Investigation of a complaint against Belfast Health & Social Care Trust

Report Reference: 202005575

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

The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

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

Reporting in the public interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Listed Authority: Belfast Health and Social Care Trust

SUMMARY

This complaint was about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's father (the patient) during his period as an in-patient for elective hemicolectomy[1] from 5 September to 7 November 2019.

The complainant believed the patient had a pre-existing infection on his admission to hospital for the hemicolectomy, but the Trust did not appropriately identify this prior to his surgery. The complainant also believed the Trust did not carry out an appropriate and timely cognitive impairment and delirium assessment with the patient. The complainant raised several concerns related to the prescription and administration of medication, as well as nursing care.

The investigation partially upheld the complaint as it identified failures in the care and treatment the Trust provided. Specifically, the Trust: -

- Did not carry out a timely Computed Tomography scan[2] when the patient exhibited signs of sepsis
- Did not carry out timely emergency surgery as indicated after the Computed Tomography scan on 4 October 2019
- Did not appropriately refer the patient for specialist advice when he continued to exhibit confusion at his discharge, in line with relevant guidance;
- Did not consistently complete all required nursing assessments. Specifically, the wound assessment chart and weekly pressure assessments;
- Did not consistently apply a wound dressing regime; and
- Did not consistently apply a SKIN bundle[3].

[1] A hemicolectomy is an operation to remove the right side of the large bowel (also called the colon or large intestine). It is normally performed to treat conditions which have caused the right-hand side of the large bowel to become diseased and which requires removal. These conditions include large right sided colon polyps, bowel cancer, Crohn's disease and certain abnormalities of the appendix.

[2] A Computed Tomography (CT) scan is a type of imaging that uses X-ray techniques to create detailed images of the body. It then uses a computer to create cross-sectional images, also called slices, of the bones, blood vessels and soft tissues inside the body. CT scan images show more detail than plain X-rays do. A CT scan has many uses. It's used to diagnose disease or injury as well as to plan medical, surgical or radiation treatment.

[3] The SKIN bundle is a bedside tool to help staff monitor skin concerns and proactively reduce the risks of developing a pressure ulcer.

The investigation also established the Trust: -

- Carried out an appropriate pre-operative assessment
- Carried out reasonable cognitive and delirium assessments during the patient's admission;
- Prescribed and administered appropriate medication;
- Completed an appropriate and timely overall nursing assessment; and
- Provided the patient with an appropriate mattress to manage the risk of pressure ulcers.

I recommended the Trust provides the patient and the complainant with a written apology for the injustices the failures in care and treatment caused. I made further recommendations for the Trust to address under an evidence-supported action plan.

THE COMPLAINT

1. This complaint was about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's father (the patient) from 5 September to 7 November 2019. During this period, the patient was admitted to the Belfast City Hospital (BCH) for an elective hemicolectomy.

Background

2. On 5 September 2019, in advance of his planned hemicolectomy, the Trust carried out a pre-operative assessment with the patient. This assessment included a range of blood tests. The Trust assessed the patient as fit for surgery. The patient was admitted to the BCH on 20 September 2019 for the hemicolectomy.

Issues of complaint

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

- **Issue 1: Whether the care and treatment the Trust provided to the patient between 5 September and 7 November 2019 was appropriate and reasonable. In particular this considered the following elements of the complaint.**
    i. Assessment of the patient for infection prior to his admission/surgery on 20 September 2019.
    ii. Cognitive impairment and delirium assessments carried out and associated care and treatment.
    iii. Medication prescribed and administered.
    iv. Nursing care during the period of 20 September to 8 October 2019 and 18 October to 7 November 2019. This included completion of required assessments.

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

    - A Consultant Anaesthetist with over 20 years' experience as a Consultant in a large tertiary teaching hospital, is an examiner for the Fellowship of the Royal College of Anaesthetists and is the Clinical Governance lead in their local Health Board; MBBS, MD, FRCA, LLM (Medical Law and Ethics) (AN IPA);
    - A Consultant Colorectal Surgeon with over 20 years' experience as a Consultant; MBChB, MSc, MD, FRCS (CR IPA); and
    - A Senior Nurse with 23 years' experience across primary and secondary care; RGN, MSc Advanced Clinical Practice, BSc (Hons) Nurse Practitioner, MA Health Service Management, Diploma in Adult Nursing, V300 non-medical prescriber (Nurse IPA).

    I enclose the clinical advice received from the AN IPA at Appendix three, the CR IPA at Appendix four and the Nurse IPA at Appendix five to this report.

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

Relevant Standards and Guidance

7. 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[4]:

    - The Principles of Good Administration
    - The Principles of Good Complaints Handling

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

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

The specific standards and guidance relevant to this complaint are:

- The Belfast Health and Social Care Trust - Pre-operative Assessment Investigation Guideline for Adult Elective Patient, February 2012 (Trust Pre-Op Assessment Guidance);
- The Belfast Health and Social Care Trust - Integrated Care Pathway, Policy and Guidance for the Prevention, Detection and Management of Delirium in Adults in a Range of Care Settings, December 2018 (Trust Delirium Pathway);
- The National Institute for Health and Care Excellence Suspected sepsis: recognition, diagnosis and early management, July 2016 (NICE Sepsis Guidance);
- The Belfast Health and Social Care Trust - Food, Fluid and Nutrition policy – Adult in-patient setting, September 2019 (Trust Nutrition Policy);
- The Belfast Health and Social Care Trust - Pressure Ulcer Prevention and Management in Adults and Children, August 2019 (Trust Pressure Policy);
- The National Institute for Health and Care Excellence British National Formulary, September 2019 (NICE Medication Guidance);
- The Royal Pharmaceutical Society Pharmacy Guides, Professional Guidance on the Administration of Medicines in Healthcare Settings, 2019 (RPS Guide);
- The Nursing and Midwifery Council - The Code Professional standards of practice and behaviour for nurses, midwives and nursing associates, October 2018 (NMC Code);
- The Nursing and Midwifery Council - Standards of proficiency for registered nurses, May 2018 (NMC Standards);
- The National Institute for Health and Care Excellence Pressure ulcers: prevention and management Clinical guideline [CG179], April 2014 (NICE Pressure Guidance);
- The National Institute for Health and Care Excellence Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition Clinical guideline [CG32], August 2017 (NICE Nutrition Guidance); and

- The General Medical Council - Good Medical Practice, April 2013 (GMC Guidance).

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

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

THE INVESTIGATION

10. Within the overall issue of complaint, four specific sub-elements were identified as requiring particular investigation. These sub-elements are those noted above, and I have addressed each separately in the report. Further, however, I addressed the overall issue of complaint, encompassing the patient's care and treatment across the specified period, as a particular aspect in the report. This is detailed after the four sub-elements.

11. During the patient's period of admission in BCH, following an emergency laparotomy,[5] the Critical Care Unit (CCU) provided him with care and treatment from 8 to 18 October 2019. The scope of the investigation did not incorporate this period of care and treatment as the complainant did not raise any concerns about this period of care.

i. Assessment of the patient for infection prior to his admission/surgery on 20 September 2019.

12. The complainant said there was a time-lapse between the patient's pre-admission tests for his planned surgery and his admission, during which he received treatment for a urinary tract infection (UTI). The complainant believed the patient had a pre-existing infection at admission which the Trust did not identify before his operation and that this impacted on his condition and recovery.

[5] A laparotomy is a surgical procedure where an incision (cut) is made through the abdomen allowing the surgeon to view the pelvic organs. It can be used either as an exploratory procedure to help diagnose your condition or as a treatment for your condition.

Evidence Considered

Legislation/Policies/Guidance

13. I considered the Trust Pre-Op Assessment Guidance. I enclose relevant sections of the guidance considered at Appendix six to this report.

Trust's response to investigation enquiries

14. As part of investigation enquiries, the Trust had an opportunity to respond to the complaint. The Trust's response to the enquiries is at Appendix two to this report.

Relevant records

15. I considered the patient's pre-operative assessment records of 5 and 6 September 2019 and his medical records related to 20 September 2019, after his admission to the BCH.

Relevant Independent Professional Advice

16. The AN IPA provided advice about the pre-operative investigations the Anaesthetic Department (ANA Dept) carried out with the patient. This included the results and timing of these tests and associated decisions the ANA Dept made.

17. The CR IPA provided advice about the actions of the Colorectal Department (CRS Dept) in relation to the patient's pre-operative assessment. This also included the CRS Dept's decisions and actions following the assessment.

Analysis and Findings

18. I refer to the Trust Pre-Op Assessment Guidance. This outlines the required tests for major surgery, which the AN IPA identified as the appropriate category for a hemicolectomy. Further, in consideration of the patient's condition, the Trust Pre-Op Assessment Guidance specifies the investigations required for a patient with '*severe systemic disease'*, as well as those the patient required in consideration of his other health issues; specifically cardiac and diabetes. I note the patient's pre-operative

assessment records indicate the Trust carried out all the necessary tests and investigations associated with the patient's specific needs.

19. I also refer to the tests which the AN and CR IPAs detailed in their advice that the Trust completed. These correlate to those specified in the Trust Pre-Op Assessment Guidance. The AN IPA advised these investigations included an Electrocardiogram[6] (ECG) and an Echocardiogram[7]. Further, the blood tests included a full blood count. I note both IPAs' advice the Trust also performed a further urine test on 20 September 2019, at the time of the patient's admission to the BCH, with a negative result. The CR IPA advised the patient's examination on 20 September 2019 was '*normal'* and, as the urinalysis indicated no infection, the Trust did not need to take any further action.

20. I note the AN and CR IPAs' advice the investigations performed were appropriate and in line with relevant guidance. No other tests were required, and the timing of the investigations was appropriate. The CR IPA advised the timing of the test was '*well within the timeframe for preoperative assessment recommendation'.* Further, in line with practice, the Trust reviewed the patient on admission, including a repeat urinalysis. The CR IPA advised *'unless any new symptoms develop it is not normal practice to repeat the tests'.*

21. The AN IPA advised the results of the investigations performed did not indicate any serious infection and the Trust took appropriate actions in response to these results. Specifically, I note the AN and CR IPAs' advice the Trust's decision to proceed with the surgery was appropriate. Further, the AN IPA advised, *'any delay would have been detrimental in view of the fact that this was cancer surgery'.*

22. I consider there is clear evidence the pre-operative assessment included all investigations stipulated in the relevant guidance. I accept the AN and CR IPAs' advice and am satisfied the timing of the pre-investigations was appropriate. Further, I accept the AN and CR IPAs' advice the Trust repeated the urinalysis on 20 September 2019 and the result did not indicate infection. I also accept the AN and

[6] An Electrocardiogram is a test that records the electrical activity of the heart, including the rate and rhythm.

[7] An Echocardiogram, or "echo", is a scan used to look at the heart and nearby blood vessels. It is a type of ultrasound scan, which means a small probe is used to send out high-frequency sound waves that create echoes when they bounce off different parts of the body.

CR IPAs' advice and am satisfied the decision to proceed with the surgery was appropriate. Therefore, I do not uphold this element of the complaint.

ii. Cognitive impairment and delirium assessments carried out and associated care and treatment.

23. The complainant said she believed the Trust did not carry out an appropriate and timely cognitive impairment and delirium assessment with the patient and did not manage the patient appropriately within the required delirium pathway.

Evidence Considered

Legislation/Policies/Guidance

24. I considered the Trust Delirium Pathway and the GMC Guidance. I enclose relevant sections of the guidance considered at Appendix six to this report.

Trust's response to investigation enquiries

25. The Trust's response to the enquiries is at Appendix two to this report.

Relevant records

26. I considered the patient's medical records related to the period from 20 September to 7 November 2019.

Relevant Independent Professional Advice

27. The CR IPA provided advice about the Trust's management of the patient's delirium, including the timing of assessments and associated actions.

Analysis and Findings

28. I note the GMC Guidance states, when assessing, diagnosing or treating patients, you must, *'promptly provide or arrange suitable advice, investigations or treatment*

where necessary' and *'refer a patient to another practitioner when this serves the patient's needs'.*

29. I note the Trust Delirium Pathway states, in relation to discharge planning, *'For patients over 65 years seek specialist advice – refer to POA[8] liaison if:*

    1. The patient is not improving after 5 days
    2. There is doubt about the diagnosis'.

30. I note the patient's records indicate, while on Ward 2 South, the Trust carried out an assessment of the patient's delirium on 18 and 22 October 2019. Further, the Trust assessed the patient's cognition on 31 October 2019.

31. I note the CR IPA advised, following the patient's apparent confusion on 25 September 2019, the Trust carried out a Computed Tomography Scan (CT) of the patient's head which *'showed no acute changes'*. At this time, the patient's clinical condition had deteriorated from sepsis[9] and *'it was reasonable to consider this delirium/confusion to be related'* to this. Therefore, the Trust's treatment and investigation was *'reasonable in this setting since the likely cause of the change in mental status was clear [and] the underlying cause was also being treated'.* After the patient's discharge from CCU, where the Trust assessed him for delirium on 11 October 2019, the Trust prescribed an antipsychotic medication, Quetiapine[10]. Later, the Trust prescribed Haloperidol[11] for the delirium. The Trust also treated the infection with antibiotics. The CR IPA advised that, although delirium assessments consider the degree of severity, *'it is the treatment of sepsis as the underlying condition which is crucial'.* The patient's cognitive assessment on 31 October 2019 indicated *'mild impairment'*.

[8] POA Psychiatry of Old Age

[9] Sepsis is a serious condition in which the body responds improperly to an infection. The infection-fighting processes turn on the body, causing the organs to work poorly.

[10] Quetiapine is a medicine that helps with mental health conditions such as: schizophrenia, the mania symptoms of bipolar disorder, depression (quetiapine is only used together with other medicines for depression). It is an antipsychotic medicine that works by affecting chemicals in your brain such as dopamine and serotonin. It does not cure your condition, but it can help with the symptoms.

[11] Haloperidol is a medicine that helps with mental health conditions such as: confusion and aggression at the end of life (palliative care), feelings of agitation or anxiety, schizophrenia, the mania symptoms of bipolar disorder, severe confusion and aggression in Alzheimer's disease and other types of dementia. It is also used as an anti-sickness medicine to treat feeling or being sick (nausea or vomiting) caused by general anaesthetics, used to put you to sleep for an operation, feeling or being sick at the end of life (palliative care). It is an antipsychotic medicine that works by blocking certain types of nerve (neuron) activity in the brain. This can help with feelings of anxiety and other symptoms of mental health conditions. It also helps block activity in the brain that controls feeling and being sick.

32. The CR IPA advised there '*were reasons why this patient would have suffered confusion/delirium. Prolonged infection, two operations, intensive care, over 75 yrs., weight loss secondary to a combination of the above and being in a hospital'.* I note his advice that there is '*no evidence the required guidance was not followed'* and, in the '*setting, and in the reasonable assumption that sepsis was the underlying cause of confusion, the assessments were acceptable … [and] carried out with reasonable timing'.*

33. However, the CR IPA advised, at the time of discharge, the patient was described as still being confused. This followed resolution of the sepsis. I note his advice, the Trust should have referred the patient for specialist advice in line with the guidance but '*this did not appear to happen'.*

34. I consider the records evidence the Trust carried out three delirium assessments and one cognitive assessment with the patient in response to confusion. This included an assessment during his period in CCU. I also consider the records evidence the Trust carried out a CT scan within two days of the patient's first incident of confusion, prior to his time in CCU.

35. I accept the CR IPA's advice and am satisfied that, during his time as an in-patient in the BCH, the Trust's investigation and treatment of the patient's delirium/confusion was reasonable.

36. However, I also accept the CR IPA's advice that, in line with the delirium pathway, the Trust should have referred the patient for specialist advice when he continued to demonstrate confusion after the sepsis cleared and when he was being discharged. I find this does not accord with either the GMC Guidance or the Trust Delirium Pathway referenced in paragraphs 28 and 29, respectively. Therefore, I consider this constitutes a failure in care and treatment.

37. I refer to my findings at paragraphs 35 and 36 above; therefore, I partially uphold this element of the complaint.

iii. Medication prescribed and administered.

38. The complainant said she believed the Trust inappropriately prescribed and administered two medications together and this led to toxicity in the patient. She said

the Trust should have discontinued one of these medications. The complainant also said she believed nursing staff neither recognised the patient's toxicity nor appeared aware that one of the medications prescribed was not one of the patient's standard pre-admission medications.

Evidence Considered

Legislation/Policies/Guidance

39. I considered the NICE Medication Guidance; the RPS Guide; the NMC Code; and the NMC Standards. I enclose relevant sections of the guidance considered at Appendix six to this report.

Trust's response to investigation enquiries

40. The Trust's response to the enquiries is at Appendix two to this report.

Relevant records

41. I considered the patient's medical records related to the period from 20 September to 7 November 2019.

Relevant Independent Professional Advice

42. The CR IPA provided advice about the medication the Trust prescribed the patient. The Nurse IPA provided advice about the medication administered to the patient and the actions of nursing staff in relation to concerns about the patient.

Responses to the Draft Investigation Report

43. The complainant and the Trust were given an opportunity to provide comments on the Draft Investigation Report. The responses to the Draft Report have been

considered and, where appropriate, comments have been reflected in the report or changes have been made.

The Complainant's response

44. The complainant queried the prescription of Haloperidol for delirium when it is not considered a *'first line treatment for delirium'.*

45. The complainant said the family had raised concerns about the overlap in administration of Quetiapine and Haloperidol on 23 October 2019. However, although nursing staff did not document this, the report indicates the surgical team requested pharmacy review of medications, after which it discontinued Quetiapine. The complainant said the pharmacist indicated the medication review related to family concerns. The complainant said, *'this was a significant conversation that absolutely should have been documented for the purpose of accurate communication throughout the team'.* The complainant also said the patient is '*incredibly sensitive to morphine and other medications that convert to morphine*'; therefore '*it is reasonable to suspect toxicity from the introduction of a new antipsychotic medication'*. The complainant reiterated her concern that nursing staff failed to recognise the patient's significant decline and involuntary jerking from 21 to 23 October 2019.

The Trust's response

46. The Trust accepted the report findings.

Further Independent Professional Advice

47. Following the complainant's comments about the Draft Investigation Report, the CR IPA provided further advice about the medication prescribed to the patient.

Analysis and Findings

48. I note the patient's records indicate once discharged from CCU to Ward 2 South on 18 October 2019, the Trust administered Quetiapine on eight occasions from 18 to 23 October 2019. The records indicate the patient received six doses of Haloperidol

between 24 October and 3 November 2019. There is no evidence in the patient's records he received both Quetiapine and Haloperidol on any day.

49. The CR IPA advised, although there was an overlap in the original prescription of Quetiapine and Haloperidol from 24 to 26 October 2019, a stop was recorded on the former on 24 October 2019. Further, the Trust administered the last dose of Quetiapine on 23 October 2019 and gave the first dose of the Haloperidol on 24 October 2019. I note the CR IPA's advice the Trust appropriately substituted Haloperidol for the Quetiapine.

50. The CR IPA also provided the following further advice about the cessation of Quetiapine. The pharmacist recommended replacing Quetiapine with Haloperidol in response to a clinician's query when the patient's family raised concerns about the patient's drowsiness. However, the prescription for Quetiapine originated in CCU. CCU also provided instructions about its future cessation when the patient returned to the ward. Originally, CCU directed that Quetiapine should cease by 26 October 2019; therefore, this medication ceased two days before the originally scheduled end date. I note the CR IPA advised the cessation of Quetiapine, and the reasons for this, were reasonable. Further, he advised that CCU previously had previously directed that Haloperidol could be prescribed if needed.

51. The CR IPA provided advice about the use of Haloperidol. He referenced the NICE Medication Guidance and advised Haloperidol *'has a range of application*'. I note his advice that the NICE Medication Guidance cites delirium as an appropriate condition; therefore, it was appropriate and reasonable to prescribe Haloperidol for delirium.

52. I note the CR IPA advised, however, the clinicians did not appear to record their response to the pharmacist's recommendation for a change in medication. He advised, although the evidence indicates the clinicians acted on the pharmacist's advice about the change in medication, the clinicians should have recorded both the pharmacist's advice and that the former medication was stopped and changed to Haloperidol.

53. The CR IPA provided the following further advice about the patient's interactions with morphine and related medication. Morphine can cause a number and range of reactions. These include a rash, decreased respiratory rate, nausea, vomiting,

behaviour changes and hallucinations. There are several references in the patient's records to sensitivity to several medications, including morphine and there are a number of records which indicate clinicians considered and discussed this with the patient. I note his advice, as *'morphine and related opioids are powerful pain relief*', clinicians will balance consideration of any sensitivity with the patient's pain relief needs.

54. The CR further advised the patient also received morphine and another opioid, Fentanyl, while in CCU. Further, on 19 September 2019, when clinicians reviewed the patient, who was in significant pain, the records evidence the Trust considered his allergy but the patient *'was adamant that he was not allergic to morphine'*. After this, although the Trust administered morphine to the patient, '*there was no evidence of any significant adverse effect'.* The CR IPA advised any significant reaction *'would be expected within 10-15 minutes'.* The CR IPA also advised that, post-operatively, the Trust injected morphine into the patent's spine area for pain relief but again, there was no apparent ill-effect. I note the CR IPA concluded there was no evidence of '*a clinically significant allergy to morphine'.* The CR IPA advised that, on 8 October 2019, the patient again refuted he had a severe reaction morphine but that it did affect *'behaviour*'. The CR advised this is '*not an unknown side effect of morphine'.* He advised this side effect is not an allergic reaction. The CR IPA explained an *'allergy causes an immune response'*; however, side effects are undesirable effects of a drug which are *'non-immune responses*'.

55. I note the CR IPA's advice the prescription of morphine for severe pain was the correct decision. Further, *'overall, it is reasonable to conclude neither anti-psychotic or opioid medication caused any significant issues and were given after balanced judgement'.*

56. The CR IPA provided the following advice about toxicity. Toxicity is normally a consequence of high doses of a medication. *'Side effects … are not toxicity'*. The CR IPA referenced the pharmacist's record that the patient's antipsychotic medication was a low dose. The CR IPA advised, therefore, toxicity *'was not likely in this case.'* He referenced the NICE Medication Guidance and further advised that the patient's *'involuntary movements'* are cited in this guidance as *'common side effects not toxicity.'* The CR IPA advised that toxicity symptoms include hypotension, abnormal

heart rate and low body temperature. I note his advice that, if the patient did experience these symptoms, these would also be present when there is sepsis, which there was in this case. However, the CR IPA provided the following advice. There was no documented evidence the patient demonstrated involuntary jerking movements or other symptoms. The doses prescribed for both medications were low and unlikely to cause toxicity. Specifically, the Trust only prescribed a sixth of the maximum dose of Haloperidol. I note the CR IPA's advice, although the patient was drowsy, he was rousable and his drowsiness *'was most likely'* related to the impact from surgery, emergency surgery, sepsis and CCU care. If either anti-psychotic was a contributory factor in the patient's drowsiness, *'it is important that there is a balance between effective treatment and side-effects'.* The CR IPA concluded it was unlikely the patient suffered '*toxicity*'. Specifically, there was also no overlap with the two medications and *'no indication that there was any excessive treatment with either anti-psychotic'.*

57. The Nurse IPA detailed the medication administered throughout the patient's period of admission in BCH. This included new, changed and stopped medication. The Nurse IPA advised, following the patient's discharge from CCU to Ward 2 South, the Trust administered Quetiapine on 18 October (PM), 19 October (AM) and both AM and PM on 21, 22 and 23 October. The Trust then administered Haloperidol on the evenings of 24 to 28 October 2019 and at 12:15pm on 3 November 2019. I note the Nurse IPA's advice, the Trust did not administer these two medications together at any time. Further, nursing staff administered both medications appropriately.

58. The Nurse IPA advised '*there is no evidence within the records that the family queried the administration of Quetiapine and Haloperidol to nursing staff*'. The patient displayed signs of confusion, but he was 'e*asily reassured …. closely observed … and there are no documented episodes of 'jerking, twitching or any involuntary movements''.* I note the Nurse IPA's advice, on 19 October 2019 when the patient was *'difficult to rouse'*, nursing staff appropriately escalated this to medical staff, in line with the NMC standards.

59. The Nurse IPA advised the Pharmacist, and not nursing staff, documented the only record which refers to Quetiapine as a *'regular anti-psychotic'*. I note her advice this was more likely to refer to the medication being administered at regular intervals rather than identification as medication which the patient took prior to his admission.

The Nurse IPA referenced the NMC Standards and the RPS Guide and advised, there is no evidence the nursing staff lacked knowledge of the patient's pre and existing medications. Further, nursing staff administered medication in accordance with prescriptions. This included that they understood they should administer Haloperidol instead of Quetiapine and these medications should not be given together. The Nurse IPA concluded the holistic nursing assessment completed after the patient's admission to the BCH demonstrates the nurses knew the patient's pre-existing conditions and plan of care.

60. I consider the records evidence the patient did not receive Quetiapine and Haloperidol at the same time at any stage. I accept the CR IPA's advice and am satisfied: -

- it was appropriate to prescribe Haloperidol for delirium;
- the Trust appropriately substituted Quetiapine with Haloperidol;
- the doses of each of these were low and unlikely to lead to toxicity;
- the patient's drowsiness was most likely related to the serious of events the patient experienced and/or a common side effect of either medication;
- it was unlikely the patient was toxic; and
- the Trust's decision to prescribe morphine was appropriate.

Further, I accept the Nurse IPA's advice and am satisfied the Trust did not administer the two medications together at any time and both medications were administered appropriately.

61. I also accept the Nurse IPA's advice and am satisfied, when it was difficult to rouse the patient, the nursing staff appropriately escalated this to medical staff; and the evidence indicates nursing staff understood the patient's pre-existing medication, conditions, plan of care and that Quetiapine and Haloperidol should not be administered together.

62. I refer to my findings at paragraphs 60 and 61 above; therefore, I do not uphold this element of the complaint.

63. I refer to the CR IPA's advice medical staff did not clearly document the decisions and actions taken in response to the pharmacist's advice about the medication. I

note this does not accord with the GMC Guidance which states, '*clinical records should include: … the decisions made and actions agreed, and who is making the decisions and agreeing the actions'.* I include an observation about this at paragraph 109 below.

iv. Nursing care during the period of 20 September to 8 October 2019 and 18 October to 7 November 2019. This included completion of required assessments.

64. The complainant said the Trust did not complete all the necessary nursing assessments appropriately. She said these included the Malnutrition Universal Screening Tool[12] (MUST), skin and pressure assessments. The complainant also said the failure to correctly complete these assessments led, respectively, to delays in referral to a dietician and a failure to provide the patient with a pressure-relieving mattress.

Evidence Considered

Legislation/Policies/Guidance

65. I considered the following guidance: -

- The Trust Nutrition Policy;
- the Trust Pressure Policy;
- the NMC Code;
- the NMC Standards;
- the NICE Pressure Guidance; and
- the NICE Nutrition Guidance).

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

Trust's response to investigation enquiries

66. The Trust's response to the enquiries is at Appendix two to this report.

[12] MUST is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

Relevant records

67. I considered the patient's records for the period from 20 September to 7 November 2019.

Relevant Independent Professional Advice

68. The Nurse IPA provided advice about the nursing assessments the Trust completed, and any associated actions and decisions and referrals made to dietetics.

The Complainant's response to the draft investigation report

69. The complainant queried the application of the wound dressing regime from 28 October 2019. She said, because the patient's wound was present from 8 October 2019, following his surgery, the Trust should have implemented a dressing regime *'significantly sooner*' than 28 October 2019.

Further Independent Professional Advice

70. Following the complainant's comments about the Draft Investigation Report, the Nurse IPA provided further advice about the management of the patient's surgical incision.

Analysis and Findings

Overall nursing assessment and plan of care

71. The Nurse IPA advised the Trust completed the overall nursing assessment within 24 hours of the patient's admission and this *'identified the priorities and requirements for person-centred and evidence-based nursing interventions and support'.* I note her advice the assessment and its timing were appropriate.

72. I accept the Nurse IPA's advice and am satisfied the Trust's overall nursing assessment was appropriate and timely.

Wound assessments

73. The Nurse IPA provided the following further advice about the management of the patient's wound. On 11 October 2019 the Trust closed the patient's surgical wound using clips to bring the edges together. Surgical wounds closed with clips do not always require dressing to facilitate monitoring of the wound to ensure there are no

signs of infection, and the wound is healing well. The Nurse IPA advised a dressing regime would not be required in this case. However, she also advised, the first reference to oozing and bleeding of the patient's wound was recorded on 20 October 2019. Therefore, the Trust should have implemented a wound assessment chart from this date. The Nurse IPA advised, although there is currently no agreed approach for assessing and managing wounds in the UK, wound assessment charts are required and these charts are included in the Trust documentation, but the Trust did not complete these. She advised that these charts help nurses to recognise when a wound is deteriorating which then enables nurses to identify when they should seek timely support from the Tissue Viability Nurse (TVN). The Nurse IPA referenced both the NMC Code and NMC Standards and advised, in addition to the Trust's failure to implement the wound assessment chart, it did not implement a dressing regime until 30 October 2019. I note her advice this was not appropriate, given that the wound began to open on 20 October 2019. The Nurse IPA further advised, because of the lack of wound assessment records and dressing regime prior to 30 October 2019, it is not clear if the patient's wound deteriorated after 20 October 2019, what dressings the Trust applied or when nurses changed these. Therefore, it is difficult to conclude if the poor wound management impacted the patient. The Nurse IPA advised the referral to the TVN was appropriate and the TVN reviewed the patient's wound in a timely manner.

74. I accept the Nurse IPA's advice and find the Trust did not consistently complete the wound assessment chart in accordance with requirements and did not apply a consistent dressing regime to the patient's wound. I consider these to be failures in care and treatment.

MUST assessments

75. I refer to the NICE Nutrition Guidance. I note this states, *'all hospital in-patients should be screened on admission and screening should be repeated weekly or when there is cause for clinical concern (for example; unintentional weight loss fragile skin and poor wound healing)'.*

76. The Nurse IPA referenced the NICE Nutrition Guidance. She advised a MUST assessment should be completed on admission and then each week. The Trust completed a MUST assessment on admission and on 22 September, 26 October and

3 November 2019. I note her advice the Trust did not complete MUST assessments weekly in line with guidance.

77. The Nurse IPA advised, on 22 September 2019, the MUST assessment score was zero. This '*represents a low risk of malnutrition*'. I note her advice this MUST score did not require any specific actions, but the Trust should have repeated a MUST assessment a week later. The Nurse IPA highlighted the patient's particular circumstances, following his surgery on 20 September 2019; specifically, his diet should be light. Further, on 21 September 2019, the patient was nil-by-mouth; therefore, the Trust should have monitored his dietary intake from this point. The Nurse IPA referenced the NICE Nutrition Guidance and advised, on 26 September 2019, because the patient had not eaten well for a week, the Trust should have repeated the MUST assessment. However, although the Trust did not repeat MUST then, because the patient received parenteral nutrition[13] on 27 September 2019, this did not impact on him.

78. The Nurse IPA advised the Nutritional Support team provided care for the patient from 30 September 2019 because of ileus[14]. He also received parenteral nutrition. At this point, the patient had not lost weight since 22 September 2019. I note the Nurse IPA's advice the Trust did not need to take any other actions at this stage. Dieticians continued to provide care for the patient after his transfer from CCU. Further, the patient had a nasogastric tube[15] fitted. After the nasogastric tube dislodged, the dietician requested monitoring of the patient's input and output, after which the Trust commenced food charts. The patient then gained some weight from 26 October to 3 November 2019. The Nurse IPA advised that the Trust did not need to take any other actions. Specifically, because the patient was very unwell with ileus, he did not require earlier dietitian referral.

79. I note the Nurse IPA concluded the Nutrition Support team provided care from 27 September 2019, the Trust administered parenteral nutrition until the patient's transfer to CCU and the patient was then fed through a nasogastric tube, with

[13] Parenteral nutrition is the intravenous administration of nutrition outside of the gastrointestinal tract. It is when IV-administered nutrition is the only source of nutrition the patient is receiving. It is indicated when there is impaired gastrointestinal function.
[14] Postoperative bowel ileus is a prolonged absence of bowel function after surgical procedures, usually abdominal surgery. It is a common postoperative complication. It is a benign condition that usually resolves with minimal intervention. Management of this relies on supportive care, after excluding more serious and reversible surgical conditions such as mechanical obstruction.
[15] A nasogastric tube is a type of medical catheter that is inserted through the nose to the stomach. It is used for limited periods to deliver substances such as food or medications or to draw substances out.

dietician care. Therefore, there was no impact on the patient from the Trust not completing the MUST assessment weekly.

80. Although I consider the Trust did not act in line with the NICE Nutrition Guidance as it failed to complete MUST assessments each week, I accept the Nurse IPA's advice that this did not impact on the patient. This is because of the patient's specific circumstances related to the ileus and the remedial measures the Trust employed, including the parenteral nutrition.

Skin/pressure assessments

81. I refer to the National Health Service study in 2014 of the use of AtmosAir mattresses[16] which confirmed the use of these mattresses, together with skin assessment and repositioning regimes, was effective in managing the risk of pressure ulcers in patients at high and very high risk. Further, I note this led to a significant reduction use of dynamic air mattresses throughout the NHS.

82. The Nurse IPA referenced the NICE Pressure Guidance and the Trust Pressure Policy. I note her advice the Trust assessed the pressure damage risk on 20 September and 18 October 2019; however, the Trust did not complete this each week as the Trust Pressure Policy required. On 20 September 2019, the patient's pressure risk assessment score was 23 which indicated a low risk of pressure damage. On 18 October 2019, the assessment scored 14, indicating a moderate risk of pressure damage. Further, although the Trust utilised a SKIN bundle with the patient from 18 to 23 October 2019, there were no records of this before 18 or after 23 October 2019. Although on 20 September 2019 the patient's risk was low, when he returned from CCU, a SKIN bundle '*was indicated*'. The Trust should have continued this until the patient's discharge. It is not clear if the patient developed any pressure damage from 18 October 2019 until his discharge. The Trust should have checked his pressure areas at least daily.

83. I note the Nurse IPA's advice the Trust's use of the AtmosAir mattress was appropriate for the patient.

[16] AtmosAir mattresses represent reactive pressure redistribution mattress replacement system to support the prevention of pressure ulcers in high-risk patients. NHS England trial, evaluation and audit of their use demonstrated that, together with skin assessment and repositioning regimes, these met the pressure ulcer preventative needs of patients at high and very high risk of developing pressure ulcers. Consequently, it led to a notable reduction in the use of dynamic air mattresses (75% reduction). Specifically, the results showed a reduction of 58% in pressure ulcers. (Taken from NHS study 2014)

84. I accept the Nurse IPA's advice and am satisfied the Trust's use of the AtmosAir mattress was appropriate.

85. Further, however, I also accept the Nurse IPA's advice and find the Trust did not act in accordance with the Trust Pressure Policy as it did not assess the pressure risk each week and did not consistently apply the SKIN bundle, most notably form 24 October 2019 until the patient's discharge. I consider this to be a failing in care and treatment.

86. I refer to my findings at paragraphs 72, 74, 80, 84 and 85; therefore, I partially uphold this element of the complaint.

Overall Issue of Complaint: Whether the care and treatment the Trust provided to the patient between 5 September and 7 November 2019 was appropriate and reasonable.

Evidence Considered

Legislation/Policies/Guidance

87. I considered the NICE Sepsis Guidance and the GMC Guidance.

Trust's response to investigation enquiries

88. The Trust's response to the enquiries is at Appendix two to this report.

Relevant Independent Professional Advice

89. The CR IPA provided advice about the Trust's management of the patient's anastomotic leak[17].

Analysis and Findings

90. I note the GMC Guidance state*s, 'promptly provide or arrange suitable advice, investigations or treatment where necessary'* and '*provide effective treatments based on the best available evidence'.*

91. The CR IPA advised the patient showed signs of sepsis on 21 September 2019, for which the Trust prescribed and administered antibiotics. The patient had ileus, was passing melaena[18] and had indications of sepsis. These factors indicated a '*high suspicion'* that there was an anastomotic leak. Further, the patient's onset of confusion indicated infection, again *'most probably from an anastomotic leak'.* I note his advice the Trust should have considered a CT scan at the onset of sepsis. The Trust carried out CT scans on 27 September, 4 and 8 October 2019 but the Trust did not carry out the first scan until seven days after the patient's surgery '*despite his ongoing clinical signs'.* Further, although the initial scan '*did not show any definitive evidence of an anastomotic leak … [it] did show features of distended small bowel to the point where the anastomosis (join) was. With the other features this was*

[17] Anastomotic leak is one of the possible complications of procedures such as bowel resection and gastric bypass. This is when the contents of the gut leak. This can be very harmful to the body as the gut contains bacteria that help digest food and are a key part of the body but, because the rest of the abdominal cavity does not have this bacteria, the leak can cause serious infections.

[18] Melaena refers to black tarry stools, which usually occurs because of upper gastrointestinal bleeding.

suspicious of a leak'. However, the Trust's initial conservative management of antibiotics, fluids and nasogastric suction was appropriate.

92. The CR IPA advised that the patient did not significantly improve and experienced ongoing nausea and increasing abdominal distension. The Trust repeated the CT scan on 4 October 2019. This scan showed traces of air at the anastomotic site and fluid in the abdomen. As the patient's symptoms did not settle, approximately two weeks after his surgery, *'there was sufficient evidence to abandon conservative management and perform emergency surgery for a clinical diagnosed anastomotic leak with progression'.* However, the Trust continued to observe. Another scan showed increased fluid in the abdomen which indicated further progression of the leak. I note the CR IPA's advice, the patient was now '*very ill',* his '*mental deterioration was significant and he had difficulties in consent'.* Although *'right-sided leaks can be difficult to diagnose when all signs including CT are not entirely obvious, … there was sufficient information to justify surgery'* on 4 October 2019. The '*further deterioration'* made the patient clinically worse *'to the point of a serious risk of dying'.*

93. I note the CR IPA's advice the delay '*likely led to prolonged illness, confusion, weight loss and slow recovery'.* Further, although '*the patient was likely to develop delirium despite an earlier intervention*', it was likely to be less severe as the infection as noted in the CT scan on 4 October 2019 '*was less widespread'* but then increased *'as confirmed'* in the surgery on 8 October 2019. '*The impact of this delay would be a higher risk of dying from the surgery, and a more prolonged recovery'.*

94. I note the CR IPA concluded, the Trust should have arranged a CT scan earlier than 27 September 2019 and the results of the CT scan on 4 October 2019, together with the patient's worsening state, *'should have led to emergency surgery*'. The CR IPA advised, although the case had some atypical elements, '*it would be expected that senior clinicians are better able to diagnose on less classical presentation … It is possible [the patient's] condition, response and outcome would have been improved had he had an earlier surgical intervention' certainly by 4 October 2019.*

95. I accept the CR IPA's advice and consider the Trust should have both carried out a CT scan prior to 27 September 2019 and most significantly, should have proceeded to emergency surgery after the CT scan of 4 October 2019. I also find this does not

accord with the GMC Guidance detailed at paragraph 90 above. I consider this to be a failure in care and treatment. Therefore, I uphold this element of the complaint.

Summary

96. I consider the failures outlined at paragraphs 36, 74, 85 and 95 constitute failures in care and treatment. Therefore, I partially uphold the overall complaint.

Injustice

97. I considered carefully whether the failures in care and treatment caused injustice to the patient and his family. In relation to the Trust's management of the anastomotic leak, I refer to the complainant's comments about the patient's prolonged period of recovery. I consider this reflects the CR IPA's advice about the impact of the Trust's delays in this matter. Therefore, I consider the patient sustained the injustice of an unnecessarily prolonged period of recovery. I also consider, because of this, the patient's family sustained the injustice of additional anxiety, distress and uncertainty about the patient's health and prognosis. Further, I consider the Trust's failure to refer the patient for his ongoing confusion at discharge caused the patient and his family to sustain the injustice of the loss of opportunity for appropriate specialist care and support. In relation to the Trust's failures in relation to the wound and pressure assessments, wound dressing regime and the SKIN bundle, I am unable to determine a specific impact on the patient. However, I consider the patient's family sustained the injustice of worry and uncertainty about the patient.

CONCLUSION

98. I received a complaint about the Trust's care and treatment of the patient in preparation for and during his period of admission to the BCH for a hemicolectomy. For the reasons outlined in the report, I partially upheld the complaint.

99. Specifically, I consider the Trust failed to: -

- Refer the patient for specialist advice for his ongoing confusion at his discharge, in line with guidance;
- Consistently complete the wound assessment chart and the weekly pressure assessments;
- Consistently apply a SKIN bundle with the patient;
- Consistently apply a wound dressing regime;

- Conduct an earlier CT scan in response to the patient's indications of sepsis; and
- Perform timely emergency surgery in response to the findings of the CT scan on 4 October 2019.

100. I recognise the Trust's failures in care and treatment caused injustice to the patient and his family. Specifically, delays in the Trust's management of the anastomotic leak, caused the patient to sustain the injustice of an unnecessarily prolonged period of recovery. I recognise this then caused the patient's family to sustain the injustice of additional anxiety, distress and uncertainty about the patient's health and prognosis. I also recognise because of the Trust's failure to refer the patient for his ongoing confusion at discharge, the patient and his family sustained the injustice of the loss of opportunity for appropriate specialist care and support. Although I am unable to conclude whether the Trust's failures to consistently complete the wound and pressure assessments, a wound dressing regime and the SKIN bundle had an impact on the patient, I recognise this caused the patient's family to sustain the injustice of worry and uncertainty about the patient.

101. I consider the Trust: - appropriately assessed the patient prior to his hemicolectomy; undertook reasonable cognitive and delirium assessments with the patient while he was an in-patient; prescribed and administered appropriate medication; carried out an appropriate and timely overall nursing assessment; and accommodated the patient on an appropriate mattress to manage the risk of pressure ulcers.

Recommendations

102. I recommend the Trust provides the patient and the complainant with a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused because of the failures in care and treatment identified (within **one month** of the date of this report).

103. I recommend the Trust ensures relevant staff are reminded of the importance of adhering to the Trust Delirium Pathway; the Trust Pressure Policy; the NICE Pressure Guidance; the NICE Sepsis Guidance; the NMC Code, section 13; and the GMC Guidance, Domain one, sections 15 and 16.

104. I further recommend the Trust should ensure that relevant staff are given the opportunity to reflect on the findings of this report and the full CR and Nurse IPAs' advice, in consideration of their own practice. The Trust should note this in appraisal documentation. The Trust should evidence this through records of information sharing.

105. I recommend the Trust should undertake a sample audit on BCH Ward 2 South to assess compliance with the Trust Delirium Pathway in relation to specialist referrals when patients display confusion at the point of discharge. The Trust should provide details of the audit outcomes to this office, with an associated action plan for any shortcomings identified.

106. I also recommend the Trust should review processes and practice in BCH Ward 2 South to ensure all the required nursing care assessments are completed, with particular reference to wound, pressure and MUST assessments. Further, this should encompass the use of SKIN bundles and wound dressing. The review should include a sample audit of compliance with the requirements, the outcomes of which the Trust should provide to this office with an associated action plan for any shortcomings identified.

107. I recommend the Trust implements an action plan to incorporate the recommendations at paragraphs 103 to 106 and should provide me with an update within **six** months of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records, information sharing and/or audit outcomes).

Observations

108. I refer to paragraph 63 above related to the patient's records. The Trust may wish to consider reminding relevant staff of the importance of the GMC Guidance, paragraph

21, in relation to ensuring accurate and complete recording of decisions and associated actions.

MARGARET KELLY

Ombudsman **August 2025**

Appendix One

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.