Investigation finds failures over care of man in hospital Emergency Department

A Health Trust has apologised for the care and treatment given to a patient in the Emergency Department of the Royal Victoria Hospital, Belfast.

The patient was taken to hospital by ambulance, suffering from breathing difficulties. Whilst in the Emergency Department his condition deteriorated, and he sadly passed away two weeks later as a result of heart failure.

The hospital's own investigation found that there were delays in the treatment provided to the man in the Emergency Department and failures in aspects of his care, but concluded that it was difficult to state definitively whether earlier treatment would have prevented his death. The man's son disputed the report's conclusion and believed that the Trust did not take responsibility for his father's death.

The Ombudsman's investigation examined the man's medical records and documents relating to the Trust's Serious Adverse Incident Investigation (SAI). It also obtained independent professional advice on aspects of the patient's care in the Emergency Department.

The Ombudsman found that he waited a total of 41 minutes to be triaged upon arrival. He then waited 3 hours 25 minutes before he was seen by a clinician. Both these waits comfortably exceeded the hospital's own targets of 15 minutes and 60 minutes respectively.

Enquiries also revealed that the patient waited longer than other patients of the same triage 'category' who arrived after him. This was because that evening the queue for patients who had arrived by ambulance was moving more slowly than the queue for 'walk-ins'.

After receiving specialist advice on the issue, the Ombudsman found that the man was incorrectly triaged by staff in the Emergency Department. He was assessed as being a Category 3 patient, whereas a Category 2 would have been more appropriate. This was a significant failure as it added to the delay in him receiving the necessary care.

A number of failures were also found with the Trust's SAI investigation into the incident. The Ombudsman found that the Trust did not inform the patient's family that the SAI had begun, did not appoint an independent chair, and failed to keep proper records during the investigation. She was also critical that it did not look at the issue of the patient's triage category and the potential implications of this on his subsequent care and treatment.

Because the SAI was not completed according to the Trust's own policies and procedures, the Ombudsman concluded that the patient's son had experienced unnecessary uncertainty and frustration.

However, she agreed with the conclusion of the SAI report which stated it was not possible to say if earlier treatment would have prevented the man's deterioration and eventual death.

In accepting the Ombudsman's report and issuing the apology, the Trust acknowledged the failures in the case. However, it also provided information on recent work undertaken within the Trust to improve the SAI process.

The full investigation report can be viewed here.