Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against

Belfast Health and Social Care Trust

NIPSO Reference: 22898

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Case Reference: 22898

Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the Belfast Health and Social Care Trust's (the Trust) care and treatment of the complainant in May and June 2019. The complainant attended the Royal Jubilee Maternity Service (RJMS) after experiencing pre-labour spontaneous rupture of the membranes[1] (SRM). She was concerned that RJMS staff asked her to return home providing her only with temperature sticks. The complainant was also concerned that when she telephoned the RJMS later that day to report feeling unwell, staff told her to remain home as it was '*busy*'. She raised further concerns that when she arrived at RJMS, a midwife felt her cheek and told her she did not have a high temperature, and that she would phone the ward to check if it had space for her.

The investigation established that staff's treatment of the complainant, and the decision to send her home following SRM, was appropriate. However, it found staff failed to inform the complainant of her increased risk of infection. The investigation also established that staff failed to retain a record of the complainant's telephone call made later that day. It found that during the call, staff failed to undertake an appropriate assessment and failed to instruct the complainant to attend admissions for immediate assessment. I considered this a failure in her care and treatment. The investigation was unable to conclude if a midwife felt the complainant's cheek to gauge her temperature. It also could not determine how long the patient waited for treatment, and if the midwife told the complainant she would need to check if the ward had space for her.

The complainant was also concerned about the decision to discharge her (as an inpatient), and the care and treatment provided to her when she returned later that evening. The investigation found the decision to discharge appropriate. However, it found that medical staff failed to document a final assessment and plan for discharge. I considered this a failure in care and treatment. The investigation found the care and treatment provided to the complainant when she returned to RJMS later

[1] Often referred to as the expectant mother's waters breaking before labour begins.

on 3 June 2019 (after her discharge) appropriate.

I was satisfied the complainant experienced frustration, uncertainty, and the loss of opportunity to receive earlier treatment for her infection. I was also satisfied the complainant experienced a loss of opportunity for staff to consider full and accurate records when deciding on her future care and treatment. I recommended that the Trust apologise to the complainant for the failures identified. I also recommended training for relevant staff to complete to prevent the failures from recurring.

THE COMPLAINT

1. I received a complaint about Belfast Health and Social Care Trust's (the Trust) care and treatment of the complainant in May 2019 during the late stages of her pregnancy. The complainant also raised concerns about the Trust's decision to discharge her as an inpatient from the Royal Jubilee Maternity Service (RJMS) in June 2019. She raised further concerns about the Trust's care and treatment of her when she returned to the RJMS after she was discharged.

Background

2. The complainant attended the RJMS in the early hours of 31 May 2019 with a suspected pre-labour spontaneous rupture of membranes[2] (at term + 4 days). Staff examined her and asked her to return at 22:00 that evening for induction of labour. The complainant said she developed a temperature and started to shake while at home. She explained she telephoned admissions and reported her symptoms. However, she was told to remain at home and return at her scheduled time as '*they were busy'*.

3. The complainant arrived at the RJMS that evening. She said she informed admissions of her symptoms. However, a midwife touched her cheek, told her she did not have a temperature, and said she would contact the ward '*to see if they had space'*. The complainant arrived on the ward at 22:05 and staff transferred her to the delivery suite at 23:15. Staff initiated the Sepsis 6 protocol[3] at 00:00 on 1 June 2019. She delivered her daughter at 07:25 on 1 June 2019.

4. RJMS staff discharged the complainant as an inpatient on 3 June 2019. The complainant said she continued to feel unwell at home and self-reported to RJMS admissions later that evening. She said staff did not provide her with any further treatment. She explained that a period of weeks later, she attended the emergency department of a different hospital. The complainant said staff prescribed her a third set of antibiotics to treat her illness. I established this

[2] Often referred to as the expectant mother's waters breaking before labour begins.
[3] The protocol consists of three diagnostic and three therapeutic steps to be delivered within one hour of the initial diagnosis.

occurred in September 2019. The complainant said her experience made her feel '*traumatised*' and she has '*lost faith'* in the service.

Issues of complaint

5. The issues of complaint accepted for investigation were:

Issue 1: Whether the care and treatment the Royal Jubilee Maternity Service provided to the complainant on 31 May 2019, prior to the induction of her labour, was in accordance with good medical practice.

Issue 2: Whether the decision to discharge the complainant from the Royal Jubilee Maternity Service on 3 June 2019 was reasonable and in accordance with relevant guidance.

Issue 3: Whether the care and treatment provided to the complainant upon her return to the Royal Jubilee Maternity Service on 3 June 2019 was in accordance with good medical practice.

INVESTIGATION METHODOLOGY

6. 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. This documentation included information regarding how the Trust handled the complaint.

Independent Professional Advice Sought

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

- A Consultant Obstetrician PhD MRCOG; with subspecialist accreditation in Fetal and Maternal Medicine (O IPA); and
- A practising midwife RM RN BSc (Hons) PgCert MA; with over 20 years' experience (MW IPA).

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

8. The information and advice that informed my findings and conclusions are included within the body of my report and its appendices. The IPA provided me with 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

9. 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. I also make reference to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[4]:

- The Principles of Good Administration
- The Principles of Good Complaint Handling

10. 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:

- The General Medical Council's (GMC) Good Medical Practice, updated April 2019 (GMC Guidance);
- The Nursing and Midwifery Council's (NMC) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, updated October 2018 (the NMC Code);
- The National Institute for Health and Care Excellence's (NICE) Intrapartum care for healthy women and babies, Clinical Guideline 190, updated February 2017 (NICE CG190);
- The National Institute for Health and Care Excellence's (NICE) Inducing labour, Clinical Guideline 70, July 2008 (NICE CG70);

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

- The Belfast Health and Social Care Trust's Induction of Labour Guideline, March 2018 (the Trust's IOL Guideline); and
- The Belfast Health and Social Care Trust's Guideline for the Initial Management of Bacterial Sepsis during Pregnancy and the Puerperium (the Trust's Sepsis in Pregnancy Guideline).

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

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

INVESTIGATION

Issue 1: Whether the care and treatment the Royal Jubilee Maternity Service provided to the complainant on 31 May 2019, prior to the induction of her labour, was in accordance with good medical practice.

Detail of Complaint

13. This issue of complaint is about the care and treatment staff in the RJMS provided to the complainant prior to the induction of her labour. The complainant said she attended RJMS in the early hours of 31 May 2019 after experiencing a spontaneous rupture of the membranes (SRM). She explained a midwife provided her with temperature sticks and sent her home. The midwife asked her to return at 22:00 for induction. The complainant said she was unsure why the midwife provided her with temperature sticks. She also said the midwife did not tell her how to use them.

14. The complainant said she started to feel unwell at home. She explained she used the sticks to take her temperature. However, she believed they were faulty as she was getting low readings. The complainant said she contacted RJMS admissions and explained she felt '*fluish*', and was getting low readings from the sticks. She said the midwife told her she was not using the sticks correctly.

She also said she was told to only come into hospital at the designated time as they were '*busy*'. The complainant said she arrived at hospital before the arranged time as she continued to feel unwell. She said when she arrived at the hospital, a staff member felt her cheek and told her she did not have a temperature. She also said the staff member told her she would contact the ward to *'see if they had space'* for her.

Evidence Considered

Legislation/Policies/Guidance

15. I referred to the following policies and guidance, which were considered as part of investigation enquiries:

    - The NMC Code;
    - NICE CG190;
    - NICE CG70; and
    - The Trust's IOL Guideline.

    Relevant extracts of the guidance considered is enclosed at Appendix three to this report.

The Trust's response to investigation enquiries

16. The Trust explained the complainant was assessed in the early hours of 31 May 2019. It said the observations taken totalled zero on the Maternal Obstetric Early Warning Score[5] (MOEWS), *'which indicated there was no deviation from normal limits'*. It said it discharged the complainant at 05:05 '*with advice in relation to monitoring her temperature and advised to contact the department if she had any concerns'*.

17. The Trust explained it did not have records of the complainant's telephone communication with RJMS admissions department, or a record of the advice given. The Trust also explained it has a '*telephone triage book that records conversation summaries, but unfortunately, on this occasion we have not been able to provide this evidence'*. In relation to learning, the Trust said '*staff have*

[5] Designed to allow early recognition of deterioration in pregnant women by monitoring their physiological parameters.

been reminded to ensure that all conversations are recorded and that the telephone triage books are stored in accordance with Trust data storage policy'. In relation to what process staff ought to take when an expectant mother contacts admissions to express concern, it explained, '*the expectant mother should be advised to attend the Admissions department for assessment'*.

18. The Trust explained it informed staff during a safety brief on 17 June 2019 that '*low temperature can be a sign of sepsis'.* It said in the event a woman raises concerns with self-monitoring of her temperature, it is '*normal practice for staff to repeat the guidance on use and ask that they call back to Admissions with the repeat result'.* The Trust said it is *'sorry that on this occasion this was not the case…[and] we are sorry if [the complainant] felt unwelcome. Women are never discouraged from attending if there is a concern'*.

19. The Trust explained it did not have a record of which staff member attended to the complainant when she arrived at RJMS on the evening of 31 May 2019. It said that *'feeling of the forehead is not a recognised clinical method of assessing a mother's temperature'.* It also said the complainant *'was not assessed in the Admissions department and there is no record of this interaction'*. The Trust explained the complainant was taken to the ward for immediate assessment at 22:05 on 31 May 2019. It said her temperature '*was above normal limits at 38.5°C and an obstetrician was therefore called'*.

Relevant records

20. A summary of the relevant records is enclosed at Appendix four to this report.

Relevant Independent Professional Advice

Attendance at RJMS following SRM

21. I obtained independent professional advice from a practising midwife (MW IPA). The MW IPA advised that the complainant presented on 31 May 2019 at 01:30 and the tests undertaken were in accordance with NICE CG190. The MW IPA advised that '*there is no indication from the observations taken at 04.30 hrs that [the complainant] had an infection as her temperature and all other observations including her pulse and baby's heart rate were within normal*

limits'. The MW IPA advised that the decision to send the complainant home at this time was appropriate.

22. The MW IPA was asked if the complainant was provided with appropriate information regarding infection when she left RJMS. She advised '*there is no indication in the records of the information given to [the complainant] regarding the risk of infection following prelabour rupture of membranes'*. She further advised that the complainant agreed she was given temperature strips so '*this may be due to poor record keeping'*.

23. The MW IPA referred to NICE CG190, which states that expectant mothers ought to be informed the '*risk of serious neonatal infection is 1% rather than 0.5%; 60% will go into labour within 24 hours; and, induction of labour is appropriate after 24 hours'*. She advised *'there is no indication in the records that [the complainant] was given this information'.* The MW IPA further advised that *'had [the complainant] been given appropriate information about induction of labour following prelabour rupture of membranes, this may have enabled her to ask additional questions and reduced her anxiety'.*

Telephone calls with RJMS admissions staff

24. The MW IPA advised that '*if a woman calls into the unit indicating that she is feeling unwell and has a temperature the midwife would ask a number of questions including whether fetal movements are present, frequency and strength of contractions, number of weeks of pregnancy, whether the membranes had ruptured or not, [and] any complications in pregnancy, and then the woman would be invited into the unit to be reviewed'*. She further advised that '*there is no documented evidence in the records that the unit received any phone calls from [the complainant] or that advice was given to [the complainant]'*. I referred the MW IPA to the complaint that staff advised the complainant to remain at home. She advised that '*if this advice had been given to [the complainant] it would not have been appropriate'.*

The complainant's attendance at RJMS admissions

25. I also referred the MW IPA to the complainant's attendance at the RJMS on the evening of 31 May 2019. She advised that the records did not document that upon her arrival, staff felt her cheek and told her that she did not have a temperature. The MW IPA advised that '*if this action occurred it would clearly not have been appropriate and would not meet NICE guidelines'*.

26. I asked the MW IPA if the records suggest that staff contacted Ward C to check if there was space for the complainant. She advised the complainant's admission is recorded at 22.05. This *'suggests that she was not kept waiting in Admissions but was transferred straight away'*. She further advised that in the absence of a record of the complainant's arrival, '*given that [the complainant] was going to be immediately transferred from admissions to Ward C there would have been no need to document this'.*

27. In relation to learning, the MW IPA advised, '*the Trust should ensure that all women receive appropriate verbal and written information in line with NICE guidelines and their own guidelines. Information for women – Staff should be careful to document the information given to women both written and verbal'*.

Other information considered

The complainant's phone records

28. The complainant provided a record of the calls she made on her mobile phone on 31 May 2019. The record documents that the complainant telephoned the RJMS at 02:50, and again at 08:38. The second call lasted one minute and two seconds. The complainant said she made an additional call to RJMS using a family member's phone later that day. However, she could not provide the records for this call.

The complainant's response to the draft report

29. The complainant described the Trust's response to the complaint '*despicable*'. She said while the Trust may see this as '*standard*', it was '*highly traumatic*' for her. The complainant explained she felt she was treated as if she was

'*burdensome*' or '*creating drama*'. She said she was labelled as '*anxious*' despite having cause to be concerned.

30. In relation to her attendance at admissions on the evening of 31 May 2019, the complainant explained she arrived '*sometime after 8pm*'. However, she was not transferred to the ward until 22:05. The complainant said she did not consider this '*immediate*'. She said, '*holding onto the side of reception, in a room full of anxious pregnant women, is something that should not be normal practice*'.

31. The complainant explained her concerns related to the Admissions department. She said she '*respects and is deeply appreciative*' of the medical staff who took '*great care*' of her and her daughter during her labour '*from C Ward to home*'.

Analysis and Findings

Attendance at RJMS following SRM

32. The complainant said following confirmation of SRM on 31 May 2019, a midwife provided her with temperature sticks and told her to monitor the situation at home. I note both NICE CG190 and the Trust's IOL Guideline state that induction of labour ought to occur 24 hours after SRM '*if there are no signs of intrauterine infection*'. I also note the MW IPA's advice that the observations undertaken for the complainant were appropriate and did not indicate infection at that time. Therefore, I accept the MW IPA's advice that the decision to ask the complainant to monitor the situation at home (and to return at 22:00 later that day) was appropriate and in accordance with relevant guidance.

33. I note NICE CG190 and the Trust's IOL Guideline also state that staff ought to advise those women who experience SRM of their increased risk of infection. The Trust's IOL Guideline further states that staff ought to provide women with an information sheet in this situation. It is clear the complainant was given the temperature sticks. However, she said she did not know why the midwife gave her them or told her how to use them. I note the MW IPA advised that the complainant's maternity records did not indicate she was informed about the increased risk of infection, or given the leaflet referred to in the Trust's guidance. Based on the evidence available to me, I consider the midwife failed

to provide this information to the complainant. I am satisfied that by not doing so, the midwife failed to act in accordance with NICE CG190 and the Trust's IOL Guideline. I consider this a failure in the complainant's care and treatment and I partly uphold this element of the complaint. I will consider the injustice to the complainant later in this report.

The complainant's telephone calls with RJMS admissions

34. The complainant said she telephoned RJMS admissions later on 31 May 2019 and reported she felt unwell and was having difficulty using the temperature sticks. She explained staff told her she was not using the sticks properly, and to stay at home because RJMS was '*busy*'. I note from the complainant's phone records she contacted RJMS at 08:38 on 31 May 2019. I also note the call lasted just over one minute. The Trust explained that notes of these types of call are normally recorded in a triage book. However, it did not provide any records relating to the complainant's calls on 31 May 2019. Therefore, I cannot determine what advice staff gave the complainant during this call.

35. I refer to Standard 10 of the NMC Code, which provides that midwives are required to '*complete all records at the time or as soon as possible after an event, and to identify any risks or problems… and steps taken to deal with them, so that colleagues who use the records have all the information they need'.* I consider a failure in maintaining accurate and contemporaneous records impedes the thorough, independent assessment of care provided. Maintaining records provides evidence of staff's actions and the treatment they provide. In doing so, it affords protection to staff. Furthermore, a lack of appropriate records limits the availability of clinical information for staff who become involved in the complainant's ongoing care and treatment. I consider the failure to create and retain a record of staff's telephone calls with the complainant a failure in her care and treatment.

36. I note the Trust's IOL Guideline states that women should report to RJMS admissions immediately if they have a very low or high temperature, or feel unwell, which the complainant did. The MW IPA advised that the midwife who

took the call ought to have asked the complainant a number of questions. These ought to have related to her health (at that time) and her baby's movements. However, the complainant said she was only told she was not using the temperature sticks correctly, and to remain at home. I consider it likely that staff would have recorded the responses in the triage book had these questions been asked and answered. However, no such note exists. Therefore, based on the available evidence, I am satisfied RJMS staff who took the complainant's call failed to undertake an appropriate assessment of her at that time. I consider this a failure in the complainant's care and treatment.

37. I note the Trust explained that when a complainant reports feeling unwell, she should be asked to attend admissions. This is also outlined in its IOL Guideline. While I cannot conclude what advice staff gave to the complainant, I note she did not attend until more than 12 hours after she telephoned. I have no reason to doubt that she would have attended urgently if told to do so. I note the MW IPA advised that in the circumstances, it was inappropriate for RJMS staff to advise the complainant to stay at home rather than attend for an assessment. Based on the evidence available, I am satisfied staff failed to advise the complainant to attend RJMS admissions immediately. I consider that by failing to do so, staff did not act in accordance with the Trust's IOL Guideline. I consider this a failure in the complainant's care and treatment and I uphold this element of the complaint. I will consider the injustice to the complainant later in the report.

The complainant's attendance at RJMS

38. The complainant said she attended admissions that evening shortly after 20:00. She explained a midwife felt her cheek and told her she did not have a high temperature. She also said the midwife told her she would check if the ward had space for her, and asked her to wait in a room before giving her directions to the ward. I note the records document that the complainant arrived on the ward and staff attended to her at 22:05.

39. I note there is no record of this interaction. The complainant said she waited approximately two hours before she was transferred. However, in the absence of a record, I am unable to determine the time she arrived at admissions. I also cannot conclude if or when she was triaged, and how long she waited before staff admitted her to the ward. Furthermore, I cannot determine if the midwife informed the complainant she would have to check if the ward had space before transferring her. Given the records document the complainant was very unwell when she arrived on the ward, I consider it was appropriate for staff to transfer her quickly. While I cannot definitively conclude how long the complainant waited for treatment, I ask the Trust to remind staff that women who present as very unwell ought to be attended to (or at the very least triaged) immediately.

40. In the absence of this record, I also cannot determine whether or not the midwife touched the complainant's cheek to gauge her temperature. I note both the Trust and the MW IPA said that touching a complainant's cheek is clearly not an appropriate method of taking a temperature. I agree with this view. I ask the Trust to remind staff to use correct equipment when taking a patient's temperature.

41. I note the MW IPA's advice that there was no need for the midwife to record a note of her interaction with the complainant as staff transferred her to the ward shortly after her arrival. However, as referred to previously, I cannot determine if the complainant was immediately transferred, and therefore, if staff ought to have documented their assessment. While I am unable to determine in this instance whether or not staff failed to act in accordance with the NMC Code, I ask the Trust to remind midwifery staff to ensure they appropriately record patient interactions.

Injustice

42. Based on the evidence available, I partly uphold this issue of complaint. I am satisfied the failures identified caused the complainant to experience the

injustice of frustration, uncertainty, and the loss of opportunity to receive earlier treatment for an infection. I am also satisfied they caused the complainant to experience the injustice of the loss of opportunity for staff to consider full and accurate records when deciding on her future care and treatment.

Issue 2: Whether the decision to discharge the complainant from the Royal Jubilee Maternity Service on 3 June 2019 was reasonable and in accordance with relevant guidance.

Detail of complaint

43. This issue of complaint is about the Trust's decision to discharge the complainant from the RJMS on 3 June 2019. The complainant said she remained unwell when she returned home and continued to shake and had a '*fluctuating temperature'* despite being on two sets of antibiotics.

Evidence Considered

Legislation/Policies/Guidance

44. I referred to the following guidance as part of investigation enquiries:
    - GMC Guidance; and
    - The Trust's Sepsis in Pregnancy Guideline.

The Trust's response to investigation enquiries

45. The Trust referred to the complainant's records and explained they document that the complainant was *'content to go home on oral antibiotics and iron tablets'.* It further explained the records do not document who made the decision to discharge the complainant. It said *'this is usually an agreement with the mother…based on the clinical assessment of her wellbeing'.* It further explained that '*whilst [the doctor] carried out a final review before discharge, the discharge was finalised by a midwife*'. The Trust said the complainant was not discharged from midwifery care but was *'transferred to Community Midwifery care'*.

46. The Trust explained that '*on discharge, [the complainant's] clinical observations were within normal limits and she stated that she was comfortable and feeling well'*.

Records relating to the complaint

47. A summary of the relevant records is enclosed at Appendix four to this report.

Relevant Independent Professional Advice

48. I obtained independent professional advice from a consultant obstetrician (O IPA). In relation to which of the medical team made the decision to discharge the complainant, the O IPA advised that '*the medical record has documentation from [the Senior House Officer[6] (SHO)] at 08:55 on [3 June 2019] which documents the recent blood tests but then nothing further, and this entry is not signed, which suggests it is incomplete. There is no written evidence that they reviewed the complainant or made a plan for discharge'*.

49. The O IPA further advised that '*there is another entry at 12:30 on the same day stating "[the complainant] content to go home on oral antibiotics" which is signed by what I believe to be the attending midwife. A doctor must have been involved in this decision because the antibiotics would need prescribing, so the notes imply that [the SHO] made the decision and prescribed the antibiotics, but this is not explicit'*. The O IPA advised that the records ought to contain this information. He further advised that '*a doctor would normally make the decision to discharge a complainant from hospital care after treatment for sepsis'*.

50. The O IPA referred to the tests the medical staff undertook for the complainant during her admission. He advised that '*the tests were repeated appropriately…to monitor the complainant's condition'*. In relation to the outcome of the tests, the O IPA advised '*from the incomplete medical notes, the blood tests reported on the morning of 3/6/19 show the c-reactive protein[7] (CRP) (a marker of inflammation) to be rising, and the white cell count[8] (WCC)*

[6] A junior doctor who has not yet begun training in a specialist area.
[7] CRP increases when there is inflammation in the body.
[8] A high white blood cell count may indicate that the immune system is working to destroy an infection.

(a marker of the body's response to infection) to be falling but still elevated. However, when I reviewed the laboratory reports they confirmed that both the c-reactive protein and white cell count were falling'.

51. In relation to the question of whether the complainant was well enough to be discharged, the O IPA advised that '*the medical notes on that morning appear incomplete. However, it appears that the complainant's temperature had settled, the inflammatory markers [CRP] were improving, and she was clinically well. In particular, the attending midwife has made a comment "very well*"'. He further advised that '*at 18:00 the evening before, the attending midwife has documented "feels well". On balance I therefore consider that the complainant was well enough to be discharged that day. Both the local and national guidelines focus on the initial management of sepsis but do not give specific advice regarding discharge. My answer is therefore based on established good practice'*.

52. In relation to medication prescribed for the complainant upon her discharge, the O IPA advised that '"*Oral antibiotics" are documented in the notes, and the drug chart has a prescription for Co-Amoxiclav*[9]*. (It is not explicit from the notes I have seen that this was the drug given).* He further advised he considers *'this medication likely to be appropriate as it is effective against most organisms that cause sepsis in this situation'*.

53. The O IPA further advised that *'as part of the investigations for sepsis, blood cultures were sent. Other cultures may have been sent (eg urine, vaginal swab, placental swab) but other than blood cultures, I could not see documentation that they had been sent, any results for the investigations, or documentation that they had been reviewed prior to discharge'*. He advised that '*the antibiotics used were usual in this situation and effective against common organisms, so if the complainant was clinically improving then treatment would be considered appropriate'*.

[9] An antibiotic medication used for the treatment of a number of bacterial infections.

54. I referred the O IPA to the Trust's response which said the complainant agreed to the decision to discharge her on 3 June 2019. The O IPA advised, '*the only documentation is by the attending midwife which states "[the complainant] content for home on [oral antibiotics and iron]". This implies that the complainant was in agreement, but is not possible to comment on the detail of that conversation*'.

55. Overall in relation to this issue of complaint, the O IPA advised he considered '*the care and treatment was appropriate and in accordance with guidance and established good practice*'. The O IPA also advised he '*identified the failing of documentation on the morning of 3/6/19, which means I have had to make inferences that it was appropriate to discharge the complainant from the associated midwifery notes. However the complainant returned that evening and the comprehensive clinical review suggests that the decision to discharge earlier that morning was appropriate*'.

56. In relation to learning, the O IPA advised that the Trust ought to consider '*the importance of full documentation of clinical review and subsequent plan*'.

Other information considered

The Trust's response to the draft report

57. The SHO who discharged the complainant said he '*strongly disagrees*' that any conclusions regarding the adequacy of his record keeping can be drawn from incomplete notes.

Analysis and Findings

58. The complainant raised concerns with medical staff's decision to discharge her as an inpatient on 3 June 2019 as she continued to feel unwell. I considered the Trust's Sepsis in Pregnancy Guideline. While it does not outline when a complainant ought to be discharged, the guidance states that IV antibiotics ought to be continued until the complainant is afebrile[10] for more than 24 hours. I note from the clinical records that the complainant's temperature remained

[10] Without a fever.

stable at 36.7 degrees Celsius from the evening of 1 June 2019 until her discharge on 3 June 2019.

59. I note the O IPA advised the blood results the SHO documented in the records on 3 June 2019 showed an increase in the complainant's CRP level. However, I also note he considered this was written in error, as the laboratory records showed a fall in her CRP and WCC levels that morning, which evidenced her condition improved. Furthermore, I note the clinical records document the complainant informed staff she was well on the evening of 2 June 2019, and that she was '*content for home*' on 3 June 2019. Therefore, I accept the O IPA's advice that the complainant was '*well enough to be discharged that day'*. I also accept his advice that staff prescribed '*appropriate*' medication for the complainant to take at home.

60. I reviewed the complainant's clinical records from the day of her discharge. I again note the attending midwife documented the complainant was '*content for home*' and that staff prescribed her oral antibiotics and iron tablets. I note the Trust explained the SHO undertook a final review of the complainant prior to her discharge. However, there is no record of the doctor's assessment, or of a plan for her discharge. I note the O IPA considered the complainant's clinical records incomplete, and advised the records ought to contain this information.

61. I refer to Standards 19 to 21 of the GMC Guidance, which provide that doctors are required to record '*decisions made and actions agreed, and who is making the decisions and agreeing the actions'*. I note in his response to the draft report, the SHO who discharged the complainant disagreed that an incomplete record demonstrated his inadequate record keeping. However, I consider a failure in maintaining full and contemporaneous records impedes the thorough, independent assessment of care provided to complainants. I also consider it limits the availability of clinical information for staff who become involved in the complainant's ongoing care and treatment. I consider the absence of this record a failure in the complainant's care and treatment. I partly uphold this issue of complaint.

Injustice

62. I am satisfied the failure identified caused the complainant to experience the injustice of the loss of opportunity for staff to consider full records when deciding on her future care and treatment.

Issue 3: Whether the care and treatment provided to the complainant upon her return to the Royal Jubilee Maternity Service on 3 June 2019 was in accordance with good medical practice.

Detail of complaint

63. This issue of complaint is about the Trust's care and treatment of the complainant when she returned to the RJMS on 3 June 2019 following her discharge. The complainant said staff did not provide her with any further treatment. She said she felt '*put down and ignored'* and was told to '*please leave it to the professionals'*. The complainant also said she later attended an emergency department in another hospital. She explained medical staff there prescribed additional antibiotics as she still had an infection. I established the patient attended the ED of the Ulster Hospital in September 2019.

Evidence Considered

Legislation/Policies/Guidance

64. I referred to the following guidance as part of investigation enquiries:
    - GMC Guidance;
    - The NMC Code; and
    - The Trust's Sepsis in Pregnancy Guidance.

The Trust's response to investigation enquiries

65. The Trust explained the complainant presented at RJMS admissions approximately eight hours following her discharge. It said '*her initial observations [were] recorded by a Maternity Support Worker, she was then assessed by [a midwife] and…[the] Obstetrician on duty'*. It said the complainant was '*given a full midwifery and medical assessment. Her temperature was recorded within normal limits at 37.1°C and blood samples*

indicated that her antibiotic therapy was effective as 'inflammatory markers' were decreasing'.

66. I referred the Trust to the complaint that a staff member told the complainant to '*please leave it to the professionals'*. The Trust explained '*there were no documented conversations with staff members, including this comment, and we therefore cannot confirm this or the context for it. We do however apologise for the tone expressed if this was the case'*.

Records relating to the complaint

67. A summary of the relevant records is enclosed at Appendix four to this report.

Relevant Independent Professional Advice

Care and treatment provided on 3 June 2019 - midwife

68. I obtained independent professional advice from a practising midwife (MW IPA). In relation to assessments that midwifery staff undertook for the complainant upon her return, the MW IPA advised that '*a full set of observations were taken which were within the normal range with her temperature being 37.1 degrees. The midwife took appropriate observations and also took bloods for a range of tests including White Cell Count (a raised WCC can be an indication of infection)*'. She further advised the complainant '*remained in admissions and was reviewed by a doctor…when her temperature was taken again orally this was recorded as 37.1 and when repeated with an ear thermometer 37 degrees. All within normal limits'*.

69. The MW IPA advised '*the documentation about this admission was clear and comprehensive'*. She further advised there was no evidence in the records to suggest a midwife told the complainant to '*leave it to the professionals'*.

70. In relation to this attendance, the MW IPA advised '*the care provided to [the complainant] when she returned on 3 June 2019 was appropriate and in line with NICE guidelines. There was no indication that she had a temperature or was unwell. She had an improving / normal blood picture and was already on antibiotics'*.

Care and treatment provided on 3 June 2019 - obstetrician

71. I also obtained independent professional advice from an obstetrician (O IPA). In relation to treatment that the medical staff provided to the complainant, the O IPA advised that '*the doctor undertook a comprehensive clinical review of symptoms, examined the complainant, and performed investigations, including the white cell count and c-reactive protein. The findings were consistent with resolving infection. The complainant was discharged with a plan to complete her course of oral antibiotics and return if she deteriorated. The complainant was offered admission for observation but the documentation states she was "keen to go home*"'.

72. I asked the O IPA if medical staff ought to have provided the complainant with further treatment. He advised, '*I do not consider that the medical staff ought to have undertaken further treatment. Based on the comprehensive documentation of the clinical review, I am in agreement that the findings were consistent with resolving infection and continued oral antibiotic treatment was appropriate'*. I also asked the O IPA if medical staff ought to have readmitted the complainant. He advised, '*I do not consider that the complainant ought to have been readmitted. Based on the comprehensive documentation of the clinical review, I am in agreement that the findings were consistent with resolving infection and continued oral antibiotic treatment as an outpatient, with instructions to return if there was deterioration, was appropriate'*.

73. I referred the O IPA to the complainant's attendance at the ED of the Ulster Hospital in September 2019. He advised, '*it appears that the complainant was treated for a suspected urinary tract infection following that attendance. I do not consider this is related to the care and treatment she received in June 2019'*.

74. In relation to this issue of complaint, the O IPA advised, '*overall, I consider that the care and treatment provided to the complainant on the evening of 3 June 2019 was appropriate and in accordance with the local guidance, which advises the clinical approach to suspected sepsis'*.

Other information considered

Records from the Ulster Hospital

75. The complainant said she attended the Ulster Hospital's emergency department some time after her discharge from the RJMS. I obtained the records from the complainant's attendance on 7 September 2019.

76. The ED record documents the complainant reported abdominal pain and heavy bleeding. The blood test results reported her WCC as 5.9 and her CRP as 2.2. The record further documents, '*imp [impression]: UTI [urine tract infection]. Plan: abx [antibiotics] + home. Advice given re menstrual bleed. Can [word unclear] GP if continue to be heavy*'. ED staff prescribed the complainant trimethoprim[11].

Analysis and Findings

Comment from midwife

77. The complainant said when she returned to the RJMS on the evening of 3 June 2019, she felt '*put down*', '*ignored*', and was told to '*leave it to the professionals*'. I note the records of this attendance document the observations taken of the complainant. However, they do not document the full discussion between the complainant and the midwife during her assessment. In the absence of additional evidence, I am unable to conclude if the midwife '*ignored*' information the complainant provided, or told her to '*leave it to the professionals*'. However, I note the Trust apologised for the midwife's tone if this is how it was interpreted.

Care and treatment provided on 3 June 2019

78. The complainant also said medical staff did not provide her with any further treatment during her attendance. I note from the clinical records that a midwife first assessed the complainant. Having reviewed the records, I accept the MW IPA's advice that the observations recorded during the assessment were appropriate and in accordance with relevant guidance.

[11] An antibiotic used mainly in the treatment of bladder infection.

79. The records document that an ST3 doctor[12] also assessed the complainant. I note the O IPA's advice that the complainant's blood test results were '*consistent with a resolving infection*', as both the WCC and the CRP markers had fallen. Therefore, I accept his further advice that there was no requirement for treatment in addition to the oral antibiotics already prescribed for the complainant.

80. I considered the records obtained from the Ulster Hospital relating to the complainant's attendance at its ED in September 2019. I note ED staff diagnosed the complainant with a UTI and prescribed trimethoprim. I accept the O IPA's advice that he does not consider this ED attendance, and diagnosis of a UTI, was related to the complainant's previous diagnosis of sepsis in June 2019. Therefore, I do not consider there is sufficient evidence to conclude that the complainant's attendance at the Ulster Hospital was as a result of RJMS staff's decision not to provide further treatment.

81. Based on the evidence available to me, I consider the care and treatment provided to the complainant when she returned to the RJMS on 3 June 2019 appropriate and in accordance with relevant guidance. I do not uphold this issue of complaint.

CONCLUSION

82. The complainant raised concerns about the care and treatment RJMS staff provided to her from 31 May to 3 June 2019. I partly uphold the complaint for the reasons outlined previously in this report. I am satisfied the failures identified caused the complainant to experience the injustice of frustration, uncertainty, and the loss of opportunity to receive earlier treatment for an infection. I am also satisfied they caused the complainant to experience the injustice of the loss of opportunity for staff to consider full and accurate records when deciding on her future care and treatment.

[12] A speciality doctor in their third year of training.

Recommendations

83. I recommend within **one month** of the date of this report, the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused to her as a result of the failures identified.

84. I further recommend that the Trust provides training to relevant staff to incorporate the following. The Trust should provide me with evidence of this training within **three months** of the date of my final report:

    i. The importance of creating and retaining contemporaneous records of advice provided to complainants, in accordance with Standard 10 of the NMC Code;

    ii. The importance of informing expectant mothers who experience SRM of the increased risk of infection, in accordance with NICE CG190 and the Trust's IOL Guideline;

    iii. The importance of informing expectant mothers who report feeling unwell that they are to attend RJMS immediately for assessment, in accordance with the Trust's IOL Guideline; and

    iv. The importance of creating and retaining contemporaneous records of a complainant's discharge from hospital, in accordance with Standards 19 to 21 of the GMC Guidance.

MARGARET KELLY
Ombudsman **13 August 2021**

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.

APPENDIX TWO

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being Customer focused

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

Being open and accountable

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

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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