Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Belfast Health & Social Care Trust

NIPSO Reference: 20976

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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: 20976
Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust) in relation to the care and treatment the staff of the Belfast City Hospital (BCH) provided to the complainant's husband (the patient) following gastrectomy surgery on 24 February 2016. The complainant believed that the patient was discharged prematurely from the intensive care unit and that the monitoring of the patient on Ward 2 North by nursing staff was not appropriate.

In order to assist with the consideration of the issues raised by the complainant independent professional advice was obtained from an experienced Consultant in Emergency and Critical Care Medicine and a Ward Sister with appropriate experience in the management of patients.

The investigation established that the patient ought not to have been discharged from the Intensive Care Unit on 25 February 2016. As a result the patient was not given the most appropriate treatment for approximately 12 hours. However I was unable to determine if this failure had a detrimental impact on the patient. I was satisfied that the complainant experienced the injustice of uncertainty and upset as result of the patient's discharge for the Intensive Care Unit on 25 February 2016.

The investigation also established failures in the monitoring of the patient on Ward 2 North of BCH. These included occasions when monitoring was not carried out in line with national guidance; the inaccurate calculation of NEWS scores; and the recording of the patient's level of consciousness score accurately and clearly.

I concluded that there these failures in the care and treatment did not cause any harm to the patient. However I was satisfied they caused the complainant to experience the injustice of uncertainty and upset. I recommended that the Chief Executive apologise to the complainant and set out recommendations for service improvement and to prevent future recurrence.

THE COMPLAINT

1. I received a complaint about the actions of Belfast Health & Social Care Trust (the Trust) in relation to the care and treatment the staff of Belfast City Hospital (BCH) provided to the complainant's husband (the patient). The complainant said the patient was discharged, on 25 February 2016, from the Intensive Care Unit[1] (ICU) prematurely, following gastrectomy[2] surgery the previous day. The complainant further believed that the patient failed to receive adequate monitoring from nursing staff on Ward 2 North of BCH following his gastrectomy surgery.

Background

2. The patient was admitted to Ward 2 North of BCH on 23 February 2016. On 24 February 2016, immediately following gastrectomy surgery, the patient was admitted to the ICU at 14.00. At around 12.00 on 25 February 2016 the patient was discharged to Ward 2 North from the ICU. However, on developing a respiratory infection the patient returned to ICU on 26 February 2016 at 00.05.

3. He was discharged to Meadlowlands, Musgrave Park Hospital (MPH) on 4 July 2016. The patient passed away at MPH on 21 November 2016. A chronology detailing the events leading to the complaint is contained at Appendix two to this report.

Issues of complaint

4. The issues of complaint accepted for investigation were:

Issue 1: Was the patient medically fit to be discharged from ICU on 25 February 2016?

Issue 2: Did the patient receive appropriate monitoring from the nursing staff on Ward 2 North from 25 February 2016 until his discharge on 4 July 2016

[1] A department of a hospital in which patients who are seriously ill are kept under constant observation
[2] Removal of stomach

INVESTIGATION METHODOLOGY

5. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of complaint.

Independent Professional Advice Sought

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

- **Consultant in Emergency and Critical Care Medicine,** MB ChB, MD, MRCP, FRCSEd, FRCEM, FFICM – A consultant with over 20 years' experience and 10 years' experience in managing postoperative upper gastrointestinal surgical patients in critical care areas. (C IPA)
- **Registered General Nurse**, Diploma in Adult Nursing – A Senior Sister with over 9 years' experience in acute assessment and 6 years' experience in a colorectal/gastro surgical ward. (N IPA)

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

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

Relevant Standards and Guidance

8. 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[3]:

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

9. The specific standards and guidance 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 and individuals whose actions are the subject of this complaint.

10. The specific standards and guidance relevant to this complaint are:

- The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
- The Nursing and Midwifery Council's (NMC) Code: Professional standards of practice and behaviour for nurses and midwives, March 2015 (the NMC Code);
- Public Health Agency (PHA): The Northern Ireland Regional Infection and Prevention Control Manual (the PHA guidance);
- Public Health England: Extended-spectrum beta-lactamases[4] (ESBLs): FAQs, December 2013 (ESBLs guidance); and
- Royal College of Physicians' (RCP) National Early Warning Score (NEWS[5]): Standardising the assessment of acute-illness severity in the NHS, 2012 (the RCP NEWS guidance).

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

[3] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[4] Bacteria that produce enzymes called extended-spectrum beta-lactamases (ESBLs) and are resistant to many penicillin and cephalosporin antibiotics and often to other types of antibiotic
[5] A guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs.

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: Was the patient medically fit to be discharged from ICU on 25 February 2016?

Detail of Complaint

13. On 23 February 2016 the patient was admitted to Ward 2 North of BCH for gastrectomy surgery. On 24 February 2016, immediately following the gastrectomy surgery, the patient was admitted to the ICU at 14.00. At 12.06 on 25 February 2016 the patient was discharged to Ward 2 North from the ICU. However, on developing a respiratory infection the patient returned to ICU on 26 February 2016 at 00.05. In particular the complainant said the patient was discharged, on 25 February 2016, from the ICU prematurely, following the gastrectomy surgery the previous day. She believed this may have had repercussions on his recovery.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following guidance:
    - the GMC Guidance

The Trust's response to investigation enquires

15. The Trust was asked if the patient was medically fit to be discharged from the ICU on 25 February 2016. It explained that Dr A, Consultant Anesthetist, reviewed the electronic notes and records and *'can confirm that both he and [Dr B] are confident that [the patient's] admission, care, and assessment for discharge were carried out in*

a considered and appropriate manner. Specifically [the patient] was reviewed and examined on the morning after his surgery by both the Intensive Care Unit (ICU) and surgical teams and later the same morning his progress, vital signs, blood tests and care plan were reassessed by two consultants, ICU trainees and senior ICU nurses on the ward round. He required no organ support and was considered fit for discharge back to the inpatient ward.'

16. The Trust provided further comments to explain how intensive care is applied to post-operative patients *'There is no pre-set time period for admission to ICU. All patients are assessed on their clinical requirements and discharged as soon as those requirements can be met at ward level. Only patients who require ongoing organ support remain in intensive care and are discharged as soon as they are independent. Organ support includes mechanical ventilation, dialysis, administration of potent drugs to support blood pressure and other invasive therapies.* The Trust explained that *'Oxygen by facemask, intravenous fluids, analgesic techniques such as morphine drips or epidurals and feeding tubes are not ICU therapies and are carried out at ward level. Specifically, patients are not admitted to, nor kept in, ICU for the single purpose of observation. It should also be stressed that ICU is not a benign environment and all our patients are at risk of complications associated with ICU such as acute delirium, which has a significant associated mortality risk. This is why we move patients to ward level as soon as possible.'*

17. The Trust provided evidence as to how soon patients were moved to ward level. Dr A *'reviewed the last 26 patients who were admitted to ICU after gastrectomy. Of these, 21 were discharged within 24 hours of admission. Two patients stayed for 48 hours, two stayed for 72 hours and one patient for four days.'* The Trust hoped that '*this explanation may provide some reassurance that [the patient's] care was delivered with due consideration and was no different in timescale to the vast majority of patients undergoing similar surgery*.'

Clinical Records

18. I considered the patient's ICU records provided by the Trust:

19. I note the patient was admitted to ICU on 24 February 2016 at 14:00. I note the patient's skin bundle documents at 07:00 on 25 February 2016 under the heading 'is patient lying on lines/leads/drains etc?' *'yes'.* I also note the patient's flowsheet for his first admission on which the patient's heart rate is recorded at 08:00 as 109, at 09:00 at 122 and at 11:00 at 103. The patient's AVPU[6] score is recorded as A. [Alert] An Intensive Care Discharge Letter was completed by Dr C, CT2[7] for Dr B at 12:06 on 25 February 2016. Within the ICU discharge letter under the heading 'Ongoing problems and management plan' Dr C records *'Communication issues – expressive dysphasia[8]. Epidural in situ but unable to assess block. Seems settled but sore when moving – c/w epidural. Poor cough – will require physio. Tachycardic overnight –received stat metoprolol to good effect.'* I note the patient's NEWS was recorded as 6 and 8 at 12.20 and 13:00 on 25 February 2016 on return to Ward 2 North.

20. I considered the 'Management of UGI (Upper Gastrointestinal) patients in ICU form dated 24 February 2016 13.31. Under the heading of *'Respiratory and Physiotherapy'* the points

    '…• Deep breathing exercises

    • Incentive spirometry[9]

    • Mobolise (stand / walk 50m) on Day 0

    • Increasing distances over following days…'.

    Under the heading of *'Analgesia'* the points

    '…• Regular Paracetamol 1g IV 6 hourly

    • Epidural at 8-12 mls/hour plus patient delivered boluses PRN

    • Bolus 2 x 5 mls 0.25% L-bupivicaine manually if needed...'

    Under the heading of 'Other' the point *'…• Discharge to ward - target Day 5…'*

21. I also considered the Trust's written response to the complainant, dated 13 March 2018 and 14 December 2018. The Trust stated that *'…Dr B and Dr A both agree that [the patient's] transfer out of the Critical Care Unit of 25 February 2016 did not*

[6] Refers to level of responsiveness: alert; responsive to verbal stimuli; responsive to painful stimuli; and unresponsive
[7] Core Trainee 2, which means that the doctor has completed their undergraduate medical degree, two years of foundation year training (F1 and F2) and one year of specialisation
[8] impairment in the production of speech
[9] A medical device used to help patients improve the functioning of their lungs.

adversely affect his recovery.' '…Unfortunately, [the patient] suffered from an unexpected deterioration later that day and required further respiratory support. [The patient] was transferred back to ICU on 00:05hrs on 26 February 2016…'

Relevant Independent Professional Advice

22. As part of investigation enquiries I received independent professional advice from a C IPA.

23. The C IPA advised that the patient's admission to ICU was planned. As the surgical procedure the patient underwent was *'…associated with a high risk of complications…'* and the patient's *'…long-term physical health status meant that he was at high risk of postoperative complications… a planned admission immediately post operatively is normal practice.'*

24. The C IPA was asked to comment on examinations or tests the patient received before discharge from ICU on 25 February 2016. He advised that the clinical staff involved in the patient's care undertook *'…what appears to be a standard critical care examination…' '… It is recorded that the patient had a heart rate of 120-130 and was in an abnormal rhythm (atrial fibrillation). This rate is higher than normal. They also identified communication issues with the patient. Pain was an ongoing issue. They documented that [the patient] was on no organ support and that his pain level was hard to assess. They planned to top up the epidural for pain relief and discharge him to the ward later that day.'* He further explained that the nursing assessments recorded *'…that the patient was very drowsy but normally had expressive dysphagia (sic). They noted that [the patient] had no cough or expectorate. They noted it was difficult to assess the state of his delirium. They record the administration of the epidural top up but had difficulties assessing the benefit for the patient.'*

25. The C IPA went on to advise that the physiotherapist recorded at 13:30 on 24 February the patient *'…was drowsy but momentarily rousable. In the problem list they have recorded that the patient had the potential to retain secretions, was in pain and had decreased mobility. A further record is documented at 1610hr. Shorthand text is used but I think that the record states – asked to see acutely, drowsy but rousable…deep breathing exercises encouraged but limited cooperation due to*

drowsiness, no cough to command…stable. The following day the patient was recorded to be in bed, drowsy ++. The therapist attempted to position [the patient] into a high upright position (which is better for deep breathing and secretion clearance) but he was non-compliant and was unable to cough to command. [Dr A] was aware.'

26. The C IPA advised that he could not *'…think of any further examinations or tests that would have added more information to support the discharge decision.'*

27. In relation to the examination results and tests the C IPA advised that the patient's *'…high risk status remained stable during his first 24 hours of critical care stay. He had issues with (1) his heart rate, (2) respiratory compromise due to baseline cognitive functions as well as (3) the operation site and drains. This respiratory compromise impacted his ability to clear his own secretions even with the help and encouragement of a therapist. He demonstrated an inability to provide any self-care. Pain was not well controlled and was difficult to assess.*

28. The C IPA was asked to comment on whether the patient should have been discharged from ICU on 25 February 2016. He advised that *'On the basis of the information provided I do not think that [the patient] should have been discharged from the ICU on the 25th February 2016.'* The C IPA went onto explain two rationale for his comments. *'…The first is based on the clinical record. [The patient's] admission was prompted because of a high-risk procedure undertaken in a high-risk patient. Neither of these factors were adequately resolved in the post-operative time prior to discharge. There are clear observations recorded by medical, nursing and therapy staff that document his respiratory capacity was challenged. This was demonstrated by his inability to clear his own secretions nor remain in a posture appropriate to clearing them. This is before the question of pain relief is discussed. The second clear reason is that the local standards documented for the management of upper gastrointestinal patients were not achieved. The document in the bundle is '[Patient] Man UGI Pts 1st adm.pdf'. The patient was unable to perform deep breathing exercises, I am unable to find a record of incentive spirometry use, the patient had not been mobilised or stood on day 0, he had been given maintenance*

fluid, he had only received a single dose epidural bolus. In the document under 'other' it is clear that the target date for discharge is postoperative day 5.'

29. He went on to advise *'There are NICE guidelines on pathways for patients with gastrectomy. Within the document there are no specific standards on the particular questions of the [patient's] care. The local standards developed by the hospital are very similar to our own.*'

30. In relation to any impact on the patient the C IPA advised that *'…I cannot conclude that his discharge caused his deterioration but there were certainly a number of hours where a critical care environment, as opposed to a ward environment, may have slowed his deterioration.'*

31. **Trust's Response to draft report**
The Trust disagreed with the C IPA's opinion that the patient should not have been discharged from ICU on the 25 February 2016 and stated that based on the evidence in the medical records that it was unfair to suggest that there was a failure in care in treatment. It went on explain that *'Inevitably, there will be occasions when patients are discharged to the ward and require re-admission to ICU. In [the patient's] case, he was promptly remediated to ICU…and he received the high level of care needed.'*

32. The Trust also provided further rational for its decision making in response to the C IPA's advice in relation to the patient's heart rate, respiratory compromise, operation site and drains and issue of pain. It disagreed with the provisional finding that there was a loss of opportunity for the patient to receive the most appropriate treatment as; the care given on the ward was not of lower standard. The Trust also wished to highlight the aspects of the draft report that suggested that patients following gastrectomy usually have a target discharge from ICU of day 5. It explained this is not the case as demonstrated by looking at the length of stay for other patients with the same procedure. *'…The reference to day 5 is in fact in relation to patient undergoing Oesphagectomy surgery, and in many cases these patients do not remain in Intensive Care as long as this.' We do not routinely use the 'Management of UGI patients in ICU' pathway for patients post Gastrectomy surgery, however, neither do we discourage its use as an aide memoir to assist our staff who wish to avail of*

information contained, for instance to set haemodynamic targets. This is likely the case why the form was created in this case. There is not a different…pathway for patients undergoing Gastrectomy surgery, however it is worth mentioning that all patients in Intensive Care undergo at least twice daily assessment by a consultant intensivist with assessment and setting of targets specific to the patient in question.' A summary of the additional medical information provided by the Trust is enclosed at Appendix six to this report.

33. The Dr B acknowledged his regret the patient's family *'…have experienced distress as a result of his discharge from Intensive Care. I am led to believe that they had understood that following his type of surgery that patients usually stay longer than 24 hours. Although this is not the case I can understand how this may have been distressing for them. I would like to assure [the patient's] family that at all time I have only acted with [the patient's] best interest in mind.'*

34. The Trust apologised to the complainant for the length of time it took to provide its response. They explained that this was due to the Covid-19 pandemic and that both Drs A and B were not able to review the draft report sooner as they were providing care to critically ill patients in the Nightingale Intensive Care Unit.

Further Independent Professional Advice received.

35. Following receipt of the Trust's response to the draft report, I sought additional C IPA advice. The additional clinical advice I received is enclosed at Appendix four to this report.

36. In relation to the patient's heart rate the C IPA advised *'…The patient's heart rate was consistently recorded to be over 100 beats per minute during his admission. This was despite the administration of a drug to slow the heart rate down. This is a red flag of concern indicating that the patient's physiology is under a degree of stress that the body cannot resolve… It would be very unusual to discharge a patient to a surgical ward environment whilst still scoring on the NEWS… In this case, [the patient's] final set of observations…gives an aggregate score of 8 which is a patient at high clinical risk in whom the Royal College of Physicians suggest an urgent/emergency response should be provided to….'*

37. In relation to the patient's respiratory compromises the C IPA advised that the partial pressure of oxygen recorded at 13:30 was *'…from a sample taken at approximately 0500 that day. At 1100 hours the partial pressure of oxygen was documented to be 8.1. The Trust have positioned themselves that 11 was an acceptable level for a post-gastrectomy patient. They go further to suggest that 11 would 'not usually cause a concern prior to discharge'….most importantly, [the patient] was not a 'usual' patient – he was at high risk of respiratory complications as a result of his baseline characteristics…'* He went on to query the record of 'effective cough' documented at 08:45 and advised that the physiotherapist record at 10:*18 '…clearly contradicts the assertion of 'effective cough'…'*

38. In relation to the patient's drain/operation site the C IPA agreed with the Trust that *'The presence of postoperative drains do not in of themselves preclude discharge from a critical care unit to a ward. In this case the issue was the inability of the patient to self-care for the positioning of the drains and any potential consequent problems like pressure areas…'* The patient's Skin Bundle 1st adm) records *'…[patient] 'lying on lines/leads/drains etc'. This is a red flag of concern to me.'* He went on to advise, about patient's pain, that *'…From the record I can only suggest that he was in some pain as evidenced by the raised heart rate, the requirement for a top up and the physiotherapist comment on the morning assessment. There were certainly efforts to control the pain…'*

39. In relation to the 'Management UGI (Upper Gastrointestinal) patients in ICU' form the C IPA advised the form *'…is clearly a standard of care that the Trust have. The document is titled to suggest that it covers upper GI surgery which includes stomach surgery. It does not discriminate between different types of surgery and indicates no inclusion or exclusion criteria. It is used by junior staff and this is permitted. It is de facto a standard.'*

40. The C IPA commented on the Trust's comments made about delirium in ICU patients. He advised the patient *'…was at higher risk of developing delirium because of his age, baseline characteristics and nature of his surgery… more care should have been*

made to ensure preventative interventions were made including a reduction in the number of ward moves.' He went on to disagree with the Trusts opinion the care during the first 5 hours in ICU was the same as on the ward. *'…[The patient] had an arterial line inserted at/around 0100 hours to monitor his condition. Arterial lines are not part of routine care on a ward. [The patient] had 1:1 nursing care on ICU. This nurse:patient ratio is not part of routine care on a ward. [The patient] had a resident doctor on the ICU for just those patients. This doctor:patient ratio is not part of routine care on a ward. To suggest that [the patient] benefitted in no way during the first 5 hours of his re-admission to ICU is patently not the case. If the Trust believe this then they conducted an inappropriate ward move (back to ICU) of a patient who was at high risk of delirium and in whom ward moves should have been limited…'*

41. The C IPA further indicated that in addition to a staffing gap surgical wards do not have the *'…constant monitoring equipment to provide the level of observation, care, pain management, encouragement to perform respiratory therapy, access to physiotherapy/medical staff etc that is available on an intensive care unit. These may have delayed, or avoided, an urgent reintubation and invasive ventilation. The severity of [the patient's] delirium may have been reduced by keeping him on the intensive care unit and not undertaking a discharge/re-admission. It is difficult to quantify this.'* The C IPA advised that he was *'…still of the opinion that [the patient] should not have been discharged form ICU on 25th February. There were a series of red flags of concern both from his pre-operative characteristics as well as the nature of the surgery, physiological progress and pain management in the post-operative period.'*

The Trust's response to additional IPA advice

42. In response to the CIPA's comments about the patient's heart rate it explained that *'…his heart rate had increased peri-operatively. He received iv metoprolol and enteral atenolol which settled his rate to around 100. He also received a bolus of alfentanil 1mg and levobupivacaine at 09:46 after which he was transiently drowsy but easily roused and appeared comfortable. We do not agree that his NEWS was 8 at time of discharge, but calculate it to be 5 at worst.'* Dr A explained, in relation to the patient's cough effectiveness that the *'…[the patient's] expressive dysphasia is documented,*

but he also had difficulty following commands and, when placed in a stressful environment, would withdraw completely. However, his spontaneous cough was effective from my assessment on day of discharge.'

43. In relation to the patient's drains, the Trust advised '*The electronic record shows that [the patient's skin bundle documents him to be clear of lines/leads/drains etc….'* The Trust reiterated that *'The management of UGI patient documents in the pathway section is advisory only and designed for oesophagectomy patients…They have been retained in the electronic record only as a guideline.*' It went on to acknowledge *'…that assessment of pain was difficult – [The patient] replied yes to every question that was put to him. There was no clinical indication that he suffered from significant wound pain.'* The Trust also agreed that the patient *'…was at high risk of developing delirium. He was particularly sensitive to the stressful environment of ICU where lighting, noise, alarms etc could not be eliminated…'* However it explained that *'The decision to discharge [the patient] was made as his condition was stable and in order to reduce his exposure to the environment which was causing him distress and was likely to increase his risk of acute delirium.'* The Trust maintained that the patient *'…received person centred care with the intention to lessen his risk of complications and produce the best outcome from his surgery…'*

Analysis and Findings

44. The complainant raised concerns that the patient was discharged, on 25 February 2016, from the ICU prematurely. She believed this may have had repercussions on his recovery.

45. I note from the clinical records that the patient was admitted to ICU on 24 February 2016 at 14:00. I further note that at 07:00 on 25 February 2016 the patient was lying on his lines/drains and at 11:00, before discharge from the ICU, the patient's heart rate was 103 and he was recorded as being alert.

46. I note the Trust's comments that *'…both [Dr A] and [Dr B] are confident that [the patient's] admission, care, and assessment for discharge were carried out in a considered and appropriate manner...[the patient] required no organ support and was considered fit for discharge back to the inpatient ward.'* Also that the patient

'…received person centred care with the intention to lessen his risk of complications and produce the best outcome from his surgery…'

47. I also note the Trust's comments that *'There is no pre-set time period for admission to ICU. All patients are assessed on their clinical requirements and discharged as soon as those requirements can be met at ward level. Only patients who require ongoing organ support remain in intensive care and are discharged as soon as they are independent….Specifically, patients are not admitted to, nor kept in, ICU for the single purpose of observation…ICU is not a benign environment and all our patients are at risk of complications associated with ICU such as acute delirium, which has a significant associated mortality risk. This is why we move patients to ward level as soon as possible.'* I further note the Trust's comments about the Management of UGI patients in ICU' form '*…is advisory only and designed for oesophagectomy patients…They have been retained in the electronic record only as a guideline…The reference to day 5 [target discharge] is in fact in relation to patient undergoing Oesphagectomy surgery…]* I also note the Trust's information as to how soon patients were moved to ward level following of gastrectomy surgery as outlined in paragraph 17 above.

48. I also note the Trust's further comments about the patient's heart rate, NEWS score, effective cough, pain assessment and him being clear of drain/lines. I further note its comments about the patient's risk of developing delirium and that the *'…decision to discharge [the patient] was made as his condition was stable and in order to reduce his exposure to the environment which was causing him distress and was likely to increase his risk of acute delirium.'* I also note the Trust comments about the standard of care provided on the ward before being re-admitted to ICU.

49. I note the C IPA advice about the Management UGI (Upper Gastrointestinal) patients in ICU' form that it*'…is clearly a standard of care that the Trust have. The document is titled to suggest that it covers upper GI surgery which includes stomach surgery. It does not discriminate between different types of surgery and indicates no inclusion or exclusion criteria. It is used by junior staff and this is permitted. It is de facto a standard.'*

50. I note the C IPA's advice that*'…The patient's heart rate was consistently recorded to be over 100 beats per minute during his admission….'* and '…*[the patient's] final set of observations…gives an aggregate [NEWS] score of 8 which is a patient at high clinical risk…'* I further note his advice on the Trust's opinion about the patient's partial pressure of oxygen and that the patient '…*was at high risk of respiratory complications as a result of his baseline characteristics…'* I also note the C IPA advised that in his view the physiotherapist record *'…clearly contradicts the assertion of 'effective cough'…'* I further note his advice about the patient drains and that the issue of concern being '…*the inability of the patient to self-care for the positioning of the drains and any potential consequent problems like pressure areas…'* I also note the C IPA's advice that *'…There were certainly efforts to control the pain…'* of the patient and the evidence provided why he advised the patient was in some pain

51. I further note the C IPA's advice that '*To suggest that [the patient] benefitted in no way during the first 5 hours of his re-admission to ICU is patently not the case. If the Trust believe this then they conducted an inappropriate ward move (back to ICU) of a patient who was at high risk of delirium and in whom ward moves should have been limited…'* and that additional provisions within the ICU '…*may have delayed, or avoided, an urgent reintubation and invasive ventilation. The severity of [the patient's] delirium may have been reduced by keeping him on the intensive care unit and not undertaking a discharge/re-admission. It is difficult to quantify this.'* I also note the C IPA's advice that the patient *'….should not have been discharged form ICU on 25th February. There were a series of red flags of concern both from his pre-operative characteristics as well as the nature of the surgery, physiological progress and pain management in the post-operative period.'*

52. The C IPA's advice on discharge was based on two rationale. The first rationale being *'…the clinical record. [The patient's] admission was prompted because of a high-risk procedure undertaken in a high-risk patient. Neither of these factors were adequately resolved in the post-operative time prior to discharge. There are clear observations recorded by medical, nursing and therapy staff that document his respiratory capacity was challenged. This was demonstrated by his inability to clear his own secretions nor remain in a posture appropriate to clearing them.'* The second rationale was

based on the local standards documented for the management of upper gastrointestinal patients not being achieved as *'…The patient was unable to perform deep breathing exercises*,…being unable to *'…unable to find a record of incentive spirometry use*, *'…the patient had not been mobilised or stood on day 0, he had been given maintenance fluid, he had only received a single dose epidural bolus… it is clear that the target date for discharge is postoperative day 5.'*

53. I acknowledge the differing opinions of the Trust and C IPA regarding the interpretation of the clinical record. It is clear that the management of the patient required the exercise of professional judgement across a range of issues to inform the most appropriate plan of care, including whether the patient should remain in ICU. Based on my review of the records and the information provided by the Trust and the C IPA, I am persuaded by the Trust's view that the patient's NEWS score was 5 at the time of discharge. , I also note the patient's score had increased to 8 within one hour of returning to Ward 2 North. The C IPA has provided detailed advice relating to other clinical matters, including the difference in the level of care provided on surgical ward and the care and in the ICU and on the decision to discharge the patient from the ICU. Having considered the C IPA's advice against the clinical records and the Trust's view I am persuaded by the advice of the C IPA. In relation to the second rationale, I note the C IPA's view about the local standards documented within the Management UGI (Upper Gastrointestinal) patients in ICU form. However, I am persuaded by the Trust's explanation that the form '…*is advisory only and designed for oesophagostomy patients…'* and it had *'been retained in the electronic record only as a guideline..'* I also accept that the 5 day discharge target is also for oesophagostomy patients. However, I would ask the Trust to consider reviewing the form/aid memoir to minimise confusion around the standards being referenced to by staff for either oesophagostomy or gastrectomy patients, including that the 5-day target relates to oesophagostomy surgery only.

54. I acknowledge the information provided by the Trust as to how soon patients were moved to ward level following gastrectomy surgery, and that day 5 is not a target for discharge. I also acknowledge the range of factors that are taken into account in determining the most appropriate plan for the management of a high risk patient.

However, on balance having reviewed the records and having the benefit of the Trust's view and that of the C IPA, I consider the patient should not have been discharged from the ICU to the surgical ward on the 25 February. I therefore uphold this issue of the complaint.

55. As a result of this failing I consider the patient experienced the injustice of loss of opportunity to be given the most appropriate treatment for approximately 12 hours. However, I note the advice of the C IPA that he *'…cannot conclude that his discharge caused [the patient's] deterioration but there were certainly a number of hours where a critical care environment, as opposed to a ward environment, may have slowed his deterioration.'* I accept this advice and therefore I am unable to conclude that had the patient remained in ICU at that time the patient's condition would not have deteriorated. I also note that the patient was readmitted to ICU on 26 February 2016 at 00:05

56. I also consider that the complainant experienced the injustice of uncertainty and upset as result of the patient's discharge.

Issue 2: Did the patient receive appropriate monitoring from the nursing staff on Ward 2 North from 25 February 2016 until his discharge on 4 July 2016?

Detail of Complaint

57. The patient was admitted to Ward 2 North of BCH on 23 February 2016 for gastrectomy surgery on 24 February 2016. Following surgery the patient had an overnight stay in the ICU and then was discharged to Ward 2 North. The following day the patient deteriorated and returned to ICU. He then returned to Ward 2 North from 5 March 2016 to 6 May 2016. The patient again returned to ICU from 6 May 2016 to 9 May 2016 after which he was cared for on Ward 2 North until 20 June 2016. On 20 June 2016 the patient was transferred to Meadowlands Care of Older People facility, MPH. However, due to the development of a respiratory infection was transferred back to BCH, Ward 6 South, on 21 June 2016. The patient remained on Ward 6 South until his final discharge back to Meadowlands on 4 July 2016. The

complainant believed that the patient failed to receive adequate monitoring from nursing staff whilst on the Ward 2 North of BCH following his gastrectomy surgery. This included monitoring when in 'isolation' close to the nurses' station.

Evidence Considered

Legislation/Policies/Guidance

58. I considered the following guidance:

- the NMC Code;
- the RCP NEWS guidance;
- the ESBLs guidance; and
- PHA guidance.

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

Trust's response to investigation enquires

59. In response to the complainant's comment that the patient was not monitored closely enough in the bay/ward, the Trust provided details as to level of nursing on Ward 2 North. It explained *'The nurse-to-bed ratio in an adult ward is less than that of an intensive care unit. The nurse-to-bed ratio on the adult ward...was 1 registered nurse-to-5 beds or patients during the day and 1 registered nurse-to-8 beds or patients during night duty. At all times these registered nurses are supported by at least two health are assistant staff.'* It also explained *'…the ward sister, along with the nursing team, will prioritise patients who are higher dependency and will adjust nursing levels and patient allocation accordingly. At times when [the patient] was clinically unwell, registered nurses will have remained with him and responded to his needs appropriately.'*

60. When the patient was suffering from post -operative delirium the Trust commented that *'The patient did not require one to one nursing supervision on the ward but he required close observation…' 'Additional staff were requested to ensure a member of staff was able to remain with him. As these staff were additional to the normal staffing complement, we were reliant on nursing bank and agency staff to fulfill these*

duties. At times, some of these additional nursing shifts remained unfilled and the ward nursing staff had to adapt the staff allocation to ensure [the patient's] needs were met.'

61. The Trust was asked if the patient received the appropriate monitoring from nursing staff on Ward 2 North from the 25 February 2016 until his discharge on 4 July 2016. The Trust explained *'The clinical team responded to [the patient's] clinical and cognitive needs and provided care according to his particular needs.'* It went on to explain that *'The Ward Sister following careful discussion with his consultant surgeon, the Patient Flow Team as well as the Infection Prevention and Control team, decided [the patient's] placement on the ward.' [The patient] was cared for at different locations on the ward during the course of his admission in response to his changing clinical and cognitive needs.'* When commenting on the placement of the patient in the observation bay closest to the nurse's station the Trust explained *'It was considered that it would have been unsafe to place him in an isolation room from both the clinical and cognitive perspective of his condition.'*

Clinical Records

62. I considered the patient's nursing records, including NEWS Observation Charts, provided by the Trust.

63. I Identified the patient was cared for on Ward 2 North during the following periods:
    - 23 February to 24 February 2016
    - 25 February to 26 February 2016
    - 5 March to 6 May 2016
    - 9 May to 20 June 2016

64. I considered the National Early Warning Score (NEWS) charts for the patient while he was in Ward 2 North for the periods outlined in paragraph 63 above. Appendix five documents the scores and the times taken, when monitoring was carried out outside recommended frequencies, as well as the times when NEWS scores indicated there should be an increase in monitoring frequency.

65. I considered the following relevant clinical records:
24 February 2016 at 08:50 *'Pt remains confused – Medical team and Anesthetist aware…'*
25 February 2016 at 13:50 *HDU Clerk-In'* was undertaken. At 15:30 a clinical review was undertaken and the clinical records document '*asked by FYI…to review patient as concerned…attended as soon as possible…'* The clinical records documents further reviews at 17:20, 19:05, 21:45, 22:45 and 23:20.
31 March 2016 at 20.00 *'Altered by family that patient was shivering +++…'* The patient was medically assessed at 20.30 and at 22:00.
16 April 2016 during night duty the patient was *'…seen by F1 and F2…'*
6 May 2016 the patient was seen by clinicians at 03:49, 05:45, 08:40, 11:20 17:40, 18:00 22:50 and 23:30.
9 May 2016 (time unclear) '*…News 9-10. F1 and registrar made aware…'*
26 May 2016 at 21:00 that *[the patient] became unwell…F1 informed…news 7…'*
4 April 2016 at 14:45, *'Infection control contacted ward to say patient has ESBL in urine form 22/3/16. Needs isolated and contact precautions. Patient not suitable for side room as ongoing disorientation and agitation. Contact precaution sign insitu.'*

66. The chronology provided by the Trust documents that from 5 March 2016 to 6 May 2016 the patient was located in *'A bay, [patient] required isolation due to infection status. He was nursed as a single patient in A Bay, (normal bed occupancy 4 patients)…'*

67. I considered care plan assessments which recorded that on assessment the patient *'…has been identified as being disorientated/confused to Time, Place, Person.'* The patient was also identified as being at a high risk of a slip, trip or fall, with the nursing invention detailed to nurse *'…in close proximity to the nurse's station.'*

68. I also considered the completed form for 'Adult Patients admitted with history of MRSA or Adult patients newly identified with MRSA.' I note that on 5 April 2016 a reason for variance from a planned intervention is recorded as *'..[the patient] not safe for side room due to delirium. Strict contact precautions.' 'Transient Global Amnesia'* was also recorded on the front of the form.

69. I also considered the Trust's written response to the complainant, dated 13 March 2018 and 14 December 2018. The Trust explained that *'…medical and nursing records indicate the early warning score…was recorded at the appropriate intervals throughout [the patient's] admission…and that appropriate action was taken when the early warning score was elevated.'*

70. The Trust also explained that patients who developed ESBLs infections are normally placed in a single room to prevent spread of the infection to others. '*…nursing staff felt, given [the patient's] condition and history of Transient Global Amnesia*[10] *this would be unsafe and alternatively provided barrier-nursing care…in a ward bay.* It went on to explain that this bay *'…was close to the nurse's station to ensure that he could be closely observed…however, as the nursing and medical teams are in the bays delivering care to patients, staff are not always present all of the time.'*

71. The Trust also explained *'Whilst [the patient] did not require one to one nursing supervision, he did require close observation…' '… nursing staff carried out a risk assessment which indicated placement in a single room may have presented additional risk…'* The Trust stated it was *'…sorry you remain of the view that this was inappropriate and would wish to reassure you this decision was made in [the patient's] best interests at the time.'*

72. The Trust stated *'…it would like to apologise for the loss of [the patient's] hearing aids and wish to reassure you that the nursing records indicates that the nursing staff contacted the Audiology Department and facilitated [the patient] to attend Audiology Outpatient on9 March and 23 March 2016…'*

Relevant Independent Professional Advice

73. As part of investigation enquiries, I received independent professional advice from a N IPA.

74. The N IPA was asked to review the level of monitoring, the patient received, from nursing staff during his time on Ward 2 North for the following periods:

[10] a condition characterised by sudden onset of memory loss and confusion

- 23 February to 24 February 2016
- 25 February to 26 February 2016
- 5 March to 6 May 2016
- 9 May to 20 June 2016

23 February to 24 February 2016

75. The N IPA advised '*The initial set of observations carried out on admission pre-operatively were incomplete as there was no temperature recorded and the total NEWS score was calculated incorrectly. The score should have been 3 and not 2… According to the NEWS escalation guideline, the observations should have been repeated at a minimum of 4-6 hourly. There was a 6.5 hour interval before a repeat set of observations were taken.* The N IPA went on to explain *'This was of no consequence to the patient as the nursing notes demonstrate that there was interaction with the patient and a medical clerking of the patient had been carried out during this time*. The N IPA further advised that *'The next set of observations were carried out at 21:00 and the score was correct at 2. Subsequent observations were appropriate. Nursing notes demonstrate awareness of the condition of the patient and escalation to the medical team of evidence of confusion.'*

25 February to 26 February 2016

76. Following the patient's transfer from ICU the N IPA advised that '*From 12.30 to 23.45 observations were carried out between 30-60 minutes. There were some discrepancies when adding up the total NEWS score which had no consequence to the patient as the level of monitoring was appropriate.'*
When recording the level of responsiveness (AVPU) the N IPA advised that this '…*was ambiguous and contributed to the miscalculation of the NEWS score. Frequently a V (which indicates responds to voice) which carries a score of 3 was often entered into the incorrect box of A (which indicates the patient is alert) and scores a 0. This resulted in some incorrect NEWS total scores. A score of 3 in one parameter would also warrant an assessment by the medical team.*'

77. The N IPA explained that nursing staff *'…clearly documented the patient's status on transfer from ICU to identify the baseline condition of the patient on admission to*

ward 2. They included assessments of the epidural, intravenous fluids, intravenous access, drains, wound site, urinary catheter, enteral feeding and oxygen requirements. They have documented the rationale for when an assessment has not been completed i.e. level of epidural block. There is evidence of ongoing medical assessment from 15.30 onwards and nursing interventions carried out following this.'

5 March to 6 May 2016

78. The N IPA advised that from 5 March to 24 March 2016 *'…there was an appropriate level of monitoring with very little change in the NEWS score… On very few occasions the frequency of the observations lapsed the recommended guidelines. For example a score of 1-4 warrants frequency of observations to be a minimum of 4-6 hourly. Occasionally this lapsed to 7 hours.* She advised that *'This did not have any consequences for the patient at this time.'*

79. On 25 and 26 March following a clinical change in the patient the N IPA advised this change was *'…escalated appropriately as there was evidence of a medical review and the increased frequency of observation was appropriate and within the guidelines.'*

80. On 31 March the N IPA advised *'the NEWS score increased to 10'* after a significant change clinically. At this time the nursing staff *'requested medical reviews twice, carried out interventions, and the frequency of monitoring increased appropriately.'* Following further clinical changes on 15 and 16 April and with NEWS scores ranging *'…between 0-9 which required medical review.'* The N IPA advised *'The nursing documentation showed acknowledgement of this, escalation to the medical team, and carrying out of planned interventions. The frequency of monitoring and observation during this time was increased and carried out appropriately.'*

81. The N IPA advised that from 26 April to 30 April *'…there seems to be a reduction in the frequency of observations. They have been conducted approximately twice a day. At this time the NEWS score was between 0-2. A score of 1-4 recommends a frequency of 4-6 hourly according to the NEWS guideline, however they were carried out 12 hourly.'*

82. The N IPA advised following a significant change clinically in the patient on 6 May *'The level of monitoring was increased appropriately. Nursing notes describe the changes in the physical status of the patient, a subsequent medical review and medical and nursing interventions.'*

83. The N IPA further commented that *'..it has been observed that frequently the time in between the final night time observation check and the first morning check exceeded the recommended frequency of observations according to the NEWS guidelines.* The N IPA went on to explain that *'This did not appear to have any consequence to the patient.'*

9 May to 20 June 2016

84. The N IPA advised *'...from 9th May to 11th May there were many occasions when the NEWS score was elevated. This was actioned and observation frequency was adjusted appropriately.'* Observations from 12 May to 19 May were *'…carried out with appropriate frequency. There were some instances of observations not being complete due to no temperature and the total NEWS score being added up incorrectly.'* The N IPA advised that *'This did not have an impact on the patient.'* There *'…was an accurate and appropriate level of monitoring by observations…'* from 20 May to 25 May 2016.

85. The N IPA further advised that from 25 May to 30 May *'there were several occasions whereby there was a deterioration in the patient evident from their News score. There was appropriate increased frequency of monitoring and evidence in the evaluation notes of escalation and nursing intervention.'* '*…there was an appropriate level of monitoring as there was very little change in the patients observations***.'** from 31 May to 20 June 2016**.** The N IPA noted *'… one instance whereby the temperature was omitted but this was rectified an hour later and there was a miscalculation of the total News score on approximately five occasions.'*
The N IPA explained that **'***Overall there was an appropriate level of monitoring during this period.'*

86. The N IPA was asked if there were any occasions the patient did not receive an appropriate level of monitoring from nursing staff. She advised that *'…there was an appropriate level of nursing care throughout his stay on Ward 2. There were appropriate frequency of observations. Nursing evaluation notes were written regularly and demonstrated escalation to the medical team when monitoring suggested a deterioration in [the patient]. Nursing notes also demonstrated a good understanding of the patients care needs.'*

87. In relation to referrals made to relevant medical staff the N IPA commented *'there is evidence that appropriate referrals were made when [the patient] showed signs of deterioration or there was a change in his medical condition. There are several entries in the nursing communication notes whereby a medical review was requested as the NEWS score had increased.'*

88. The N IPA was asked if it was appropriate for the patient to be nursed as a single patient in a bay from 5 March to 6 May 2016. The N IPA advised it was *'…appropriate for [the patient] to be nursed in this location as a single patient. He was identified as having an infection which required isolation.'* The N IPA advised *'When a decision to isolate is made, a risk assessment is carried out to determine whether a patient's safety can be maintained whilst in isolation or whether there is significant risk of the patient experiencing harm. There is documentation from the nursing staff that they considered a significant risk to [the patient] by being isolated in a side room due to his cognition and compliance with care.* The N IPA explained *'This was an appropriate action and was taken in the best interests of the patient.'*

89. The N IPA concluded the patient *'…received an appropriate level of monitoring during his inpatient stay on Ward 2 during the time periods stated. On occasions the NEWS score was calculated incorrectly however this did not appear to have any consequence to the patient. When there was a clinical change in the patient's status which was indicated by an increased NEWS score there was evidence of an increased level of observations. There was appropriate escalation to the medical team and nursing interventions were carried out appropriately post review.' 'When an ESBL infection was diagnosed which required patient isolation, there is evidence of*

appropriate rationale as to why this was not carried out but a variation to this was implemented to maintain the patients safety and minimise any risk of harm.'

Complainant's response to the draft report

90. The complainant provided photographs by way of explanation as to the care given to the patient during his stay on Ward 2 North and explained that the concerns she raised were based on what she saw and observed whilst visiting the complainant on a daily basis. The complainant believed the photographs demonstrated why she gradually became concerned about her husband's medical condition and also made her ask questions and highlight concerns to the medical staff. The complainant also raised concerns that the patient's hearing aids and glasses were lost and that, all replacements were sourced by her. She highlighted that during this time any communication between the patient and medical staff would have been difficult as a result.

Analysis and Findings

91. The complainant raised concerns that the patient failed to receive adequate monitoring from nursing staff whilst on the Ward 2 North, including monitoring when in 'isolation' close to the nurses' station. I considered each of the periods of admission and provided an overall summary of the monitoring the patient received. I note the photographs provided by the complainant and the further comments that she had to replace the patient's glasses and hearing aid. I also note the Trust's apology in relation to the patient's hearing aid.

23 February to 24 February 2016

92. I refer to the RCP NEWS guidance which recommends the frequency of monitoring for a patient should be '…*4–6 hourly for scores of 1–4…'*

93. I note from clinical records on 23 February 2016, following admission, an initial set of observations were taken at 14:30 with a NEWS score of 2 recorded. A further set of observations were taken at 21:00 with a NEWS score of 2 recorded. The next set of observations were then taken at 07:45 on 24 February 2016. I note that these monitoring frequencies exceeded the RCP NEWS guidance. However, I note the N IPA comment about the monitoring frequency on 23 February 2016 and that this

'…was of no consequence to the patient as the nursing notes demonstrate that there was interaction with the patient and a medical clerking of the patient had been carried out during this time.'

94. I note the N IPA comment that the initial set of observations were calculated incorrectly with no temperature being taken. '*The score should have been 3 and not a 2.'* I note from clinical records and from the N IPA that evidence of confusion in the patient was escalated to the medical team.

25 February to 26 February 2016

95. I refer to the RCP NEWS guidance which recommends the frequency of monitoring for a patient should be '…*a minimum of hourly for those patients with a NEW score of 5–6, or a red score (ie a score of 3 in any single parameter) until the patient is reviewed and a plan of care documented… We recommend continuous monitoring and recording of vital signs for those with an aggregate NEWS score of 7 or more'*.' The RCP NEWS guidance also states '…*A medium score (ie NEW score of 5–6 or a RED score) should prompt an urgent review by a clinician skilled with competencies in the assessment of acute illness… A high score (NEW score of 7 or more) should prompt emergency assessment by a clinical team/critical care outreach team with critical-care competencies and usually transfer of the patient to a higher dependency care area.'*

96. I note from clinical records that on 25 February 2016, on return from ICU, the patient had observations taken at 12:30 with a NEWS score of 6 recorded. Between 13:00 and 15:00 the NEWS score rose to 8. Observations were carried out until 23:45 at a frequency of between 30 to 60 minutes. I note the monitoring frequency of observations during this time to be in line with RCP NEWS guidance.

97. I note the N IPA comment relating to *'… discrepancies when adding up the total NEWS score which had no consequence to the patient as the level of monitoring was appropriate.'* I also note the N IPA comments about recording the level of responsiveness (AVPU). This '…*was ambiguous and contributed to the miscalculation of the NEWS score. Frequently a V (which indicates responds to voice) which carries a score of 3 was often entered into the incorrect box of A (which*

indicates the patient is alert) and scores a 0. This resulted in some incorrect NEWS total scores. A score of 3 in one parameter would also warrant an assessment by the medical team.' I note from clinical records the patient had ongoing medical assessment from 15:30 onwards.

5 March to 6 May 2016

98. I note from clinical records that on 31 March 2016 at 20:00 the patient's NEWS scores were documented as 10 after staff were alerted by family members that the patient was shivering. His previous observations were taken at 19:40 but no score was documented. I note after 20:00 observations were taken at a frequency of 25 minutes and 35 minutes respectively. I note from clinical records and the N IPA comments that medical reviews were requested, inventions carried out and the frequency of monitoring increased appropriately. I note this was in line was RCP NEWS guidance.

99. I note on 15 April 2016 at 17:50 the patient's NEWS score was documented as 6. I note the frequency of monitoring until 23:00 was undertaken at the most hourly. I note at 00:29 on 16 April 2016 the patient's NEWS score was documented as 9. I note that until 05:15 the frequency of monitoring increased in line with RCP NEWS guidance. I note from clinical records the escalation to the medical team which was in line with RCP NEWS guidance.

100. I note from clinical records on 6 May 2016 the patient's NEWS scores was documented as 9. I note the frequency of monitoring was every 15 minutes from 04:45 until 06:15. I note that from 08:20 to 17:05 that the frequency of monitoring decreased, up to a maximum of 3 hours, and was not in accordance with RCP NEWS guidance given the range of documented NEWS scores (5-10). However, I note from medical records the patient was seen by the medical team during this time. From 17:05 I note monitoring took place on almost an hourly basis until the patient's admission to ICU. I note from clinical records and the N IPA's advice that nursing notes *'…describe the changes in the physical status of the patient, a subsequent medical review and medical and nursing interventions.'*

101. I note from clinical records that on at least 27 occasions, between 5 March 2016 and 6 May 2016, the time between the final nighttime observation check and the first morning check exceeded the recommend frequency of observations. NEWS scores on these occasions were documented as being between 0 and 3. I note the RCP NEWS guidance which recommends the frequency of monitoring for a patient should be '…*4–6 hourly for scores of 1–4…'* However, I note the N IPA's advice that the increased monitoring frequency *'…did not appear to have any consequence to the patient.'*

102. I note from clinical records that between 5 March 2016 and 24 March 2016 there were two occasions, on 23 and 24 March 2016 during the day, that the frequency of observations was not in line with the RCP NEWS guidance which recommends the frequency of monitoring for a patient should be '…*4–6 hourly for scores of 1–4…'* On these occasions the frequency of monitoring increased to almost seven hours and just over 12 hours respectively. I note the N IPA comment that *'This did not have any consequences for the patient at this time.'* I also note that during this period, 5 March 2016 to 6 May 2016 the N IPA commented on one occasion *'…where the NEWS score had a score of 3 in 1 parameter…*' which required a *'…discussion with the medical team and further nursing assessments made…'* in accordance with guidance. This does not appear to have occurred on this occasion.

103. I note from clinical records that from 26 April 2016 to 30 April 2016 that observations were carried out approximately twice daily. I note during this time NEWS scores ranged from 0-2. I note that the majority of these monitoring frequencies are not in line with the RCP NEWS guidance which recommends the frequency of monitoring for a patient should be '…*4–6 hourly for scores of 1–4…'*

104. I note from 5 March 2016 until 6 May 2016 the patient was nursed as single patient in A Bay. I note from clinical records that 04 April 2016 at 14:45, *'Infection control contacted ward to say patient has ESBL in urine from 22/3/16. Needs isolated and contact precautions. Patient not suitable for side room as ongoing disorientation and agitation. Contact precaution sign insitu.'* I refer to both the PHA guidance and the ESBLs guidance both of which highlight patient isolation as a means to preventing

spread of infection. I note the clinical records document on 5 April 2016 why there was a variance from the guidance of isolation. That being *'..[the patient] not safe for side room due to delirium.* I also note the N IPA advice '*There is documentation from the nursing staff that they considered a significant risk to [the patient] by being isolated in a side room due to his cognition and compliance with care.'*

105. I note the level of monitoring the patient received when he was nursed in isolation as detailed in paragraphs 98 to 104 above.

9 May 2016 to 20 June 2016

106. I note from clinical records, when the patient returned to Ward 2 North from ICU, his NEWS score was documented as 8, further observations were taken at 15:00, 16:15 and 17:40. The NEWS scores were documented as 12, 6 and 5 respectively. I note these monitoring frequencies are not line with the RCP NEWS guidance. I note the clinical record from the 9 May 2016 stated the F1 and registrar were informed of the NEWS scores. I also note the IPA comment that from 9 May 2016 to 11 May 2016 *'…there were many occasions when the NEWS score was elevated. This was actioned…'*

107. I note from clinical records from 17:40 on 9 May 2016 to 07:15 on 10 May 2016 the patient's NEWS scores ranged from 2 to 5. Monitoring during this time was carried out one to two hourly. I note this was in line with the RCP NEWS guidance.

108. I note the N IPA's advice that between 12 May 2016 and 19 May 2016 '*There were some instances of observations not being complete due to no temperature and the total NEWS score being added up incorrectly*.' I refer to the Standard 10 of the NMC code which states *'..complete records accurately...'* I also note the N IPA advice that *'This did not have an impact on the patient.'*

109. I note from clinical records the patient's NEWS scores rose at 21:40 on 26 Nay 2016. Between this time and 11:30 on 27 May the patient's NEWS scores ranged from 2 to 7 with the frequency of monitoring ranging from half hourly to 2 hourly. I note the clinical records dated 26 May 2016 at 21:00 state that *[the patient] became*

unwell…F1 informed…news 7…' I also note the N IPA comment that during this time *'There was appropriate increased frequency of monitoring and evidence in the evaluation notes of escalation and nursing intervention.'*

110. I note the N IPA comments that from 31 May 2016 to 20 June 2016 there was *'..one instance whereby the temperature was omitted but this was rectified an hour later and there was a miscalculation of the total News score on approximately five occasions.'*

111. I note from clinical records there were six occasions during the day, between 9 May 2016 and 20 June 2016, when monitoring should have been completed 4-6 hourly. On these occasions I note monitoring was carried out approximately 8 to 11 hourly.

112. I note from clinical records there were at least 16 occasions, between 9 May 2016 and 20 June 2016, when the time between the final night time observation check and the first morning check exceeded the recommend frequency of observations. NEWS scores on these occasions were documented as being between 1 and 3. I note the RCP NEWS guidance which recommends the frequency of monitoring for a patient should be '…*4–6 hourly for scores of 1–4…'* However, I note the N IPA's advice that the increased monitoring frequency *'…did not appear to have any consequence to the patient.'*

In Summary

113. From the available evidence I am satisfied that during the patient's time on Ward 2 North there are many occasions when the frequency of monitoring fell outside the recommended monitoring frequencies as set out in the RCP NEWS guidance. I accept the N IPA'S advice that on occasions the NEWS score was calculated incorrectly as well as the inaccuracies in the recording the AVPU score. I am critical that monitoring was not in accordance with national guidelines. I consider this a failure in the patient's care and treatment. However I do not consider that the patient experienced an injustice as a consequence of these failures. This is because the N IPA's advised that there is evidence that appropriate referrals were made when the patient showed signs of deterioration or there was a change in his medical condition. She also advised that the frequency of monitoring or the miscalculation of NEWS

scores *'…did not appear to have any consequence to the patient.'* and I hope this provides reassurance to the complainant. Nonetheless, I am concerned that there is potential for, the miscalculation of NEWS scores and lapses in the frequency of monitoring of observations, to impact on the safe delivery of patient care. I consider these failures caused the complainant to experience the injustice of uncertainty and upset. Therefore I uphold this issue of complaint. It is important that clinical staff on the ward, dealing with patients and their families, create an environment where issues can be raised and discussed in a constructive way to ensure the best interests of the patient are met. I would ask the Trust to reflect on the experience of the complainant and the points she has raised.

CONCLUSION

114. I received a complaint about about the actions of the Trust regarding the care and treatment provided to the patient by staff of BCH following surgery on 24 February 2016. The complainant said her husband was discharged, on 25 February 2016, from the ICU prematurely, following the gastrectomy surgery the previous day. She believed this may have had repercussions on his recovery. The complainant also believed that her husband failed to receive adequate monitoring from nursing staff on the Ward 2 North of BCH following his gastrectomy surgery. This included monitoring when in 'isolation' close to the nurses' station.

Issue 1

115. The investigation established a failure in the care and treatment in relation to the following matter:

    i. Discharging the patient prematurely from the ICU on 25 February 2016.

116. I am satisfied that the failing in care and treatment caused the patient to experience the injustice of loss of opportunity to be given the most appropriate treatment for approximately 12 hours. I am also satisfied that the complainant experienced the injustice of uncertainty and upset as result of this failing.

Issue 2

117. The investigation established failures in the care and treatment in relation to the following matters:

i. The failure to carryout monitoring of the patient in accordance with RCP NEWS guidance;

ii. The failure to accurately calculate NEWS scores; and

iii. The failure to accurately and clearly record the level of consciousness in the AVPU score.

118. I do not consider that these failings caused the patient to experience an injustice. However, I am satisfied that the failures in care and treatment identified caused the complainant to experience the injustice of uncertainty and upset.

Recommendations

119. I recommend within **one** month of the date of this report:

i. 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 and the patient as a result of the failures identified; and

ii. The Trust discusses the findings of this report with the clinicians involved in the patient's care in the ICU and in Ward 2 North

120. I further recommend, for service improvement and to prevent future recurrence, the Trust:

i. Carryout out a random sampling audit of patients' nursing records on Ward 2 North of BCH with a particular emphasis on NEWS observations to ensure monitoring is being carried out at appropriate intervals, scores are calculated correctly and the AVPU score is accurately and clearly recorded. Take action to address any identified trends or shortcomings. The Trust should include any recommendations identified in its update to this office; and

ii. Carry out a review of the last five gastrectomy surgery patients discharged from ICU to ward level, who had a return to ICU within 24 hours, to establish if there is any opportunity for further learning. The Trust should include any learning identified in its review to this office.

121. I recommend that the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **3 months** of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings).

MARGARET KELLY
Ombudsman **23 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.