Investigation Report

Investigation of a complaint against the South Eastern Health and Social Care Trust

NIPSO Reference: 18351

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
@NIPSO_Comms

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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. She may also investigate and report 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.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

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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EXECUTIVE SUMMARY

I received a complaint about the actions of the South Eastern Health and Social Care Trust (the Trust) in relation to the level of communication they provided to the complainant's partner upon her discharge from the Ulster Hospital in October 2013.

Issue of Complaint

I accepted the following issues of complaint for investigation:

- Whether the Trust's communication upon the patient's discharge from hospital on 18 October 2013 was adequate?

Findings and Conclusion

I have not found maladministration in respect of the Trust's communication upon the patient's discharge from hospital on 18 October 2013.

Recommendations

I have not made any recommendations in this case.

THE COMPLAINT

1. The complaint relates to the level of communication provided by Trust staff to the complainant's partner upon her discharge from the High Dependency Unit at the Ulster Hospital on 18 October 2013. The complainant alleged that Trust staff failed to provide adequate information to his partner in relation to possible brain injury, Bacterial Meningitis and its after-effects, and the after-effects of being a patient in a High Dependency Unit.

Issues of complaint

2. The issue of complaint which I accepted for investigation was:

Issue 1: Whether the Trust's communication to the patient upon her discharge from hospital was adequate?

INVESTIGATION METHODOLOGY

3. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant.

Independent Professional Advice

4. After further consideration of the issue of complaint, I obtained independent professional advice from a nursing independent professional advisor (IPA).

6. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPA has provided me with 'advice'; however how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

7. In order to investigate complaints, I must establish a clear understanding of the

standards, both of general application and those which are specific to the circumstances of the case.

8. The general standards are the Ombudsman's Principles[1]:

- The Principles of Good Administration.

9. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative and professional judgement functions of the Trust and clinicians whose actions are the subject of this complaint.

10. The specific standards relevant to this complaint are:

- GAIN: Guidelines and Audit Implementation Network (2011);
- Department of Health. "Ready to go?" (2010);
- Department of Health. "Achieving Timely, simple discharge from hospital, a toolkit for the Multidisciplinary team" (2004); and
- Nursing and Midwifery Council. The Code: Professional standards of practice and behavior for nurses and midwives (2008).

Relevant extracts of these documents are reproduced at paragraph 13 of this report.

11. I have not included all of the information obtained in the course of the investigation in this report. However, I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

MY INVESTIGATION

Issue 1: Whether the Trust's communication to the patient upon her discharge from hospital was adequate?

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

Detail of Complaint

12. The complainant alleged that Trust staff failed to provide his partner with adequate information and guidance upon discharge from the High Dependency Unit (HDU) of the Ulster Hospital in October 2013. In particular, he complained that as a patient who suffered from Bacterial Meningitis (BM) and septicemia, his partner was not provided with information and guidance on BM and its after-effects, possible brain injury and the after-effects of being a patient in a HDU.

Evidence considered

13. I considered the following relevant policies and guidance:

- GAIN: Guidelines and Audit Implementation Network (2011)

These are guidelines on regional immediate discharge documentation for patients being discharged from secondary in to primary care, which state: '*Effective communication between secondary and primary care is vital to ensure a smooth and seamless transition of care for all patients when they leave hospital*'.

- Department of Health: Ready to go? (2010);

- Department of Health: Achieving Timely, simple discharge from hospital, a toolkit for the Multidisciplinary team (2004);

- Nursing and Midwifery Council (NMC) The Code: Standards of conduct, performance and ethics for nurses and midwives (2008). This states:

'*You must listen to the people in your care and respond to their concerns and preferences';*

'*You must share with people, in a way they can understand, the information they want or need to know about their health*'.

- Desai, S. J., Law, T. J., and Needham, D. M. (2011) "Long-term complications of Critical Care". *Critical Care Medicine.* Vol. 39, pp. 371-379.

Investigation enquiries

14. In response to investigation enquiries in relation to the complaint, the Trust explained that *"the Trust has considered all the issues raised directly by [the patient] via written correspondence. We issued our final report to [her] on 16 June 2017*".

15. The Trust provided a comment to the complaint through its Consultant in Chemical Pathology and General Medicine, on 15 January 2018. The Consultant commented that "*She* [the patient] *was asked many times how she was and the comment was made many times, well in excess of 10 times, that she had 'no complaints*'". The Consultant further commented that '*the nursing notes for her hospital stay show that she was asked many questions to do with her medicines management, her property, her social home circumstances, her safety and mobility, the ability to communicate and as a result of these answers in her notes, it is clear that a very complete discussion must have taken place with her*".

16. The Consultant stated that '*under emotional and psychological needs – the question was asked, "do you have any fears, concerns regarding the admission" and the answer given was "no". Additionally, "do you have any other worries you would like to talk about", and the answer again was "no". "Do you have someone – friend, family member you can discuss these with' – after family member the answer is "yes"'.* The Consultant further stated that '*She* [the patient] *was asked on many occasions if she had any problems and the answer was always the same that she had "no problems". I find it difficult to know what else we could have done'.*

17. In the same correspondence the Consultant explained that '*Great care is taken to introduce people to the ward, to introduce them to intensive care when that seems appropriate, to make sure they are informed about their condition and they are given every opportunity to voice any questions or queries and it appears that on this occasion no questions were forthcoming*'.

Clinical records

18. I carefully examined the patient's HDU and Ward medical records between 6 October 2013 and 18 October 2013.

Independent Professional Advice

19. The Investigating Officer enquired of the Nursing IPA whether the patient's discharge from the Ulster Hospital was conducted fully and appropriately by the discharging nurse on 18 October 2013. The Nursing IPA advised that '*In [this] case the discharge process involved nursing, medical and physiotherapy staff. On 10.10.13, [the patient] was assessed by the physiotherapist. The assessment concluded that [she] was bright and alert and safe in all aspects of her mobility. From a medical perspective, [the patient] had recovered from the Bacterial Meningitis and was well enough to go home and back to the care of her GP on 18.10.2013*'.

20. The Nursing IPA advised that '*On reviewing [the patient's] discharge letter from the hospital to her GP, all sections were fully completed and the information contained within the discharge followed GAIN guidance, page 5*'. The IPA further advised that "*on the day of discharge, the discharging nurse needed to ensure that [the patient's] discharge was "safe". This means that she continued to feel well, that she had a short supply of take home medication until she could get her medications from the GP and that her partner (whom she lived with) had been communicated with regarding discharge… In summary, [her] overall discharge planning was appropriate and in line with national guidance*'.

21. The Investigating Officer enquired of the Nursing IPA whether the discharging nurse ought to have provided information leaflets or appropriately communicated with the patient any affects her time in the HDU and her illness may have on her prior to discharge. The Nursing IPA advised that '*It is in line with national guidance (DoH 2010 "Ready to go?") to communicate well with patients and their carers regarding the discharge process. This is to ensure a safe discharge. [The patient] would have been considered a "simple discharge" which refers to patients who are returning to their own home; and have simple ongoing care needs which do not require complex planning and delivery'.*

22. The Nursing IPA advised that '*on discharge, the discharging nurse gave [her] the information that she needed at the time. She had fully recovered and was not showing any signs of anxiety on discharge'.* Importantly, the Nursing IPA further

advised that '*[the patient] had a very short two day stay on HDU, PTSD (post-traumatic stress disorder – referred to by the patient in her complaint letter) would not have been suspected or anticipated by the discharging nurse for reasons which will be explained in response to Q3*' (paragraph 23 refers).

23. The Investigating Officer enquired of the Nursing IPA whether the patient's medical records support the Consultant's view that it was difficult to know what else could have been done. The Nursing IPA advised that '*The clinical records do identify that [the patient's] mental health was explored whilst she was an in-patient. This was apparent from the nursing assessments and nursing evaluations. [Her] decline in mental health post discharge was not anticipated by clinicians, nor is it reasonable to expect that it could have been. This is because [she] made a fast recovery and had a short stay on HDU and research tells us that PTSD is associated with prolonged stays on ICU*'.

24. The Nursing IPA further advised that '*However, as [she] had faced a life threatening disease, it is expected good practice to give "safety netting" advice, which is to advise the patient to seek help from her GP should her condition deteriorate. This is why national guidance advocates a thorough discharge letter from the hospital to the GP*'. The Nursing IPA advised that '*the Trust has identified that they will give patients information leaflets on discharge when they have been admitted with Bacterial Meningitis. This is sufficient service improvement because discharge was already in line with national guidance quoted throughout the advice*'.

25. The Nursing IPA concluded that '*the discharge of [the patient] was in line with national guidance within this advice. [Her] decline in mental health post discharge could not have been anticipated by nursing staff*'.

ANALYSIS AND FINDINGS

26. I have carefully considered the complaint and the Trust's response as well as the Nursing IPA's advice. I accept the Nursing IPA's advice. I am satisfied that '*the patient's overall discharge planning was appropriate and in line with national*

guidance'. I am also satisfied that the Nursing IPA did not consider it necessary for staff to provide the patient with additional information leaflets. I am satisfied that '*the discharging nurse gave [her] the information that she needed at the time*'. I accept that the IPA considered the communication at discharge was reasonable. I note the Trust has put in place service improvements since the patient's stay at the Ulster Hospital. The Trust now provide patients with information leaflets on discharge when they have been admitted with Bacterial Meningitis.

27. I am satisfied with the explanation provided by the Nursing IPA that '*[the patient] had a very short two day stay on HDU,* [and] *PTSD (post-traumatic stress disorder – referred to in her complaint letter) would not have been suspected or anticipated by the discharging nurse*'. Overall, I accept that the '*decline in [her] mental health post discharge was not anticipated by clinicians, nor is it reasonable to expect that it could have been*'. **I therefore do not uphold this issue of complaint.**

CONCLUSION

28. I have investigated the complaint and have not found maladministration in relation to the Trust's communication to the patient upon her discharge from hospital in October 2013.

29. The Trust have accepted my findings.

Marie Anderson

MARIE ANDERSON
Ombudsman **September 2018**

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.