Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 22329

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

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: 22329/201916085

Listed Authority: South Eastern Health and Social Care Trust

SUMMARY

I received a complaint about the care and treatment staff in the South Eastern Health and Social Care Trust (the Trust) provided to the complainant's mother (the patient) while she was in the Ulster Hospital (UH) in September 2018. The complainant raised concerns with medical staff's failure to continue an antibiotic when the patient transferred to the ward, and to treat spikes in the patient's glucose levels. She also said medical staff delayed the prescription of a diuretic[1] for the patient. The complainant raised further concerns with information the Consultant provided to her in October 2018.

The complainant said nursing staff failed to undertake a urinalysis[2] for the patient when she arrived on the ward. She also raised concerns about the decision to use incontinence pads in the patient's bed rather than insert an indwelling catheter[3]. She raised further concerns about staff's monitoring of the patient's glucose levels and fluid intake. The complainant said the patient's nursing assessment was incomplete, and staff failed to obtain the patient's history from the family. In addition, she was concerned that a nurse was not allocated to sit with the patient when she was agitated.

The investigation examined the details of the complaint, the Trust's response, and relevant local and national guidance. I sought independent professional advice from a Geriatric Consultant and a Nurse. The investigation established that the medical care and treatment of the patient was appropriate. It also established that information the Consultant communicated to the complainant in October 2018 was appropriate. The investigation did not identify failures with nursing staff's decision to use incontinence pads in the patient's bed, or with their monitoring of the patient's glucose levels. It further established it was not necessary for a nurse to sit with the patient at any time during her time on the ward.

[1] Medications designed to increase the amount of water and salt expelled from the body as urine.
[2] A clinical examination of patients' urine.
[3] A catheter that is left in place for a duration.

The investigation identified delays in the process to obtain a sterile urine specimen. It also established the methods used to obtain the urine sample from the patient on 12 September 2018 were inappropriate. The investigation established that the records did not provide evidence that staff discussed and agreed how the patient's fluids ought to be monitored. It also identified that staff failed to appropriately monitor the patient's fluid levels on 12 September 2018. The investigation found that the nursing assessments were incomplete and inaccurate. It identified that staff failed to correct the inaccuracies using history obtained from the patient's family. The investigation also identified failures in record keeping that were considered service failures.

The investigation found the failures identified caused the patient to experience the loss of opportunity:

- To have a sterile urine specimen taken and tested earlier;
- To have her fluid levels accurately monitored; and
- For staff to consider full and accurate records when deciding on her future care and treatment.

I recommended actions for the Trust to take to prevent the identified failures from recurring.

THE COMPLAINT

1. This complaint is about care and treatment staff of the South Eastern Health and Social Care Trust (the Trust) provided to the patient in ward 6c of the Ulster Hospital (UH) between 11 and 17 September 2018.

Background

2. The complainant said her mother (the patient) was diagnosed with a urine tract infection (UTI) in the days leading up to her admission to hospital. The patient's community doctor prescribed trimethoprim[4] to treat the infection at home. The complainant said the patient remained unwell and an ambulance transported her to the emergency department (ED) of the UH on 10 September 2018. While in the ED, the patient was diagnosed with '*dehydration'* and '*UTI with confusion'* and was admitted to ward 6C in the early hours of 11 September 2018. She was treated on the ward until 17 September 2018 when she sadly passed away in hospital.

Issues of complaint

3. The issue of complaint accepted for investigation was:
   Issue 1: Whether the care and treatment the patient received at the Ulster Hospital in September 2018 was in accordance with good medical practice.

INVESTIGATION METHODOLOGY

4. 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 relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

5. Independent professional advice was obtained from the following independent professional advisors (IPAs):

[4] An antibiotic used mainly in the treatment of bladder infections.

- [redacted] MB MSc MD FRCP FRCPE FRCPI Dip Card RPMS; a consultant physician for over 30 years and an accredited geriatrician for 20 years (G IPA); and
- [redacted] BSc (Hons) MA RGN; a senior nurse with twenty years nursing and managerial experience across both primary and secondary care (N IPA).

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

6. The information and advice which informed my findings and conclusions are included within the body of my report and its appendices. The IPAs 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

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

The general standards are the Ombudsman's Principles[5]:

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

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

The specific standards relevant to this complaint are:

- The Nursing and Midwifery Council's (NMC) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, March 2015 (the NMC Code);

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

- The Northern Ireland Practice and Education Council for Nursing and Midwifery's (NIPEC) Standards for person centred nursing and midwifery record keeping practice, May 2017 (the NIPEC Standards);
- The National Institute for Health and Care Excellence's (NICE) Urinary Tract Infections in Adults, Quality Standard 90, June 2015 (NICE QS90);
- The National Institute for Health and Care Excellence's (NICE) Intravenous fluid therapy in adults in hospital, Clinical Guideline 174, May 2017 (NICE CG174);
- The Royal Marsden Manual of Clinical & Cancer Nursing Procedures, ninth edition, May 2015 (the RM Manual);
- The Royal College of Nursing's (RCN) Catheter Care: RCN Guidance for Health Care Professionals, 2012 (RCN Catheter Care guidance);
- The South Eastern Health and Social Care Trust's Empirical Antimicrobial Therapy Guidelines for Hospitalised Adults (aged 16 years and above), 2017 (the Trust's Empirical Antimicrobial Therapy Guidelines);
- The South Eastern Health and Social Care Trust's Intravenous (IV) Fluid Prescription in Adults, February 2018 (the Trust's IVF policy); and
- The South Eastern Health and Social Care Trust's Clinical Guidelines for Adult Urethral Catheterisation and their Associated Management, September 2017 (the Trust's policy on catheterisation).

9. 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.

10. 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 patient received at the Ulster Hospital in September 2018 was in accordance with good medical practice.

Detail of Complaint

11. The complainant raised the following concerns regarding the care and treatment of the patient between 11 and 17 September 2018:

- Staff failed to undertake a urinalysis for the patient when she first arrived on the ward despite a request from ED staff to do so;
- The Consultant informed the complainant that tests of the patient's urine were negative. She said this was despite the samples testing positive for mixed flora[6] and yeast;
- Staff failed to continue an antibiotic that was administered to the patient in the ED;
- Staff failed to appropriately monitor the patient's fluid balance leading to increased fluid intake. The complainant said that despite this, medical staff delayed the prescription of a diuretic;
- Staff used incontinence pads in the patient's bed rather than insert a catheter;
- The Consultant informed the complainant the patient's poor swallow was caused by her dementia;
- Staff failed to appropriately monitor and treat the patient's high glucose levels;
- The nursing assessment of the patient was incomplete, and staff failed to obtain the patient's history from the family; and
- A nurse was not allocated to sit with the patient when she was agitated.

Evidence Considered

Legislation/Policies/Guidance

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

[6] Presence of mixed flora may mean the specimen is contaminated.

- The NMC Code;
- The NIPEC Standards;
- NICE QS90;
- NICE CG174;
- The RM Manual;
- The RCN Catheter Care Guidance;
- The Trust's Empirical Antimicrobial Therapy Guidelines;
- The Trust's IVF Policy; and
- The Trust's Policy on Catheterisation.

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

The Trust's response to investigation enquiries

13. The Trust explained the patient had an '*acute kidney injury*[7] *and not a urinary tract infection'*. It further explained that '*a urinalysis on a swab was performed just after 2am on 12 September 2018 which was positive for ketones*[8]*, blood and leukocytes*[9]*. An MSU [mid-stream urine] was also sent at this time and returned positive for mixed flora'*. The Trust explained that the urine samples '*did grow mixed flora on first sample, and yeast on the second'*. It said the yeast identified was *'much more likely to be contamination'*. It further explained that blood cultures on 13 September 2018 were '*negative for any organism*'. The Trust said a CSU [catheter sample of urine] obtained on 14 September 2018 was *'positive for a yeast infection'*. It said that by this time the patient was already on *'a broad spectrum antibiotic'*. The Trust explained staff considered UTI as a '*potential underlying cause'*. However, it considered the clinical pictured was '*in keeping with an acute kidney injury, secondary to dehydration"*.

14. The Trust explained that in the ED, '*intravenous fluids were commenced and Tazocin*[10] *(antibiotic) was administered to cover for infection whilst blood tests were pending'*. It further explained the patient's '*CRP*[11] *[C-reactive protein]*

[7] When the kidneys stop working properly.
[8] Ketones are produced when the cells do not get enough glucose and the body burns fat for energy instead.
[9] White blood cells in urine that can be a sign of infection.
[10] Antibiotic used to treat bacterial infections.
[11] A high level of CRP in the blood is a marker of inflammation.

(inflammation marker) was noted to have improved from the previous week to 16.7 from 34, and her white cell[12] (inflammation marker) count was noted to be normal…' The Trust explained that *'as there was no definite evidence of infection, the medical plan was to hold off on further antibiotics and to consider them if the clinical picture changed'*. It said this occurred on 12 September 2018, which it considered was *'most likely the result of a chest infection'.* It explained that a repeat x-ray '*showed evidence of a Left Basal Infection[13], likely secondary to aspiration[14]'*.

15. The Trust explained that staff considered the patient's deterioration on 12 September 2018 could have been caused by '*infection or fluid overload causing pulmonary oedema[15]'.* It said staff repeated the chest x-ray and slowed IV fluids. It explained that IV diuretics were not prescribed at this time as the x-ray was '*more in keeping with infection and [the patient] had presented less than 48 hours earlier with acute kidney injury'*. The Trust said the Consultant reviewed the patient later that afternoon and held the diuretic '*as she was 'peripherally shut down'. At this stage infection was considered to be more likely than fluid overload'.* It explained that a '*stat dose of 40mg IV Furosemide[16] was administered on 13 September 2018 following the Consultant Ward Round*'.

16. The Trust explained that medical staff considered that '*progression in [the patient's] Alzheimer's condition may have contributed to deterioration in her swallow, along with an acute deterioration caused by her community urine infection, her lack of food and fluids in the days prior to admission and the chest infection which developed rapidly following admission'*.

17. The Trust explained the patient's glucose levels were monitored throughout her admission and were noted to be *'elevated on several occasions'.* It said her blood sugars reduced *'naturally within normal range'.* The Trust explained that medical staff '*did not prescribe insulin due to [the patient's] nil by mouth status*

[12] A high white blood cell count usually indicates an increased production of white blood cells to fight an infection.
[13] An infection in the left lung.
[14] Aspiration occurs when a person inhales food, stomach acid, or saliva into their lungs.
[15] A condition caused by excess fluid in the lungs.
[16] A diuretic medication.

and the risk of further lowering her blood sugars and causing a hypoglycaemic[17] episode'.

18. The Trust explained nursing staff considered inserting an indwelling catheter for the patient. However, staff had to '*balance the risk of maintaining [the patient's] skin integrity[18] and introducing further infection'.* It considered that *'incontinence pads were used appropriately'.*

19. The Trust explained the ED Nursing Assessment documents are *'incomplete'.* It said that sections relating to the patient's skin and interventions taken were *'completed following her transfer onto a hospital bed at 10:15pm on 10 September 2018'*. The Trust further explained that the ED was *'particularly busy'* on 10 September 2018. It said that *'whilst it is the expectation for this paperwork to be completed, direct patient care can at times take precedence'*.

20. The Trust explained that staff completed a nursing assessment following the patient's admission to the ward. It also said that '*Nursing and Medical Teams spoke with [the] family regularly to gain a collateral history'*. It said *'the patient was unable to assist due to tiredness and confusion'.* The Trust explained that the urinalysis section was incomplete as '*staff were unable to obtain a urinalysis on admission'.*

21. The Trust said the ward was '*adequately staffed throughout [the patient's] admission'* and it did not deem 1:1 nursing necessary. The Trust explained that open visiting was encouraged and the family *'spent long periods by [the patient's] bedside'*.

Relevant medical records

22. A summary of the relevant clinical records is enclosed at Appendix five to this report.

Relevant independent professional advice

[17] A condition in which the blood sugar (glucose) level is lower than normal.
[18] A skin integrity issue might mean the skin is damaged, vulnerable to injury or unable to heal normally.

G IPA - urinalysis

23. I obtained independent professional advice from a general physician who is also an accredited geriatrician (G IPA). The G IPA advised that '*based on her presentation and the fact that she had already been treated with three days of trimethoprim, UTI need not have been the first diagnosis'*. He advised that '*the only symptom that [the patient] had was pleasant confusion and…based on that symptom alone, it is unlikely that she had active UTI when she arrived on the ward'*. The G IPA advised that the patient's '*blood test results did not reflect infection on admission. The clinical impression was that there was no overwhelming infection…Markers in the blood for infection only crept upwards when she showed evidence of chest infection. These began to rise on 12/9/18'*.

24. The G IPA advised that the urine samples were positive for mixed flora and yeast. He was asked if this was indicative of infection. He advised that '*these were contaminants from the skin, especially as she was incontinent, and specimen was obtained from the pad. Yeasts are commonly present on the skin along with other microbes[19]'.* The G IPA further advised that *'there was no pathogenic growth[20] on culture and therefore treatment was not required'.*

G IPA - antibiotic

25. The G IPA advised that ED staff prescribed and administered to the patient a single dose of Tazocin, which was not continued when she transferred to the ward. He further advised that '*no antibiotic was necessary at that point when she was admitted to hospital in the absence of definitive diagnosis of infection. This is in keeping with NICE [QS90] recommendation'*.

G IPA – fluids and treatment with a diuretic

26. The G IPA advised that the decision to prescribe IV fluids for the patient following her admission to the ward was appropriate. He advised the patient was '*clinically and biochemically dehydrated. Intravenous fluids were required because she was not able to drink'*. The G IPA said the patient became '*more responsive'* on 12 September 2018 following administration of the fluids.

[19] A microscopic organism, which may exist in its single-celled form or a colony of cells.
[20] Growth of bacteria.

27. The G IPA advised that on 12 September 2018, '*the clinician found air entry to be reduced at the bases and felt that that represented fluid overload. That is an incorrect assumption because reduced air entry does NOT invariably mean fluid overload, for which condition, clinically the signs would have been different'*. He further advised that '*the report on the x-ray of 12/9/18 says there was no pulmonary oedema – which means there NO fluid overload'*. The G IPA advised that '*it is impossible to clinically distinguish between the three conditions. Thus, there was NO failing'*. He advised the medical team decided to '*hold off*' the diuretic and requested a chest x-ray. He said '*this was the correct approach'*.

28. The G IPA was asked if medical staff ought to have prescribed the diuretic earlier than 13 September 2018. He advised that '*fluid overload was not suspected prior to that. The chest x-rays before and after did not show evidence of fluid overload…it is clinically impossible to make out a definitive diagnosis purely clinically because the three conditions… causing pulmonary oedema all sound the same clinically on examination and need radiological confirmation*[21]*'*. He further advised that '*it was NOT a failing to have prescribed two doses furosemide prior to getting the x-ray result because if it was fluid overload, furosemide was the correct drug to use. And it was impossible to determine. Administration of two doses of furosemide even when she did not need it would not and did not have an adverse impact on the patient*'.

29. The G IPA advised that '*the fluids prescribed were in line with the recommendations for maintenance intravenous therapy as provided for in the Trust IV Policy. Fluids in volumes of 1 litre over 24 hours using 0.9% saline and 5% glucose were prescribed. This is enough to cover insensible fluid loss (loss in sweat and respiration) and additional 500 ml because she was not otherwise eating and drinking. Hence fluids were not prescribed excessively and were administered in keeping with the Trust IVF Policy'*.

[21] Such as an x-ray.

G IPA – cause of poor swallow

30. The G IPA advised that the records document the patient experienced difficulties with her swallow in the days leading up to her admission to hospital. He further advised it was appropriate for medical staff to inform the patient's family that her swallow became impaired due to the progression of her Alzheimer's disease. In relation to the concern that medical staff did not consider the question of the infection causing poor swallow, the G IPA advised that '*urinary infection will not cause poor swallow. The medical team would have known that there was no relevance of UTI to impaired swallow. It is not expressly recorded that they did consider the complainant's query'*.

G IPA - treatment of glucose levels

31. The G IPA advised the patient's glucose levels were noted to be raised and were monitored. He advised that medical staff had to ensure it '*was not caused by the glucose in the intravenous fluids being administered. Therefore, anti-diabetic medication is not always required to be commenced immediately when high blood sugar readings are recorded'*. The G IPA further advised that '*other readings varied between 13.2 and 18 and were more reasonable values and would justify not starting anti-diabetic medication forthwith. Further, in diabetes in the elderly, one prefers the base line blood sugar to remain slightly on the higher side rather than lower because of the hazards of low blood sugar in the older population. The blood sugar returned to normal values spontaneously, confirming that the decision not to treat was correct'*.

32. The G IPA advised that '*capillary glucose was being monitored and recorded. They changed the intravenous fluid to normal saline instead of 5% glucose when the result came back as being 23.7. That was the correct action'*. He further advised that '*it was not required for blood glucose to be obtained at that time…because [the patient] was being treated with intravenous intake control (because she was not eating or drinking). Not having measured the laboratory blood glucose did not represent a failure'*.

G IPA - overall

33. The G IPA said the medical care provided to the patient '*cannot be faulted. Medical records were well kept. There is no learning or service improvement that is required'*.

N IPA - urinalysis

34. I also sought independent professional advice from a senior nurse (N IPA). The N IPA advised that a '*MSSU (mid-stream sample of urine) was requested on 10.09.2018 at 17:36. Given that the patient was incontinent of urine, an in-out catheter sample was advised "if required"*'. She further advised that the records document '*at 05:35 on 11.09.2018 she was transferred to the ward, "need MSSU" is also documented at this time within the medical notes'*. The N IPA advised that '*on 12.09.2018 at 02:33 it is documented that an RWT [reagent water test] (urine dip test…) had been taken and an MSSU sent. It is not clear from the records documented at the time of the events, how this sample was obtained. It was later clarified…that it was from "sterile cotton wool"*'.

35. The N IPA was asked if nursing staff obtained a catheter sample of urine (CSU). She advised the records document '*that a catheter was inserted on 14.09.2018 at 10:40 and that a urine sample was taken. This record also shows a sample being taken at 08:30 on 15.09.2018. The accuracy of the recorded catheter sample from the 15th is questioned because there is no further reference to a sample on that date within the progress records or the complaints correspondence'*. The N IPA advised that the process to obtain the sample '*was therefore delayed'*. She further advised that there was '*no documented rationale for the delay'*. The N IPA referred to the patient's records following her admission to the ward and advised that the request to obtain a urine sampled '*was not included in the medical plan following admission to the ward. It is not clear therefore if the sample was deemed necessary and therefore if the delay was appropriate or not'*.

36. The N IPA was asked about the methods used to obtain the urine samples. She advised '*the urine dipstick test was not appropriate as it can give false positive results in this age group (NICE QS90)…Furthermore utilising the guidance provided by the Trust; urine dip tests are only appropriate in a continent person*

who can provide urine on request. The cotton wool method is not recommended in any guidance or standard'.

37. The N IPA advised that '*an MSU (midstream sample) and CSU (catheter sample) are appropriate methods for obtaining a sample of urine in this age group when a UTI is suspected following medical assessment. For MSU in an incontinent patient, a bed pan could be used at frequent intervals (for example two hourly); however this does not always produce the desired result. The cotton wool however is not appropriate as it could only have been taken from the pad and thus it can be heavily contaminated (it will catch other bodily waste such as perspiration, faeces, vaginal discharge). The need to obtain a sterile urine specimen is an appropriate rationale for a catheter (RCN guidance for nurses)*'. The N IPA advised that '*by not documenting the method of urine collection on 12th [September 2018], staff did not act in line with national records keeping standards'*.

N IPA – monitoring of fluids

38. The N IPA was asked if nursing staff appropriately monitored the patient's fluids. She advised '*it is not possible to maintain an accurate fluid balance on a patient who is incontinent of urine unless a catheter is used. However, the volume of fluids taken could be recorded. This should be discussed with the medical team and a decision made as to the need for further monitoring or the need for a catheter to maintain accurate monitoring…This is in line with local policy for patients receiving IV fluids for routine maintenance, this policy states that you should "reassess and monitor the patient" and "stop IV fluids when they are no longer needed". This should be communicated with nurses so that monitoring can either stop or continue. There is no evidence that any discussions regarding fluid balance monitoring took place'*. The N IPA also referred to points 8.5 and 8.6 of the NMC Code regarding the requirement for staff to share information with their colleagues.

39. The N IPA advised that '*fluid intake over 10th to 13th [September 2018] was monitored. Fluid output could not be monitored as the patient was incontinent. Fluid intake was incomplete and not calculated on 12th [September 2018] and it is not clear why fluid intake monitoring stopped on 13th [September 2018]*'. She

further advised that her '*assumption is that it was not necessary. This is because output could not be monitored, she was not taking much orally, and IV intake could be monitored from IV charts'*. The N IPA advised that '*fluid balance charts were not maintained accurately on 12th and stopped on 13th [September 2018]. Monitoring was therefore not in line with national or local guidance'*.

40. The N IPA was asked if nursing staff appropriately escalated their concerns about the patient to medical staff. She advised '*the times when the patient was escalated were appropriate as they were either in response to deterioration (the raised NEWS[22] and the low oxygen saturations) or to clarify the management plan. The patient was escalated on a daily basis and I could not see any other reasons for her to be escalated more frequently. Escalation was therefore appropriate and in line with national standards'*.

N IPA – use of incontinence pads

41. The N IPA advised, '*it is identified that pads were used from admission through until 14th [September 2018] when the catheter was inserted'*. She further advised that '*the patient's incontinence was managed appropriately. This is because she was checked regularly throughout the day and her skin remained intact over this time period'*. In relation to the insertion of a catheter, the N IPA advised one should not be inserted for '*nurse convenience. There should be an appropriate rationale for its use (RCN 2012 Catheter Care). In this instance, the catheter was used initially to obtain a clean sample of urine. It was then left insitu until the patient died three days later'*.

N IPA – monitoring of patient's glucose levels

42. The N IPA advised that '*the patient was very unwell and 'safe' diabetic control was needed rather than 'excellent' diabetic control. There is no national standard for the frequency of monitoring in such circumstances. The Royal Marsden guidance…suggests once or twice a day, more if needed'*. The N IPA further advised that '*the patient's blood glucose levels were monitored from 11th through to 15th [September 2018]. They were monitored 3 or 4 times a day. On*

[22] National Early Warning Score – a tool used to detect and respond to clinical deterioration in adult patients.

15th monitoring stopped in accordance with the family's wishes…There were no concerns with blood glucose monitoring over the patient's admission…Escalation was appropriate'.

N IPA – nursing assessments

43. The N IPA advised that '*the ED nursing assessment is largely blank, it only contains a skin assessment and the patient's name and date of birth. The ward nursing assessment is not fully complete'*. The N IPA identified assessments that were not retained in the patient's clinical records (full details are enclosed at Appendix two to this report). She advised that '*all assessments should be completed because they inform a person-centred plan of care which is in line with NIPEC Standards…and the [NMC Code]*'.

44. The N IPA said information documented in the nursing assessments was obtained from the patient. She advised '*the concern here is that the assessment was inaccurate…The mobility pre-admission is noted as 'walks with assistance' and 'walks with a stick' despite the fact that family had informed staff that the patient has been bed bound for a week prior to admission. The nutrition and hydration section…had 'no issues' documented despite the fact that swallow was poor and she had been referred to SALT[23]. She was also nil by mouth, which was not ticked. On…response to 'do you have any current problems with your bowel?', no is ticked. This is despite the fact that she was constipated and her family stated that she had not opened her bowels for 6 -8 days….under medications, it is indicated that the patient did not have any problems swallowing her medication, this was inaccurate, she was unable to swallow her medications on admission. The patient also had cognitive problems (diagnosed with Alzheimer's prior to admission) but was only documented as 'pleasantly confused' on the nursing assessment…*'

45. The N IPA was asked if the family ought to have been consulted regarding the nursing assessment. She advised that '*information should come from the patient unless they are unable to respond; in which case it should be the family or carer. In this case, it does not appear that the patient would have been able*

[23] Speech and language therapist.

to complete their assessments…The assessment could have been completed briefly on admission to the ward, noting factors that were already known, such as urinary incontinence and poor swallow. The assessments could then have been completed fully when the daughter phoned on 11th [September 2018]'. In relation to communication, the N IPA advised that '*if the family were more involved in care planning, the rationale for using continence pads over a catheter (a catheter can increase the risk of a urinary tract infection) could have been explained; this was a major source of worry for the family and need not have been'*.

46. The N IPA was referred to nursing staff's telephone call with the patient's daughter on 11 September 2018. She advised that '*the nurse should have realised the inaccuracy of the existing nursing assessment and used the information given by the patient's daughter to fully complete the assessment. This is in line with NIPEC standards and NMC [Code]*'. The N IPA was also referred to staff's use of the term 'pleasantly confused' to describe the patient. She advised that the term '*should not be used in isolation within a nursing assessment…more detail is required'*. She further advised that '*it is good practice to ask the family to complete an 'all about me' booklet for anyone admitted to hospital with dementia. This should ensure that their preferences are known and their needs are addressed'*.

N IPA – allocation of a nurse to sit with the patient

47. In relation to the concern that a nurse was not allocated to sit with the patient when she became agitated, the N IPA advised that '*1:1 is a last resort. There are many actions that can be taken before 1:1 is required'. She further advised that '1:1 is therefore carefully considered and usually requires an application to a senior nurse…It is only to be considered when the patient is a risk to themselves or others and all other methods…have failed'*.

48. The N IPA advised that '*there is no account of the patient being a risk to themselves or others. There is only one occasion when the patient is described as 'agitated' (early hours of 14th [September 2018]). She had a relative with her who was described as 'anxious regarding same' (anxious in response to the patient's agitation). Medication was administered with 'good effect' and the*

patient settled quickly. 1:1 was not required for these reasons'. She further advised that '*what has been written within the nursing progress records/ evaluations, is in line with NIPEC standards'*.

N IPA - overall

49. In conclusion, the N IPA advised that '*nursing care was reactive to the patient's needs rather than proactive. Involving family in the care of a patient with confusion is important in the delivery of proactive and person-centred care. Furthermore, involving the family helps them to understand why decisions have been made (pads over catheter) and gives them confidence that the patient is receiving appropriate and timely nursing care. If fluid balance charts form part of the medical plan, they should be accurately documented. If the patient is incontinent of urine, a decision should be made as to the clinical need for ongoing monitoring and an agreement documented that either intake only can be measured, or a catheter can be inserted for accurate intake and output measuring'*.

50. In relation to the impact of the failings identified, the N IPA advised that the impact '*was on the patient's family. The patient's family should have been partners in their mother's care. If they were fully involved in assessment and care planning they may have been able to accept and understand that their mother died as a result of frailty and her inability to 'bounce back' from her recent illnesses and not hospital neglect*'.

The complainant's response to the draft report

51. The complainant referred to the Trust's comment that the patient did not have a UTI. She said she did not understand how it was possible to confirm this. The complainant explained that the first sample obtained was '*not an accurate method of specimen collection*'. She also explained that the sample obtained on 14 September 2018 was '*positive for a yeast infection*'. The complainant said if the patient had a urinalysis shortly after admission by in/out catheter, this '*could have highlighted the presence of a UTI and antibiotics could have been commenced at an earlier date*'. The complainant further explained that the patient presented with several signs and symptoms indicating a UTI, and she

had previous UTIs '*with a similar presentation and had been treated successfully with IV antibiotics*'.

52. The complainant also referred to the patient's records, which documented she was '*pleasantly confused*'. She explained it was highlighted to staff on numerous occasions that the patient's symptoms, '*including the delirium, was new and there was no dysphagia until two days prior to admission*'. The complainant said there was '*a sense of urgency to commence antibiotics as it is known that a UTI can exacerbate dementia*'. She explained that while the patient's CRP decreased, '*no urinalysis was appropriately obtained until 14 September 2018 to establish if a UTI was present*'.

53. The complainant said the medical team considered the patient was '*dehydrated*' and this caused confusion. She explained the patient stopped eating and drinking two days prior to hospital admission. The complainant said this '*was in-line with symptoms of a UTI*'. She also said the '*UTI caused her [the patient] to become dehydrated as [she] became drowsy at home a week prior to hospital admission*'. The complainant explained the patient's family contacted the GP, who prescribed an antibiotic, which the patient could only take for three days. She said that previously, '*oral antibiotics had no effect and IV antibiotics were successful*'. The complainant explained the patient's family had '*multiple conversations*' with the medical team. She said they expressed the patient was '*eating and drinking unassisted, no dysphagia present, living alone, sat in her chair, mobilised with a stick, plus able to carry out a normal conversation most times and only sometimes the signs of her dementia was apparent until recent illness and the symptoms were a rapid onset*'.

54. The complainant explained that when the family asked why a CSU could not be used to obtain a sample, the nursing team explained the doctor did not request it. She said a nurse explained it was a simple procedure and asked the doctor herself if it could be done. She explained the family also asked the Consultant. However, he said it was '*not necessary*'. The complainant said '*it was apparent from the multiple signs and symptoms that a UTI could be a potential diagnosis*'. She explained the patient's family '*expressed concerns many times regarding this, after witnessing the patient's history of UTIs and knowing a UTI*

could exacerbate [her] dementia'. The complainant questioned why a CSU was not obtained when the patient had UTI symptoms. She explained there was an '*absence of UTI symptoms*' in the patient's records as it refers to an AKI rather than a UTI. The complainant said the patient's symptoms were '*indicative that AKI was as a result of dehydration, however [there was a] failure for staff to consider the multiple UTI symptoms which could have caused the dehydration*'.

55. The complainant referred to the G IPA's advice that the '*basis for making the initial diagnosis of UTI is unclear. It may be due to carers reporting strong smell of urine*'. The complainant said '*there were multiple symptoms of a UTI*'. She also referred to his advice that the patient was '*almost at the end-stage dementia*'. She said this is *'incomprehensible*'. The complainant explained that a few days before her hospital admission, the patient was mobilising with a stick in her own home and living alone. She said she had no dysphagia, and was eating and drinking unassisted with no delirium and able to carry out a conversation with family. The complainant explained '*there is an apparent failure to mention that the patient's presenting symptoms were new*'.

The Trust's response to the draft report

56. The Trust said it recognised my investigation identified a delay in the process to obtain a sterile urine specimen. However, it explained that based on the patient's presentation, and that she was previously treated with three days of antibiotics (trimethoprim), '*a UTI was not the first diagnosis*'. The Trust said *'therefore, in the absence of a UTI, the collection urinalysis or sterile specimen of urine was not considered a clinical priority within her treatment plan*'.

57. The Trust explained that collection of a urine sample when the patient is incontinent is difficult. It said in the patient's case, '*it was not possible to obtain a "clean catch" MSSU*'. The Trust said it '*welcomes the opportunity to reflect on this aspect of [the patient's] care and to identify appropriate methods for obtaining a sterile urine sample from incontinent patients in line with evidence based practice and National Clinical Guidance*'.

58. The Trust further explained that '*whilst it can be difficult to accurately record fluid output in a patient who is incontinent, the Trust accept that there was a*

shortfall in this aspect of [the patient's] nursing care'. It said it welcomes the opportunity to demonstrate improvement regarding accurate record keeping for fluid balance charts.

59. The Trust said the team within Ward 6c '*pride themselves*' on the standard of person centred care delivered. It explained they '*recognise that family members and loved ones play an integral role in the care of patients, particularly those patients who present as delirious or confused*'. The Trust further explained that the staff '*accept that strong, clear lines of communication with families are critical*'. It said the team '*would like to once again sincerely apologise that this was not the experience of [the patient's] family. It was not the intention of the team to have caused any distress to the…family*'.

Analysis and Findings

Urinalysis

60. The complainant was concerned staff did not undertake a urinalysis for the patient upon her admission to the ward in the early hours of 11 September 2018. The Trust explained that the clinical impression of the patient was of acute kidney injury rather than a UTI. I note the N IPA advised that a urinalysis was not documented in the patient's medical plan. However, while I acknowledge the Trust's view, and the G IPA's advice that UTI need not have been the first diagnosis, the admission records and the ward clinical notes both document requests for an MSU (or catheter sample if necessary). I also note there is no record documenting that a urinalysis was no longer required. Therefore, I am satisfied there was a clear instruction for ward staff to undertake a urinalysis for the patient upon her admission.

61. The records document that a sample was not obtained from the patient until 02:33 on 12 September 2018. This was 21 hours after the patient was admitted to the ward. I would have expected staff to make efforts to follow the instruction and obtain a sample as soon as possible to rule out a urine infection for the patient. I accept the N IPA's advice that the process to obtain the urine sample was delayed. I consider this delay unacceptable and a failure in the patient's care and treatment. I will consider the injustice to the patient later in this report.

62. I note the N IPA's advice that the records did not document a rationale for the delay. Therefore, I cannot determine why the process experienced such a significant delay. I note the patient was incontinent and a nurse later informed the family this made it difficult to obtain a sample. However, the clinical records do not document that staff made any attempt to obtain a sample before this time. Where there is such a delay, I would expect staff to document the reason for it in the patient's clinical record. I refer to the NMC Code, Standard 10, which provides that nurses 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 that maintaining accurate and appropriate records affords protection to staff involved in a patient's care by providing a clear record of their actions (or inaction) and the treatment provided. I consider the absence of this record a service failure.

63. The clinical records document that staff obtained a urine sample and undertook a dip test for the patient at 02:33 on 12 September 2018. I am critical that staff failed to document in the records how they obtained this sample. However, I note from the clinical records a nurse later informed the family it was obtained using '*sterile cotton wool*'. The N IPA advised that this method is not recommended in any guidance. I also note her advice that it was an inappropriate method of collection given the high risk of contamination. The N IPA advised that the method of testing (reagent water test / dip test) was also inappropriate given the patient's age and that she was incontinent of urine (as outlined in NICE QS90). I note the samples showed evidence of mixed flora and yeast, which staff considered pointed to contamination rather than an infection. I consider this ought to have demonstrated to staff that the methods used to obtain the samples were inappropriate.

64. I note that staff did not initially obtain a CSU from the patient. I refer to both the Trust's Policy on Catheterisation and the RCN Guidance on Catheter Care, which state the need to obtain a sterile urine specimen is an appropriate rationale to use a catheter. I acknowledge the Trust's comment that staff considered inserting a catheter alongside the risk of maintaining the patient's

skin integrity and introducing further infection. I am critical the records do not document this consideration or the staff's rationale for not using a catheter to obtain the sample. In the absence of any documented rationale for the decision, and given the patient was incontinent of urine and other methods of collection proved unsuccessful, I accept the N IPA's advice that it was appropriate for staff to obtain a CSU.

65. I note a CSU was not obtained from the patient until 10:40 on 14 September 2018. This was three days after she was admitted to the ward and more than 48 hours after staff obtained the contaminated urine sample. I would have expected staff to have obtained a CSU as soon as it was known that the previous method of collection was unsuccessful. I consider this delay unacceptable and a failure in the patient's care and treatment. I will consider the injustice to the patient later in this report.

66. The complainant raised further concerns that the Consultant later informed her that the patient's urine samples provided negative results when they tested positive for mixed flora and yeast. I note in his letter issued to the complainant in October 2018, the Consultant explained the urine samples were '*negative for any significant organisms'*.

67. I considered if this statement was reasonable. I note that while the samples detected mixed flora and yeast, the G IPA advised there was no '*pathogenic growth on culture'*. Therefore, I consider it reasonable for the Consultant to inform the complainant that the samples did not grow any significant organisms. I do not uphold this element of the complaint. However, I consider that had the Consultant provided further clarification in his letter, it would likely have assisted the complainant's understanding.

Antibiotic

68. The complainant was concerned that staff did not continue the patient's antibiotic treatment when she was transferred to the ward on 11 September 2018. I note the patient was administered a single dose of Tazocin when she was in the ED. I also note that further antibiotics were not administered until she started displaying symptoms of a chest infection on 12 September 2018.

69. I refer to the Trust's Empirical Antimicrobial Therapy Guidelines, which state that *'antibiotic therapy should be guided by relevant culture results'.* The records document that ED staff administered Tazocin to the patient as a precaution while they awaited her culture results. I note that once obtained, the results showed an improvement in the patient's CRP level (from the previous week) and a normal white cell count. Therefore, I accept the G IPA's advice that there were no signs the patient was suffering from an infection at the time she was admitted to the ward, and there was no cause to continue the antibiotic. I consider the decision not to continue the antibiotic when the patient was admitted to the ward on 11 September 2018 appropriate and in accordance with the Trust's Empirical Antimicrobial Therapy Guidelines. I do not uphold this element of the complaint.

Monitoring of fluids and treatment with a diuretic

70. The complainant said staff did not appropriately monitor the patient's fluid balance leading to increased fluid intake. I note the patient's fluid intake was monitored from 10 to 13 September 2018. However, the patient's output was not monitored. While I note the N IPA's advice that this is normal for patients who suffer from urine incontinence, I also note her advice that nursing staff ought to discuss with the medical team a plan for monitoring fluids. However, the N IPA advised that *'there is no evidence that any discussions regarding fluid balance monitoring took place'.* In the absence of this record, I cannot conclude if staff discussed and agreed how the patient's fluids should have been monitored. I consider the absence of this plan a failure in the patient's care and treatment. I will consider the injustice to the patient later in this report.

71. I refer to the Trust's IVF Policy which states that *'fluid management will be assessed and completed at least daily or more frequently if clinically indicated'*. I note from the clinical records and from the N IPA's advice that the patient's fluid intake was incomplete and not calculated on 12 September 2018. I also note that monitoring of the patient's fluids was stopped on 13 September 2018; the reason for which is not documented in the clinical records. Based on the incomplete records, I accept the N IPA's advice that the patient's fluids were not accurately monitored on these dates. By failing to do so, I consider that

nursing staff did not act in accordance with the Trust's IVF Policy. I consider this a failure in the patient's care and treatment and I uphold this element of the complaint. I will consider the injustice to the patient later in this report.

72. The N IPA advised that monitoring of the patient's fluids may have stopped on 13 September 2018 as her '*output could not be monitored [and] she was not taking much orally'*. However, the reason for stopping the monitoring was not documented in the records. I would expect the reason for this to be clearly outlined. I note the Trust's IVF Policy states that '*information recorded on fluid prescription and balance charts is used to inform clinical decisions about care. A persistent need for improved record keeping in relation to fluid prescription and balance charts has been a key theme emerging both locally and nationally and is a priority for safe and effective care…'* I am critical of staff's failure to document the rationale for the decision to stop monitoring the patient's fluids. I consider this a failure to act in accordance with the Trust's IVF Policy and with Standard 10 of the NMC Code. I consider the absence of this record a service failure.

73. The complainant was concerned the failure to appropriately monitor the patient's fluids led to her increased fluid intake. I note the G IPA's advice that while fluid overload was suspected on 12 September 2018, this was an incorrect assumption, and the subsequent chest x-rays showed signs of infection rather than fluid overload. I do not consider there is sufficient evidence to conclude that the patient suffered fluid overload caused by inappropriate monitoring of her fluid intake.

74. The complainant also said staff delayed the prescription and administration of a diuretic for the patient. I note that following medical staff's suspicion of fluid overload, they stopped administration of IV fluids. However, they decided not to prescribe a diuretic at that time as the patient was recently dehydrated. I note the G IPA's advice that this decision was appropriate as the diagnosis of fluid overload was not confirmed at that time. I accept this advice. I consider the decision not to prescribe a diuretic earlier than 13 September 2018 appropriate and was based on the patient's clinical indicators at that time. I do not uphold this element of the complaint.

Use of incontinence pads

75. The complainant was concerned that staff used incontinence pads in the patient's bed rather than insert an indwelling catheter. I note the Trust explained that nursing staff assessed the patient's needs and did not insert an indwelling catheter to prevent risk of further infection.

76. I refer to the RCN's Guidance for Catheter Care which states that staff should *'never catheterise or continue catheter usage for nursing convenience'.* It also outlines the risks associated with the insertion of an indwelling catheter and states that there ought to be an appropriate rationale for insertion. I note the N IPA's advice that the decision to use incontinence pads rather than an indwelling catheter for the patient (prior to 14 September 2018) was appropriate. I also note her advice that the patient's skin was checked regularly and remained intact during the period the pads were used. Therefore, there is no evidence to suggest the decision to use pads caused the patient to experience any discomfort. Based on the information available to me, I consider the nursing staff's decision to use incontinence pads for the patient was appropriate and in accordance with RCN Guidance. I do not uphold this element of the complaint.

Cause of poor swallow

77. The complainant said the Consultant informed her the patient's dementia caused her poor swallow rather than the infection. She did not consider this accurate given the patient was not in the late stages of the disease. I note that shortly after the patient was admitted, nursing staff referred her to the speech and language team (SLT), as she was unable to '*initiate swallowing from a straw*'. I note that following their review, SLT were concerned about the patient's poor swallow and recommended she be placed nil by mouth. The patient was later trialled on thickened fluids. However, I note this was not continued, as the SLT considered it unsafe due to the patient's ongoing difficulties with her swallow.

78. I note in his letter to the complainant issued in October 2018, the Consultant explained that '*patients with Alzheimer's dementia often develop difficulty with swallowing*…' I consider this a general comment about patients with

Alzheimer's disease and do not agree the Consultant definitively said the disease caused the patient's poor swallow. However, I accept it can be interpreted that the Consultant considered it a contributing factor otherwise he would not have referred to it. Based on the evidence available to me, I consider the Consultant's statement reasonable. I cannot definitively conclude if the patient was in the late stages of Alzheimer's disease, and if this was the cause of her poor swallow. However, I consider it possible that the patient's Alzheimer's contributed to the swallowing difficulties she experienced while in hospital. I do not uphold this element of the complaint.

Monitoring and treatment of glucose levels

79. The complainant raised further concerns with inappropriate monitoring and treatment of the patient's high glucose levels. I note the patient's capillary glucose levels were monitored from her admission to the ward on 11 September 2018 until 15 September 2018 when her family requested for monitoring to stop.

80. I note the RM Manual recommends glucose levels to be monitored once or twice a day, or more if required. The N IPA advised the patient's levels were monitored three or four times a day until 15 September 2018, which she considered appropriate. I also note her advice that staff appropriately escalated their concerns when they obtained an abnormal result. Therefore, I consider staff monitored and recorded the patient's glucose levels in accordance with the RM Manual.

81. The records evidence the patient did not receive any medication to treat her high glucose levels during her time on the ward. However, I note that on one occasion, her IV fluid was changed from 5% glucose to normal saline, which led to a reduction in the patient's levels. I acknowledge the Trust explained that staff did not prescribe medication so as to minimise the risk of further lowering her blood sugars. I also note her levels returned to normal without any additional medication. I accept the G IPA's advice that medical staff's decision not to treat spikes in the patient's glucose levels with medication was appropriate. I do not uphold this element of the complaint.

Nursing assessments

82. The complainant said the nursing assessment for the patient was incomplete, and staff failed to obtain the patient's history from the family. I note from the clinical records that the ED nursing assessment is largely blank. I refer to the NIPEC Standards which state that staff *'must demonstrate details of all assessments, risk assessments, plans of care and reviews undertaken, and provide clear evidence of the arrangements made throughout a person's journey from admission to discharge from the service…'* Furthermore, the N IPA advised that complete nursing assessments inform staff of the plan of care for the patient. While I acknowledge the Trust's comment that the ED was particularly busy that day, I consider an incomplete ED nursing assessment would have limited the availability of clinical information for ward staff who were involved in the patient's ongoing care and treatment. I consider the incomplete assessment a failure in the patient's care and treatment. I will consider the injustice to the patient later in this report.

83. I note the N IPA's advice that the ward assessment contained inaccurate information obtained from the patient (as outlined previously in this report and in the N IPA's advice). I acknowledge that information for a nursing assessment ought to firstly come from the patient. However, in this case, the patient was diagnosed with Alzheimer's and it was noted she was 'confused' on admission. It is of great concern that the inaccurate information obtained was used to inform staff about the patient's ongoing plan of care. I accept the N IPA's advice that staff ought to have initially completed the assessment with information known at the time of admission, then later updated it with information obtained from the family.

84. I note the N IPA also advised that nursing staff failed to realise the inaccuracy of the existing assessment and failed to use information obtained from the patient's daughter on 11 September 2018 to fully and accurately complete the assessment. I consider the failure to accurately complete the ward nursing assessment was not in accordance with the NIPEC Standards and the NMC Code. I consider this a failure in the patient's care and treatment and I uphold

this element of the complaint. I will consider the injustice to the patient later in this report.

Allocation of a nurse to sit with the patient

85. The complainant was concerned that a nurse was not allocated to sit with the patient when she was agitated. I note the Trust explained it did not deem one to one nursing care necessary for the patient during her time on the ward.

86. The clinical records document one occasion in which the patient became agitated. I note that on this occasion, staff administered medication and the patient quickly settled. I note the N IPA's advice that one to one nursing is usually a 'last resort' and occurs when the patient is a risk to themselves and/or others. I note the N IPA advised there is no evidence within the clinical records to suggest the patient posed any such risk. Based on the information contained in the records and the N IPA's advice, I do not consider it was necessary for a nurse to sit with the patient during her time on the ward. I do not uphold this element of the complaint.

Injustice

87. Based on the evidence available, I partly uphold the complaint. I am satisfied the failures identified caused the patient to experience the injustice of the loss of opportunity to have a sterile urine specimen taken and tested earlier, and to have her fluid levels accurately monitored. I am also satisfied they caused the patient 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.

CONCLUSION

88. This complaint is about care and treatment Trust staff provided to the patient in ward 6c of the UH between 11 and 17 September 2018. The investigation established that the medical care and treatment of the patient was appropriate. It also established that information the Consultant communicated to the complainant in his letter in October 2018 was appropriate. The investigation did not identify failures with nursing staff's decision to use incontinence pads in the patient's bed, or with their monitoring of the patient's glucose levels. It further established it was not necessary for a nurse to sit with the patient at any time

during her time on the ward.

89. The investigation identified delays in the process staff followed to obtain a sterile urine specimen. It also established that the methods used to obtain the urine sample from the patient on 12 September 2018 were inappropriate. I am satisfied these failures caused the patient to experience the injustice of the loss of opportunity to have a sterile urine specimen taken and tested earlier. The investigation found that staff failed to document reasons for the delays, which I considered a service failure.

90. The investigation established that the records did not provide evidence that staff discussed and agreed how the patient's fluids ought to be monitored. It also identified that staff failed to appropriately monitor the patient's fluid levels on 12 September 2018. I am satisfied this caused the patient to experience the injustice of the loss of opportunity to have her fluid levels accurately monitored. It also established that staff failed to document the rationale for the decision to stop monitoring the patient's fluids on 13 September 2018, which is considered a service failure.

91. The investigation found the ED nursing assessment was largely blank and the ward nursing assessment inaccurate. It identified that staff failed to correct the inaccuracies using history obtained from the patient's family. I am satisfied the failures identified caused the patient 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.

Recommendations

92. I recommend the Trust discusses the findings of this report with the staff involved in the patient's care within **one month** of the date of this report.

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

i. The importance of obtaining sterile urine specimens from patients within an appropriate timeframe, in accordance with relevant guidance, where there is a clear instruction to do so;
ii. Appropriate methods for obtaining a sterile urine specimen from incontinent patients over the age of 65, in accordance with NICE QS90;
iii. The importance of monitoring patients' fluid levels in accordance with the Trust's IVF Policy;
iv. The importance of fully and accurately completing patients' nursing assessments, and using history obtained from those close to the patient, if necessary; and
v. The importance of creating and retaining contemporaneous records of care and treatment provided to patients in accordance with Standard 10 of the NMC Code. This should include the importance of documenting reasons for any delays experienced and rationales for decisions taken.

94. While the complainant did not raise a specific concern about communication, I wish to highlight the N IPA's observation regarding nursing staff's communication with the patient's family. She advised the family ought to have been 'partners' in the patient's care. I consider that had staff communicated more closely with the patient's family during her time on the ward, it would likely have assisted their understanding of the reasons for her deterioration. I recognise the impact reduced communication has on families. While not a formal recommendation, I would ask the Trust to reflect on its staff's communication with patients' families and/or next of kin, and the importance of documenting such conversations in the relevant records.

95. I wish to offer my condolences to the complainant and her family on the loss of their mother. It is clear the complainant was keen to ensure her mother received the highest level of care and treatment available. I hope the information contained in this report answers some of the remaining questions she had in relation to the care provided to her mother.

MARGARET KELLY
Ombudsman **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.