* during the time she spent in Altnagelvin. The complainant said she was particularly concerned about the period between the Patient's admission to Altnagelvin, late in the evening of 18 September 2021, and her review during the post-take ward round the following morning. The complainant also expressed concern about a number of aspects of the care the Trust provided to the Patient in the following days.

My investigation found that, for the most part, the care and treatment the Trust provided to the Patient during her admission to Altnagelvin was appropriate and reasonable. However, I also found that on the morning of 19 September 2021, in the hours leading up to the post-take ward round, there was delay in nursing staff performing the Patient's clinical observations. In addition, I found that after the post-take ward round, when nursing staff noted the Patient's clinical condition had deteriorated, there was delay in a doctor from the Medical Team reviewing her. I found too that the Patient's chest was not examined during that medical review, despite her respiratory rate and oxygen requirement having both increased.

For reasons set out in this report, I did not conclude that these failings in the

Patient's care had an adverse impact on her clinical condition or her overall prognosis. However, I considered they caused the Patient to sustain the injustice of loss of opportunity to have her observation checks completed at the appropriate time; to be reviewed by a doctor within the appropriate timeframe; and to receive any further care considered appropriate to her clinical condition at that time. I also considered they caused the Patient's family to sustain the injustice of uncertainty about what the outcome may have been, had action been taken sooner.

I partially upheld the complaint.

I recommended that the Trust provide a written apology to the complainant and that it share learning from my investigation with relevant staff.

THE COMPLAINT

1. I received a complaint about the actions of the Western Health and Social Care Trust (the Trust). The complainant made the complaint on behalf of her late sister, who is referred to in this report as 'the Patient'. The complaint is about the care and treatment the Trust provided to the Patient in Altnagelvin Area Hospital (Altnagelvin) during the period 18 to 23 September 2021. Sadly, the Patient passed away, in Altnagelvin, on 23 September 2021. I offer, through this report, my sincere condolences to the complainant on the loss of her sister.

Background

2. On the evening of 18 September 2021, the Northern Ireland Ambulance Service Trust (NIAS) transferred the Patient to Altnagelvin from the Roval Victoria Hospital (RVH) in the Belfast Health and Social Care Trust (the Belfast Trust), where she had been receiving care from the RVH Neurosurgical Team since 28 August 2021. During that time, the Patient underwent two surgical procedures to treat subdural haematomas.[1] The Patient was transferred to Altnagelvin for rehabilitation, as the RVH Neurosurgical Team considered no further intervention by them was necessary or appropriate.

3. The Patient was admitted directly to Altnagelvin's Ward 41 (Ward 41) at 21:47, under the care of a Consultant in General Medicine (the General Medicine Consultant). At 09:20 on the morning of 19 September 2019, during the post-take ward round, doctors noted that the Patient's clinical condition had deteriorated, and her level of consciousness had reduced. They arranged an urgent CT scan of the Patient's brain and later discussed the findings of the scan with the RVH Neurosurgical Team. The RVH Neurosurgical Team advised that there was no indication for the Patient to have further neurosurgery.

[1] A subdural haematoma is a serious condition, usually caused by a head injury, where blood collects between the skull and the surface of the brain.

4. During the following days, the Patient's clinical condition continued to deteriorate. Sadly, she passed away, in Altnagelvin, in the early hours of 23 September 2021.

5. On 1 April 2022, the complainant and another of the Patient's sisters met with the General Medicine Consultant and the Trust's Bereavement Coordinator. The purpose of the meeting was to give the Trust the opportunity to address the complainant's concerns about the Patient's care and treatment during her admission to Altnagelvin the previous September. The Trust later wrote to the complainant, providing notes of the discussion at the meeting.

6. Subsequently, on 26 July 2022, the complainant sent a letter to the General Medicine Consultant, requesting further information about the circumstances of the Patient's transfer from RVH to Altnagelvin on 18 September 2021 and about the care and treatment she had received in the days following her admission to Altnagelvin. The Trust dealt with the complainant's letter under its complaints procedure. Its Chief Executive wrote to the complainant on 22 December 2022, providing the Trust's response.

Issue of complaint

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

   Whether the care and treatment the Trust provided to the Patient during the period 18 to 23 September 2021 was appropriate, reasonable and in accordance with relevant standards, guidelines, policies and procedures.

8. I decided that, in particular, the investigation of this issue of complaint would consider the following:

   (i) the care and treatment the Trust provided to the Patient during the period between her admission to Altnagelvin at 21:47 on 18 September 2021 and her review at the post-take ward round at 09:20 on 19 September 2021;

   (ii) the care and treatment the Trust provided to the Patient once a change in her clinical condition and a reduction in her level of consciousness was noted at the post-take ward round at 09:20 on 19 September 2021; and

(iii) the care and treatment the Trust provided to the Patient following the decision taken on 19 September 2021 to commence intravenous antibiotics.

INVESTIGATION METHODOLOGY

9. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation and records, together with the Trust's comments on the issues the complainant raised. The Investigating Officer also obtained records from the Belfast Trust relating to the Patient's admission to RVH from 28 August to 18 September 2021.

10. In addition, in accordance with the legislation that governs my role[2], I invited the Trust's Foundation Year 2 doctor who assessed the Patient on her admission to Altnagelvin on 18 September 2021 (the Admitting Medical Doctor) and the General Medicine Consultant who reviewed the Patient during the post-take ward round on the morning of 19 September 2021, to submit comments on the complaint, in so far as it concerned their actions. The Admitting Medical Doctor provided written comments on the complaint. The General Medicine Consultant advised he did not wish to submit any comments directly to me.

Independent Professional Advice Sought

11. After further consideration of the issues raised in this complaint, I obtained independent professional advice from the following independent professional advisors (IPAs):

- A Consultant Physician with 13 years' experience, including experience in the rehabilitation and medical care of patients with multiple medical comorbidities (the General Medicine IPA);
- A Consultant Neurosurgeon with experience in a wide range of neurosurgical emergencies in both adults and children (the Neurosurgery IPA); and
- A Registered Nurse with more than 25 years' experience, including experience in acute care, intensive care, emergency department, medical,

[2] Section 30(3)(b) of the Public Services Ombudsman Act (Northern Ireland) 2016.

surgery and high dependency ward, and community nursing (the Nursing IPA).

12. The IPAs provided me with 'advice'. How I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

13. I should also make it clear that I obtained independent professional advice from the Neurosurgery IPA because the input the RVH Neurosurgical Team provided to the Trust on 19 September 2021 (following the Patient's CT brain scan) informed its decisions about on the care and treatment it provided to the Patient subsequently; the actions of the Belfast Trust's RVH Neurosurgical Team were not examined within the scope of this investigation.

Relevant Standards and Guidance

14. 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:[3]

    - The Principles of Good Administration; and
    - The Principles of Good Complaints Handling.

15. The specific standards and guidance are those which applied at the time the events complained of 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 (GMC) Good Medical Practice, published March 2013, updated April 2021 (the GMC Guidance);
    - The Nursing and Midwifery Council (NMC) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing

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

associates, published January 2015, updated October 2018 (the NMC Code);

- The National Institute for Health and Care Excellence[4] (NICE) Clinical Guideline 50 - 'Acutely ill adults in hospital: recognising and responding to deterioration', published July 2007, updated April 2019 (NICE Guideline 50);
- The National Institute for Health and Care Excellence (NICE) Clinical Guideline 191 - 'Pneumonia in adults: diagnosis and management', published December 2014, updated September 2019 (NICE Guideline 191);
- The National Institute for Health and Care Excellence (NICE) Guideline 139 - Pneumonia (hospital-acquired): antimicrobial prescribing, published September 2019, updated October 2020 (NICE Guideline 139);
- GMC Guidance - 'Treatment and care towards the end of life: good practice in decision making', July 2010 (the GMC End of Life Guidance)
- The Western Health and Social Care Trust's Hospital at Night Operational Policy, May 2009, reviewed December 2010, (the Trust's Hospital at Night Operational Policy);
- The Western Health and Social Care Trust's Secondary Care Antimicrobial Therapy Guidelines, September 2010 (the Trust's Antimicrobial Therapy Guidelines);
- The Western Health and Social Care Trust's Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy, December 2012 (the Trust's DNACPR Policy).

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

17. I shared a draft of this report with the complainant, the Trust, the Admitting Medical Doctor, the General Medicine Consultant and a Medical Registrar who reviewed the Patient at 11:40 on 19 September 2021 (the Medical Registrar), to

[4] NICE guidelines are evidence-based recommendations for health and care. They set out the care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings.

allow them to comment on its factual accuracy and the reasonableness of my proposed findings and recommendations. The complainant submitted comments in response and I gave careful consideration to those comments in finalising this report. Neither the Trust nor the clinicians with whom I shared the draft report provided comments on my proposed findings and conclusion.

THE INVESTIGATION

Issue of Complaint: Whether the care and treatment the Trust provided to the Patient during the period 18 to 23 September 2021 was appropriate, reasonable and in accordance with relevant standards, guidelines, policies and procedures.

Detail of Complaint

18. The complainant said the Patient *'died unexpectedly'* in Altnagelvin on 23 September 2021, and that she believed her death was *'avoidable'.* The complainant also said that she, and other members of the Patient's family, were *'not convinced'*, on the basis of the information the Trust provided in the notes of her meeting with the General Medicine Consultant on 1 April 2022, and in the Trust's Chief Executive's letter of 22 December 2022, that the Patient had received *'the appropriate level of clinical care from her admission [to Altnagelvin on the evening of Saturday, 18 September 2021] until her death on [23 September 2021]'*. She also said she was of the view that the Patient's death was *'avoidable'.*

19. The complainant said she was particularly concerned about the care and treatment the Patient received between the time of her admission to Altnagelvin on the evening of 18 September 2021 and the time she was reviewed by the General Medicine Consultant at the post-take ward round on the morning of Sunday, 19 September 2021. The complainant also said that she was seeking a full explanation of *'the clinical decision making, escalation options and optimal clinical care that should have been provided'*, particularly during this period.

Evidence Considered

Legislation/Policies/Guidance

20. I considered the following policies and guidance:

- The GMC Guidance;
- The NMC Code;
- NICE Guideline 50;
- NICE Guideline 191;
- NICE Guideline 139;
- the GMC End of Life Guidance;
- the Trust's Hospital at Night Operational Policy;
- the Trust's Antimicrobial Therapy Guidelines; and
- the Trust's DNACPR Policy.

21. Relevant extracts of the policies and guidance I considered are at Appendix Two to this report.

The Trust's response to investigation enquiries

22. I made enquiries of the Trust about the issues the complainant raised. Relevant extracts of the Trust's response to my enquiries are at Appendix Three to this report.

The Admitting Medical Doctor's written comments on the complaint

23. The Admitting Medical Doctor submitted written comments on the elements of the complaint that related to his actions. Relevant extracts of the Admitting Medical Doctor's comments are at Appendix Four to this report.

Documentation and records reviewed

24. I completed a review of the documentation the complainant submitted in support of her complaint; the documentation the Trust provided in response to my investigation enquiries; and the Patient's clinical records relating to her admission to Altnagelvin during the period 18 to 23 September 2021 and her admission to RVH during the period 28 August to 18 September 2021. These included records relating to the Patient's transfer from RVH to Altnagelvin. Relevant extracts of the documentation I reviewed are at Appendix Five to this report.

25. Based on my review of the documentation and records, I compiled a chronology of key events relating to the care and treatment the Trust provided

to the Patient during the period 18 to 23 September 2021. This chronology is at Appendix Six to this report.

Independent Professional Advice

26. I considered the advice I obtained from the IPAs. The advice related to the nursing care the Trust provided to the Patient following her admission to Ward 41; the care and treatment the Trust's Medical Team provided to the Patient during her admission to Ward 41; and the input the RVH Neurosurgical Team provided to inform the Patient's care, following her CT brain scan on the morning of 19 September 2021.

27. The Nursing IPA's full advice report is at Appendix Seven to this report.. The General Medicine IPA's full advice reports is at Appendix Eight. The Neurosurgery IPA's full advice report is at Appendix Nine.

Analysis and Findings

(i) The care and treatment the Trust provided to the Patient between the time of her admission to Altnagelvin on 18 September 2021 and the time of her review at post-take ward round on 19 September 2021

28. On the basis of the available evidence – the Patient's Altnagelvin and RVH records; the Trust's response to my investigation enquiries; the Admitting Medical Doctor's comments on the complaint; and the Trust's communication with the complainant about the Patient's care - I established the following events took place during the period between the time of the Patient's admission to Ward 41 and the post-take ward round the following morning:

- the Patient was admitted directly to Ward 41 at 21:47 on Saturday, 18 September 2021, on transfer from RVH;
- nursing staff completed clinical observations for the Patient at 22:00;
- at 01:30 on Sunday, 19 September 2021, the Admitting Medical Doctor assessed and 'clerked-in' the Patient;
- the Admitting Medical Doctor arranged a chest x-ray, and blood and urine tests for the Patient;

- nursing staff repeated the Patient's clinical observations at 02:00;
- the Patient had bloods taken at 04:00 and a chest x-ray was performed at 04:23;
- at 07:30, the Admitting Medical Doctor reviewed the results of the Patient's chest x-ray and blood tests;
- the Admitting Medical Doctor's night shift ended at 08:15 and he handed over the Patient's case to the day team for consultant review during the post-take ward round; and
- the General Medicine Consultant's post-take ward round took place at 09:20.

29. My investigation into this element of the complaint looked firstly at the nursing care the Trust provided to the Patient, following her admission to Ward 41 and before she was assessed by the Admitting Medical Doctor.

30. I asked the Nursing IPA for advice on whether there was any evidence within the Patient's Altnagelvin records to indicate what action nursing staff took, on the Patient's admission, to inform the Admitting Medical Doctor of her arrival. The Nursing IPA advised there was no documented evidence within the Patient's records that nursing staff informed the Admitting Medical Doctor of the Patient's admission to Ward 41. The Nursing IPA advised, however, that *'there is an assumption made that this was done'* because *'the nurse documents that the Patient is to be clerked by [the Admitting Medical Doctor] in the written progress notes'* and because *[the Admitting Medical Doctor] also documents at 0130 on 19th September 2021 that they have seen the Patient and clerked them in'.*

31. The Nursing IPA further advised, *'The only documentation that refers to the doctor being informed about the Patient having been admitted on Ward 41 is the statement[5] from the doctor. This refers to the doctor being bleeped by the*

[5] The Nursing IPA was referring to the written comments the Admitting Medical Doctor had submitted to me about this complaint.

nurse on the ward that the Patient had arrived and needed clerking in. Although there is nothing in the Patient's notes to indicate this, the doctor was informed and did see the Patient a few hours after [she was] admitted to the ward.'

32. The Nursing IPA pointed out that Section 10 of the NMC Code '*is very clear about documentation'* and that it *'discusses when and how to do this'.* In this regard, I noted Section 10 of the NMC Code, which concerns the requirement to *'Keep clear and accurate records relevant to your practice'*, states, *'complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event'.* It also states, *'identify any risks of problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need'.* The Nursing IPA advised, *'In this instance – this was not the case for contacting the doctor for clerking. This may have been done verbally however, it is not documented in any of the documentation [I] received.'*

33. I asked the Nursing IPA for advice on whether there was any evidence within the Patient's records to indicate that nursing staff asked the Admitting Medical Doctor to assess the Patient urgently, following her admission to Ward 41. I also sought the Nursing IPA's advice on whether it would have been reasonable and appropriate in the circumstances for nursing staff to have done this.

34. The Nursing IPA advised, *'although the Patient had a slight temperature at the time of admission, the nurse who was looking after her did all of the clinical tests that could be done by the nurse at the time'.* The Nursing IPA also advised that at the time of admission, the Patient had a [National Early Warning Score[6] (NEWS)] of 2 and that *'it was clinically appropriate to not escalate further at that time or attempt to call the doctor again and prioritise the Patient at the top of [his] list of patients to see.'*

[6] The National Early Warning Score (NEWS) is a system for scoring the physiological measurements that are routinely recorded at a patient's bedside. The NEWS scoring system measures six physiological parameters: respiration rate; oxygen saturation; systolic blood pressure; pulse rate; level of consciousness or new-onset confusion; and temperature. A score of 0, 1, 2 or 3 is allocated to each parameter. A higher score means the parameter is further from the normal range. These individual parameter scores are then aggregated to determine the overall NEWS.

35. I accept the Nursing IPA's advice that although nursing staff's contact with the Admitting Medical Doctor, following the Patient's admission to Ward 41, is not documented in the Patient's notes, there is evidence to show that this contact did take place. I also accept the Nursing IPA's advice that the Patient's clinical condition at the time of her admission to Ward 41 was such that it would not have been appropriate for nursing staff to request that she was prioritised for more urgent assessment by a doctor. In this regard, I noted the Trust's NEWS documentation provides guidance on the frequency of monitoring and the clinical response required, depending on a patient's NEWS score. This indicates that a NEWS score within the range one to four does not require nursing staff to alert the medical team caring for the patient.

36. Having considered the available evidence, I am satisfied that nursing staff took appropriate action to inform the Admitting Medical Doctor of the Patient's admission to Ward 41. I am also satisfied that the actions of nursing staff, in not indicating that the Patient required urgent assessment when they alerted the Admitting Medical Doctor of her arrival on Ward 41, were appropriate in the circumstances.

37. That said, I am mindful that the Nursing IPA highlighted an absence of documentation, within the Patient's records, relating to nursing staff's initial contact with the Admitting Medical Doctor. However, I am satisfied there is no indication that this omission in the Patient's records had an adverse impact on the standard of care she received, as it is evident that she was assessed by a doctor not long after her admission. Consequently, I do not consider the fact that nursing staff did not document their initial contact with the Admitting Medical Doctor to be a failing in the Patient's care. It is, nevertheless, my expectation that the Trust reflects on this matter, and that it takes steps to remind relevant nursing staff of the need to ensure that patients' notes are complete.

38. I asked the Nursing IPA for advice on nursing staff's monitoring of the Patient during the time between her admission to Ward 41and the Admitting Medical Doctor's assessment. The Nursing IPA advised that the Patient's records document that observations checks were completed at 22:00 on 18 September

2021, approximately 15 minutes after her arrival on the ward. The Nursing IPA advised, *'The Patient had a very slight temperature at the time, but this was below 38 degrees Celsius … It is also clearly documented that the Patient's [Glasgow Coma Scale (GCS)[7]] was 10 which is what was considered her baseline from transfer from RVH.'* The Nursing IPA also advised that at this time, the Patient *'was assessed as having a NEWS score of 2'* which, she advised, *'does not warrant more observations than 4 hourly'.*

39. I referred previously to the Trust's NEWS documentation stating the intervals at which observation checks should be completed for a patient. This states that a NEWS score of 2 requires observation checks to be carried out at a minimum of four to six hour intervals. The documentation therefore supports the Nursing IPA's advice that the Patient's NEWS of 2 at 22:00 did not require her observations to be repeated any sooner than 02:00 on 19 September 2021.

40. On the basis of this advice from the Nursing IPA, which I accept, I am satisfied that appropriate observations were completed for the Patient shortly after her admission to Ward 41. It is of concern, however, that the Nursing IPA highlighted in her advice that there is a contradiction in the Patient's records with regard to her documented temperature at that time. This is that the Patient's nursing progress notes relating to her admission refer to her having a temperature of 38.3 degrees Celsius, while her NEWS observation chart documents that her temperature at 22:00 was within the range 37.1 to 38.0 degrees Celsius. The Nursing IPA advised that a possible explanation for this is that the nursing notes were written *'at a different time to that of the actual observations'*, but that this is not certain because the time at which the nursing progress notes were written was not recorded.

41. It is not possible for me to say, on the basis of the available evidence, whether the Patient's temperature, shortly after her admission to Ward 41, was within the range 37.1 to 38.0 degrees Celsius, as recorded on her NEWS chart, or it was 38.3 degrees Celsius, as documented in her nursing progress notes. I

[7] The Glasgow Coma Scale (GCS) is used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients. The scale assesses patients according to three aspects of responsiveness: eye-opening, motor, and verbal responses. The total score has values between three and 15, three being the worst and 15 being the highest.

accept that, as the Nursing IPA suggested, it is possible that the nursing progress notes were not written at the time the 22:00 observation checks were completed. In any event, I am mindful that even if the Patient's temperature was 38.3 degrees Celsius when her observations were completed at 22:00, which would have resulted in her NEWS score being calculated as 3 rather than 2, this would not have indicated any requirement to repeat her observations any sooner than within the following four to six hours, or to escalate her care to the Medical Team. Consequently, I do not consider this anomaly in the temperature that was recorded for the Patient shortly after her admission to Ward 41 indicates a failing in the care the Trust provided. It is, however, a further matter relating to patient record keeping on which I expect the Trust to reflect, with a view to taking appropriate remedial action.

42. Next, I considered the Admitting Medical Doctor's assessment of the Patient following her admission to Ward 41, and the decisions he took at that time regarding her care and treatment.

43. I noted that when he commented on the complaint, the Admitting Medical Doctor said it was his recollection that the nursing staff in Ward 41 informed him of the Patient's admission and asked him *'to clerk her in'.* He also said that because the Patient had been *'deemed fit for transfer from another hospital'* and because nursing staff *'had not asked [him] to review her urgently',* he considered the Patient's condition *'was likely to be relatively stable and would not require immediate review'.*

44. The Admitting Medical Doctor also informed me that he assessed the Patient at 01:30 on 19 September 2021. I asked the General Medicine IPA for advice on whether it was appropriate and reasonable that the Admitting Medical Doctor did not assess the Patient any sooner than this.

45. The General Medicine IPA advised, *'given that there was nothing highlighted as being of urgent clinical concern earlier in the shift, it was reasonable that [the Admitting Medical Doctor] was prioritising other more urgent clinical situations first'.* The General Medicine IPA highlighted that the Admitting Medical Doctor's actions were in keeping with the Trust's Hospital at Night Operational Policy. I

noted this refers to the requirement for tasks and duties to be completed by the Hospital at Night Team, which included the Admitting Medical Doctor, to be prioritised.[8]

46. I accept the General Medicine IPA's advice. I am satisfied that it was appropriate and reasonable that the Admitting Medical Doctor did not assess the Patient sooner, following her admission to Ward 41.

47. The Admitting Medical Doctor provided me with a detailed account of his assessment of the Patient at 01:30 on 19 September 2021 and the decisions he took at that time regarding her care. He informed me that when he assessed the Patient, she *'was unable to give [him] a history'* and was *'unable to cooperate with [his] examination'*. He said he noted from the Patient's RVH records that *'post operatively, [she] was reviewed by Neurology in RVH'* who *'had documented that [the Patient] had spastic quadriparesis (i.e. abnormally stiff muscles in all limbs)'* and that *'her GCS was 10/15';* she *'was fed via a nasogastric tube'*; *'her last bowel motion was on 15th September 2021'*; and *'Her NEWS score was documented as 2'*.

48. The Admitting Medical Doctor informed me that he completed *'a full physical examination'* of the Patient, which *'demonstrated she had no overt evidence of infection'* but that she had *'spastic quadriparesis (as previously noted by Neurology in RVH), and her GCS was 10/15 (the same as at the time of her previous assessment in the RVH)'*. The Admitting Medical Doctor said he did, however, note that the Patient was *'very warm to touch and [that] she had a temperature of 38.2^{O}C'*. He said he considered the Patient's condition at this time *'appeared similar to that when she was discharged from RVH'* and that *'her fever was most likely secondary to her recent operations'*. Being concerned, however, that the Patient's raised temperature *'might be a possible early sign of infection'*, the Admitting Medical Doctor said he considered *'it was appropriate to look for possible sources of infection by performing relevant investigations (i.e. a septic screen)'*. He informed me he *'requested a chest X-ray, bloods to be taken including blood cultures, and a urine sample to be sent'.*

[8] Trust's Hospital at Night Operational Policy, paragraph 5.5.1.

49. The Admitting Medical Doctor also informed me that he *'had immediate access to more senior colleagues'* and that if he had had concerns about the Patient, *[he] would have immediately escalated to [his] registrar'.* He said he considers the Patient's records *'indicate that [he] had no reason to ask for immediate senior review or to commence any treatment following [his] first assessment, since her condition appeared to be stable'*. He also explained that nursing staff *'directly monitor patients'* and that they will contact the on-call doctor if they are concerned about a patient's condition. The Admitting Medical Doctor informed me that he *'was not asked to see [the Patient] again on the night of 18th/19th September 2021'*.

50. The Admitting Medical Doctor further informed me that he *'considered that a repeat CT brain scan was not indicated at the time [he] saw [the Patient], as her neurological examination remained unchanged from what was previously described by Neurology in RVH'.* He said that because *'CT scans involve significant doses of ionising radiation which carry their own risks'*, he *'would only have arranged one if it might have changed [his] management plan, which [he] believed it would not at that stage'.*

51. When the Trust responded to my enquiries, it also provided an account of the Admitting Medical Doctor's assessment of the Patient. The Trust informed me that the Admitting Medical Doctor *'appropriately performed a full septic screen*[9] *in line with current recommendations'.* It also said, *'As bloods were normal with no raised infection markers and no clear source of infection, a clinical decision was made to hold off antibiotics at that time, which is deemed appropriate considering the one off temperature and no clinical concern at that time of review.'*

52. I sought the General Medicine IPA's advice on whether the Admitting Medical Doctor's assessment of the Patient was appropriate and reasonable. The General Medicine IPA advised that the Admitting Medical Doctor *'documented a thorough and appropriate assessment of the Patient at 01:30. They documented clearly the events leading up to that point, and undertook a careful*

[9] The Trust advised this sceptic screen involved blood tests, blood cultures, a urine culture test and a chest x-ray.

and thorough physical examination and a review of recent results from bloods and scans.' I noted the General Medicine IPA advised, *'I have no concerns about [the Admitting Medical Doctor's] assessment of the Patient'.*

53. I also noted the General Medicine IPA's advice that it was reasonable that at the time of his assessment of the Patient, the Admitting Medical Doctor did not ask a more senior doctor to review her. In this regard, the General Medicine IPA advised, *'Other than the one-off fever, the Patient's condition was the same as it had been at the time of transfer to the ward. [The Admitting Medical Doctor] made appropriate plans for some initial investigations, and I would not have expected this to have been escalated to a more senior doctor at that stage'.* In relation to the tests and investigations the Admitting Medical Doctor arranged for the Patient at the time he assessed her – chest x-ray, blood tests and blood cultures, and a urine culture test - I noted the General Medicine IPA advised, *'these are the appropriate tests I would have expected'.*

54. In relation to the Admitting Medical Doctor's decision not to commence any treatment for the Patient, I noted it was the General Medicine IPA's advice that the Patient *'did not meet the criteria for Systemic Inflammatory Response Syndrome (SIRS)*[10] *or sepsis'*. The General Medicine IPA also advised that it is common for patients to develop fever in the days after surgery and that this does not always mean there is infection present. The General Medicine IPA advised that it was, nevertheless, appropriate *'to assess and investigate for infection'*, and that the Admitting Medical Doctor *'arranged the appropriate investigations for this'.*

55. The General Medicine IPA further advised, '*In the case of an isolated episode of fever, when the Patient was otherwise stable and showing no signs of infection, it was reasonable that [the Admitting Medical Doctor] opted to wait for the blood results and X-ray rather than immediately starting antibiotics … the blood results at that time were not suggestive of infection (the CRP which is a marker of infection was normal at that time) so it was reasonable to watch and wait.'* The General Medicine IPA highlighted that this was in keeping with the

[10] SIRS is an inflammatory state affecting the whole body. It is the body's response to an infectious or non-infectious insult.

Trust's Antimicrobial Therapy Guidelines, which I noted emphasise, *'Start Smart: Do not start antibiotics in the absence of clinical evidence of bacterial infection'.*[11]

56. In addition, I noted it was the General Medicine IPA's advice that *'there was no indication for a repeat CT brain scan'* at the time of the Admitting Medical Doctor's assessment of the Patient *'as her neurological condition was unchanged from the time she was in the [RVH] Neurosurgical Unit prior to transfer [to Altnagelvin]'* and *'her GCS was stable, and there were no new neurological deficits'.*

57. I accept the General Medicine IPA's advice on the Admitting Medical Doctor's assessment of the Patient following her admission to Ward 41, and the decisions he took at that time regarding her care. Having given careful consideration to this advice, and the other available evidence, I am satisfied that the Admitting Medical Doctor's actions were appropriate and reasonable, and in accordance with the relevant standards.

58. I next considered nursing staff's further monitoring of the Patient in the hours that followed the Admitting Medical Doctor's assessment of her at 01:30. I established that nursing staff completed further observation checks for the Patient at 02:00 and 03:00. I sought advice from the Nursing IPA about these observation checks.

59. The Nursing IPA advised that the Patient's records show that at the time of the observation checks completed at 02:00, *'[her] GCS remains at 10, however her pulse had [risen] slightly (but still within the normal range of 60 – 100 beats per minute) and her temperature had [risen] above 38 degrees Celsius'.* The Nursing IPA also advised, *'At this time, [the Patient's] NEWS was recorded as 3. As per the guidance,*[12] *this still only requires a clinical monitoring of 4 – 6 hourly'.*

[11] Trust's Antimicrobial Therapy Guidelines, section 1.2.
[12] The Nursing IPA was referring to the guidance on the Trust's NEWS documentation regarding the frequency with which observation checks should be performed.

60. In relation to the observation checks repeated at 03:00, the Nursing IPA advised that the Patient's records show that at this time, *'[her] temperature has come back down to below 30 degrees Celsius and therefore NEWS is recorded once again as 2'.* The Nursing IPA advised that this score meant that the Patient's *'next set of observations would only need to be completed between 0700 and 0900'*.

61. Having noted, however, that the Patient's records documented that her next set of observations, following those completed at 03:00, were not performed until 10:10, after the post-take ward round at 09:20, I sought the Nursing IPA's advice on whether this particular set of observations ought to have been completed sooner.

62. The Nursing IPA advised that at 04:00 on 19 September 2021, a member of the Trust's Hospital at Night Team documented in the Patient's records that *'she took blood cultures and bloods … and inserted a venflon*'.[13] The Nursing IPA further advised that the Hospital at Night staff member documented the Patient's temperature as 38.8 degrees Celsius, but that there was no record of any other observations, *'such as blood pressure, pulse, respiratory rate, oxygen saturations or the patient's [GCS]',* having been completed at that time.

63. The Nursing IPA also highlighted an entry made at 07:30 in the Patient's nursing progress notes, advising that this documented the same temperature (38.8 degrees Celsius), and that the Patient required blood cultures, which had been performed. The Nursing IPA advised, *'there is no evidence to when this temperature occurred',* but indicated she considered the two documented activities were connected, that is, that the entry made in the nursing progress notes at 07:30 was referring to the blood cultures that had been taken at 04:00, when the Patient had had a temperature of 38.8 degrees Celsius.

64. It was also the Nursing IPA's advice that because the Patient's temperature *'had risen again at 0400 to above 38.1 degrees Celsius, it would not be unreasonable to expect a further set of observations to have been completed*

[13] A venflon is a type of cannula, a thin tube inserted into the body, often used for the delivery and removal of fluids, or for gathering samples.

before the 9.20am ward round', which, the IPA advised, *'according to the documentation were not done.'*

65. I should highlight here that when I reviewed the Patient's records, I considered the entry the Hospital at Night Team made at 04:00 documented a temperature of 38.2 degrees Celsius, rather than the 38.8 degrees Celsius the Nursing IPA had referred to. I sought clarification about this from the Nursing IPA. The Nursing IPA advised that the temperature documented at 04:00 was *'difficult to read'* but that she remained of the view that the Hospital at Night Team had documented a temperature of 38.8 degrees Celsius. The Nursing IPA advised that if even if the Patient's temperature had been 38.2 degrees Celsius at 04:00, this was still higher than the temperature that had been recorded when observation checks were completed at 03:00 (which is documented on the NEWS chart as falling within the range 37.1 to 38 degrees Celsius). I noted the Nursing IPA advised that this apparent increase in the Patient's temperature *'warrants another set of [observations] doing'.*

66. Having considered the available evidence, including the advice I obtained from the Nursing IPA, which I accept, I am satisfied that the Patient's observation checks were completed at appropriate intervals up to 03:00 on 19 September 2021. However, the NEWS recorded at 03:00, a score of 2, indicated that observation checks were to be repeated within the next four to six hours, that is between 07:00 and 09:00. The further temperature spike the Patient experienced at 04:00, which I noted the Nursing IPA advised was to be considered '*a clinical change'*, was further reason to complete a full set of observation checks within that four to six hour period. It is evident, however, from the Patient's records that her observations were not repeated until 10:10. I consider this was a failing in the Patient's care.

67. I am not in a position to determine whether this failing had an adverse impact on the Patient's clinical condition, as it is not possible for me to know what the findings of her observation checks would have been, had they been performed at or before 09:00, or what escalation of the Patient's care or other action, if any, would have been appropriate on the basis of them. I am, however, satisfied that the failing I have identified caused the Patient to sustain the

injustice of loss of opportunity to have her observation checks performed at the appropriate time.

68. My investigation then established that at 07:30 on 19 September 2021, the Admitting Medical Doctor reviewed the results of the chest x-ray and the blood tests he had requested for the Patient some hours previously. The Trust informed me that the chest x-ray was performed at 04:23 and that bloods were taken at 04:00. I noted the Patient's records confirm these timings.

69. When he commented on the complaint, the Admitting Medical Doctor informed me that he *'reviewed [the Patients] blood test results and chest X-ray on NIECR'.*[14] He said the Patient's bloods *'showed inflammatory markers within the normal limits and her chest X-ray showed no obvious consolidation, i.e. there was no evidence to suggest any particular source of infection'*. The Admitting Medical Doctor also said he considered, *'This, in combination with [the Patient's] stable presentation and low NEWS score, meant that [he] could not see any indication to commence antibiotics'.*

70. I noted that in relation to the Admitting Medical Doctor's review of the Patient's blood tests and chest x-ray, the General Medicine IPA advised she agreed with his *'interpretation of the blood results'*, which, she advised, was appropriate and reasonable. The General Medicine IPA also advised that she had reviewed the images of the Patient's chest x-ray and had noted that the subsequent formal Radiology report *'mentioned that "there may be a little patchy consolidation medially behind the left heart".'* I noted the General Medicine IPA commented, *'As a non-Radiologist, I would not have necessarily appreciated this very subtle change'*. The General Medicine IPA also advised she was therefore of the view that the Admitting Medical Doctor's interpretation of the Patient's chest x-ray was reasonable in the circumstances.

71. The General Medicine IPA provided advice in relation to the Admitting Medical Doctor's decision, on the basis of his interpretation of the results of the Patient's 19 September 2021 blood tests and chest x-ray, not to commence antibiotics. I noted the General Medicine IPA advised that the blood results *'were not in*

[14] Northern Ireland Electronic Care Record

keeping with infection'. The General Medicine IPA also advised. *'I would not have expected the [Admitting Medical Doctor] to pick up on such subtle [chest x-ray] signs (given that even the specialist radiologist did not appear convinced of the of the findings … "may be a little patchy consolidation"). In that situation, since the NEWS score was low and the fever had settled at that point it was reasonable to hold off antibiotics and monitor the situation.'*

72. I have given careful consideration to the Admitting Medical Doctor's interpretation of the Patient's chest x-ray, which he reviewed at 07:30 on 19 September 2021. I am mindful that at that time, the x-ray had not yet been formally reported by a Consultant Radiologist. I am mindful too, that as the General Medicine IPA highlighted in her advice, which I accept, even the Consultant Radiologist, in reporting the chest x-ray, did not indicate certainty about whether infection was present. In the circumstances, I consider the Admitting Medical Doctor's interpretation of the Patient's chest x-ray was reasonable. I am satisfied that on the basis of this interpretation of the chest x-ray and his review of the Patient's blood results, it was appropriate that the Admitting Medical Doctor did not commence antibiotics for the Patient at that time.

73. Finally, in relation to this first element of the complaint, I considered whether other aspects of the nursing care the Trust provided for the Patient (other than monitoring) during the period between her admission to Ward 41 and the post-take ward round the following morning, were appropriate and reasonable.

74. I noted the Nursing IPA advised that other aspects of nursing care[15] provided for the Patient were *'well identified in the nursing assessment'*[16] and that the aspects of care that were appropriate to manage and address within this timeframe were handled appropriately. The Nursing IPA advised that not all the risks and needs documented in the nursing assessment *'would need to be*

[15] Details of these other aspects of nursing care, in addition to the monitoring of the Patient, are set out in the Nursing IPA's advice report (page 8) at Appendix Seven to this report.
[16] A assessment that documents the patient's risks and needs, such as, any alerts that may be in place; the patient's immediate and past medical history; a mobility assessment; a falls risk assessment; how and if the patient is passing urine; and their ability to communicate.

addressed overnight' but that those that should and could be addressed during that time were dealt with.

75. I accept the Nursing IPA's advice about the aspects of nursing care, other than monitoring, which the Trust provided to the Patient during the (approximately) eleven hours following her admission to Ward 41. I am satisfied these other aspects of nursing care were reasonable and appropriate.

76. My investigation into this first element of the complaint examined the nursing and medical care and treatment the Trust provided to the Patient during the period between her admission to Altnagelvin at 21:47 on 18 September 2021 and the post-take ward round at 09:20 on 19 September 2021.

77. I found that, for the most part, the Trust provided appropriate nursing care to the Patient. I also found, however, that in relation to its monitoring of the Patient on 19 September 2021, the Trust failed to repeat her observation checks between 07:00 and 09:00 - the timeframe indicated by the outcome of observations completed at 03:00, that is, a NEWS of 2. I concluded this was a failing in the Patient's care and treatment. While I am unable to determine whether this failing had an adverse impact on the Patient's clinical condition, I am satisfied it caused her to sustain the injustice of loss of opportunity to have observation checks performed at the appropriate time.

78. In relation to the medical care and treatment the Trust provided, I found that the Admitting Medical Doctor completed an appropriate assessment of the Patient when he saw her at 01:30 on 19 September 2021. I also established that the decisions the Admitting Medical Doctor took at the time of his assessment regarding the Patient's care and treatment, including his decision that it was not necessary to ask a more senior doctor to review the Patient at that time, were reasonable and appropriate in the circumstances. In addition, my investigation found the Admitting Medical Doctor's interpretation of the results of blood tests and a chest X-ray the Patient had in the early hours of 19 September 2021 was reasonable in the circumstances, as was the decision he took at that point not to prescribe antibiotics for her.

79. I partially uphold the first element of the complaint.

(ii) The care and treatment the Trust provided to the Patient after her review at post-take ward round on 19 September 2021

80. I considered the care and treatment the Trust provided to the Patient on 19 September 2021, during the period between the post-take ward round and the decision to start her on intravenous antibiotics. My investigation established the following events during that period:

- the General Medicine Consultant reviewed the Patient at 09:20 during the post-take ward round;
- a reduction in the Patient's GCS, from 10/15 on her admission to Ward 41, to 6/15 (indicating a reduction in her level of consciousness) was noted;
- the plan made for the Patient's care included an urgent CT brain scan, and antibiotics, if there was an increase in her temperature or raised infection markers;
- the Patient had a CT brain scan at 09:45;
- at 10.10, nursing staff completed the Patient's clinical observations, which resulted in a NEWS of 7, and alerted the Medical Team about this;
- at 10.25 and 10.40, nursing staff repeated the Patient's clinical observation, noting each time that her NEWS was 5 and her GCS was 4/15;
- the Medical Registrar reviewed the Patient at 11:40;
- A Consultant Radiologist reported the Patient's CT brain scan at 12:01;
- A Foundation Year 2 doctor in the Medical Team (the Medical FY2) discussed the findings of the Patient's CT brain scan with the RVH Neurosurgical Team;
- The antibiotic, Tazocin, was prescribed for the Patient and administered intravenously at 14:00.

81. When the Trust responded to my investigation enquiries, it provided an account of its review of the Patient at the post-take ward round. The Trust advised that *'a change in clinical condition [was] noted with evidence of reduced conscious level'.* The Trust said that *'in view of recent neurosurgical intervention'* it prioritised an urgent CT brain scan for the Patient, as well as discussion with the RVH Neurosurgical Team. The Trust also stated that the General Medicine Consultant *'advised on the Medical Ward round to have low threshold to cover for other potential causes of reduced conscious level including covering for infection with antibiotics if any further temperatures or raised infection markers'.* The Trust said too that the General Medicine Consultant also advised cover for hepatic encephalopathy,[17] in view of the Patient's past medical history, and an electroencephalogram (EEG) as this *'is useful in clarifying underlying brain activity.'*

82. I asked the General Medicine IPA for advice on the plan for the Patient's care and treatment, which the General Medicine Consultant put into place at the time of the post-take ward round, once a change in her clinical condition and reduction in her level of consciousness had been observed. I noted the General Medicine IPA advised she *'was content with the plan'* the General Medicine Consultant made at that time. The General Medicine IPA also advised, *'… the Patient's other observations were satisfactory, with no fever, so … it remained appropriate to hold-off antibiotics unless there was a further fever or rise in inflammatory markers …'.* She further advised, *'… [the General Medicine Consultant] noted that the Patient's neurological status [had] changed since the night before, and so an appropriate plan for an urgent repeat CT brain was made'.*

83. I accept the General Medicine IPA's advice. I am satisfied that the plan the General Medicine Consultant put in place for the Patient's care at the time of the post-take ward, including the plan for an urgent CT brain scan and to begin antibiotics, should the Patient's temperature rise again or her inflammatory markers increase, was appropriate and reasonable in the circumstances.

[17] A condition that causes temporary worsening of brain function in people with advanced liver disease. It occurs due to the liver's inability to remove toxic substances from the blood, leading to a buildup of toxins in the brain.

84. The Trust informed me that the report of the Patient's CT brain scan '*noted a hyperattenuating rim suggesting some degree of acute bleed'* and that it confirmed *'bilateral subdural haematoma with mild acute on chronic changes'.*

85. I asked the Neurosurgery IPA to explain the findings of the Patient's CT brain scan. The Neurosurgery IPA advised that the CT scan *'showed the presence of a subdural collection*[18] *on both sides of the brain's surface'.* The Neurosurgery IPA also advised that these collections of blood were not *'causing any pressure effects on the [Patient's] brain'.*

86. The Neurosurgery IPA further advised that the collection of blood on the right side of the Patient's brain was *'associated with a craniotomy'*[19], due either to *'residual chronic subdural haematoma [which was] an entirely normal and expected finding [as] not all the subdural blood is evacuated during burr hole procedures and they don't need to [be] either'* or to *'subdural empyema (infection of the subdural space) following two operations'.* The Neurosurgery IPA advised, *'I have seen the [Patient's] medical records and have no reason to believe that there was any evidence to suggest infection of the brain.'* In relation to the collection of blood on the left side of the Patient's brain, the Neurosurgery IPA advised this was also considered to be *'a subdural haematoma in the context of previous trauma'*. He advised, *'It is seldom necessary to intervene with surgical decompression unless there is considerable pressure effect on the brain.'*

87. The Trust informed me that after the report of the Patient's CT scan was available, the Medical Registrar[20] telephoned the RVH Neurosurgical Team *'who advised that despite [what] the CT report documented, the Neurosurgical Team were not convinced of any new intracranial findings in comparison to previous scans'.* The Trust also said that the RVH Neurosurgical Team *'advised that [the Patient] already had 2x operations and that there was no*

[18] A collection of blood between the dura mater (a protective layer of tissue surrounding the brain) and the surface of the brain.
[19] Surgery to cut a bony flap from the skull to access the brain.
[20] The name of the doctor who documented the Medical Team's contact with the RVH Neurosurgical Team is not recorded in the Patient's notes. However, I consider the handwriting indicates the doctor who documented that contact is that of the Medical FY2. I consider this indicates that it is likely that it was the Medical FY2, and not the Medical Registrar, who spoke with the RVH Neurosurgical Team.

indication for further neurosurgical input'. The Trust said too that the RVH Neurosurgical Team *'advised to update [the Patient's] family on this decision that no further neurosurgical intervention was planned'.*

88. The Medical Team's contact with the RVH Neurosurgical Team is documented in the Patient's records. I noted that either the Medical Registrar or (as I consider more likely) the Medical FY2 documented at 12:40 that when they spoke with the RVH Neurosurgical Team about the findings of the Patient's CT brain scan, the Neurosurgical Team said they were not *'convinced of an acute bleed on CT'.* I also noted the Patient's records document that the RVH Neurosurgical Team advised that the Patient was *'for no further intervention as already had two operations'.*

89. I asked the Neurosurgery IPA about the RVH Neurosurgical Team's opinion that there was no convincing evidence of *'an acute bleed'* on the Patient's CT brain scan. The Neurosurgery IPA advised, *'"Acute bleeding" suggests fresh blood within the subdural space. There was none. This advice was appropriate and reasonable.'*

90. I sought the Neurosurgery IPA's advice about the RVH Neurosurgical Team's opinion that the Patient should have no further neurosurgical intervention. The Neurosurgery IPA advised, *'This was an appropriate and reasonable response given the Patient's extensive past medical history and clinical decline.'*

91. I also noted that the Patient's records document that the Medical Team asked the RVH Neurosurgical Team about the drop in the Patient's level of consciousness. The Patient's records document that the RHV Neurosurgical Team suggested that the Medical Team should *'rule out other causes of low GCS, eg infection'.* I noted the Neurosurgery IPA advised this suggestion from the RVH Neurosurgical Team was appropriate and reasonable.

92. I found the Patient's records document that the Medical Team asked the RVH Neurosurgical Team for advice on the plan for the Patient's care, should her condition deteriorate further. It is documented in the Patient's records that the RVH Neurosurgical Team advised the Medical Team *'to then talk to family'.* It is evident from the Patient's records that the Medical Team took action to do

this. Specifically, I noted the records document that at 17:00, the Medical Registrar spoke with the Patient's husband, making him aware that the RVH Neurosurgical Team was not *'able to offer further surgery'* and informing him that the Trust was *'currently treating all possible causes of [reduced] GCS]'.* I noted that at this time, the Medical Registrar also informed the Patient's husband that given there were *'no surgical options',* if the Patient's condition deteriorated further, it was considered *'she would not be candidate for ICU and therefore resuscitation'.*

93. In relation to the action the Trust took to investigate other possible causes of the Patient's reduced consciousness level, such as infection, I noted her records include a copy of radiology report relating to CT brain scan that was requested on 19 September 2021 and cancelled on 20 September 2021. I noted the radiology report documents the following information from the scan request: *'Temp spike and dropped GCS. Advised by the Neurosurgical reg to eclude* [sic] *IC*[21] *abscess with CT and contrast'.*

94. I sought the Neurosurgery IPA's advice on the RVH Neurosurgical Team's suggestion (as it was documented in the radiology report) that the Patient should have a CT brain with contrast *'to exclude IC abscess'*. The Neurosurgery IPA advised that while the proposal for this further scan was appropriate and reasonable, the Patient's *'previous medical history, associated co-morbidities and recent decline would have meant that any neurosurgical intervention arising out of the contrast CT scan (e.g. further surgery) would have been futile'.*

95. I accept the Neurosurgery IPA's advice about the input the RVH Neurosurgical Team provided on 19 September 2021 to the Patient's care and treatment, and I consider it was appropriate, in the circumstances, for the Trust to have regard to that input in making decisions about the Patient's care and treatment from that point on. In addition, I am satisfied that the Trust took appropriate action to keep the Patient's husband informed about the Patient's condition and her prognosis.

[21] An abbreviation for intracranial, which means within the skull.

96. In response to my investigation enquiries, the Trust informed me that after it discussed the findings of the Patient's CT brain scan with the RVH Neurosurgical Team, *'it was … deemed appropriate to commence empirical intravenous antibiotics to cover for a possible chest infection, albeit it was deemed unlikely to change the ongoing clinical outcome considering [the Patient's] reduced conscious level and CT findings'.* The Trust informed me the intravenous antibiotic it prescribed for the Patient was Tazocin, to be administered three times daily, every eight hours. It also informed me the Patient had her first dose of Tazocin at 14:00 (on 19 September 2021).

97. I noted the Trust's decision to commence antibiotics for the Patient is referenced in a documented discussion on 19 September 2021 between the Medical Team and the RVH Neurosurgical Team. The Patient's records document that the Medical Team informed the Neurosurgical Team that the Patient *was 'being started on [antibiotics]'* and was on *'Rifaximin for encephalopathy because of her [history]'.*

98. I asked the General Medicine IPA for advice on the Trust's decision to prescribe Tazocin for the Patient at this stage. I noted the General Medicine IPA advised, *'given the Trust had explored a possible neurological cause for the Patient's deterioration and since the Neurosurgeons did not feel that further surgical intervention would be appropriate, it was reasonable to cover for other possible causes of deterioration such as infection.'* The General Medicine IPA highlighted that by this time there had been other changes in the Patient's condition – *'increased respiratory rate, and an increased oxygen requirement'* – which *'could now indicate a possible lung infection'.*

99. I also sought the General Medicine IPA's advice on whether antibiotics ought to have been started earlier for the Patient, before the findings of her CT brain scan were known. The General Medicine IPA advised that *'in the absence of further fever and with normal bloods, it was not unreasonable to wait and see if the CT brain revealed a cause for [the Patient's] deterioration'*.

100. In relation to the specific antibiotic that the Trust prescribed for the Patient, that is, Tazocin, I noted the General Medicine IPA advised this was *'an appropriate*

broad-spectrum antibiotic for the circumstances' and was *'in keeping with [the Trust's Antimicrobial Therapy Guidelines]'*. I noted these guidelines state that for cases of hospital acquired pneumonia and aspiration pneumonia, the antibiotic pipercacillin with tazobactam[22] should be prescribed.

101. I accept the General Medicine IPA's advice. I consider the Trust's decision to await the findings of the Patient's CT brain scan before prescribing antibiotics for her, and its prescribing and administering of Tazocin in particular, was reasonable and appropriate.

102. That said, I noted the General Medicine IPA highlighted in her advice that when, at 10:10, the Patient's NEWS score increased to 7, and there was an increase in her respiratory rate and oxygen requirement and a reduction in her level of consciousness, there was a delay in her being reviewed by the Medical Team. Specifically, the General Medicine IPA advised, *'I can see that the notes state that the nurses informed the medical team immediately of the rise in NEWS, but the medical team did not document a review of the Patient until 11:40am.'* The General Medicine IPA further advised, *'There is also no documentation of any re-examination of the Patient's chest, which I would have expected given the increased respiratory rate and increased oxygen requirement.'* I noted the General Medicine IPA advised she considered it *'unreasonable … that there was a delay of 90 minutes from the time of the deterioration in [the Patient's] NEWS to the time of the medical review, and also that the medical review did not document a further examination of [the Patient's] chest'.*

103. My review of the Patient's records confirmed they document that the clinical observations performed at 10:10 resulted in an increased NEWS of 7, when previously (at 03:00) this score had been 2. I found the Patient's records document that at this time, her respiratory rate was 23 breaths per minute, when previously this had been in the range of 15 to17, and that she required two litres of oxygen per minute when this requirement had previously been one litre of oxygen per minute. In addition, I found that an entry nursing staff made

[22] Tazocin is a brand name for piperacillin with tazobactam.

on the Patient's NEWS chart at 10:10 documents, *'Resp rate 23, on 2L O^2 and only responding to voice. Dr informed, 15 min obs commenced, awaiting CT of brain…'*

104. As I pointed out previously in this report, the Trust's NEWS documentation provides guidance on the frequency of monitoring and the clinical response required, depending on a patient's NEWS score. This indicates that a NEWS of 5 or more requires nursing staff to *'urgently inform medical team caring for the patient'* and an *'urgent assessment by clinician (within 30 minutes)'* to be carried out.

105. However, my review of the Patient's records found no reference to the Medical Team having reviewed her until at 11:40, some 90 minutes after having been first informed of the decline in her condition. At that time, the Medical Registrar documented in the Patient's notes, *'Noted earlier review GCS 6/15. Called by [nursing staff] re GCS drop 4/15. On arrival GCS 5/15 … Alert with eye opening. Non-verbal … NEWS = 5. Conscious level P[23] … Plan: Await CT. May require neurosurgical input …'* As the General Medicine IPA highlighted in her advice, there is no record of the Patient's chest having been examined at that time.

106. I noted the General Medicine IPA also advised that there could have been *'a number of causes'* for the change seen in the Patient's condition at 10:10, and that she referred in her advice to two such possible causes - *'a further bleed around the brain [which] could affect things such as respiration rate'*, and *'infection'*. It is evident that by the time of the further decline noted in the Patient's clinical condition at 10:10, the Medical Team had already taken steps to arrange an urgent CT brain scan to investigate whether her reduced level of consciousness at the time of the post-take ward round was due to a further bleed around her brain. However, the available evidence, including the General Medicine IPA's advice, which I accept, indicates that the Medical Team ought to have also taken action to review the Patient more quickly, and to

[23] 'P' is an abbreviation for 'responsive to pain'.

examine her chest, when at 10.10, her NEWS rose to 7,her GCS dropped to 4/15, and her respiratory rate and her oxygen requirement both increased.

107. I consider the delay in the Trust's review of the Patient, after nursing staff escalated the change in her condition to the Medical Team, and the fact that despite the rise in the Patient's respiratory rate and oxygen requirement, her chest was not examined as part of that review, to be failings in her care and treatment.

108. I am mindful that the General Medicine IPA advised that given the Patient's *'overall condition and comorbidities'*,[24] she was of the opinion that the delayed medical review and the lack of chest examination would not have had *'any significant impact on the outcome for this patient'.* While I accept this advice, I am nevertheless of the view that the Patient sustained injustice as a result of these failings in her care. Specifically, I consider she sustained a loss of opportunity to be reviewed by the Medical Team within the timeframe stipulated in the Trust's NEWS documentation, and to receive any additional care considered appropriate to her clinical condition at that time.

109. My investigation into this second element of the complaint considered the care and treatment the Trust provided to the Patient at the time of the post-take ward round on the morning of 19 September 2021 and in the (approximately) five hours that followed. I found that when a deterioration in the Patient's clinical condition was noted during the post-take ward round, the General Medicine Consultant put in place an appropriate plan for her care, including an urgent CT brain scan. I also found that, following the reporting of the Patient's CT brain scan, the Medical Team had appropriate regard to advice obtained from the RVH Neurosurgical Team, that it appropriately commenced intravenous antibiotics for her and requested a further CT brain scan to investigate a possible source of infection in her skull (albeit that that CT brain scan was later cancelled), and that it updated her next of kin about her prognosis.

110. My investigation also found, however, that when the Patient's condition continued to decline, there was a delay in her being reviewed by the Medical

[24] Two or more health conditions occurring in a person at the same time.

Team and that despite her respiratory rate and oxygen requirement having increased, her chest was not examined at the time of that review. I found these were failings in the Patient's care and treatment. However, on the basis of the General Medicine IPA's advice, I cannot conclude that these failings had a significant impact on the Patient's prognosis, given her condition at the time and her underlying health issues. Nevertheless, I consider they caused the Patient to sustain the injustice of loss of opportunity to have a timely medical review and to receive any additional care or intervention deemed appropriate as a result. I also consider they caused the Patient's family to sustain the injustice of uncertainty about what the outcome may have been, had action been taken sooner.

111. I partially uphold the second element of the complaint.

(iii) The care and treatment the Trust provided to the Patient after the decision on 19 September 2021 to commence intravenous antibiotics

112. I considered the care and treatment the Trust provided to the Patient after it decided, on 19 September 2021, to start her on intravenous antibiotics. My investigation established the following events took place during that period:

19 September 2021

- the Patient's first dose of intravenous Tazocin was administered at 14:00
- the Medical Registrar documented at 17:00 that he had spoken with the Patient's husband, updating him about the Patient's condition and prognosis, and the plan for her care;
- the Medical Registrar signed a DNACPR 'communication sheet' in relation to the Patient at 17:00;

20 September 2021

- the Medical Registrar and the Medical FY2 reviewed the Patient at 09:35;

- the Medical Registrar and the Medical FY2 spoke with the Patient's family at 10:15, providing an update on the Patient's condition and the plan for her care;

- the Trust's Palliative Care Team (the Palliative Care Team) assessed the Patient at 10:30 and suggested a number of medications for her;

- the Medical FY2 cancelled a CT brain scan that had been requested for the Patient the previous day;

21 September 2021

- at 09:30, the General Medicine Consultant endorsed the DNACPR decision taken on 19 September 2021;

- the General Medicine Consultant reviewed the Patient at 09:45;

- the Palliative Care Team reviewed the Patient at 11:00;

- a decision was taken at 22:00 to stop administering Tazocin to the Patient;

22 September 2021

- the Palliative Care Team reviewed the Patient at 10:45;

- at 12:02, a Medical senior house officer (the Medical SHO) reviewed the Patient and spoke with the complainant and two of the Patient's other sisters about bruising they had noted on the Patient's chest;

- at 14:00, following a decision to prescribe Tazocin again for the Patient, she received her last dose; and

23 September 2021

- the Patient passed away at 01:40.

113. I examined the Trust's decision that it was not appropriate to resuscitate the Patient should her condition decline further (the DNACPR decision); its decision to cancel a CT brain scan it had ordered for the Patient on 19 September 2021 (to investigate possible causes of her reduced consciousness level), and its

decision to stop the Patient's intravenous antibiotics. I also considered the Trust's handling of concerns the complainant raised about bruising she had noticed on the Patient's chest.

114. In relation to the DNACPR decision, I noted that when the Trust wrote to the complainant on 22 December 2022, responding to her concerns about the Patient's care, it said that when the Medical Registrar spoke with the Patient's husband on 19 September 2021, *'appropriate discussion regarding cardiopulmonary resuscitation was documented with ceiling of care for [the Patient] maximized to ward level care'.* The Trust also informed the complainant in its response that the Patient's husband *'was in agreement with ceiling of care for maximum to ward level care and DNACPR form was signed with consent'.*

115. I noted too that when the Trust responded to my investigation enquiries, it again said that the DNACPR decision it took on 19 September 2019 *'was discussed with [the Patient's] husband and next of kin … on 19th September 2021 at 17:00hrs'.* The Trust also said, '*Due to underlying comorbidities, and frailty postoperatively, ICU was not deemed appropriate therefore ceiling of care was decided at maximised ward level.'*

116. I noted the Medical Registrar who spoke with the Patient's husband at 17:00 on 19 September 2021 documented in the Patient's notes, *'Relayed info to date to husband … He himself feels like she is deteriorating and may not survive. I informed our feelings are the same. States her baseline is poor, not speaking. Explained as no surgical options if deteriorates would not be candidate for ICU and therefore resuscitation. [Therefore] DNACPR instituted'.* In addition, I noted the DNACPR communication sheet the Medical Registrar completed at that time documents the basis on which the DNACPR decision had been made as, *'Poor baseline, not for further neurosurgical intervention'*. It also documents that the General Medicine Consultant was involved in the making of the decision and that the decision was communicated to the Patient's husband.

117. I sought the General Medicine IPA's advice on whether the DNACPR decision was appropriate and reasonable in the circumstances. I noted the General

Medicine IPA advised that *'in view of the overall condition of the Patient'* and the fact that the RVH Neurosurgical Team had advised that the Patient was not to have further surgical intervention, *'CPR would sadly have been futile'.* The General Medicine IPA also highlighted in her advice that the DNACPR decision *'was appropriately discussed with the Patient's husband, since the Patient lacked capacity to be involved in this decision'.*

118. The General Medicine IPA advised further, *'The handling of this aspect was undertaken in keeping with good medical practice and [the GMC End of Life Guidance] and also [the Trust's DNACPR Policy].* In this regard, I noted the Trust's DNACPR Policy states that it is appropriate to consider a DNACPR in circumstances '*Where the patient's condition indicates that effective CPR is unlikely to be successful'*, while the GMC End of Life Guidance states that where it is considered that resuscitation would not be clinically appropriate, and the patient lacks capacity to make a decision about resuscitation, the clinician *'must consult those close to the patient as part of the decision making process …'.* The GMC End of Life Guidance also makes it clear that there is a requirement to document in a patient's records *'Any discussions with a patient, or with those close to them, about whether to attempt CPR, and any decisions made'.*

119. I accept the General Medicine's advice. I am satisfied the DNACPR decision the Trust made on 19 September 2021 was appropriate in the circumstances, and taken in accordance with relevant standards. I am also satisfied there is evidence that the DNACPR decision was discussed with the Patient's husband, and that it was documented in Patient's records.

120. In relation to the Patient's cancelled CT brain, the Trust said, in response to my enquiries, that this scan was requested at 13:18 on 19 September 2021, following the Medical Team's discussion with the RVH Neurosurgical Team about the findings of the CT brain scan the Patient had had earlier that day. I noted the Patient's medical records document that the RVH Neurosurgical Team advised the Trust *'to rule out other causes of low GCS eg infection'* and that the CT brain scan request form recorded, *'Temp spike and dropped GCS.*

Advised by neurosurgical [registrar] to [exclude intracranial] abscess with CT …'

121. The Trust said, in response to my enquiries, that the CT brain scan requested on the afternoon of 19 September 2021 *'was recorded as cancelled on 20th September 2021 at 13:21hrs after radiology contacted [the Medical FY2] on Ward 41'.* The Trust informed me that the CT brain scan was cancelled *'due to clinical deterioration in [the Patient's*] condition', and it said that the General Medicine Consultant *'would also have been involved with this decision making'.*

122. When it expanded on the reason for cancelling the Patient's CT brain scan, the Trust referred to a discussion the Medical Registrar had with the Patient's family at 10:15 on 20 September 2021. The Trust said that the Medical Registrar *'asked [the Patient's] family for their thoughts on organising further imaging due to concerns over further deterioration'.* It said too that within the Patient's medical records, *'it mentions that family advised to hold off on further imaging including chest x-ray*[25] *as it may be too distressing for the Patient'.* The Trust also informed me that at this time, *'a decision was made to offer [the Patient] palliative care team involvement with reduced blood monitoring and observation checks'* and that *'[the Patient's] family were in agreement that management should be focused also on comfort care at this stage'*.

123. The Patient's records document the discussion that the Medical Registrar, along with the Medical FY2, had with the Patient's family at 10:15 on 20 September 2021. I noted the Patient's records document, *'Spoke with family. Updated on condition. Unfortunately patient has continued to deteriorate. Discussion about focusing more on comfort. Explained still treating with [antibiotics] to cover any infection … Asked family thoughts on further imaging, asked re [chest x-ray] and family noted to hold off as may be more distressing … Family in agreement that should be more towards comfort'.*

124. I sought advice from the General Medicine IPA on whether it was appropriate and reasonable in the circumstances that on 20 September 2021, the Trust

[25] The Patient's records document that when the Medical Registrar and the Medical FY2 reviewed the Patient at 09:35 on 20 September 2021, the plan for her care included *'Possible chest xray'.*

cancelled the CT brain scan that had been requested for the Patient the previous afternoon. I noted the General Medicine IPA advised that by this time, *'it was apparent that that the Patient was unfortunately dying despite treatment, and further imaging would not have changed the overall management/treatment options of her'.* The General Medicine IPA also advised, *'As such, it was reasonable to consider that undertaking further imaging would likely just add distress, without any discernible benefit to her'.* It was the General Medicine IPA's advice, therefore, that the Trust's decision to cancel this CT brain scan was appropriate and reasonable in the circumstances.

125. On the basis of the available evidence, including the advice I obtained from the General Medicine IPA, which I accept, I am satisfied that it was reasonable and appropriate that the Trust cancelled the CT brain scan it had requested for the Patient on the afternoon of 19 September 2021.

126. I next considered the decision the Trust took to stop the Patient's intravenous antibiotics. I noted that in response to my investigation enquiries, the Trust said that the Patient's intravenous antibiotics *'were stopped on 21st September 2021 at 22:00hrs'.*

127. Despite the Trust's response, I noted that the Patient's records indicated that Tazocin was administered to her on 22 September 2021. Specifically, I noted the Patient's nursing progress notes document, at 07:00 on 22 September 2021, *'IV Paracetamol and IV Taz given'*; at 14:30 on the same day, *'IV Paracetamol 1g given and IV Tazocin continued"*; and at 15:20, *'Reviewed by medics, plan: … [continue with antibiotics] and paracetamol until cannula dislodges'.* I asked the General Medicine IPA about this anomaly. The General Medicine IPA advised, *'According to the drug charts, [Tazocin] was initially scored off after the 10pm dose on 21st Sept, but then it was re-prescribed on 22nd Sept and [the Patient] was given her final dose at 2pm on that day.'*

128. The time on 22 September 2021 at which Tazocin was again prescribed for the Patient is unclear, although I noted the Patient's records indicate that Tazocin was administered that day at 06:00 and 14:00 on 22 September 2021. I noted too that the Patient's records document that when the Medical SHO reviewed

the Patient at 12:02, she documented that the plan for her care included *'[Intravenous antibiotics] and [intravenous fluids] until cannula tissues.'*[26]

129. I sought the General Medicine IPA's advice on the Trust's decision not to administer Tazocin to the Patient after 14:00 on 22 September 2021. It was the General Medicine IPA's advice that this was an appropriate and reasonable decision in the circumstances. I noted the General Medicine IPA advised, *'from the notes, it would appear that the Patient was unfortunately dying by this stage and continuing the antibiotics would have been futile. Furthermore, additional attempts at cannulation for administration of these would likely have caused unnecessary distress without any benefit for [the Patient]'.*

130. I accept the General Medicine IPA's advice. I am satisfied that in the circumstances, it was appropriate and reasonable that after the 14:00 dose on 22 September 2021, the Trust stopped administering the Patient's intravenous antibiotics.

131. Finally, my investigation examined the Trust's handling of concerns about bruising on the Patient's chest, which the complainant, and two of the Patient's other sisters, brought to its attention on 22 September 2021.

132. I noted the Patient's records document that the complainant and two of the Patient's other sisters were present when the Medical SHO reviewed the Patient at 12:02 on 22 September 2021. It is documented that they asked the Medical SHO about *'bruising on chest'* and that the Medical SHO *'explained [it was] unclear where bruising has come from but will try to find out'.* The Medical SHO also documented, *'large bruise centrally'.*

133. When it responded to my investigation enquires, the Trust acknowledged that bruising had been brought to the Medical SHO's attention *'on the final phase of [the Patient's] illness'.* It also said, *'There was no clear explanation for this at the time of the review and [the General Medicine Consultant] is therefore unable to speculate further, as it was not previously identified or brought to his*

[26] An intravenous cannula is said to 'tissue' when it moves out of the vein and into the surrounding tissue.

attention or the attention of nursing staff or [the Palliative Care Team] involved in [the Patient's] care.'

134. The Trust also stated, in responding to my enquiries, that the General Medicine Consultant *'advises that bruising can be more prevalent in patients with liver disease, but has advised that he will ask the Trust to investigate further to ensure that no other reason can be identified.'* Subsequently, when I asked the Trust for details of the action, if any, it had taken to investigate the cause of the bruising to the Patient's chest area, it informed me, *'A discussion regarding [the Patient's] case has taken place between Senior Clinicians, there may be multiple clinical reasons for bruising and it is not possible to pinpoint what the aetiology was in this case.'* The Trust later clarified that this discussion was specifically about the cause of bruising on the Patient's chest, and that it took place between the General Medicine Consultant and a senior colleague of his, a Consultant Nephrologist. The Trust was unable to confirm the date on which this discussion took place and it informed me that there was *'no recorded documentation'* of it.

135. I sought advice from the General Medicine IPA on the Trust's position that bruising can be more prevalent in patients with liver disease and that it was not possible to pinpoint the cause of the bruising to the Patient's chest. The General Medicine IPA advised that *'due to abnormal clotting of the blood due to liver disease, easy bruising is a common feature in patients such as this lady'.* The General Medicine IPA also advised that there can be multiple causes of bruising and that in the Patient's case, with her *'underlying risk factors for easy bruising, it would be very difficult to determine an exact cause'.*

136. I accept the General Medicine IPA's advice that the Patient was susceptible to bruising; that there could have been multiple reasons for the bruising noted on her chest on 22 September 2021; and that it is not possible to specify the cause. Consequently, I consider it likely that the bruising on the Patient's chest was attributable to an underlying illness – her liver disease – and not due to any failing in the care the Trust provided during her admission to Altnagelvin.

137. That said, it is apparent that despite the Medical SHO having given an undertaking to the complainant on 22 September 2021, to *'try to find out'* what had caused the bruising, there was no investigation into a possible cause until I asked the Trust about the matter. I am satisfied this lack of action, in follow up to the complainant's concerns, had no bearing on the standard of care and treatment the Trust provided to the Patient during the period I examined in my investigation. However, it is a matter on which I expect the Trust to reflect, with a view to taking steps to ensure that, where at all possible, it delivers on the commitments it makes to address relatives' concerns about a patient's condition or their care.

138. My investigation into this third element of the complaint examined the care and treatment the Trust provided to the Patient in the days following its decision on 19 September 2021 to prescribe intravenous antibiotics. I found the Medical Team's decision on 19 September 2021 that it would not be appropriate to resuscitate the Patient, should she require it; its decision on 20 September 2021 to cancel a CT scan that had been requested for the Patient the previous day; and its decision on 22 September 2021 to stop administering intravenous antibiotics to the Patient were all reasonable and appropriate in the circumstances. I addition, I am satisfied there is no evidence to indicate the bruising noted on the Patient chest on 22 September 2022 resulted from a failing in her care.

139. I do not uphold the third element of the complaint

CONCLUSION

140. I received a complaint about the care and treatment the Trust provided to the Patient in Altnagelvin during the period 18 to 23 September 2021. In particular, the complainant said she was *'not convinced'* that the Patient had received *'the appropriate level of clinical care'* during that period. She said she was particularly concerned about the period between the time of the Patient's admission to Altnagelvin on the evening of 18 September 2021 and the time she was reviewed by the General Medicine Consultant at the post-take ward round the following morning.

141. For the reasons set out in this report, I am satisfied that, for the most part, the care and treatment the Trust provided to the Patient during her admission to Altnagelvin was appropriate and reasonable. However, my investigation disclosed evidence of some failings in the Patient's care. Specifically, although there is evidence to show that nursing staff completed the Patient's clinical observations at the appropriate intervals up to 03:00 on 19 September 2021, I found that these observations ought to have been repeated between 07:00 and 09:00, before the post-take ward round, but were not performed until 10:10. I also found that later that morning, when the Patient's clinical condition deteriorated to the point that urgent assessment by the Medical Team was warranted, there was delay in a medical review being carried out. In addition, I found that the Patient's chest was not examined during that medical review, despite her respiratory rate and oxygen requirement having both increased.

142. I do not conclude that these failings had an adverse impact on the Patient's clinical condition at the time or affected her overall prognosis. The reasons for my view on this are explained earlier in this report. However, I consider the failings I identified caused the Patient to sustain the injustice of loss of opportunity, not only to have observation checks completed at the appropriate time but also to be reviewed by the Medical Team within the stipulated timeframe, and to receive any further care considered appropriate to her clinical condition at that time. I also consider they caused the Patient's family to sustain the injustice of uncertainty about what the outcome may have been, had action been taken sooner.

143. Overall, I partially uphold this complaint.

Recommendations

144. I recommend that within one month of the date of this report, the Trust provides the complainant with a written apology, made in accordance with NIPSO's 'Guidance on issuing an apology'[27] for the injustice caused as a result of the failings identified by my investigation.

[27] NIPSO Guidance on issuing an apology, July 2019

145. I further recommend that within three months of the date of this report, the Trust takes action to ensure that the learning highlighted by this investigation is communicated to relevant staff, in particular, that medical staff are reminded of the need for prompt and thorough review of patients when their NEWS score indicates that escalation is appropriate and that nursing staff are reminded of the need to complete clinical observations for patients within appropriate timescales.

146. In addition, although not a formal recommendation, it is my expectation that the Trust reflects on my findings in relation to the Patient's nursing notes and with regard to its handling of the complainant's concern about bruising on the Patient's chest, and that it takes appropriate remedial action, such as, reminding nursing staff of the need to ensure that patients' records are accurate and complete, and making all staff aware of the need to meet the commitments they make to address patients' and relatives' concerns and queries.

147. In concluding this report, I am aware that in submitting her complaint to me, the complainant was seeking answers to her unresolved questions about the standard of care and treatment the Trust provided to the Patient – her late sister. I consider it understandable that given her sister's rapid deterioration following her transfer from RVH to Altnagelvin, the complainant described her sister's passing as *'unexpected'* and *'avoidable'.* However, I am mindful of the General Medicine IPA's remarks in concluding her advice, namely, *'Although [the Patient] was stable at the time if her transfer to Altnagelvin … her overall outlook remained uncertain at that time - whilst the surgeon's hope was that she would improve, in my experience patients in this situation remain at high risk of acute deterioration. Unfortunately, when [the Patient] deteriorated again, she had a high risk of non-survival due to her comorbidities …'* I hope this report addresses the complainant's concerns and that it goes some way to assuring her that the care and treatment the Trust provided to her sister was, for the most part, appropriate.

MARGARET KELLY **July 2025**
Ombudsman

Appendix One

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.