



Northern Ireland

**Public Services**

Ombudsman

# Investigation Report

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

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**NIPSO Reference: 19185**

The Northern Ireland Public Services Ombudsman

33 Wellington Place

BELFAST

BT1 6HN

Tel: 028 9023 3821

Email: [nipso@nipso.org.uk](mailto:nipso@nipso.org.uk)

Web: [www.nipso.org.uk](http://www.nipso.org.uk)



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## **The Role of the Ombudsman**

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

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

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

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

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

## **Reporting in the Public Interest**

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

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

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## SUMMARY

I received a complaint about the care and treatment of the complainant's late husband while he was an in-patient in the Lagan Valley Hospital from 22 August 2017 until 8 September 2017 when he sadly passed away.

The patient had decompensated liver disease which is a serious condition with a poor prognosis. The complaint was about particular aspects of the patient's care and treatment which the complainant considered were not appropriate. She complained that the administration of propranolol<sup>1</sup> and midazolam<sup>2</sup> was not managed appropriately, about her husband's fluid management, and she said that her husband should have had a urinary catheter inserted.

The investigation established that the patient's initial management was appropriate to deal with his excess fluid. However a diagnostic tap to exclude infection should have been carried out, or if this was not possible empirical antibiotic treatment should have been commenced. I also established that as the patient became more unwell his kidney function deteriorated, most likely as a result of his liver failure. The patient was commenced on IV albumin<sup>3</sup> treatment, however the dose given was not correct for his weight and was not continued for the recommended 3-5 days. There was no recorded rationale as to why this was the case.

In addition to the albumin, the patient should have received a drug called terlipressin,<sup>4</sup> and propranolol treatment should have been stopped two days earlier than it did. The advisors indicated that while these failures meant that the patient's care and treatment was not in accordance with relevant guidelines, they were unlikely to have affected the outcome.

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<sup>1</sup> Propranolol, sold under the brand name Inderal among others, is a medication of the beta blocker class. It is used to treat high blood pressure, a number of types of irregular heart rate, thyrotoxicosis, capillary hemangiomas, performance anxiety, and essential tremors.

<sup>2</sup> Midazolam is a benzodiazepine medication used for anesthesia, procedural sedation, trouble sleeping, and severe agitation. It works by inducing sleepiness, decreasing anxiety.

<sup>3</sup> **Albumin** is a protein made by your liver. **Albumin** helps keep fluid in your bloodstream so it doesn't leak into other tissues. It is also carries various substances throughout your body, including hormones, vitamins, and enzymes. Low **albumin** levels can indicate a problem with your liver or kidneys.

<sup>4</sup> **Terlipressin** is an analogue of vasopressin used as a vasoactive drug in the management of low blood pressure

The investigation established that it was appropriate for the patient to be administered midazolam and that a urinary catheter was not required in this case.

I recommended the Trust apologise to the complainant for the failures identified in this report and I made recommendations for service improvements.

I am pleased to note the South Eastern Health and Social Care Trust accepted my findings and recommendations.

## THE COMPLAINT

1. The complaint is about the actions of the South Eastern Health and Social Care Trust (the Trust). The complainant stated her husband (the patient) was admitted to the Lagan Valley Hospital on the 22 August 2017 with decompensated liver disease<sup>5</sup>. The complainant said that her husband's fluid management between 22 August 2017 and 8 September 2017 was not adequate. She also complained her husband was wrongly administered propranolol between 30 August 2017 and 3 September 2017 and midazolam on 5 September 2017. The complainant also complained she had wanted her husband to have a catheter inserted, however medical staff failed to provide the patient with a catheter.

### Issue of complaint

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

**Issue 1: Whether the Trust's care and treatment was appropriate and reasonable.**

## 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. This documentation included information relating to the Trust's handling of the complainant's complaint and the patient's medical records.

### Independent Professional Advice Sought

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

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<sup>5</sup> **Decompensated liver disease** is also known as **decompensated cirrhosis**. **Cirrhosis** is a chronic **liver disease** that's commonly the result of hepatitis or alcohol use disorder. **Cirrhosis** is the severe scarring of the **liver** seen at the terminal stages of chronic **liver disease**.

- A Consultant Gastroenterologist (CG IPA) MB ChB with commendation FRCP with experience managing decompensated liver cirrhosis including renal failure.
- An Advanced Nurse Practitioner, (N IPA) RGN BA (Hons) MSc PHD, with 16 years' experience as a consultant nurse based in an acute medical unit.

5. 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**

6. 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.

The general standards are the Ombudsman's Principles<sup>6</sup>:

- The Principles of Good Administration
- The Principles of Good Complaints Handling
- The Public Services Ombudsman's Principles for Remedy

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

The specific standards relevant to this complaint are:

- British Society of Gastroenterology (BSG) British Association for the Study of Liver (BASL) Decompensated Cirrhosis Care Bundle Guidelines (2014)

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<sup>6</sup> These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- (BASL Decompensated Cirrhosis Guidelines);
- British Society of Gastroenterology (BSG) Guidelines on the Management of Ascites in Cirrhosis<sup>7</sup> (BSG Guidelines);
  - British Medical Journal (BMJ) Best Practice Guidelines – Hepato-renal Syndrome<sup>8</sup> (BMJ Guidelines);
  - Department of Health, Social Services and Public Safety (DHSSPS) Promoting Good Nutrition Strategy (2017) (Promoting Good Nutrition Strategy);
  - European Association for the Study of the Liver (EASL) Guidelines (2010) (EASL Guidelines)
  - National Institute for Health and Care Excellence (NICE) Guidelines: Nutrition support in adults (2006) (NICE Nutrition Guidelines);
  - Nursing and Midwifery Council (NMC) The Code for Professional Standards of Practice and Behaviour for Nurses Midwives and Nursing Associates (The NMC Code)

8. I have not included 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 has been taken into account in reaching my findings.

9. In accordance with the NIPSO process, a draft copy of this report was shared with the Trust and the complainant for comment on factual accuracy and the reasonableness of the findings and recommendations.

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<sup>7</sup> Accumulation of fluid in the abdominal cavity is called **ascites**. **Ascites** is common in people with **cirrhosis** and it usually develops when the liver is starting to fail. In general, the development of **ascites** indicates advanced **liver disease** and patients should be referred for consideration of liver transplantation.

<sup>8</sup> **Hepatorenal syndrome** (HRS) is a form of impaired kidney function that occurs in individuals with advanced liver disease. Individuals with **hepatorenal syndrome** do not have any identifiable cause of kidney dysfunction and the kidneys themselves are not structural damaged.



# INVESTIGATION

**Issue 1**                      **Whether the Trust’s care and treatment was appropriate and reasonable?**

## **Detail of Complaint**

10. The complainant said that her husband’s fluid management was inadequate between 22 August 2017 and 8 September 2017. In particular, the complainant stated that his fluid input and fluid output should have been monitored, however this did not occur. The complainant also stated her husband was administered propranolol between 30 August 2017 and 3 September 2017. However, she believed he should not have been administered propranolol because his blood pressure was decreasing and this medication would have caused his condition to deteriorate causing him unnecessary harm. She also complained that he was wrongly administered midazolam on 5 September 2017 for an itch. The complainant also said that her husband’s medical team failed to provide him with a catheter between 22 August 2017 and 8 September 2017. She believes her husband should have had a catheter fitted as this would have made him more comfortable.

## **Evidence Considered**

### **Guidance**

11. I have considered the following relevant extracts of the NICE nutrition guidelines: Section 1.5.3: *‘Healthcare professionals should refer to the protocols for nutritional, anthropometric<sup>9</sup> and clinical monitoring when monitoring people having support in hospital.*

*Protocol for nutritional, anthropometric and clinical monitoring of nutrition support*

<i>Parameter</i>	<i>Frequency</i>	<i>Rationale</i>
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<sup>9</sup> of or relating to the scientific study of the measurements and proportions of the human body

<i>Fluid Balance charts (enteral and parenteral<sup>10</sup>)</i>	<i>Daily initially, reducing to twice weekly when stable</i>	<i>To ensure patient is not becoming over/under hydrated'</i>
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12. I have considered the following relevant extracts of the Promoting Good Nutrition Strategy:

Key characteristic 3 – *'The care provider must include specific guidance on food and beverage services and nutritional care in its service delivery and accountability arrangements...Food and beverage consumption is monitored where appropriate'.*

13. I have considered the following extracts of the BASL Decompensated Cirrhosis Guidelines:

*'Decompensated cirrhosis is a medical emergency with a high mortality...checklist for all patients admitted with decompensated cirrhosis within the first 6 hours of admission....this checklist aims to provide a guide to help ensure that the necessary early interventions are completed in a timely manner and appropriate treatments are given at the earliest opportunity'.*

14. I have considered the following extracts of the EASL Guidelines:

*'It is therefore recommended that all patients presenting with ascites have a diagnostic ascetic tap to exclude spontaneous bacterial peritonitis (SBP)<sup>11</sup> on admission to hospital, or if there is a deterioration in their clinical status...upon diagnosis, SBP should be empirically treated with broad spectrum antibiotics.....Patients with SBP are at high risk of developing hepatorenal syndrome (HRS) and should have intravenous albumin administered to prevent worsening of renal function'.*

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<sup>10</sup> **Enteral nutrition** generally refers to any method of **feeding** that uses the gastrointestinal (GI) tract to deliver part or all of a person's caloric requirements. ... **Parenteral nutrition** refers to the delivery of calories and nutrients into a vein.

<sup>11</sup> **Spontaneous bacterial peritonitis (SBP)** is infection of ascitic fluid without an apparent source. Manifestations may include fever, malaise, and symptoms of ascites and worsening hepatic failure.

## Clinical Records

15. I considered relevant extracts from the patient's clinical records.

### The Trust's response to investigation enquiries

16. In response to investigation enquiries, the Trust stated '*[the patient] was admitted to the medical assessment unit in the LVH on 22 August 2017 at approximately 19.00. The plan on admission was diuretic therapy<sup>12</sup>, review as per renal function, daily weight, ultrasound abdomen request, blood cultures and antibiotics if temperature spikes, chase ED bloods, ensure Amylase<sup>13</sup>, coagulation screen<sup>14</sup> and liver function blood tests, daily urea and electrolyte blood tests; monitor for signs of encephalopathy<sup>15</sup> and commence stool chart. [The patient] was commenced on a fluid balance chart...while awaiting an ultrasound scan of abdomen [the patient] was commenced on diuretic therapy. On 24 August 2017 at 19.30 [the patient] was transferred to Ward 1B. While fluid balance charts were recorded, you will note that there are clear deficits in the documentation*'. The Trust further stated '*diuretics were prescribed by the medical team in an attempt to alleviate [the patient's] modest ascites, his weight reduced from 131.0kg (23 August 2017) to 126.3 kg (27 August 2017). They were administered by the nursing team*'.

17. In response to enquiries regarding the patient's fluid management care, the Trust stated '*The fluid management plan for [the patient] from the time of admission included recording of his fluid input and output on a fluid balance chart, daily weights, spironolactone<sup>16</sup> (which was later stopped on 31 August 2017 in response to deteriorating renal function) and a salt restricted diet. Furosemide<sup>17</sup> IV (intravenously, existing or taking place within, or administered into a vein or veins).*

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<sup>12</sup> **Diuretic Drug Therapy. Diuretics (known as water tablets)** reduce the amount of salt and water in the body. As the kidneys filter the excess water from the blood, the volume of blood the heart has to pump is reduced, causing blood pressure to go down.

<sup>13</sup> **Amylase** is a protein made by your pancreas and by glands in and around your mouth and throat. It helps you break down carbohydrates and starches into sugar. It's normal to have some **amylase** in your blood. But too much of it could mean one of the ducts (tubes) in your pancreas is blocked or injured

<sup>14</sup> **coagulation screen** is a combination of screening laboratory tests, designed to provide rapid non-specific information, which allows an initial broad categorization of haemostatic problems. The basic **screen** consists of: platelet count, bleeding time for platelet function.

<sup>15</sup> **Encephalopathy** is a term that means brain disease, damage, or malfunction. **Encephalopathy** can present a very broad spectrum of symptoms that range from mild, such as some memory loss or subtle personality changes, to severe, such as dementia, seizures, coma, or death.

<sup>16</sup> **Spironolactone** is used to treat high blood pressure and heart failure. Lowering high blood pressure helps prevent strokes, heart attacks, and kidney problems. ... **Spironolactone** is known as a "water pill"

<sup>17</sup> **Furosemide** is a type of medicine called a diuretic. It's used to treat high blood pressure, heart failure and oedema (a build up of fluid in the body)

was also prescribed and administered for a short period between (23 August 2017 to 26 August 2017)'. The Trust stated the patient's fluid balance chart was 'commenced at 20.00 on 22 August 2017 and daily weights were recorded by the nursing team'.

18. The Trust provided the patient's daily fluid balance chart and weight chart:

<i>Date</i>	<i>Input</i>	<i>Output</i>	<i>Weight</i>	<i>Comments</i>
<i>22/08/2017</i>	<i>300ml</i>	<i>400ml</i>		<i>Commenced at 20.00</i>
<i>23/08/2017</i>	<i>1755ml</i>	<i>2510ml</i>	<i>131.3kg</i>	
<i>24/08/2017</i>	<i>850ml</i>	<i>3210ml</i>	<i>130.8kg</i>	
<i>25/08/2017</i>	<i>1100ml</i>	<i>2300ml</i>	<i>128kg</i>	
<i>26/08/2017</i>	<i>430ml</i>	<i>2300ml</i>	<i>126.85kg</i>	<i>Documented refused fluids on 3 occasions throughout day</i>
<i>27/08/2017</i>	<i>180ml</i>	<i>950ml</i>	<i>126.3kg</i>	<i>No fluid input documented at lunch and teatime – patient independent with Activities of Daily Living (ADL)</i>
<i>28/08/2017</i>	<i>700ml</i>	<i>1100ml</i>	<i>126.4kg</i>	<i>Refused fluid documented on 5 occasions</i>
<i>29/08/2017</i>	<i>200ml</i>		<i>126.85kg</i>	<i>Chart incomplete. Documented refused lunch</i>
<i>30/08/2017</i>	<i>900ml</i>	<i>550ml</i>	<i>128.3kg</i>	<i>Fasting from 12.00 for oesophago-gastroduodenoscopy (OGD)<sup>18</sup>. Fluid refused at 17.00</i>

<sup>18</sup> The proposed procedure you will be having is called an oesophago-gastroduodenoscopy (OGD) sometimes

<i>31 August 2017</i>	<i>650ml</i>	<i>250ml</i>	<i>129.1kg</i>	<i>Documented refused lunch, dinner and fluid on one occasion. Received two units of albumin.</i>
<i>1 September 2017</i>	<i>700ml</i>	<i>350ml</i>		<i>Refused breakfast, supper and fluid on one other occasion. Independent with toileting.</i>
<i>2 September 2017</i>	<i>50ml</i>	<i>Passed urine in toilet</i>		<i>Refused fluid throughout toilet. 3 occasions documented passed urine in toilet (PUT)</i>
<i>3 September 2017</i>	<i>820ml</i>	<i>Passed urine in toilet</i>		<i>Incomplete chart. Refused breakfast and lunch</i>
<i>4 September 2017</i>				<i>Sleeping at breakfast, refused lunch and tea. Chart not completed.</i>
<i>5 September 2017</i>				<i>Chart not completed</i>
<i>6 September 2017</i>				<i>Chart not completed</i>
<i>7 September 2017</i>				<i>Chart not completed</i>

19. The Trust further stated '*fluids were recorded by the nursing team. It is recognised that the fluid balance charts were not always completed. However, [the*

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known more simply as a gastroscopy or endoscopy. This is an examination of your oesophagus (gullet), stomach and the first part of your small bowel called the duodenum.

*patient] was independent in his ADL up until his condition deteriorated and he entered the terminal phase of his life. Food and drinks that were regularly brought in by his family were not always recorded’.*

20. In response to investigation enquiries regarding the patient being administered propranolol, the Trust stated ‘*On admission [the patient’s] blood pressure was 103/74 and in subsequent days it was within normal limits. He was commenced on propranolol 40mg<sup>19</sup> on 30 August 2017 for oesophagael varices<sup>20</sup>. Following the third dose it was noted that [the patient’s] blood pressure was continuing to fall. The following dose of medication (1 September 2017) was omitted, awaiting, medical review). Following the ward round later that morning, it is documented in the treatment plan to continue with the administration of propranolol’.* The Trust confirmed ‘*[the patient] received six doses of propranolol 40mg between 30 August 2017 and 3 September 2017...[the patient’s] blood pressure was at an acceptable level when the drug was prescribed and was later stopped as his blood pressure dropped...the low dose of propranolol used is not thought to have had significant impact on his condition...he was deteriorating to his end stage liver failure’.*

21. In response to investigation enquiries regarding the patient being administered with midazolam, the Trust stated ‘*on the morning of 5 September 2017 the nursing documentation recorded [the patient] was presently calling out and agitated’.* The Trust stated ‘*[the patient] was subsequently administered midazolam 2.5mg subcutaneously<sup>21</sup> as prescribed for his agitation.* The Trust further clarified that ‘*[the patient’s] medical record had indicated that he had been prescribed midazolam for an itch, however this appears to have been a miscommunication for the indication of the prescribed medication’.* The Trust stated ‘*midazolam was appropriately prescribed in the “as required medications” section of the medicine kardex for agitation...and they do not consider that midazolam was given in error’.* The Trust reiterated ‘*the nursing staff clearly documented that at 05.30 on 5 September 2017,*

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<sup>19</sup> **Mg: Abbreviation** for milligram, a unit of measurement of mass in the metric system equal to a thousandth of a gram.

<sup>20</sup> **Esophageal varices** are abnormal, enlarged veins in the tube that connects the throat and stomach (**esophagus**). This condition occurs most often in people with serious liver diseases. **Esophageal varices** develop when normal blood flow to the liver is blocked by a clot or scar tissue in the liver.

<sup>21</sup> A **subcutaneous** injection is administered as a bolus into the subcutis, the layer of skin directly below the dermis and epidermis, collectively referred to as the cutis.

*“presently calling out and agitated. Midazolam given...the Trust later apologised to the family as they had informed them that [the patient] had complained of an itch. It was the doctors understanding that midazolam was given in error for itch. This was not the case’.*

22. In response to investigation enquiries regarding the patient having a catheter inserted, the Trust stated *‘[the patient] did not have a catheter inserted at any stage throughout out his episode of care. From the time of admission [the patient] was able to mobilise to the toilet. It was only in the final days of his illness that he was unable to get out of bed. [The patient] was agitated and un-cooperative at times and it was felt that he would not have tolerated a catheter’.*

23. The Trust further stated *‘[the Doctor] spoke with [the patient’s] family on 2 September 2017 when he discussed his [the patient’s] deteriorating condition. The family were informed at this point that [the patient] was sadly unlikely to survive. [The patient] had decompensated liver disease which was not responding to medical intervention which carries a high mortality. This conversation is clearly evidenced in both the medical and nursing documentation’.*

24. The Investigating Officer made further enquiries of the Trust in relation to this element of the complaint. The Trust stated *‘[the patient] was nursed in bed from 7 September 2017. A repositioning chart was commenced at that time. There is a record of urinary incontinence on 7 September at 02.00 and again at 11.15 when continence care was provided. There was no documented urinary output following this. [The patient] would have had incontinence pad in place which would have been checked on each repositioning round and is documented as being dry on each occasion’.*

25. The Trust further confirmed *‘[the complainant] and her family were in attendance throughout [the patient’s] final days. There is a record in the nursing documentation on 7 September 2017 at 11.15 that family consent was gained in relation to repositioning and incontinence case. It would have been explained at each repositioning round what the staff intended to do although it is not clearly documented if [the complainant] left the room or stayed on each occasion. On*

*previous occasions, it has been documented that [the complainant] attended to his personal care’.*

## **Independent Review Report**

26. I examined the Independent report carried out on 10 May 2018 and consider the following extracts relevant:

*‘[The patient’s] admission to the LVH on 27 August 2017 was with further decompensated liver disease with increasing abdominal distention<sup>22</sup>...subsequent ultrasound revealed moderate ascites....he had a past history of encephalopathy<sup>23</sup> which would indicate a child’s c cirrhosis<sup>24</sup> with a score of 12 indicating severe liver disease and guarded short to medium term prognosis. He was treated appropriately with diuretics....there was an initial improvement in his condition...unfortunately there was a deterioration in his renal function between 29 August and 31 August 2017...his diuretics were stopped and he was treated with albumin. ‘Over the subsequent dates he continued to deteriorate more drowsy in keeping with encephalopathy...I note a discussion with the family and [the Doctor] on 2 September 2017 communicating the clinical problems of organ failure with a poor outlook with no clear reversible cause and that [the patient] would be unlikely to survive this event.*

*Clinical opinion, renal failure as a secondary event to hepatic failure is common and this was recognised between 29 and 31 August 2017...at this point mortality significantly increase due to the presence of multi organ failure. Abdominal paracentesis<sup>25</sup> is often performed to rule out SPB but I believe this was very difficult due to the amount of oedema<sup>26</sup> that [the patient] had and also his increased body mass index would make the paracentesis potentially more hazardous. Urinary*

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<sup>22</sup> **Abdominal distension** occurs when substances, such as air (gas) or fluid, accumulate in the abdomen causing its expansion. It is typically a symptom of an underlying disease or dysfunction in the body, rather than an illness in its own right.

<sup>23</sup> a disease in which the functioning of the brain is affected by some agent or condition (such as viral infection or toxins in the blood).

<sup>24</sup> In [medicine](#), specifically [gastroenterology](#), the **Child–Pugh score** is used to assess the prognosis of chronic liver disease, mainly [cirrhosis](#)

<sup>25</sup> the perforation of a cavity of the body or of a cyst or similar outgrowth, especially with a hollow needle to remove fluid or gas.

<sup>26</sup> a condition characterized by an excess of watery fluid collecting in the cavities or tissues of the body.



*catherisation would often be performed but it is not clear from the notes whether the patient had refused to have a catheter placed’.*

*‘I felt his fluid balance could potentially have been more accurately recorded and this is often helped by urinary catheterization but again, this would depend on the patient’s compliance with a urinary catheter. I feel it would have been worth a trial of IV fluid bolus<sup>27</sup> to ensure [the patient] was not intra-vascularly deplete<sup>28</sup> and if there was no improvement in urinary output, to instigate terlipressin, albumin and antibiotic treatment. Unfortunately despite this management mortality of patients with both liver and renal failure remains exceptionally high’.*

### **Independent Professional Advice**

27. In relation to the patient’s plan of care upon admission to the LVH, the CG IPA advised *‘the initial care plan was for blood tests, ultrasound imaging of the liver to better assess the fluid/ascites and he was appropriately commenced on intravenous diuretic therapy, drugs that help the kidneys excrete excess fluid, which has been retained as a consequence of the liver failure. Daily weight measurement was also requested which is a helpful way of assessing the response to the diuretic therapy’.* Overall, *the initial plan was appropriate, as the ascites was not tenses, an ascetic drain was not needed and it was acceptable to try diuretic therapy in the first instances, in accordance with British Society of Gastroenterology guidelines on management of ascites. However, a diagnostic ascetic tap to assess for underlying infection in the ascites (SBP) should have been carried out’.*

28. In relation to the patient’s fluid management plan of care, the CG IPA advised *‘[the patient] did have a fluid management plan of care, there was a plan to monitor the weight, the clinical situation and the blood tests to assess the response to diuretics and there was a plan to monitor fluid intake and the total fluid output. On reviewing the input and output charts these where on the whole completed somewhat inconsistently at times as already noted in the [Trusts] response and*

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<sup>27</sup> In medicine, a **bolus** (from Latin **bolus**, ball) is the administration of a discrete amount of medication, drug, or other compound within a specific time, generally within 1 - 30 minutes, in order to raise its concentration in blood to an effective level.

<sup>28</sup> In medicine, intravascular volume status refers to the volume of blood in a patient’s circulatory ... For instance, intravascular volume **depletion** can exist in an adequately hydrated person if there is loss of water into interstitial tissue

*external review. Despite the occasional missing documentation on the fluid charts, this did not have a material impact on the overall care or outcome’.*

29. In response to enquiries made regarding the patient’s kidney function before and during his admission to the LVH, the CG IPA advised ‘*The deterioration in the renal function was a result of worsening liver failure and in part the diuretics (expected side effect as discussed above.) It is also possible that there was underlying infection (such as in the ascites) but this was not tested or treated (empirical treatment with IV antibiotics would normally also be considered and this was not given.) It is clear [the patient] had severe (HRS), which is renal failure as a consequence of liver failure. Treatment should be aimed at addressing the underlying cause (liver failure and exclude infection as well as stopping drugs toxic to the kidneys such as naproxen and diuretics as occurred here.) The use of propranolol (see below) probably also exacerbated the situation by lowering the blood pressure further although its overall impact was probably small. Treatment was correctly started with 2 units IV albumin. However, the dose should be around 1mg/Kg (the patient’s weight was 120kg and therefore the dose given was too small.) Furthermore, the duration of therapy should be 3-5 days and IV terlipressin (a drug that helps improve blood pressure and renal function in HRS) should also be given. This is based on established practice and I also reference BMJ best practice guidelines. I also concur with the conclusions of the external reviewer commissioned by the Trust.....a discussion with the teaching hospital with the hepatology team who had recently treated the patient may have been appropriate.*

30. Overall, the management of HRS was not in accordance with guidelines with some omissions, as discussed above. However, even if partial or full reversal of the kidney failure was achieved through these measures, it is likely that on balance the patient would still have died based on the extreme severity of the liver failure. In this context it would have been inappropriate to escalate to intensive treatment unit (ITU) or offer renal dialysis<sup>29</sup>. The CG IPA also advised ‘*The use of diuretics helped improve the leg oedema. It is likely that the diuretics contributed to the worsening kidney function as did the worsening liver failure. However, the diuretics were*

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<sup>29</sup> **Dialysis** is a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly. It often involves diverting blood to a machine to be cleaned.

*needed and the kidney function was closely monitored and therefore it was appropriately managed and the deterioration is an accepted side effect of appropriate therapy'. The CG IPA further confirmed the patient was entering the end stages of life 'around 2 September 2017 after the deterioration in kidney function that did not respond to the initial IV albumin therapy. The deterioration in kidney function kept getting worse and did not respond to the initial treatment of 2 units of IV albumin, albeit sub-optimally managed as discussed above.*

31. In relation to whether it was appropriate and reasonable to cease monitoring food and drink when the patient was entering the end phases of life, the CG IPA advised *'when the decision that [the patient] was entering the final phase of life, it would be appropriate to decide not to closely monitor the oral intake as closely as before without impacting the expected eventual outcome'.*

32. In response to enquiries made regarding the patient being administered propranolol, the CG IPA advised *'The propranolol was commenced by the medical team (on the basis of advice from the consultant who had performed the gastroscopy which revealed varices, enlarged veins in the gullet due to liver cirrhosis which can bleed) on 30 August 2017 and administered by nursing staff. The propranolol drug is commonly used to reduced the blood flow around the abdominal and liver circulation, hence reducing the size of varices and their risk of bleeding. Propranolol can lower blood pressure as a recognised effect and may in turn worsen kidney function. The dose prescribed was 40mg twice daily, which is a standard starting dose in patients with liver disease and adequate blood pressure'. The CG IPA further advised 'prior to commencing propranolol the blood pressure was being recorded at around 120/80 and therefore it was reasonable to start this. The blood pressure subsequently was lower and he developed the kidney failure. It is unlikely that the kidney failure was directly related to the use of propranolol, nor the significant drop in blood pressure. Both were more likely to have occurred due to an overall deterioration in condition (perhaps induced by sepsis for example.)'*

33. The CG IPA advised *'it was appropriate to have commenced the propranolol but once HRS had been detected and blood pressure dropped then it should have been stopped. The propranolol should have been withheld or stopped altogether following*

*the deterioration of the kidney function and the noting of low blood pressure around 31 August 2017. It was continued for 2 days afterwards with at least 2-3 doses given. Whilst this was not appropriate, it is unlikely to have had a material impact on the overall outcome'.*

34. In response to enquiries made regarding the prescription and administration of midazolam, the CG IPA advised *'yes it appeared to be reasonable. I feel on balance it was appropriate. It is recognised that patients with advanced liver disease can have agitation and complex symptoms that can be distressing. These should be effectively managed even if it requires powerful palliative medications such as midazolam with some potential side-effects'.*

35. In response to enquiries made regarding the patient being administered midazolam, the CG IPA advised *'The midazolam was prescribed by the medical team...the initial prescription on the drug chart was 4 September 2017 and I would therefore assume the decision was made following the review by the Consultant on 4 September 2017. Though the rationale it is not clearly documented, it would appear to have been related to the worsening prognosis and lack of improvement and to help manage any discomfort'.* The CG IPA further advised *'midazolam is a sedative drug that can lead to relaxation (a benzodiazepine, similar to diazepam.) It was prescribed to manage symptoms of agitation and is commonly used for this indication, particularly for patients in the terminal phase of their illness undergoing palliative care. It was prescribed as the patient was agitated and there might have been a miscommunication that it had been prescribed for itch. Based on documentation on 5 September 2017 at 05:30 the patient was 'calling out and agitated' and hence midazolam was administered. Assuming the documentation to be accurate, then this is an acceptable indication'.*

36. In response to enquiries made regarding the patient having a catheter inserted, the CG IPA advised *'strict monitoring of urine output was required. This does not always mandate insertion of a urinary catheter but if there is no improvement in urine output and the renal function then it may become necessary. In this case, a decision*

*was made to effectively withdraw therapy in view of likely futility<sup>30</sup> and therefore a urinary catheter insertion was not essential’.*

37. The CG IPA further advised *‘I cannot see medical documentation regarding this specific issue. There is documentation on 7 September 2017 by nursing staff regarding catheterisation. This appears more due to the problems with incontinence rather than for accurate monitoring (which would have been futile at this advanced stage of the illness.) It appears that it was agreed that a catheter was not necessary and alternative means of managing the incontinence could be deployed. Under the circumstances a catheter was not absolutely required and at any rate it would not have altered the outcome.....insertion of a urinary catheter would not have had a material impact on the overall outcome’.*

38. The CG IPA concluded *‘overall the care was largely appropriate. [The patient] was very ill at the time of admission with severe liver failure. There were some omissions in care as described but on balance the outcome was unlikely to have been different due to severity of the liver failure’.*

39. The Investigating Officer made enquiries with a Nursing IPA in relation to the completion of the patient’s fluid management care. The N IPA advised *‘[The patient] had MUST<sup>31</sup> assessments completed on three occasions during this admission, 22 August 2017, 24 August 2017 and 30 August 2017. [The patient’s] MUST score was recorded as 0 on all three occasions. Nursing assessments were stopped when it was determined that [the patient] was to be treated palliatively’.* The N IPA advised *‘there is no fluid management care plan in [the patient’s] notes. Use of a fluid management care plan is not standard practice...fluid management would typically form part of a care plan addressing nutrition and hydration. There are recommendations in the medical notes for fluid balance monitoring on 25 August 2017 and daily weights would constitute a plan for fluid balance. This was also documented again on 31 August 2017 by the medical staff’.*

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<sup>30</sup> **futility** definition: the fact of having no effect or of achieving nothing

<sup>31</sup> **MUST**<sup>31</sup> 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.

40. The N IPA also advised *'on each shift the individual nurse responsible for [the patient's] care would be responsible for monitoring [the patient's] fluid intake and output and completion of the fluid managements chart. The ward manager would be responsible for ensuring that documentation on the ward was of the required standard....it is not clear from the nursing notes how [the patient's] fluid input and output was measured particularly in terms of urine output. In the absence of a catheter, standard practice would involve the use of urine bottles by the patient in order for urine output to be measured and recorded'*. The N IPA advised *'[The patient's] fluid balance charts have been reviewed from 22 August 2017 to 8 September 2017. A fluid balance chart is in place for each day, however not all charts have been completed accurately. Fluid balance monitoring appears to have been discontinued from 3 September 2017 at the time [the patient's] treatment was determined to be palliative. It is standard practice to discontinue fluid balance recording at this time. A lack of accuracy in fluid balance recording whilst evidence of poor nursing documentation is unlikely to have affected the treatment plan already in place for [the patient]. Further, such inaccuracies would have had no impact on the progression of [the patient's] condition'*. The N IPA further advised *'it is standard practice that monitoring of dietary and fluid intake is ceased when patients enter the terminal phase of their illness, therefore it is appropriate and reasonable for this step to be taken in the case of [the patient]'*.

41. In response to enquiries made regarding the patient having a catheter inserted, the N IPA advised *'there is only one reference in the nursing notes at 02.00 on 7 September 2018 when the family requested a catheter the nurse informed the medical staff but there is no record in the medical notes'*. The N IPA further advised *'it was reasonable'* that the patient did not have a catheter fitted between 22 August 2017 and 8 September 2017 and *'by not having a catheter [the patient] was not at risk of urine infections or discomfort imposed by the insertion of a urinary catheter. Documentation of urinary incontinence was noted on 7 September 2018 up to this point it is documented he was able to pass urine independently. The only impact by not having a catheter would be prevention of changing him following an incontinence episode. There is no clinical indication to insert one for monitoring of his kidney function as he was for palliative care at this point [7 September 2017] and it would be for comfort only. There is no clear documentation around the decision for this'*.

42. The N IPA concluded '*[The patient] clearly had life limiting condition of end stage liver disease and developed kidney failure, both together have very poor prognosis...there are no obvious concerns in the care and management of his condition that would have changed the outcome. Some documentation could have been better*'.

### **The Trust's response to Independent Professional Advice**

43. A copy of the CG IPA and N IPA advice was shared with the Trust. In relation to the accuracy of the fluid balance charts, the Trust stated '*the nursing team recognize and accept that fluid balance charts were not completed accurately on every occasion. The ward managers within Lagan Valley and Down Hospital have developed a training programme for the nursing team, which will ensure guidance on completion of fluid balance charts form part of this training. It is intended that this training will ensure that compliance of completion of fluid balance charts will achieve the high standard we expect*'.

44. The Trust confirmed '*[The patient] did receive two units of albumin as part of his treatment plan. Although the IPA recognizes that this was correct treatment it considers this treatment to be sub-optimal and recommended treatment to extend over 3-5 days. Unfortunately [the patient's] poor venous access would not have supported a treatment plan of this nature and it was considered by the medical team that insertion of a central line in a patient entering the palliative phase of his life to be inappropriate. The medical team did not document their thought process in relation to this treatment and accept that had they done so, greater clarity may have been provided*'.

45. In response to the CG IPA's comments regarding a discussion with the liver centre, the Trust stated '*The Liver Unit in the RVH had discharged [the patient] from their care on 17 August 2017 when his bilirubin had gone from 158 to 251 over the previous four days. They were aware of this worsening and declining picture. The medical team therefore did not feel, rightly or wrongly, that there was anything to be gained in contacting them again*'.

46. In response to the CG IPA's comments regarding referral to palliative care, the Trust stated *'the medical team discussed the deterioration in his condition and the likelihood of his imminent death with [the patient's] family. Unfortunately as a family, they were not receptive to this information. As [the patient's] symptom management was well controlled, the team did not see the need for input from the palliative team. However, they recognize that perhaps their early involvement may have been a support measure for [the patient's] family and may have aided in their acceptance of his deteriorating condition'*.

47. After consideration of the comments from the Trust and the CG IPA, the Investigating Officer sought additional advice from the CG IPA.

48. In response to investigation enquiries regarding the level of odema the patient had, the CG IPA advised *'There is clear evidence that [the patient] was oedematous<sup>32</sup> in his legs based on the clinical records. This would be consistent with his known history of advanced decompensated liver cirrhosis. There is no clear mention of abdominal wall oedema as most of the documented findings related to peripheral oedema. However, peripheral oedema can often track up to the upper legs and then into the abdomen. Nonetheless, the presence of abdominal wall oedema should not contraindicate an attempt at diagnostic paracentesis'*.

49. In regards to whether the patient had an infection present, the CG IPA also stated *'The CRP was mildly raised at 9-11 and the WCC was in normal range. However, the mere fact that [the patient] presented with significantly worsening jaundice and then later renal function could indicate underlying infection such as SBP. It is recognised that patients with advanced liver disease do not have a normal or typical rise in inflammatory markers and the usual signs of infection may be suppressed. Hence, there needs to be a low index of suspicion and a proactive attempt to diagnose or exclude SBP. This is a clear part of the BASL decompensated liver disease bundle'*.

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<sup>32</sup> The definition of **oedematous** in the dictionary is characterized by an excessive accumulation of serous fluid in the intercellular spaces of tissue.



50. In regards to the Trust's decision to not perform an abdominal paracentesis the CG IPA advised *'An ascitic tap to diagnose or exclude infection in the ascites is a critical step in the diagnosis and management as per the accepted guidelines. This again is a clear part of the BASL decompensated liver disease bundle. Whilst having abdominal wall oedema can make obtaining an ascitic sample difficult it is not a contraindication or a reason to not attempt the procedure. Furthermore, in difficult cases ultrasound guidance may also be helpful in obtaining a sample. Therefore, I do not feel it reasonable for the trust to have not at least attempted a diagnostic paracentesis'*.

51. The CG IPA further advised *'Infection was not definitively excluded and I cannot see that antibiotics were started empirically either. Patients with advanced liver disease are very prone to infections (mentioned as a clear cause for decompensation and deterioration in the liver bundle) that may benefit from antibiotic treatment. Based on the severity of the presenting illness, it would seem that this omission was unlikely to have altered the outcome..... the failure to exclude or empirically treat infection was an omission in care. As per all the guidelines on managing liver disease, there needs to be a low index of suspicion for an infection as a precipitating cause for acute deterioration, particularly in the absence of alternative causes. However, the guidelines do not state that empirical antibiotics should be prescribed in all cases, assuming infection has been confidently excluded. The omission in care was therefore in the exclusion of infection rather than the commencement of antibiotics'*.

52. The Investigating Officer made further enquiries with the CG IPA in regards to the Trust's response regarding the use of IV teripressin/albumin and the patient's poor venous access. The CG IPA advised *'Yes this was noted by the referring GP stating that venous access 'terrible.' [The patient] used to inject drugs intravenously and often in such cases IV access can be very challenging indeed. It was further noted in the medical notes that there was 'very poor IV access.'* Furthermore, there were difficulties in obtaining blood samples. Insertion of a picc line<sup>33</sup> can mitigate

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<sup>33</sup> A **PICC line** is a thin, soft, long catheter (tube) that is inserted into a vein in your child's arm, leg or neck. The tip of the catheter is positioned in a large vein that carries blood into the heart. The **PICC line** is used for long-term intravenous (IV) antibiotics, nutrition or medications, and for blood draws.

*such difficulties by allowing a long-term access into a deep vein. This can be used to administer drugs and obtain the required blood samples’.*

53. The CG IPA also advised *‘If the patient was for active treatment then the appropriate duration and treatment regimen should have been administered. If the condition was felt irreversible then I think cleared documentation of the thought process should be made to justify the decision to not start therapy or to withdraw treatment early. It appears unusual to decide to start on a treatment regimen and then discontinue after a single dose without allowing for an adequate duration to assess the impact. The documentation was clear on 4 September 2017 where limitation on active treatment was placed but less certain prior to that. If there was a plan for active ward based management then it should have included therapy for hepatorenal syndrome with terlipressin and albumin’.*

54. In regards to the impact of the patient not having received IV terlipressin, the CG IPA advised *‘Again in the view of the severity of the illness, it would seem that, on the balance of probabilities, the impact would have been relatively limited as I do not feel the outcome would have been different. However, as discussed above, I feel an attempt at delivering the appropriate treatment for around three days would have been appropriate in the context of the fact that the patient had been previously relatively stable, accepting the caveat of a low likelihood of response. As identified by the trust the overall thought process was not optimally documented to help clearly support the decision making process. Having said that after the initial dose of albumin the thought process and documentation was clearer on 4 September 2017’.*

55. In response to the Trust’s comments regarding a discussion with the liver centre, the CG IPA advised *‘This was a suggestion to consider discussion with the transplant centre. I acknowledge it would not have made any difference but the patient was only recently under their care and there may have been some benefit in the discussion including additional information on any recent infections, the probability of ever getting a transplant (accepting this to be extremely low) and also common courtesy to the hospital where he had recently been in and only recently discharged’.*

56. The CG IPA concluded '*Managing advanced decompensated liver disease can be extremely challenging due to a variety of different reasons, as proven in this case. Following established guidelines can help offer improved standardised care. It may not always be appropriate to offer active treatment if felt to be futile but this needs to be clearly documented and communicated*'.

57. In response to the additional CG IPA sought, the Trust reiterated '*[the patient] had an ultra sound scan carried out in the RVH one week prior to his admission to the LVH showing a small amount of ascites, which would not have been amenable to tapping. The reason not to tap was based on this knowledge and not on the potential difficulty that abdominal wall oedema may have been present.....given [the patient's] established poor prognosis, the medical team did not believe that the insertion of a PICC line to be appropriate*'. The Trust also confirmed '*the medical team concur with the findings of the IPA in that on the balance of probabilities the impact of albumin therapy would have been relatively limited. They had commenced this treatment and then withdrew it, based on their opinion that it had shown no added benefit to that point*'.

58. The Trust concluded '*As a team the medical and nursing staff responsible for [the patient's] care are of the opinion that they did try to communicate and engage with the patient's family, however despite their best efforts, the family remained unreceptive to information they were given*'.

The Complainant's response to the draft report

59. The complainant provided a response to the draft report. The complainant stated she disagrees that her husband was agitated on 5 September 2017. The complainant stated that '*she hopes no other family has to endure the pain and sorrow*' that they as a family have endured.

The Trust's response to the draft report

60. Upon receipt of the draft report the Trust stated '*they have shared the draft report with the named persons and they have no further comments to make on the draft report, other than what has been previously submitted to this office*'.

## Analysis and Findings

### *Fluid Management*

61. The complainant said that her husband's fluid management was inadequate between 22 August 2017 and 8 September 2017. I established the patient had a fluid balance chart commenced on 22 August 2017. I further established that on 22 August 2017, 24 August 2017, 27 August 2017 and 31 August 2017, the patient's medical team requested strict monitoring of his fluid input and output. The Trust state the fluid management plan for the patient included recording his fluid input and output on a fluid balance chart and taking daily weights. Upon examination of the patient's clinical notes I established the Trust recorded approximately 13 fluid input levels and 10 output levels and nine weights between 22 August 2017 and 7 September 2017. I was not provided with any evidence that the patient's fluid output was recorded on the 29 August 2017, 2 September 2017 and 3 September 2017. I have not been presented with any evidence that the patient's weight was recorded on 22 August 2017 and between 1 September 2017 and 7 September 2017. However, I note the Trust recorded on the 2 September 2017 and 3 September 2017 the patient had '*passed urine in the toilet*'. I further established the Trust did not record fluid input or output levels between 4 September 2017 and 7 September 2017. I note the Trust stated fluids had been recorded by the nursing team, however they recognised that the fluid balance chart had not always been completed. I also note the Trust stated that drinks brought in by the family had not been accounted for in establishing his input and output levels and therefore not always recorded.

62. I considered and I accept the advice of the CG IPA that '*[The patient] did have a fluid management plan of care, there was a plan to monitor weight, the clinical situation, blood tests and monitor input and output of fluids....the input and output charts were on the whole completed, somewhat inconsistently at times... this did not have a material impact on the overall care or outcome*'.

63. I also considered the N IPA advice that '*...use of a fluid management care plan is not standard practice....recommendations in the medical notes for fluid balance monitoring and daily weights would constitute a plan for fluid balance*'. I note and I

accept the N IPA advice that *'a fluid balance chart is in place for each day although they are not all completed accurately'*. I established the independent review report also reported concerns regarding the recording on fluid charts, in particular that *'I felt his fluid balance could potentially have been more accurately recorded'*. I note the N IPA highlighted the patient's fluid monitoring was discontinued from 3 September 2017 at a time when his condition deteriorated and he was deemed to be in palliative care. I further considered and I accept the N IPA advice that *'it is standard practice to discontinue fluid balance recording at this time'*. I would highlight the N IPA advised *'documentation of fluid balance needs to be addressed for accuracy'* as a learning improvement. I welcome the Trust's acceptance that fluid balance charts were not completed accurately on every occasion and that they have developed a training programme for the nursing team which will ensure guidance on completion of fluid balance charts. The NMC code states *'keep clear and accurate records relevant to your practice, complete records at the time or as soon as possible after an event, recording if the notes are written some time after event'*.

64. The evidence indicates the patient was very ill during his admission to the LVH between the 22 August 2017 and 8 September 2017. I accept the Trust's assertion that fluid charts were commenced and I accept the N IPA advice that *'fluid intake is ceased when patients enter the terminal phase of life'*. Therefore, I consider it reasonable the Trust did not record the patient's fluid input and output levels between the 3 September 2017 and 7 September 2017 as the patient was receiving palliative care at this stage of his admission to the LVH. Nevertheless, I consider the patient's medical team had requested there was to be strict monitoring of his fluid input and output, therefore I consider the absence of fully completed records between 22 August 2017 and 2 September 2017 to be a failure by nursing staff involved in the patient's care. Therefore, I uphold this element of the complaint. I have also considered and I accept the N IPA advice that *'a lack of accuracy in fluid balance recording whilst evidence of poor nursing documentation is unlikely to have affected the treatment plan'*. This was a view supported by the CG IPA who advised *'this did not have a material impact on the overall care or outcome'*. Therefore, I do not consider the patient to have suffered an injustice as a result of this failing.

65. I note the Trust's acceptance of the CG IPA and N IPA's advice that the fluid balance records were not always fully completed. With that in mind, I would remind the Trust of the importance of ensuring that all fluid records are completed appropriately. I also wish to highlight that during the course of this investigation, the Trust did not provide the investigating officer with any policies and/or procedures in regards to its fluid management processes and procedures. The Trust stated '*there is a clinical nutrition and sub-committee who oversee the implementation of the [DHSSPS] regional promoting good nutrition strategy*'. However, I am of the view that it would be of assistance to the Trust's clinical and nursing staff if the Trust developed its own fluid balance record keeping policy reflective of recommended clinical guidance and best practice.

66. I note the BASL decompensated cirrhosis guidelines state '*a checklist for all patients admitted with decompensated cirrhosis should be completed within the first 6 hours of admissions...*' I have not been presented with any evidence that the patient had a BASL decompensated cirrhosis (care bundle) checklist completed between the 22 August 2017 and 8 September 2017. I would draw to the Trust's attention the CG IPA's recommendation for a learning improvement that '*consideration should be given to introducing the BASL liver bundle...*'.

67. In relation to ascites, the CG IPA has identified that a diagnostic paracentesis was not attempted by the Trust. The CG IPA emphasised '*an ascitic tap to diagnose or exclude infection in the ascites is a critical step in the diagnosis and management*' of decompensated liver disease. I also note the EASL guidelines state '*a diagnostic paracentesis with an appropriate ascitic fluid analysis is essential in all patients prior to any therapy to exclude causes of ascites other than cirrhosis and rule out SBP*'. This was also a view highlighted by the independent review officer that "*an abdominal paracentesis could have been performed to rule out SBP*".

68. The CG IPA also advised that '*patients with advanced liver disease are very prone to infections*' and '*empirical treatment with IV antibiotics would normally also be considered and this was not given*'. Therefore, I consider careful assessment for infection is important as is prompt treatment with antibiotics. I note the CG IPA advised '*the guidelines do not state that empirical antibiotics should be prescribed in*

*all cases, assuming infection has been confidently excluded*'. I have considered carefully the CG IPA advice that *'the omission in care was therefore in the exclusion of infection rather than the commencement of antibiotics'*. It is my view that by not performing a diagnostic ascitic tap to assess if the patient had an underlying infection, the Trust could not confidently exclude a diagnosis of SBP or any other type of infection.

69. Furthermore, I consider that by not establishing if the patient had an infection, the potential for considering different treatment options was missed. Therefore, I consider the absence of performing a diagnostic ascetic tap to be a failure by the Trust in the patient's care and treatment and not in accordance with published guidelines. However, I note and I accept the CG IPA advice that *'based on the severity of the presenting illness, it would seem that this omission was unlikely to have altered the outcome'*. I consider the failure to perform a diagnostic ascetic tap to have caused the patient the injustice of loss of opportunity in not having his condition adequately assessed to establish if he had an infection and then treated accordingly. I also consider this failure in care and treatment caused the complainant and her family the injustice of uncertainty over the appropriateness of the care and treatment received by the patient.

70. With reference to the use of albumin in the patient's care and treatment, the Trust confirmed the patient received two units of albumin, commenced on 31 August 2017 which I note the CG IPA advised had been correctly commenced. However, I note the CG IPA advised *'the dose should be around 1mg/kg and [the patient's] weight had been 120kg and therefore the dose was too small and that delivering the appropriate treatment for around three days would have been appropriate in the context of the fact that the patient had been previously relatively stable'*. While I accept treating the patient with albumin was an appropriate course of care and treatment, I consider the dose administered to the patient was incorrect and I find this to be a failure in his care and treatment. I have also considered and I accept the CG IPA advice that *'the duration of therapy should be 3-5 days and 'IV terlipressin (a drug that helps improve blood pressure and renal function in HRS) should also be given'*. I consider the patient's albumin treatment could have been extended to between the 2 September 2017 and 4 September 2017. I consider that by not

extending his treatment of albumin by 3-5 days and administering the patient with IV terlipressin to represent failures in the care and treatment provided to the patient. I consider these failures in care and treatment to have caused him the injustice of frustration and uncertainty in having his condition adequately treated.

71. I note the Trust recognise the CG IPA comments that the patient's treatment in regards to the administration of IV terlipressin/albumin to *"have been sub-optimal"*. I also note the CG IPA highlighted the Trust had recorded clearly on 4 September 2017 *'where limitation on active treatment was placed'*, however, the CG IPA has highlighted that the Trust's documentation on its decision making process regarding this issue prior to the 4 September 2017, had not been *'optimally documented'*. I have considered and I agree with the CG IPA advice that *'it appears unusual to decide to start on a treatment regimen and then discontinue after a single dose without allowing for an adequate duration to assess the impact'*. If the patient's clinical team had decided prior to the 4 September 2017 that there would be no administering of IV terlipressin and limited treatment of albumin then I would have expected to see a record within the clinical records explaining the thought process behind withdrawing treatment.

72. I further established during the investigation that the Trust stated *'[The patient] had poor venous access and it was considered by the medical team that insertion of a central line<sup>34</sup> in a patient entering the palliative phase of his life to have been inappropriate'*. However, I have considered and I accept the CG IPA advice that while the patient had poor venous access *'the insertion of a central line can mitigate such difficulties by allowing a long term access into a deep vein...this can be used to administer drugs and obtain the required blood samples'*.

73. Having considered the CG IPA advice, I note the treatment of 3-5 days of albumin and IV terlipressin is unlikely to have affected the outcome. I welcome the Trust's acknowledgement the medical team did not document their *'thought process in relation to this treatment and had they done so greater clarity would have been sought'*

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<sup>34</sup> **A central line** is a long, thin hollow tube. It is inserted into a vein in your chest to give chemotherapy and other drugs. ... **The central line** is put in (tunnelled) under the skin of the chest and into a vein close by.



#### *Administration of Propranolol*

74. The complainant said that her husband was being administered propranolol which should not have occurred due to his low blood pressure. The Trust state the patient was commenced on propranolol on 30 August 2017, on the basis that he had a gastroscopy performed which had '*revealed oesophageal varices*'. The Trust further confirmed that after the patient had been administered his third dosage, it was noted that his blood pressure was falling and therefore the fourth dose of propranolol was omitted until a medical review took place. I established the Trust administered the patient with a further three dosages of propranolol before it was stopped by his medical team. I note the Trust stated '*the low dose of propranolol used would not have had an impact on his condition*'.

75. I considered the CG IPA advice that '*propranolol is commonly used to reduce the blood flow around the abdominal and liver circulation, reducing varices...it can lower blood pressure...and the dose prescribed (40mg) twice daily is a standard starting dose.....it was appropriate to commence the propranolol but once HRS had been detected and blood pressure dropped it should have been withheld/stopped...it was continued for a further two days with at least two/three doses given...whilst this was not appropriate, it is unlikely to have had a material impact on the overall outcome*'.

In accepting the CG IPA advice, I consider the failure to withhold or stop administering propranolol once it was established he had HRS to have been a failure in the care and treatment provided to the patient. Therefore, I uphold this element of the complaint. However, I do not consider the patient suffered any injustice in regards to this failure as the CG IPA concluded that '*it was unlikely to have had a material impact on overall outcome*'.

#### *Administration of Midazolam*

76. The complainant said that her husband was wrongly administered midazolam on 5 September 2017. The Trust stated the patient was prescribed and administered midazolam on 5 September 2017 as he had been showing signs of agitation, in particular '*calling out and agitated*'. The Trust further stated his medical record had indicated he had been administered midazolam for an itch, however the Trust confirmed this had been a miscommunication and misunderstanding by his doctor for

*'the indication of the prescribed medication'*. I note the complainant does not agree that her husband had been agitated on the 5 September 2017.

77. I considered and I accept the advice of the CG IPA *'midazolam was prescribed to manage symptoms of agitation and is commonly used for this indication, particularly for patients in the terminal phase of their illness undergoing palliative care... there might have been a miscommunication that it had been prescribed for itch ....on balance it was appropriate'*. I consider the miscommunication by the patient's doctor to his family that he had been prescribed and administered midazolam for an itch, led to the confusion and concern regarding an error in the administering of midazolam. As outlined above I note the complainant does not agree that her husband was agitated and that she has indicated that she was with the patient. However on the basis of the contemporaneous records and the advice of the IPA I consider that the decision by the nursing team to administer midazolam was for agitation and not an itch and the administration was appropriate. Therefore I do not uphold this element of the complaint.

#### *Insertion of a catheter*

78. I note the complainant asked her husband's medical team if he could have a catheter inserted on 7 September 2017. The Trust stated the patient did not have a catheter inserted during his time in the LVH as he had *'been able to mobilise to the toilet and it was only in the final few days of his illness that he had been unable to get out of bed...[The patient] was agitated and un-cooperative at times...it was felt he would not have tolerated a catheter'*. The investigating established that the patient had been independent with activities of daily living, including independently going to the toilet up until 6 September 2017. Furthermore, I established a skin bundle chart was commenced by nursing staff for the patient on 7 September 2017 which included the introduction of incontinence pads. I note the patient had his incontinence pad changed approximately nine times between 7 September 2017 and 8 September 2017 before he sadly passed away.

79. I considered and I accept the CG IPA advice that *'a decision was made to effectively withdraw therapy in view of likely futility and therefore a urinary catheter insertion was not essential....insertion of a urinary catheter would not have had a*

*material impact on the overall outcome*'. I also considered and I accept the N IPA advice that *'documentation of urinary incontinence was noted on 7 September 2018 as up until this point he had been able to pass urine independently...there is no clinical indication to insert one for monitoring of his kidney function as he was for palliative care at this point and it would be for comfort only*'. I note the N IPA advised that there was *'no clear documentation*' around the decision taken to not provide the patient with a catheter. With that in mind, I would remind the Trust of the importance of ensuring the reasons for decision making are appropriately recorded on clinical notes.

80. The investigation established the patient had been mobilising and was independent with activities of daily living between 22 August 2017 and 6 September 2017. The use of a urinary catheter was not essential in monitoring the patient's fluid balance as there were other techniques which can be used. I accept the advice of the CG IPA that the decision taken to withdraw [fluid] therapy *'in view of likely futility.....therefore a urinary catheter insertion was not essential*'. I further established the patient's condition deteriorated between 6 September 2017 and 8 September 2017 and he was unable to mobilise to the toilet himself. While the patient's family requested the insertion of a catheter on 7 September 2017, I consider the patient was being treated palliatively at this stage and unfortunately his care was comfort only and there was no clinical reason to provide the patient with a catheter. Therefore, in accepting the CG IPA and N IPA advice, I consider the patient did not require a catheter during his admission to the LVH. I further consider the decision taken by his medical team to not fit him with a catheter when requested to do so by the complainant to have been appropriate and reasonable. Therefore, I do not uphold this element of the complaint.

#### *Discussion with the Liver Centre*

81. The investigation also established the CG IPA identified *'consideration for discussion of such complex cases with the liver centre where the patient had recently been admitted*' as a learning outcome. This was a view supported by the independent review report. I note the Trust clarified that the medical staff had been aware of the patient's treatment by the liver specialist team in the RVH. Given he

was entering the palliative phase of his life, the Trust did not consider a referral to a specialist unit would have benefited the patient. On the balance of probabilities, I consider contacting the patient's medical team in the liver centre would not have changed or made a difference to the outcome as he was entering the palliative phase of his life. However, I agree with the CG IPA that *'there may have been some benefit in the discussion'*, where potentially any additional information in regards to recent infections could have been passed to his current medical team. I note the CG IPA has highlighted this learning outcome as a *'mere suggestion which can be done on a case by case basis'*.

### *Referral to Palliative Care*

82. I also note the CG IPA identified *'referral to palliative care when it was recognised that [the patient] was approaching the end of life as this would have offered better support for managing the patient's symptoms and also for the family'* as a learning/service improvement. This was also a learning outcome highlighted by the N IPA *'if palliative care teams were involved, they may have assisted in some of the communication with family members'*. I welcome the Trust's acceptance of this learning outcome and its *'recognition that early involvement may have been a support measure for [the patient's] family and may have aided their acceptance of his deteriorating condition'*.

## **CONCLUSION**

81. The complainant submitted a complaint to me about the actions of the South Eastern Health and Social Care Trust.

82. The investigation of the complaint did not find a failing in the administration of midazolam. The decision taken to administer midazolam was appropriate and reasonable. In addition, the investigation did not find a failure in the Trust's decision to not provide the patient with a catheter.

83. However, the investigation of the complaint found a failure in the patient's care and treatment in relation to the following matters:

- i. Failure to adequately complete fluid balance charts
- ii. Failure to perform a diagnostic ascetic tap
- iii. Failure to administer the correct dose of albumin and continue the treatment for the recommended period
- iv. Failure to administer IV terlipressin
- v. Failure to withhold/stop the administration of Propranolol when The patient developed HRS

I am satisfied that the failures in care and treatment I identified caused the patient to experience the injustice of loss of opportunity, frustration and uncertainty in not having his condition adequately assessed and treated. I am also satisfied these failings to have caused the complainant and her family the injustice of frustration and uncertainty over the appropriateness of the patient's care and treatment.

## **Recommendations**

I recommend:

- i. In accordance with NIPSO guidance on issuing an apology, provide a written apology to the complainant for the injustice identified in this report. The Trust should provide the apology to the complainant within one month of the date of my final report.
- ii. In acknowledging the steps already taken by the Trust in developing a training programme on the completion of fluid balance charts, I recommend the Trust bring the failure identified in this report regarding the completion of fluid balance charts to the attention of the relevant nursing staff within three months of the date of my final report.
- iii. The Trust share the outcome of this investigation with relevant medical staff highlighting the learning outcomes identified in regard to the use of IV terlipressin/albumin, discussion with the liver centre and referral for palliative care, within three months of the date of my final report.
- iv. In order to highlight the importance of accurate and complete recording of fluid balance, the Trust develop and implement a Fluid Balance Record Keeping Policy within six months of the date of my final report.

I am pleased to note the South Eastern Health and Social Care Trust accepted my findings and recommendations.

A handwritten signature in black ink, appearing to read 'Paul McFadden', written over a horizontal line.

**PAUL MCFADDEN**  
Acting Ombudsman

**12 March 2020**

# Appendices

## 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.