Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Belfast Health and Social Care Trust

NIPSO Reference: 201913310

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Case Reference: 201913310
Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the staff of the Mater Infirmorum Hospital (the hospital) provided to her father, (the patient), who sadly passed away after contracting Pneumonia. In particular, the complainant was concerned that the patient remained in the hospital's emergency department (ED) for over 16 hours. The complainant said that the patient missed two doses of a prescribed controlled drug, Methadone[1] on his admission to hospital. She also believed that the patient did not receive medical attention when he was severely ill in the medical admissions unit (MAU). The complainant also had concerns about the Trust's handling of her complaint.

In order to assist with the consideration of the issues the complainant raised, I obtained independent professional advice (IPA) from an experienced Consultant in Emergency and Critical Care Medicine, a Consultant in Respiratory Medicine and a Senior Nurse with appropriate experience of nursing care.

My investigation established that the decision to treat the patient in the MAU was reasonable, however I found failures in the patient's care and treatment in the following areas: the failure of ED staff to carry out an initial medical assessment of the patient within recommended timescales, a delay in the initial administration of antibiotics and the failure to place the patient in an appropriate place of care within recommended timescales. In addition, ED staff failed to administer a dose of Methadone prescribed to the patient for pain relief on 12 February and subsequently failed to offer him alternative pain relief when another dose was delayed on 13 February. I also established that nursing staff should have increased the frequency of observations and escalated the patient for a medical review in the early hours of 17 February and this did not occur. Having reviewed the medical records and with

[1] a synthetic opioid agonist used for chronic pain management

the benefit of the IPA advice I have concluded that these failures in care and treatment did not ultimately lead to a deterioration in the patient's health, however they caused the complainant and the patient to experience the injustice of uncertainty, upset and the loss of opportunity.

The investigation also established failings in the Trust's handling of the complaint.

I am satisfied that the maladministration I identified caused the complainant and her family to experience frustration and uncertainty and the time and trouble of bringing a complaint to this office.

I recommended that the Trust provide the complainant with a written apology for the injustice caused as a result of the maladministration and failure in care and treatment I identified. In addition, I recommended that the Trust carry out a review of patient records on the MAU to address any identified trends or shortcomings.

I also made recommendations for service improvements in relation to record keeping and complaint handling.

THE COMPLAINT

1. The complainant raised concerns about the actions of the Belfast Health and Social Care Trust (the Trust) in relation to the care and treatment provided to her father (the patient) at the Mater Infirmorum Hospital (the hospital) between 12 February 2018 and 19 February 2018.

Background

2. The patient attended the emergency department (ED) at 22.58 on 12 February 2018 with chest pain and unresponsiveness. He also had a medical history of spinal fractures, asthma and COPD[2].

3. The patient remained in the ED until he was transferred to the medical admissions unit (MAU) at 14.40 on 13 February. The patient remained in the MAU until 18 February. A Respiratory Consultant reviewed the patient on 16 February and considered him to be making an improvement. A doctor did not review the patient on 17 February.

4. The patient deteriorated on the morning of 18 February. He was transferred to Ward B where he sadly passed away on 19 February.

Issue(s) of complaint

5. The issues of complaint accepted for investigation were:

Issue one: Was the care and treatment provided to the patient in the Hospital between 12 February 2018 and 19 February 2018 reasonable and appropriate? In particular:

- Was the care and treatment provided to the patient in the ED on 12 and 13 February 2018 appropriate?
- Was the patient's Methadone medication appropriately considered and administered on 12 and 13 February 2018?

[2] COPD: Chronic Obstructive Pulmonary Disease, an umbrella term to describe a number of lung conditions including emphysema and bronchitis

- Was the level of input by medical staff into the patient's care and treatment on 16 and 17 February 2018 appropriate?

Issue two: Whether the complaints handling by the Trust was appropriate?

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

- **Consultant in Emergency medicine**: FRCEM, FRCSEd (A&E), MBBS, LLM (Medical Law), RCPathME with over 11 years' experience attending acutely unwell or injured patients (ED IPA);
- **Registered General Nurse (RGN)**: Diploma in Asthma, Diploma in Chronic Obstructive Pulmonary Disease, BSc (Hons) Nurse Practitioner, MA Health Service Management, V300 Non-medical prescriber Association for Respiratory Technology & Physiology. Spirometry. A senior nurse with eighteen years nursing and managerial experience across both primary and secondary care (N IPA); and
- **Consultant in respiratory and general internal medicine** MBBS FRCP with over 14 years' experience at a large university teaching hospital (R IPA).

The clinical advice I received is enclosed at Appendix six to this report.

8. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'; however

how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

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

The general standards are the Ombudsman's Principles[3]:

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

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

The specific standards and guidance relevant to this complaint are:

- The Belfast Health and Social Care Trust (BHSCT) Hospital Medicines Code March 2017 (the hospital's medicine code);
- The Belfast Health and Social Care Trust (BHSCT) Policy for Recording Prescription and Balance Charts February 2015 (Balance charts policy);
- British National Formulary (BNF) Methadone Hydrochloride side effects-dependence and withdrawal (BNF Methadone side effects-dependence and withdrawal) ;
- British Thoracic Society (BTS) guidelines for the management of community acquired pneumonia in adults July 2009 (BTS guidelines for the management of community acquired pneumonia) ;
- The Department of Health's (DoH) Guidance in relation to the Health and Social Care Complaints Procedure, April 2009 (the DoH's

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

Complaints Procedure).

- The General Medical Council's (GMC) Good Medical Practice April 2013 (The GMC Guidance);
- The National Institute for Health and Care Excellence (NICE) Guidelines:CG50 Acutely ill Adults in hospital- recognising and responding to deterioration July 2007 (NICE CG50);
- The National Institute for Health and Care Excellence (NICE) Guidelines: CG191 Pneumonia in adults diagnosis and management December 2014 (NICE CG191);
- The National Institute for Health and Care Excellence (NICE) Guidelines: NG51 Sepsis, recognition, diagnosis and early management September 2017 (NICE NG51);
- The National Institute for Health and Care Excellence (NICE) Guidelines: CG95 Recent onset chest pain of suspected cardiac origin, assessment and diagnosis November 2016 (NICE CG95);
- The National Institute for Health and Care Excellence (NICE) Guidelines: CG 101 Chronic obstructive pulmonary disease in over 16s: diagnosis and management June 2010 (NICE CG101);
- Nursing & Midwifery Council (NMC) The Code – Standards of Conduct, performance and ethics for nurses and midwives, March 2015 (NMC Code);
- Nursing & Midwifery Council (NMC) – Standards for Medicines Management May 2009 (NMC Standards for Medicines Management);
- Royal College of Emergency Medicine (RCEM) Clinical Standards for Emergency Departments, Severe Sepsis and Septic Shock in Adults February 2013 (RCEM Severe Sepsis and Septic Shock); and
- Royal College of Physicians (RCP) National Early Warning Score (NEWS[4])2 Standardising the assessment of acute-illness severity in the NHS December 2017 (RCP NEWS Guidance)

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

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

12. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue one: Was the care and treatment provided to the patient in the hospital between 12 February and 19 February 2018 reasonable and appropriate? In particular:

- Was the care and treatment provided to the patient in the ED on 12 and 13 February 2018 appropriate?
- Was the patient's Methadone medication appropriately considered and administered on 12 and 13 February 2018?
- Was the level of input by medical staff into the patient's care and treatment on 16 and 17 February 2018 appropriate?

Detail of Complaint

13. The complainant was concerned that the patient was in the ED for over 16 hours and on the MAU for five days, despite having pulmonary fibrosis[5], emphysema[6] and COPD, in additional to Bronchopneumonia[7].

14. The complainant said that the patient did not receive his controlled drug Methadone on the evening of 12 February. The complainant also said that the Trust informed her in its complaint response letter that the patient was administered Methadone on the morning of 13 February. However, she said that she does not believe this happened.

[5]A disease in which the lungs become scarred (fibrosed) and damaged causing difficulty in breathing
[6] A lung disease which results in shortness of breath due to over-swelling of the alveoli
[7]a type of pneumonia that causes inflammation in the alveoli

15. The complainant said although the patient was gravely ill on the evening of 16 February and on 17 February a doctor did not review him.

Evidence Considered

Legislation/Policies/Guidance

16. I considered the following guidance:

- The NMC Code;
- The GMC Guidance;
- BTS guidelines for the management of community acquired pneumonia; and
- RCP NEWS Guidance.

Relevant extracts are enclosed at Appendix three to this report

The Trust's response to investigation enquiries:

Care and treatment in the ED and admission to the MAU

17. The Trust explained that '*[the patient] attended the ED at 22.58 hours on 12 February 2018… [The patient] was triaged at 23.10 hours as a category 3 using the Manchester triage tool[8]. Observations were taken at 23.10 and these were noted in the ED records'*. The Trust noted that the NEWS was 0. '*At 01.35 hours, [the patient] had repeat observations taken and his NEW (National Early Warning) Score had risen from 0 to 6. He was re-triaged as a category 2 and escalated to Dr [A], who assessed [the patient] at 01.39 hours. [The patient] was clinically assessed by the inpatient medical staff…at approx. (sic) 05.00 with a working diagnosis of broncho pneumonia... On 13 February 2018 at 10.45 hours [a] Respiratory Consultant reviewed [the patient] in the ED. [The patient] was subsequently transferred to the medical admissions unit (MAU) at 14.40 hours on 13 February 2018.* The Trust explained *'it is normal practice for patients with respiratory conditions to be admitted to the MAU. Patients who require direct admission to the respiratory ward are identified in the ED but this was not the case for [the patient]'.*

[8] a clinical risk management tool used by clinicians worldwide to enable them to safely manage patient flow when clinical need far exceeds capacity

Administration of Methadone

18. The Trust stated '*In order for staff to confirm [the patient's] medication, the ECR (Electronic Care Record) was accessed and the medication information was verified with [the patient's] wife, his own drug blister pack was considered and the community pharmacist contacted…Given the time of [the patient's] arrival at the ED at 22.58 hours, it was considered he had taken his prescribed medications for that day. It is recorded on the drug Kardex, [the patient] received his dose of methadone at 10am and 10pm on 13 February. It is also recorded that [the patient's] medications were discussed with the community pharmacist*

Treatment in the MAU on 16 February and 17 February 2018

19 The Trust explained, '*The Trust is not in a position to deliver Consultant led review 7 days a week therefore medical reviews are prioritised for those patients who are new admissions to the hospital at the weekend or those patients previously admitted and showing signs of clinical deterioration. [The patient's] records do not identify or indicate [the patient] as becoming gravely ill on Friday 16 February 2018. Records indicate staff recognised [the patient] was ill and was continuing to be off baseline. [The] Respiratory Consultant assessed [the patient] on 16 February at 14:30 hours, the physiotherapy team assessed him at 14:50 hours, and a period of rehabilitation was being considered. The records indicate [the patient] had not shown signs of clinical deterioration on the (sic) Saturday 17 February 2018.*

20 The Trust also stated that, '*after considerable reflection and review, the team have not been able to identify a particular element of [the patient's] clinical care, in the days leading up to his death, which rendered him more vulnerable to his clinical deterioration on the morning of his death. [The patient's] death was discussed at the Morbidity and Mortality (M&M) meeting where a review was undertaken by four Consultants. The length of time treated with intravenous antibiotics was recorded, discussed at M&M, and considered in conjunction with blood results and clinical status. No failings in [the patient's] medical care were identified. The formal outcome of the M&M was "was satisfactory. There were no particular learning lessons".'*

Clinical records

21 The records document that at 02.30 on 13 February '*obs repeated NEWS 5 sats O2 95% on 1L T. 38.0 HR 96bpm. [Doctor A] in attendance'*.

22 The records document that on 13 February at 05.02 a doctor assessed the patient in the ED. The doctor diagnosed the patient as suffering from community-acquired pneumonia (CAP) with collapse secondary to this.

23 The records document that on 13 February at 10.45 a consultant reviewed the patient in the ED. The consultant assessed the patient as being Severity 4 using the CURB65[9] scoring system. The consultant recommended '*Abx* (antibiotics) *for severe CAP'.*

24 The records document that on 16 February at 14.30 a consultant reviewed the patient on the MAU. The consultant noted *'Obs stable, no temps CRP[10] 42 (140). Reports feeling 'content in life' Change ABx to oral. MMFD* (medically fit for discharge) *when back to baseline stability'.*

25 The records document that at 20.30 on 16 February '*[the patient] has got sleepier as the day has went on, reduced oral intake and not eating meals, only picking at them*.'

Discussion with the complainant

26 As part of the investigation, the Investigating Officer spoke by telephone with the complainant. She said that the patient did not receive his Methadone on the evening of 12 February, prior to his arrival at the hospital. She said that the family provided his blister pack to ED staff upon his arrival at the hospital. The complainant said that the hospital returned the blister pack to the patient's family following his death. She said that the Methadone tablets that the patient

[9] The CURB-65 Severity Score estimates mortality of community-acquired pneumonia to help determine inpatient vs. outpatient treatment

[10] **C-reactive protein** (CRP) is a protein made by the liver. CRP levels in the blood increase when there is a condition causing inflammation somewhere in the body. A CRP test measures the amount of CRP in the blood to detect inflammation due to acute conditions or to monitor the severity of disease in chronic conditions.

was scheduled to take on the evening of 12 February were still in the pack. The complainant said that on 13 February she advised an ED nurse that the patient was scheduled to receive his Methadone tablets at 10.00 and that they had not been administered. The complainant said that the nurse contacted the community pharmacist and confirmed the prescription. She said that the nurse took the Methadone from the patient's blister pack and administered it to the patient in the complainant's presence at approximately 14.00.

Independent Professional Advice

Care and treatment in the ED on 12 and 13 February.

27 The ED IPA was asked if the examinations and investigations carried out in the ED were appropriate; he advised '*[t]he initial Triage category assigned was category 3 which would recommend [the patient] be seen by a doctor within 60 minutes of arrival'.* He noted however *'continued nursing care identified a change in condition which prompted escalation and medical attention'* The ED IPA also advised *'[t]he investigations carried out as part of the initial evaluation of [the patient] in the emergency department were appropriate. The primary triage assessment was completed at 23:20 and whilst initial observations were all normal there was escalation to the medical team at 01:35 when [the patient's] condition had changed'.*

28 The ED IPA advised '*it is noted in the nursing record that [the patient] was being attended by a doctor at 02:30 when it was noted he had a high temperature. At this point I would expect the doctor to have prescribed antibiotics for a possible developing sepsis. This was not the case and [the patient] did not receive antibiotics until 05:45- Good practice recommendations require antibiotics to be administered within 1 hour of arrival in patients with suspected sepsis'.* The ED IPA stated that the doctor who attended the patient at 02.30 requested a urine dip test for him. The ED IPA advised '*I cannot find a record of this test being completed but its value is limited as not diagnostic on its own but could prompt a microbiology investigation if abnormal. There is a positive urine bacteriology test (S.Pneumoniae Ag- Positive). This would suggest urine testing had been completed although a result is not recorded by the ED team*.'

29 The ED IPA was asked to comment on the length of time the patient spent in the ED, and if there was evidence that he had suffered deterioration or detriment because of this. The ED IPA stated *'[the patient] was delayed in the Emergency department for almost 16 hours from arrival at the Mater Hospital. Standard clinical guidance expects patients who attend an emergency department to be treated and in a definitive place of care e.g. a hospital ward within 4 hours[11]. This standard was not met'*.

30 The ED IPA advised that the patient's NEWS score reduced throughout the period he was in the ED and commented *'[t]he final observations recorded for [the patient] in the emergency department record showed a NEWs score of 1 which is the lowest it had been since admission. So, whilst being delayed in the Emergency department was not best practice and was most likely a suboptimal patient experience, there is no evidence to suggest that his condition deteriorated or that he suffered as a result of the length of time he spent in the emergency department*'.

31 The R IPA was asked that given his condition on 12 and 13 February, whether the patient should have been admitted directly to a respiratory ward rather than the MAU. The R IPA advised that *'[t]he [NICE] guideline does not stipulate where the treatment should be given. Pneumonia is a common cause for admission to hospital and does not necessarily require specialist respiratory input….[The patient's] condition on 12 and 13 Feb was correctly diagnosed and managed as pneumonia. There was no indication to transfer to the respiratory ward*'

Administration of Methadone

32 The ED IPA was asked if there was evidence in the clinical records to support the complainant's belief that the patient was not administered Methadone at 10:00 on 13 February 2018. The ED IPA advised '*Th (sic) Medicines Kardex*

[11] The 95% Four-Hour Standard was introduced to the NHS in England in 2004 to combat crowding in EDs. The 95% four hour emergency access standard was adopted by NHS Northern Ireland in 2006 with the intention of working to meet the standard by 2008

has a coded note 6/7 written at 10am on 13 February. With reference to the key for the codes on the front page of the Kardex this means 6= Drug not available. 7 Other (record on pg9). There is no record in the Kardex that relates to none (sic) *administration of Methadone'.*

33 The complainant said that a nurse administered Methadone to the patient at approximately 14:00 on 13 February 2018. The ED IPA was asked if the delay in administering the patient's Methadone would have impacted on him. The ED IPA advised *'missing a dose of medication was unlikely to precipitate acute withdrawal or adverse symptoms, but if this medication was unavailable it would have been appropriate to offer an alternative pain relief medication for use until the Methadone was available if [the patient] was experiencing pain whilst in the emergency department. It is recorded that whilst in the emergency department [the patient's] Pain score was 0, this was noted on 7 occasions between 01:35 and 13:30. It would be reasonable to conclude that [the patient] was not experiencing any pain at the time of the assessment.*

34 The IPA further advised '*Methadone withdrawal typically starts to appear between 24 and 36 hours after the previous administration. There is no medical or nursing records or NEWs observations to suggest a deterioration in [the patient's] condition during this period (NEWS improved from 6 to 1), or any symptoms that would be attributed to methadone withdrawal during the period prior to him having his medication administered. I do not consider that he was adversely affected by the delay in administration of methadone*'

35 The ED IPA concluded '*On balance, the ED team should have confirmed whether or not [the patient] had taken his evening medication prior to attending and documented this. It can be considered entirely appropriate to have not administered further oral medications in ED as [the patient] had been vomiting. (A common side effect of methadone is nausea and vomiting). Furthermore, Methadone may also cause chest pain which was the main reason for his attendance. However, decision making around these considerations should have been recorded'.*

Care and treatment on 16 and 17 February 2018

Nursing Care in the MAU

36 The N IPA advised that *'It is the responsibility of the nurse to ensure that NEWS is recorded at a frequency determined by the patients score*. *The expected frequencies of monitoring are:*

- *Score 0 (12 hours)*
- *Score 1-4 (4-6 hourly)*
- *Score 3 in a single parameters (minimum 1 hourly)*
- *Score 5 or more (urgent response threshold; minimum hourly repeat)'.*

37 Upon examining the patient's medical records for 16 and 17 February 2018, the N IPA advised '*On 16.02.2018 despite scoring 4 at 09:50 (4-6 hourly repeat), NEWS was not documented until 21:10 (approx. 11 hours later), by which time it had rose to 6, with 3 in a single parameter. It was repeated one hour later and had improved to 2. It rose again however and at 02:10 on 17.02.2018 NEWS was 5, 3 in a single parameter (one hour repeat, urgent response). It wasn't repeated for a further 4 hours (06:10) when it had improved to 4. It remained stable for the rest of the 17th. Although it was documented as 5 at 15:00 when it should have been 4. In summary, there are occasions when NEWS has been miscalculated and occasions when the frequency of monitoring was outside of national guidance. This is only acceptable if the frequency has been changed by a competent clinical decision maker; if this is the case, the rationale should be clearly documented. There is nothing documented within the nursing or medical notes regarding the deviation from national guidance with regards to the frequency of NEWS'.*

38 The N IPA further advised '*[t]he MUST*[12] *(malnutrition universal screening tool) was not completed and thus it is not possible to say if [the patient] was at risk of malnutrition. Fluid balance charts are poorly completed and on most days the intake and output has not been calculated'*

[12] a five- step nationally recognised and validated screening tool to identify ADULTS who are malnourished or at risk of malnutrition. It is the most commonly used screening tool in the UK

39 Enquiries were made of the N IPA if there was any indication that the patient required escalation for a review by a doctor during the period 16 and 17 February. The N IPA advised '*There was a definite indication that [the patient] needed a medical review on 16.02.2018. This was not just because of his high NEWS at 21:10 but also because his clinical description is sleepy and with a reduced oral intake. It is not clear to me, as a nurse, if an earlier medical intervention (16th) would have changed the outcome for [the patient]'.*

40 In relation to the nursing care provided on 16 and 17 February the N IPA advised *'[n]ursing care on 16 February was not appropriate and reasonable in light of the fact that [the patient] had refused his oral medications, was described as sleepy and with a low oral intake and had high NEWS score but he was not escalated to medics or monitored more closely (in line with NEWS guidance). His fluid charts show's (sic) no intake from 14:00 to 21:00 on 16th. [The patient] continued to be unwell during the early hours of 17th February 2018 with no action taken and no increased frequency of monitoring (should have been hourly from 02:10 as per NEWS guidance).*

41 The R IPA was asked if the failures in nursing care on 16 and 17 February 2018 identified by the N IPA had an impact on the patient. The R IPA advised '*the absence of NEW scores from 09:50 until 21:10 on 16 Feb 2018 did not make a difference to [the patient's] eventual outcome. The reason being, that his NEW scores improved and stabilized prior to the significant deterioration on the morning of his death'.* The R IPA further advised *[b]ased on these scores I do not consider that the failure to escalate [the patient] for medical review at 21:10 on 16 Feb made a difference to his clinical outcome*

42 The R IPA further advised that '*[the patient] should have received a medical review at 02:10 on the 17 Feb on the basis of the NEW score of 5'*. However, he concluded that '*I do not consider that a medical review at that time would have changed the eventual clinical outcome'.*

Medical care in the MAU 16 and 17 February

43 In response to enquiries made regarding Trust's statement that the patient's clinical markers indicated he was improving when reviewed at 14.30 on 16

February 2018, the R IPA advised '*The C-reactive protein level (CRP – a blood marker of infection) dropped from 140 to 42. [The patient's] temperature was normal. His NEW scores had dropped to 3. This in keeping with a good response to the antibiotic treatment'.*

44 The R IPA stated '*[The patient] did develop respiratory failure whilst on MAU. This occurred on the 18 Feb at 05:30 when there was a sudden drop in his oxygen saturations and increase in his breathing rate. [The patient] was promptly assessed on MAU by the on call doctor who undertook the appropriate investigations and treatment. [The patient] was transferred within 2 hours to the respiratory ward for a trial of non-invasive ventilation. This is in keeping with national guidance.* The R IPA advised *'[The patient] received appropriate treatment for pneumonia whilst on MAU. The treatment would not have differed had he been transferred to the respiratory ward'*

45 I do not consider that the patient's NEWS scores on the 16 and 17 February warranted escalation to a different antibiotic. Co-amoxiclav and clarithromycin cover all the causes of pneumonia that were relevant to this case.

46 The R IPA concluded *'I do not find any evidence that [the patient's] deterioration on the 18 Feb could have been predicted or prevented. Neither do I find any evidence that [the patient's] care and eventual outcome would have been different if he had been transferred to a respiratory ward sooner during the admission'.*

The complainant's response to the draft report

47 The complainant raised a number of issues in response to the draft report; I considered her responses and obtained additional independent professional advice where appropriate.

48 The complainant raised concerns about the Trust's decision to move the patient from intravenous (IV) antibiotics to oral antibiotics on the afternoon of 16 February. While the complainant agreed that this decision was correct at the time, she believed that the decision ought to have been reviewed following a

rise in the patient's NEWS on 16 and 17 February. She believed that restarting the patient on IV antibiotics might have prevented his deterioration on the 18 February.

49 The complainant raised a concern that while Methadone may not have been available from the hospital pharmacy on the morning of 13 February, the patient's family provided ED staff with the blister pack containing his Methadone upon his arrival at the hospital.

50 The complainant believed that the Trust's response to the issue of the administration of Methadone on 12 and 13 February lacked candour.

51 In relation to the patient's treatment in the MAU, the complainant believed the treatment would have differed greatly if the Trust had transferred the patient to the respiratory ward at an earlier date.

52 In order to address the complainant's concern that the Trust ought to have reviewed its decision to switch the patient from intravenous to oral antibiotics, I obtained additional independent professional advice.

53 The IPA advised '*restarting intravenous antibiotics was not indicated and would not have changed the eventual outcome. .It is a common misconception that intravenous antibiotics are "stronger" than oral antibiotics. This is generally not the case. Giving any medication intravenously is only indicated if the patient cannot swallow or the medication is not available in the oral form*'

Analysis and Findings

Care and treatment in the ED on 12 and 13 February.

54 I will consider the patient's care and treatment in the ED firstly in terms of the medical care he received and then I will address the length of time he spent in the ED.

Medical care in the ED

55 I was able to establish that the patient attended the ED at 22:58 on 12 February. He remained there until 14:40 on 13 February, when he was

transferred to the MAU. Upon examination of the clinical records, I established that nursing staff examined the patient and took his observations in the ED at approximately 23.10, 01.35, 02.30, 04.05, 08.55 and 13.40. I also note that ED doctors examined the patient at 02.30 and 05.00. A Respiratory Consultant assessed him at 10.45. I note that the ED medical and nursing team took observations and reviewed the patient on nine occasions prior to his transfer to the MAU. I acknowledge the efforts made by ED staff to monitor the patient and provide him with appropriate medical care during his stay in the ED.

56 I note that the ED IPA advised that at initial triage ED staff assessed the patient as Category 3 at 23.10; he therefore ought to have seen a doctor within 60 minutes. I note that the IPA advised '*[t]he time of the medical examination is not recorded by the attending doctor'.* I note that in its response to investigation enquiries, the Trust stated that a doctor assessed the patient at 01.39. In response to further enquiries from the Investigating Officer, the Trust acknowledged that this was incorrect. The Trust was unable to confirm the time of the patient's first medical assessment. I have examined the ED nursing notes that record the ED doctor attended to the patient at 02.30. I therefore conclude from available records that the first medical assessment occurred at approximately 02.30. I consider that the failure to assess the patient within 60 minutes of initial triage constitutes a failure in care and treatment. I consider that because of this delay, the patient and his family suffered the injustice of upset and frustration. I will comment on the record keeping below.

57 I note the ED IPA's advice that *'[the patient] was being attended by a doctor at 02:30 when it was noted he had a high temperature. At this point I would expect the doctor to have prescribed antibiotics for a possible developing sepsis. This was not the case and [the patient] did not receive antibiotics until 05:45- Good practice recommendations require antibiotics to be administered within 1 hour of arrival in patients with suspected sepsis'.* However, I accept the ED IPA's observation that the patient's clinical condition improved during his time in the ED. I consider the delay in the administration of antibiotics was a failure in the care and treatment of the patient, however, I accept the IPA's advice that the patient suffered no detriment as a result of this delay.

Time spent in the ED

58 I note the complainant's concern that the patient was in the ED for almost 16 hours. I note that in the Trust's response to investigation enquiries, it did not address the fact that the patient had been in the ED for over 16 hours. However, I note that in a meeting between the Trust and the complainant on 17 April 2018, the Trust explained that at the time of the patient's admission to the hospital, there were not enough beds to accommodate all patients. I note the ED IPA advised that *'[s]tandard clinical guidance expects patients who attend an emergency department to be treated and in a definitive place of care e.g. a hospital ward within 4 hours'.*

59 I acknowledge the difficulties the Trust faces in moving patients from the ED when there are no available beds on the relevant ward. This highlights the significant pressures experienced in the ED. I also accept the ED IPA's advice that *'there is no evidence to suggest that [the patient's] condition deteriorated or that he suffered as a result of the length of time he spent in the emergency department'.* However, I do not consider it acceptable that a patient has to wait 16 hours to be transferred to a definitive place of care. The patient waited four times longer than clinical guidance recommends before being transferred to the MAU. I am critical of the Trust that this issue continues to be a feature in complaints to my office. While acknowledging that Trust staff take steps to make patients and their families awaiting admission comfortable, the ED is not an environment designed for a 16-hour stay. I consider that the patient and his family suffered the injustice of upset and frustration as a result of his extended delay in the ED. I therefore uphold this element of the complaint

Record keeping in the ED

60 I note that the ED doctor who carried out the initial medical assessment of the patient requested a number of investigations. This included a urine dip test. I note the ED IPA's comment that '*I cannot find a record of this test being completed but its value is limited as not diagnostic on its own but could prompt a microbiology investigation if abnormal. There is a positive urine bacteriology test (S.Pneumoniae Ag- Positive)… This would suggest urine testing had been*

completed although a result is not recorded by the ED team.' I also note that the ED doctor failed to record the time of the patient's initial assessment.

61 I further note the ED IPA identified that the patient's hospital notes contained no record that the patient received an explanation or apology for the delay in admitting him to the MAU. In addition, there was no record that basic care needs were being provided. The IPA stated '*[r]ecording this information is valuable to evidence the care provided and keeping patients informed of their plan of care is essential'.*

62 In my view, the clinical records should precisely record the times and dates on which examinations referred to are performed in order to ensure clarity for those clinicians who will later rely on the information that is recorded in the patient's medical record.

63 I am satisfied that these actions in relation to record keeping fall below the required standard and constitute service failures; however, I consider that the patient did not suffer injustice as a result of these failures as they did not adversely affect his clinical condition.

Overall

64 I considered whether the patient suffered injustice as a result of the failings identified and concluded that he did. I note the ED IPA's advice that '*[t]he final observations recorded for [the patient] in the emergency department record showed a NEWs score of 1 which is the lowest it had been since admission'.* I also note the ED IPA's advice that the observations carried out by the ED nursing staff *'reflects a good standard of care with appropriate responses and adjustments to observation frequency'.* On review, I accept this advice. However, while I accept that the patient's stay in the ED did not adversely affect his clinical condition, I remain concerned by the upset and frustration the patient and his family experienced during his stay. I hope that the complainant is reassured by the ED IPA's advice that the patient's health did not suffer as a result of the failings identified.

Administration of Methadone

65 The complainant believed that the patient did not receive his prescribed dose of Methadone on the evening of 12 February and the morning of 13 February. I note that in the Trust's response to the complainant on 1 October 2018 it states '*in relation to the prescribed controlled medication omission (sic) Your daddy did not attend ED until 11pm on 12 February, at which stage he already had his daily medication. The drug Kardex has been reviewed, your father received two prescribed doses of Methadone at 10am and 10pm on 13 February 2018, no doses missed'*

12 February

66 I was able to establish from clinical records that the ED doctor recorded a list of medications prescribed to the patient as part of the initial assessment. There is no record in the ED notes of when the patient took his medications.

67 I note that the complainant said the patient did not receive his second daily dose of Methadone prior to his arrival at the ED on 12 February 2018. She said that staff received the blister pack containing the Methadone upon the patient's arrival at the ED. Notes in the patient's Electronic Care Record GP Medications Form and the Trust's response to investigation enquiries confirms that this is correct.

68 I note that in its responses to the complainant and investigation enquiries the Trust acknowledged that it did not administer Methadone to the patient on the evening of 12 February. It stated this was because '*it was considered he had taken his prescribed medications for that day'.* There are no indications in the clinical records, or the Trust's investigation of the complaint that ED staff made enquiries to establish if the patient had received Methadone prior to his arrival at the ED. I am concerned that the Trust did not provide evidence to support its conclusion that he did. I considered the complainant's account of events, in addition to the medical records and on the balance of probabilities, I am satisfied that the patient did not receive a second dose of Methadone on 12 February.

69 I note the ED IPA's advice that there may have been additional reasons why ED staff did not administer Methadone to the patient. He advised '*It can be considered entirely appropriate to have not administered further oral medications in ED as [the patient] had been vomiting. (A common side effect of methadone is nausea and vomiting). Furthermore, Methadone may also cause chest pain which was the main reason for his attendance'.*

70 There is no record to confirm that the Trust proactively considered withholding the Methadone for the reasons indicated by the IPA; indeed the responses by the Trust to the complainant imply that it was as a result of an assumption, which I consider poor practice. I note the GMC Guidance states '*Clinical records should include:*
a relevant clinical findings
b the decisions made and actions agreed, and who is making the decisions and agreeing the actions
c the information given to patients
d any drugs prescribed or other investigation or treatment
e who is making the record and when'
I consider that the failure of ED staff to administer Methadone to the patient on 12 February and to document their decision making process in this regard constitutes a failure in the patient's care and treatment. I consider that the patient suffered the injustice of the loss of opportunity as a result of this failure. Therefore, I uphold this element of the complaint.

13 February

71 I note that the complainant said that she knew the patient did not receive Methadone on the morning of 13 February, as an ED nurse administered it at her request and in her presence at approximately 14:00 on 13 February. This occurred following consultation between the ED staff and the community pharmacist on the complainant's mobile phone.

72 I carefully examined the patient's clinical records and I note that on 13 February, the drug Kardex was circled at 10:00 and 22:00 indicating at first glance that the patient received Methadone at those times. I also note that in its responses to the complainant and the investigation, the Trust stated that the

patient received Methadone at 10.00 and 22.00 on 13 February. However, I note the ED IPA's observation that the '*Medicines Kardex has a coded note 6/7 written at 10am on 13 February. With reference to the key for the codes on the front page of the Kardex this means 6= Drug not available. 7 Other*'. This indicates that the patient was not administered Methadone at 10:00. I note the ED IPA's advice that '*if this medication was unavailable it would have been appropriate to offer an alternative pain relief medication'*.

73 I am satisfied from the information on the drug Kardex and from the complainant's account that the patient was not administered Methadone at 10.00 on 13 February. Therefore, the patient did not receive Methadone from 10.00 on 12 February until 14.00 on 13 February. I accept the ED IPA's advice that it would have been appropriate to offer the patient alternative pain relief medication when his Methadone was unavailable and I consider this a failure in his care and treatment. I note the complainant's concern that ED staff had access to patient's blister pack, containing his Methadone. However, I also note IPA's advice that '*It is recorded that whilst in the emergency department [the patient's] Pain score was 0, This was noted on 7 occasions between 01:35 and 13:30. It would be reasonable to conclude that the patient was not experiencing any pain at the time of the assessment.* I also note the ED IPA's advice that '*Methadone withdrawal typically starts to appear between 24 and 36 hours after the previous administration… I do not consider that he was adversely affected by the delay in administration of methadone'.*

74 In light of this, I do not consider that the patient suffered detriment as a result of not receiving Methadone, or alternative pain relief. However, I consider that the complainant experienced the injustice of uncertainty and upset as result of the failure of ED staff to offer alternative pain relief to the patient, as she had to ask an ED nurse to administer Methadone to the patient at 14.00. I am extremely concerned that ED staff did not make sufficient enquiry to determine what medication the patient had taken and that there was a significant delay in providing this to the patient and I uphold this element of the complaint. I hope that the complainant is reassured by the ED IPA's advice that the patient did not suffer detriment because of this failure.

75 I have addressed the Trust's responses to the complainant and investigation enquiries in relation to the administration of Methadone under the section on complaint handling.

Care and treatment in the MAU on 16 and 17 February

76 I will consider the patient's care and treatment in the MAU firstly in terms of the nursing care he received and then in terms of his medical care.

Nursing Care in the MAU 16 and 17 February

77 I considered NEWS charts for the patient while he was in the MAU for the periods 16 and 17 February 2018. I note that on 16 February the patient had observations taken at 09;50 with a NEWS score of 4 recorded. There were no further observations taken until 21.10 when the NEWS score was documented as 6. I note that RCP NEWS guidance states '*We recommend that for patients scoring 0, the minimum frequency of monitoring should be 12 hourly, increasing to 4–6 hourly for scores of 1–4, unless more or less frequent monitoring is considered appropriate by a competent clinical decision maker*'

78 I note from clinical records that on 17 February, the patient had observations taken at 02:10 with a NEWS score of 5 recorded. There were no further observations taken until 06.10 when the NEWS score was documented as 4. I note that RCP NEWS guidance states '*We recommend that the frequency of monitoring should be increased to a minimum of hourly for those patients with a NEW score of 5–6, or a red score (ie a score of 3 in any single parameter) until the patient is reviewed and a plan of care documented'*

79 I note the N IPA's advice that '*there are occasions when NEWS has been miscalculated and occasions when the frequency of monitoring was outside of national guidance. This is only acceptable if the frequency has been changed by a competent clinical decision maker; if this is the case, the rationale should be clearly documented. There is nothing documented within the nursing or medical notes regarding the deviation from national guidance with regards to the frequency of NEWS'*

80 I note the N IPA's advice that '*[t]here was a definite indication that [the patient] needed a medical review on 16.02.2018. This was not just because of his high NEWS at 21:10 but also because his clinical description is sleepy and with a reduced oral intake'.* I refer to the NMC Code, which states that nurses should '***13.1** accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care and **13.2** make a timely referral to another practitioner when any action, care or treatment is required'*.

81 I accept the N IPA's conclusion that '*[n]ursing care on 16 February was not appropriate and reasonable'* as *'[the patient] was not escalated to medics or monitored more closely… in line with NEWS guidance'* and that he '*continued to be unwell during the early hours of 17th February 2018 with no action taken and no increased frequency of monitoring'.* I am critical that monitoring and escalation was not in accordance with national guidelines. It is also my view clinical records should precisely record the NEWS scores in order to ensure clarity for those clinicians who will later rely on the information recorded in the patient's medical record. It ensures that the clinical practice of monitoring a patient's physical condition is evidence-based and consistent. I note that the N IPA also advised that the MUST was not completed,'*thus it is not possible to say if [the patient] was at risk of malnutrition'* and that '*[f]luid balance charts are poorly completed and on most days the intake and output has not been calculated'.*

82 I consider the lack of repeat observations, the miscalculation of NEWS and the lack of escalation for medical review by nursing staff to be significant failures in the patient's care and treatment. There is no evidence that the patient suffered harm because of these failings; however, I consider that the patient suffered the injustice of the loss of opportunity to have appropriate observations and a medical review. The R IPA advised *'[t]here were occasions when [the patient] should have been referred for a medical review. However, the scores following these occasions were either stable or improved so I do not consider that the lack of escalation affected the eventual clinical outcome'.* While I accept the R IPA's advice that the failures identified did not adversely affect the patient on

this occasion, I remain concerned about the wider significance of failures such as these and their potential impact on other critically ill patients in the Trust's care. I uphold this element of complaint in terms of nursing care.

83 While not part of the issues of complaint, the N IPA also identified further failures in nursing care in the MAU on 15 February. In relation to the patient's NEWS charts, the N IPA advised '*[o]n 15.02.2018 at 06:30 when [the patient] scored 5 the frequency set was four hourly whereas national guidance recommends hourly with an urgent response. At 09:30 when it was repeated the score was calculated as 4 when it should have been 5… There are also a couple of occasions when it was scored higher than it actually was. The impact from the miscalculations was on 15.02.2018 at 09:30, [the patient] should have had NEWS repeated after one hour and an urgent medical review should have been requested*.'

84 I note the R IPA's advice that '*the fact that the [patient's] NEW score did not deteriorate between 06:30 and 09:30 suggests that there was no clinical impact of the lack of escalation of his score at 06:30'.* I also note the R IPA advised '*[t]he NEW scores recorded from 13:00 improved and remained at 3 for the rest of the day. This suggests that there was no clinical impact on [the patient] of the score of 5 at 09:30 not being escalated*.' Therefore, I consider that the patient suffered no detriment as a consequence of the failures identified by the N IPA. However, this does point to a significant failure to increase the frequency of observations and to ensure that a gravely ill patient received a medical review at the appropriate time. I am extremely concerned about the nursing practice in the MAU.

Medical care in the MAU 16 and 17 February

85 I note that in the Trust's response to investigation enquiries, it stated that at weekends, it was only able to deliver medical reviews to new admissions, or to patients showing signs of clinical deterioration. The Trust indicated that the patient showed signs of improvement in his condition on 16 February, and furthermore showed no signs of deterioration on 17 February. I note that in respect of 16 February the R IPA advised that *'[the patient's] NEW scores had*

dropped to 3. This in keeping with a good response to the antibiotic treatment.' I note the R IPA further advised that *'[the patient] should have received a medical review at 02:10 on the 17 Feb on the basis of the NEW score of 5'.* However, the R IPA concluded that '*I do not consider that a medical review at that time would have changed the eventual clinical outcome.'*

86 The R IPA advised that *'[the patient] received appropriate treatment for pneumonia whilst on MAU. The treatment would not have differed had he been transferred to the respiratory ward'*. The R IPA further added '*I do not find any evidence that [the patient's] deterioration on the 18 Feb could have been predicted or prevented".* While I did not identify any failings in the treatment plan for the patient in the MAU on 16 February, I note the patient showed signs of deterioration in the early hours of 17 February and should have had a medical review, which did not occur. I therefore uphold the complainant's concern that there was no medical review on the 17 February. I note that in her response to the draft report the complainant remained concerned that the Trust's failure to review the patient on 16 and 17 February might have contributed towards his acute deterioration on 18 February. The complainant believed that restarting the patient on IV antibiotics might have prevented his deterioration. I acknowledge the complainant's concern in this regard; however, I considered the IPA's additional advice that restarting the patient on IV antibiotics would not have changed the eventual outcome. I accept the R IPA's advice that the decline in the patient's condition was due to an acute deterioration on 18 February and was not attributable to the lack of medical review on the evening of 16 February and 17 February. .

Issue 2: Whether the complaints handling by the Trust was appropriate?

Detail of Complaint

87 The complainant raised concerns about the Trust's handling of her complaint, in particular, the time taken by the Trust to respond to her complaint. She also believed that the Trust's written record of its meeting with the patient's family lacked candour.

Evidence Considered

Legislation/Policies/Guidance

88 I considered the following guidance:

- The DoH's Complaints Procedure.

Relevant extracts of the guidance referred to are enclosed at Appendix three to this report

The Trust's response to investigation enquiries

89 In its response to enquiries about the delay in responding to the complaint, the Trust stated '*[t]he Trust apologises for the delay in responding to [the complainant] and the undue distress caused. The delays were due to staff annual leave and also ensuring fully informed responses were provided to [the complainant's] correspondence. The Trust made all reasonable efforts to keep [the complainant] informed of any delays'*

The Trust's records

90 I carefully considered the Trust's records relating to the complaint. A detailed chronology of the process was prepared and is enclosed at Appendix five to this report.

Analysis and Findings

91 I note that the complainant said that the Trust acted with a lack of candour in the manner in which it dealt with her complaint. The complainant believed that the Trust did not accurately record a discussion that took place between Trust staff and the patient's family on 17 April 2018. In investigating the complaint, I am reliant on the contemporaneous records supplied by the Trust. Therefore, I cannot conclude that they are inaccurate or incomplete and I am unable to make a finding in respect of this element of the complaint, however I note the complainant's concern in this regard.

92 The complainant raised concerns about the Trust's delay in responding to her complaint. I note that the DoH's Complaints Procedures states that *'a full*

investigation of a complaint should normally be completed within 20 working days'. I note that the complaints team initiated an investigation following the Trust's receipt of the patient's wife consent to share his confidential information with the complainant. The Trust received this on 2 March 2018. I note that the Trust contacted the patient's family on 8 March 2018 and proposed a meeting to discuss the complainant's concerns. I note further that the Trust contacted the complainant on 14 March to advise that due to staff annual leave, the meeting would be delayed until April. I note that the meeting took place on 17 April 2018.

93 I carefully considered the records contained within the complaints file. I note that on 8 May 2018, the complainant requested that amendments be made to the meeting minutes of 17 April 2018 and raised concerns about several other issues. The Trust sent its reply on 15 June 2018. On 2 July 2018, the complainant sent a response to the Trust's reply, in which she raised further concerns arising out of the amendments to the meeting minutes of 17 April 2018.

94 I note that the Trust drafted its final response letter on 27 July 2018. I note further that the Trust issued the final response letter on 1 October 2018. I reviewed the complaints file and I acknowledge that annual leave and the difficulty in arranging mutually convenient times for Trust staff involved in handling the complaint to meet to discuss the response letter, led to delays in issuing the final response. However, I do not consider that those involved in the complaints process demonstrated sufficient urgency to respond to the complaint. I accept that it may not always be possible for the Trust to fully respond to a complainant within the stated 20 working day timeframe. However, I consider that the Trust's delay in responding to the complaint was significant and unacceptable.

95 The Second Principle of Good Complaint Handling, 'being customer focused', requires bodies to deal with '*complainants promptly and sensitively, bearing in mind their individual circumstances*'. I consider that the failure to respond to the complainant in a timely manner constitutes maladministration

96 I considered the complaints file and note that the Trust corresponded with the complainant at regular intervals during the investigation. However, I also note that in the majority of instances the Trust did not initiate this correspondence. Rather, the correspondence followed requests for updates from the complainant. I also note that in its replies to the complainant, the Trust did not advise her when it expected to provide her with an outcome. I note that the DoH's Complaints Procedure states that *'as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales*'. I consider that the Trust ought to have provided a revised timescale in accordance with the DoH's Complaints Procedure.

97 The First Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned'*. I consider that the failure to provide the complainant with anticipated timescales constitutes maladministration

98 I considered the Trust's final response letter to the complainant. In its response to the complainant's concern that ED staff did not administer the patient's Methadone, the Trust states '*Your daddy did not attend ED until 11pm on 12 February, at which stage he already had his daily medication'.* I note that there is no evidence in the patient's medical records to support this statement. The Trust further states '*The drug Kardex has been reviewed, your father received two prescribed doses of Methadone at 10am and 10pm on 13 February 2018, no doses missed'.* The investigation established that this statement was incorrect and that an examination of the Kardex by the ED IPA revealed that the patient did not receive Methadone at 10.00 on 13 February.

99 The Third Principle of Good Complaint Handling 'Being open and accountable' requires public bodies to provide '*honest evidence-based explanations and giving reasons for decisions'.* In addition the Fourth Principle of Good Complaint Handling 'Acting fairly and proportionately' requires public bodies to ensure '*that complaints are investigated thoroughly and fairly to establish the*

facts of the case'. In its response to the complainant regarding the administration of methadone to the patient, I do not consider that the Trust meets these standards for the reasons outlined above. I consider that this failure to conduct a thorough and accurate investigation constitutes maladministration. I note the complainant's concern that the Trust's response to this issue lacked candour. While I am satisfied that the failure arose out of the Trust's failure to thoroughly investigate the complaint rather than a lack of candour, I acknowledge that failures such as these can lead to a loss of confidence in the integrity of the complaints process.

100 Consequently, I am satisfied that the maladministration identified caused the complainant to experience the injustice of frustration, uncertainty and the time and trouble of bringing a complaint to this office. Therefore, I uphold this element of the complaint.

CONCLUSION

101 I received a complaint about the actions of the Trust. The complainant raised concerns about the care and treatment the hospital staff provided to her father, the patient. The complainant also had concerns about the Trust's handling of her complaint.

Issue One

102 The investigation of the complaint found that the patient's death on 19 February was not attributable to the failure of ward staff to carry out a medical review on 17 February. The investigation established failures in the care and treatment in relation to the following matters:

- The failure to carry out an initial medical assessment within recommended timescales;
- The failure to administer antibiotics to the patient at the appropriate time;
- The failure to place the patient in an appropriate place of care in line with clinical guidance;
- The failure to administer Methadone to the patient on 12 February;

- The failure to provide alternative pain relief to the patient when his Methadone was unavailable on 13 February;
- The failure to calculate NEWS correctly and to carry out observations in accordance with national guidance; and
- The failure to escalate the patient and conduct a medical review.

103 I am satisfied that the failures identified did not contribute to the deterioration of the patient's condition. However, I consider that failings such as these can lead to a lack of confidence on the part of the patient and relatives about the adequacy of the care and treatment provided. I am satisfied that the complainant experienced injustice as a consequence of the failings identified. I consider that the complainant experienced the injustice of uncertainty and upset

Issue Two

104 The investigation established maladministration in relation to the following matters:

- The failure to respond to the complainant in a timely manner;
- The failure to provide the complainant with anticipated timescales in relation to her complaint; and
- The failure to conduct a thorough and accurate investigation.

105 I am satisfied that the maladministration identified caused the complainant the injustice of frustration, uncertainty and the time and trouble of bringing a complaint to this office.

Recommendations

106 I recommend that within **one month** of the date of this report:

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

- The Trust ensures all relevant ED staff are made aware that patients taking medication for chronic pain are to be provided with alternative pain relief if their own medication is unavailable;
- Carry out a random sampling audit of patients' nursing records on Ward E with a particular emphasis on NEWS observations to ensure monitoring is being carried out at appropriate intervals; scores are calculated correctly and are clearly recorded and that patients are escalated for medical review when required. Take action to address any identified trends or shortcomings. The Trust ought to include any recommendations identified in its update to this office;
- All staff involved in complaint handling on this case should be reminded of the importance of meeting response times and where this is not possible to update the complainant, provide reasons for the delay and indicate when they can expect a response. Staff should also keep complainants informed in accordance with guidance; and
- The Trust provide evidence that it has reviewed why its own investigation did not identify or acknowledge all the failings highlighted here

107 I also recommend for service improvement and to prevent future recurrence, the Trust:

- Carry out a random sampling audit of patients' records in the ED to ensure that clinical records contain relevant information in accordance with GMC guidance

108 I recommend that the Trust implement an action plan to incorporate these recommendations and should provide me with an update within **three months** of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

109 I am pleased to note the Trust accepted my findings and recommendations

Margaret Kelly
Ombudsman **August 2021**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure in the right way and at the right time.

2. Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.

- Publishing service standards for handling complaints.
- Providing honest evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions and actions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learned from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on learning from complaints.
- Regularly reviewing the lessons to be learned from complaints.
- Where appropriate, telling the complainant about the lessons learned and the changes made to services, guidance or policy.