Investigation Report

Investigation of a complaint against the Southern Health and Social Care Trust

NIPSO Reference: 16974

Northern Ireland Public Services Ombudsman

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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. She may also investigate and report 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.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration.

The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report. The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

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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EXECUTIVE SUMMARY

1. I received a complaint regarding the actions of the Southern Health and Social Care Trust (the Trust) in relation to the care and treatment the complainant's mother received while a patient in Craigavon Area Hospital. The complainant had complained to the Trust on 30 April 2015 but remained dissatisfied with its response.

2. I investigated the complaint and found failures in a number of areas. In particular, I found that there were delays in arranging a Speech and Language Therapist (SALT) and dietician referral and inadequacies in nutritional and nursing care and treatment. I also made a finding of maladministration in regard to record keeping. As a result of these failings, I am satisfied that the complainant suffered the injustice of loss of opportunity, upset, distress and discomfort. I am also satisfied that the complainant and her family suffered the injustice of upset, distress, uncertainty and frustration.

3. By way of remedy I recommended the Trust apologises to the complainant and her family for these failings. I recommended the Trust provide a consolatory payment of £750 in respect of the injustice identified, within one month.

4. I also recommended that the failings identified in this report should be shared and discussed with the medical and nursing teams involved in the patient's care. This discussion should focus on learning and improvement and highlight the importance of good communication and record keeping. I also recommended the Trust should remind the medical team in the ward of the importance of co-ordinating recommendations and communications from all health professionals when devising a patient's plan of care and ensuring that the agreed plan of care is consulted and adhered to by all staff. I recommended that the Trust provides me with an action plan within three months evidencing these discussions.

THE COMPLAINT

5. The complainant stated that she sustained injustice as a result of maladministration by the Trust and failings in its exercise of professional judgment in relation to the provision of health care to her late mother. In particular, she complained about the care and treatment received in Craigavon Area Hospital between 6 April 2014 and 6 June 2014.

Background to the Complaint

6. The complainant's mother was 83 years old when she was transferred to Ward 1 South (the ward) on 10 April 2014. She sadly passed away on 6 June 2014. The complainant stated that when her mother was admitted to the ward she was on a diet of soft food and drinking normal liquids. She complained that, on 9 April 2014 the diet was modified by her medical team to thickened liquids without prior consultation with SALT. She complained about the poor nutritional care and treatment her mother received on the ward which she believes contributed to her significant weight loss and may have accelerated her death. She also complained about the nursing care and treatment her mother received. In particular, that nursing staff attempted to artificially feed her mother without sedation on one occasion, which was against the instructions of both her mother and her mother's medical team.

Issues of complaint

7. The issues of complaint which I accepted for investigation were:

Issue One: Was the nutritional care and treatment provided on the ward appropriate and reasonable?

Issue Two: Was the nursing care and treatment provided on the ward appropriate and reasonable?

INVESTIGATION METHODOLOGY

8. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint. The Investigating Officer also conducted a telephone interview with a Trust Medical Registrar involved in the patient's care.

9. I have examined all of this documentation and information carefully and it has assisted me in reaching my findings. I have not included every detail of my investigation in this report but I am satisfied that everything which I consider to be relevant and important has been taken into account in reaching my findings

Independent Professional Advice Sought

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

- A Physician, Consultant Rheumatologist, FRCP, MSc, MBChB, Certificate of Medical Education (CP IPA)
- A Nurse Practitioner, DIP Asthma, Dip COPD, Dip Advanced Diabetes Care (Nursing IPA)
- A Registered Dietician (Dietician IPA)

Although the IPAs have provided me with advice, how I weigh this advice, within the context of a particular complaint, is a matter for my discretion.

Relevant Standards

11. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the

circumstances of the case.

The general standards are the Ombudsman's Principles:

- The Principles of Good Administration[1]
- The Principles of Good Complaints Handling

12. The specific standards are those applicable at the time the events occurred which governed the exercise of the administrative functions and professional judgment of those organisations and individuals whose actions are the subject of this complaint. The specific standards relevant to this complaint are

- General Medical Council (GMC) Good Medical Practice Guidelines (2013)
- National Institute for Health and Care Excellence (NICE) Guidance - Nutrition support for adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition (2006)
- Nursing & Midwifery Council (NMC) The Code – Standards of Conduct, performance and ethics for nurses and midwifes (2008)
- Nursing & Midwifery Council (NMC) – Standards for Medicines Management (2010)
- Patient Client Experience Standards 2009 and 2012

I have included relevant extracts of these documents within this report.

MY INVESTIGATION

Issue One Was the nutritional care and treatment provided on the ward appropriate and reasonable?

Detail of the complaint

13. The complainant advised her mother was transferred to the ward on 10 April

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

2014.

She complained that the Trust failed to provide adequate nutritional care and treatment to her mother whilst she was a patient on the ward. She stated the Trust had adjusted her mother's diet of soft food and drinking normal liquids to a thickened liquid diet on 9 April 2014. However, she stated that the Trust failed to consult with the SALT prior to modifying her diet. She also informed the Investigating Officer that when her mother was admitted to the ward, she was reviewed and assessed by a Dietician and weighed approximately 48.1 kg on 11 April 2014. However, she stated her mother's weight had dropped to 39kg by 12 May 2014 and that the Trust did not provide adequate food and fluids to her mother which led to her experiencing the significant weight loss. She remains concerned that the poor nutritional care and treatment her mother received contributed to her death.

14. She also complained that the Trust failed to administer Glandosane[2] (artificial saliva) to her mother. She advised that her mother had been prescribed Glandosane on 24 May 2014, and this was not administered until 28 May 2014. She complained that Glandosane should have been prescribed and administered earlier as she believes this would have enabled her to eat and swallow more comfortably.

Evidence Considered

I shall consider this complaint under the following headings:

i. Policy/Guidance

I consider the following extracts of policies and guidance documents to be relevant to my investigation:

15. The GMC Guidance on Good Medical Practice (2013) describes what is expected of all doctors registered with the GMC. I have included the following relevant extracts:

[2] **Glandosane** Artificial Saliva Spray is a spray that lubricates and coats the mouth and throat, providing relief from dry mouth.

Paragraph 15 (b) states '*If you assess, diagnose or treat patients you must promptly provide or arrange suitable advice, investigations or treatment where necessary'.*

Paragraph 16 (c) states '*take all possible steps to alleviate pain and distress whether or not a cure may be possible'.*

Paragraph 32 states '*you must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs'.*

Paragraph 33 states '*you must be considerate to those close to the patient and be sensitive and responsive in giving them information and support'.*

16. I have considered the following sections of the NICE Guidance – Nutrition Support for adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition (2006).

Section 1.3 addresses the need for nutritional support in hospital and in the community, as follows:

1.3.1 *Nutrition support should be considered in people who are malnourished, as defined by any of the following:*

- *a BMI of less than 18.5 kg/m^2*
- *unintentional weight loss greater than 10% within the last 3–6 months*
- *a BMI of less than 20 kg/m^2 and unintentional weight loss greater than 5% within the last 3–6 months.*

1.3.2 *Nutrition support should be considered in people at risk of malnutrition who, as defined by any of the following:*

- *have eaten little or nothing for more than 5 days and/or are likely to eat little or nothing for the next 5 days or longer*
- *have a poor absorptive capacity, and/or have high nutrient losses and/or have*

increased nutritional needs from causes such as catabolism.

1.3.3 *Healthcare professionals should consider using oral, enteral or parenteral nutrition support, alone or in combination, for people who are either malnourished or at risk of malnutrition, as defined in 1.3.1 and 1.3.2. Potential swallowing problems should be taken into account.*

Section 1.7 addresses Enteral[3] tube feeding in hospital and the community

1.7.1 Healthcare professionals should consider enteral tube feeding in people who are malnourished or at risk of malnutrition as defined in 1.3.1 and 1.3.2, respectively, and have:

- *inadequate or unsafe oral intake, and*
- *a functional, accessible gastrointestinal tract.*

Section 1.8 addresses Parenteral[4] nutrition in hospital and the community as follows:

1.8 *Healthcare professionals should consider parenteral nutrition in people who are malnourished or at risk of malnutrition as defined in 1.3.1 and 1.3.2, respectively, and meet either of the following criteria:*

- *inadequate or unsafe oral and/or enteral nutritional intake*
- *a non-functional, inaccessible or perforated (leaking) gastrointestinal tract.*

Section 1.2 addresses screening for malnutrition and the risk of malnutrition in hospital and the community.

Paragraph 1.2.6 states '*Screening should assess body mass index (BMI) and percentage unintentional weight loss and should also consider the time over which nutrient intake has been unintentionally reduced and/or the likelihood of future nutrient intake. The Malnutrition Universal Screening Tool (MUST) for example may be used to do this'*.

Section 1.4 lists the criteria for determining people at high risk of developing

[3] **Enteral feeding** refers to the delivery of a nutritionally complete **feed**, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach, duodenum or jejunum.

[4] Parenteral feeding is the **intravenous administration** of nutrients. This may be supplemental to oral or tube feeding, or it may provide the only source of nutrition as total parenteral nutrition (TPN).

refeeding problems.

17. I considered the DHSPPS 'Improving the Patient Client Experience' Standards document which was first published in April 2009. The document comprises five core standards: - Respect, Attitude, Behaviour, communication, Privacy and Dignity. All HSC Trusts adopted these standards during 2009/10 and arrangements were put in place to develop methodologies to support its implementation.

18. In relation to the prescription of the drug Glandosane, I considered the GMC Good Medical Practice Guidelines (2013), entitled 'Record your work clearly, accurately and legibly'. Paragraph 19 of the guidance states *'documents you make (including clinical records to formally record your work must be clear accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards'.*

19. I also considered the NMC Standards for Medicines Management (2010) - Section 4 Standards for Administration of Medicines. Standard 8, Administration, states '*Nurses must make a clear, accurate and immediate record of all medicine administered intentionally, withheld or refused by the patient, ensuring the signature is clear and legible. It is also your responsibility to ensure that a record is made when delegating the task of administering medicine'.*

ii. <u>The Trust's response to investigation enquiries into the complaint about the nutritional care and treatment provided on the ward</u>

20. The Investigating Officer asked the Trust to explain why the patient's diet was modified prior to referral to SALT. The Trust stated '*that it was recorded on [the] medical chart at 09.00 on 8 April 2014 'managed porridge. Choking a bit on clear fluids'.* The Trust confirmed that '*medical staff requested [the patient] be commenced on thickened liquids after this assessment, this was an*

immediate recommendation'. The Trust advised '*it is the role of medical staff to assess if a patient requires a modified diet as part of their medical management plan'*. The Trust stated '[the patient*'s] Consultant appropriately advised the nursing staff regarding adjustment to [her] diet prior to the SALT assessment occurring'*. The Trust further stated '*that following medical assessment, a referral to SALT is normal practice, however medical staff are qualified to alter a patient's diet without SALT authorisation'*.

21. The Trust clarified that there is no written policy or criteria for adjusting a patient's diet. However, accepted protocol is that medical staff take responsibility for managing all aspects of a patients care until they have been assessed by another professional with specialist clinical skills in relation to that aspect of care. The Trust further advised that the '*dietary changes were managed by medical staff, SALT and dieticians in a collaborative manner as reflected in discussions between the multidisciplinary team'*. On enquiry, the Trust confirmed '*there is no written record that the change in diet was communicated to [the patient] or her daughter*'.

22. The Trust stated '*a SALT referral was made on 9 April 2014 by the Ward Sister and the written medical referral was completed by a Doctor. SALT confirmed receipt of referral on 9 April 2014'*. The Trust advised that the nursing records state '*encourage oral intake as per medical staff'.* The Trust advised '*the food charts indicate that [the patient] refused meals frequently, however she did take small amounts on a regular basis and she was encouraged and assisted by the nursing staff*'. The Trust confirmed that nursing documentation does not record intake for every meal. The Trust stated that '*on occasions despite assistance and encouragement, meals were refused or only a small amount was eaten'.*

23. I note that the SALT referral was made as 'priority 2' with a target time of three to four working days rather that a 'high priority' referral with a target time of two working days. I note that the Trust had informed the complainant in June 2015

'unfortunately the speech and language therapy team were not aware that interim management of your mother following the receipt of referral had been thickened liquids. This new clinical information would have altered the speech and language therapy team response time to see her'.

24. The Trust advised '*[the patient] had a SALT assessment completed on 15 April 2014 and the recommendation was made for … to have stage 3 thickened liquids and texture C pureed diet'.* The Trust confirmed '*that the response time for … referral would be five working days as SALT are unable to provide a service at weekends'.* The Trust '*clarified that the time from SALT referral to assessment was four working days'*. The Trust further stated '*that SALT had no concerns regarding the adjustment of [the patient's] diet. In light of the medical and nursing staffs concern regarding the safety of her swallow and her chest presentation (pneumonia), SALT were in agreement that thickened fluids and a modified diet were appropriate as part of the management plan'*.

25. I note that the patient was assessed by the nursing staff on 11 April 2014. Her weight was recorded as 48.1 kg and she had a body mass index (BMI) of 16. She was therefore found to have a Malnutrition Universal Screening Tool[5] (MUST) score of two. I note that this score indicates a high risk of malnutrition. I asked the Trust how the nursing team responded to this information. The Trust stated that, based on this score, '*[the patient] was referred to a Dietician on 11 April 2014. Dieticians confirmed receipt of referral on 11 April 2014'.* The Trust added the patient was initially assessed by a Dietician on 15 April 2014 and that she was reviewed and assessed by the Dietician on eighteen occasions from 15 April 2014 – 29 May 2014. They confirmed *'nursing records indicate her weight was recorded at 51 kg on 7 April 2014 and 42.8 kg on 8 May 2014'.* The Trust further stated *'that after this reduction in weight the patient's Consultant met with her family and [she] was to start artificial feeding,*

[5] **MUST'** is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan

in particularly Nasogastric[6] *(NG) Intubation feeding and the Dietician was made aware of the need to prescribe the same'*.

26. In relation to the NG feeding tube, the Trust stated '*two attempts were made to NG feed on the 8 May 2014 and 9 May 2014 and then a further three attempts were made on 14 May 2014 whilst under sedation'*. The Trust advised '*attempts to NG feed failed'*. The Trust advised, in light of difficulties in attempting NG feeding, the patient '*was commenced on Total Parenteral Nutrition (TPN) feeding on 12 May 2014.'* The Trust highlighted TPN feeding '*was stopped at approximately 19.00 on 13 May 2014 to allow for further attempts to NG feed [her] while under sedation. However, as these attempts failed, TPN was recommenced at approximately 17.20 on 14 May 2014'.* The Trust concluded '*the Medical, Nursing and Allied Health Professionals (AHP) staff were concerned regarding weight loss during this admission, this is reflected in the referrals to SALT and Dietician teams and subsequent modification of diet, including supplements, trial of NG tube insertion for feeding and the commencement of TPN to address weight loss'.*

27. In relation to enquiries about the administration of Glandosane, the Trust stated '*The Medical Registrar prescribed Glandosane in the 'as required' medicine section of the drug kardex on 24 May 2014 for comfort measures, so nursing staff would have been able to administer this when … required'.* The Trust advised the start date was not documented. They further confirmed '*Glandosane was prescribed in the 'as required' medicine section of the drug kardex on 28 May 2014'*. The Trust did not state who prescribed Glandosane on 28 May 2014. However, they stated '*Glandosane is a synthetic saliva and was only administered on 28 May 2014 at 15.00'*. They stated that '*Glandosane may not have been required regularly and the nursing notes do reflect mouth care was carried out as a comfort measure'*.

[6] A **nasogastric** tube (**NG** tube) is a special tube that carries food and medicine to the stomach through the nose. It can be used for all feedings or for giving a person extra calories.

28. The Investigating Officer conducted a telephone interview with the Medical Registrar on 8 May 2017. The Medical Registrar confirmed '*if he prescribed Glandosane medication in the 'as required' section of the patient's Kardex, then it was not his intention for [her] to receive Glandosane daily but rather as and when she required it'.* The Medical Registrar stated '*that if nursing or medical staff found a patient to be in distress then Glandosane could be given for symptom control'.* Furthermore, the Medical Registrar confirmed '*in circumstances where a patient cannot communicate they want something then a daily review would be carried out on the patient's needs by the medical team'*.

iii. The patient's medical notes and records

29. In relation to the SALT referral, I note from the SALT records that a telephone referral was made to SALT on 9 April 2014 at 2.53 from Ward 2 North. This indicated that the patient was diagnosed with a respiratory infection and that she was 'currently eating/ drinking'. This was followed by a written referral signed by a junior doctor on 9 April 2014. In the comments section it is recorded '*soft diet/thickened fluids at present – had been normal diet*'.

30. In relation to the SALT assessment on 15 April 2014, it is recorded that the patient was suffering from *'moderate to severe dysphagia secondary to facility/cognitive decline'* and that management of her condition would include a recommendation for '*a pureed diet and stage 3 fluids, amounts as tolerated*' with '*full assistance'* and '*slow pace of feeding'*. The SALT recorded that her family was present during examination and the examination findings were explained to them as follows '*dysphagia and therefore there is a risk of ongoing aspiration. Current regime is safest consistencies to decrease risk of further aspiration'.*

31. A Dietician review also took place on 23 April 2014 at 12.15 hours. This recorded '*estimated oral intake difficult to estimate but obviously poor. No*

further weight recorded. Poor nutritional status and likely will continue to deteriorate unless oral intake improves significantly. Risk of further skin breakdown given poor nutritional status. Query appropriateness of trial alternative feeding via NG to promote wound healing and improve nutritional status although may be difficult given cognitive decline. Will suggest in medical notes'.

32. Subsequently, on 23 April 2014 at 15.30 hours, a further SALT review took place. The SALT recorded a '*further deterioration in swallow response'* since the initial assessment on 15 April 2014. The record indicates that there was a *'detailed discussion with the patient's daughter'* at 16.00 hours and that the SALT '*described the aspirational risk to daughter i.e. food/liquids going the wrong way block windpipe/lings'*. The SALT recommended a reduction in oral intake to '*1-2 teaspoons of thickened liquid' and 1-2 teaspoons of stage 3 supplements'.* The SALT also advised *'any concerns consider nil by mouth (NBM)'.* It is recorded by a doctor in the clinical record on 24 April 2014 that he intends to *'consider the appropriateness of NG feed – will discuss with rest of medical team'.*

33. On 28 April 2014, the SALT recorded '*Patient continues to present with a Delayed/effortful/ weak swallow response. Overt signs of aspiration therefore increase amounts of stage 3 consistency foods. Advise pudding consistency only stage 3, max 3-4 tea spoons per feeding. Little and often regime i.e. forticremes/stage 3 fluids. No puree. Discontinue if signs of aspiration/chest deterioration'.*

34. I note that the entry in the Clinical notes on 29 April 2014 records '*oral intake remains poor, patient not wanting thickened diet' and o*n 30 April 2014, '*poor swallow on thickened diet'.*

35. On review on 2 May 2014, the dietician recorded a weight loss of 4kg since admission and again queries if '*trial alternative feeding would be considered*

appropriate'. On 2 May 2014, the dietician recorded '*Note from reading back in medical notes – SHO had responded to suggestion at NG feeding and indicated it would be discussed with rest of the medical team, however then medical registrar indicated patient is unlikely to recover, wasn't mentioned again in medical notes. This was one week ago however notes indicate patient has clinically improved and suggestion to consider NG tube feed made again.*

36. A second course of antibiotic medication was completed on 25 April 2014. However in response to a request from the patient's family on 4 May 2014 for their mother *'to be given a chance'* by continuing the administration of antibiotic medicine*,* the doctor *records on* 6 May 2014, '*recommenced on IV ABX. Note conversation with family, continues on thickened diet'.* It is also noted that, on 6 May 2014, the dietician '*spoke with Dr … on ward, he is not keen for alternative feeding at present, investigating for possible end stage dementia'.*

37. On 7 May 2014, the SALT recorded '*no significant change noted in swallow function from 2 May 2014. Continues to present with delayed and effortful swallow response. Trialled 2 teaspoons of stage 2 custard and liquids, however effort and in co-ordination in comparison to stage 3 pudding consistency. After very small quantity increased swallow fatigue increased overall effort to laryngeal excursion and likely risk of aspiration increased quantities'.*

38. On 8 May 2014, the Dietician recorded ' *no real change to current situation will be difficult to prevent nutritional status deteriorating further, taking very small amounts orally as per SALT, medical team not keen for alternative feeding at present, medical team are to review situation tomorrow'.* However on 9 May 2014, the Dietician recorded '*nursing staff reported to me at the end of yesterday Dr … had indicated for potential NG feeding – he is to discuss with family. Medical Notes indicate attempted to pass NG tube last night, not successful, patient has stated she does not want this'.*

39. In relation to the prescription and administration of Glandosane, I note the

medical record on 24 May 2014 states '*Glandosane (sync saliva) for comfort only'.*

40. On 28 May 2014, the Medicine Prescription and Administration Record states 'Glandosane' prescribed in 'As Required Medicines'. This record states Glandosane was signed and administered by nursing staff at 15.00.

iv. IPA Advice

Dietician IPA

41. The Dietician IPA was asked if it was appropriate and reasonable for the diet to be amended. The Dietician IPA advised that the patient '*was found to have Oropharyngeal Dysphagia*[7] *once she was assessed by SALT on 15 April 2014. SALT advised a pureed diet and thickened fluids. The medical team had already highlighted concerns regarding the safety of her swallow, and so it would appear their suggestion to start thickened fluids was appropriate'*. The Dietician IPA advised 'a *SALT opinion should have been sought sooner as there are variations within consistencies of thickened fluids depending on the patients swallowing ability'*. On enquiry, the Dietician IPA advised '*there is no documentation that the medical team discussed the changes in fluid consistency on 8 April 2014 with either [the patient] or her family'.*

42. The Dietician IPA was asked if the change in diet prevented her from eating as she would have done prior to her admission. She advised '*while some patients do not like modified diet and fluids there is no documentation that [she] did not tolerate the suggested consistencies. Medical records indicate [her] swallow was delayed, effortful and weak and the medical team noted she was at times short of breath, low in mood and sleepy. It is likely that the deterioration in her clinical condition also led to her reduced poor oral intake, not just the change in*

[7] **Dysphagia** is defined as a subjective sensation of difficulty or abnormality of swallowing. ● **Oropharyngeal** or transfer **dysphagia** is characterized by difficulty initiating a swallow. Swallowing may be accompanied by nasopharyngeal regurgitation, aspiration, and a sensation of residual food remaining in the pharynx.

her diet'.

43. The Dietician IPA was asked if the patient's dietary and nutritional requirements were adequately considered during her hospital admission. She referred to the record of a MUST screen on 11 April 2014 '*when her weight was 48.1 kg (BMI 16kg/m² = underweight) which provided a MUST score of 2 and triggered referral to Dieticians'.* The Dietician IPA advised that the patient '*was seen by a Dietician on a total of 18 occasions between March 2014 and June 2014'.* The IPA further stated she *'received a high level of dietician care, and the dietician documentation is excellent'.*

44. The Dietician IPA further advised '*the food record charts indicate poor oral intake by [the patient], approximately 200-300 calories which was inadequate and on some days she would decline all oral intake. Furthermore, on 23 April, SALT advised no more than 1-2 tea spoons of stage 3 liquid /supplements to be given at any one time'*. The Dietician IPA advised *'that based on this level of intake it would have been extremely difficult to provide [her] with sufficient calories and protein to meet her requirements*'.

45. The Dietician IPA advised '*[the patient] was reviewed on 15 April 2014 by a Dietician who recommended she be prescribed oral nutritional supplements to improve her intake of food. Upon [her] dietician review on 23 April 2014, 1 May 2014, 2 May 2014, 6 May 2014 and 8 May 2014, the Dietician highlighted that [she] was not meeting her nutritional requirement and suggested to the medical team to consider the appropriateness of artificial feeding'*.

46. The Dietician IPA stated that NICE Guidelines for Nutrition Support in Adults 2006 advises enteral (tube) feeding to be considered for patients with inadequate or unsafe oral intake. The Dietician IPA advised that recommendations made by the Dietician were in accordance with NICE Guidance and that artificial feeding should have been considered by the medical team at the patient's second review on 23 April 2014. However, the Dietician IPA highlighted '*the dietician notes on 6 May 2014 that the consultant*

was not keen for non-oral artificial feeding as the medical team wished to rule out a diagnosis of dementia'.

47. The Dietician IPA further advised '*following discussions with family on 8 May 2017, the decision was made to attempt artificial [NG] feeding. This represents a total of sixteen days between when the dietician first suggested the medical team consider the appropriateness of artificial feeding [23 April 2014].* The Dietician IPA advised '*I cannot see further documentation from the medical teams that artificial feeding was considered until the discussion with the family on 8 May 2014. During this time there is documentation on medical, nursing and dietician notes to highlight that [the patient's] oral nutritional intake was inadequate during this period and will have resulted in deterioration in her nutritional status and weight loss. This is reflected in her weight loss as documented in her nutritional screening tool'*.

48. The Dietician IPA advised '*it was decided on 8 May 2014 to offer a two/three week trial of NG feeding'.* The Dietician IPA further advised '*attempts were made to NG feed ... on 8 May 2014 and 14 May 2014, however these attempts were unsuccessful, even with the administration of a light sedative. [The patient] was deemed to have capacity to refuse NG tube insertion and the decision to start TPN nutrition was made on 12 May 2014, by this time [she] had been almost one month with minimal nutrition'.*

49. The Dietician IPA stated that the patient '*continued to receive TPN feeding until 29 May 2014 and she was given additional phosphate and magnesium to replace low serum levels which is in line with NICE guidance. The Dietician estimated ... TPN feeding requirements to be in the region of 1200 calories and 60g protein per day, however due to issues with fluid overload, poor venous access, TPN was only able to provide approximately 70% energy requirements and 45% protein requirements'. During this time [she] was declining nearly all oral intake and so her nutritional status would have continued to deteriorate*

despite the best efforts of the nutrition team to support her with TPN'.

50. In relation to the introduction of NG tube insertion, the Dietician IPA advised '*this is complex, as in line with good practice and NICE guidance (TPN) should only be reserved for patients with either a non-functioning or non-accessible GI tract. In the case of [the patient], while she had a functioning GI tract and enteral nutrition would have been the most appropriate form of nutrition support, she did not tolerate and was declining insertion of an enteral feeding tube. In view of this the medical team made the decision to start TPN. The Trust's nutrition team also raised the point that enteral feeding was much preferred over TPN feeding, however in this case, TPN was chosen'.* The Dietician IPA further highlighted '*the dietician reviewed [the patient] on 12 May prior to her commencing TPN and estimated her weight to be 39.6 kg, which was very underweight'.* In line with NICE guidance, the Dietician IPA also advised '*[she] was at high risk of re-feeding syndrome*[8]*'.*

51. The Dietician IPA highlighted '*[the patient] received a high level of dietician care and the dietician records were excellent'.* The Dietician IPA further clarified '*I am unable to comment if in this case [the patient's] weight loss directly contributed to her death, however she was malnourished at the time of her death. Clinical manifestations of malnutrition include increased vulnerability to illness increased clinical complications and higher mortality rates, therefore her poor nutritional state was likely to be a contributing factor'.*

The Consultant Physician (CP) IPA

52. The CP IPA advised '*It is noted that [the patient] had lost significant weight and it has been estimated at 18% of her body mass by 12 May 2014 and had low albumin levels. Her nutritional intake was clearly very poor. This has certainly been highlighted on a number of occasions by the Dietician team'*. The CP IPA

[8] **Refeeding syndrome** is a **syndrome** consisting of metabolic disturbances that occur as a result of reinstitution of nutrition to patients who are starved, severely malnourished or metabolically stressed due to severe illness

also advised '*it is difficult to say whether earlier intervention in terms of artificial feeding would have altered the outcome ... It is quite clear that she had a number of medical co-morbidities and health problems complicated by infections'*. The CP IPA also advised '*there was a significant period of time during which [the patient] was inadequately nourished and non-oral feeding could have been considered at an earlier stage given the difficulties in [her] swallow as well as her general frailty and poor health. It is more than likely that this contributed to [her] poor health and susceptibility to infection but the end outcome may not have been any different had this intervention been any earlier'.*

53. The CP IPA was asked if action should have been taken by the patient's medical team earlier to improve her nutritional status. He advised '*supplementary feeding was first suggested by the Dietician team on 23 April 2014 but it wasn't until 8 May 2014, some 16 days later that NG tube feeding was considered. In fact there were difficulties following this as well in nasogastric tube placement and it wasn't until 12 May 2014 when intravenous TPN was actually commenced. In total this represents almost 20 days where nutrition was suboptimal. A few days suboptimal nutrition can be tolerated but prolonged periods will have adverse effects. There have certainly been discussions from the dietician team with the medical staff and for a variety of reasons it appears that feeding was not considered at an earlier stage to be the best course of action. It is my opinion that [the patient's] medical teams should have considered action earlier in order to improve her nutritional status'.*

54. The CP IPA was asked if these delays had any adverse effects on the patient's overall care and treatment. He advised '*There certainly does appear to have been some delay in pushing forward with the recommendations from the Dietician team when it came to [her] nutrition. However, it is to be noted that [she] was unwell for a fairly prolonged period of time during this period between 15 April 2014 and 8 May 2014. It may not have been appropriate for NG or TPN to be considered in light of other medical issues. This has certainly been*

mentioned in some of the dietician documentation. I don't think any of these were absolute contraindications to starting supplementary feeding.

55. The CP IPA advised '*I think it is fair to say that [the patient] was without adequate nutrition for this time period* [7 April 2014 – 12 May 2014] *of just over a month prior to TPN being commenced. This whilst not ideal was likely to have been an inevitable consequence of [her] poor health but the duration of time period for which she was without supplemental nutrition is longer that would have been ideal. It would have been appropriate and reasonable to consider supplemental nutrition at an earlier stage during this 1 month period prior to it actually being commenced'.* The CP IPA observed that '*the dietician notes appear to be separate from the remainder of the medical notes and these may not have always been visible to the medical team'*. He added '*it is not clear why this information is not in the case notes where the nurses, doctors and speech and language team have been documenting'.*

56. I asked the IPA if the patient's poor nutritional status contributed to her death. He advised *'I believe [her] poor nutritional status did contribute to her death. How much is difficult to say. It has to be noted that [she] had a number of significant medical problems during her final admission including severe infection with pneumonia and urinary infection, pressure ulcers, dehydration, acute kidney injury and recent surgery for hip fracture. Irrespective of nutritional status, these significant medical problems put [her] at very high risk of poor outcome or death, particularly given her frailty at her time of admission. [Her] poor nutritional status was just one factor that contributed to her death'.*

57. The CP IPA concluded '*It is noted that at the time of death [the patient] was frail, weak and unwell and I am certain that she was malnourished at the time of her death. I do not feel that earlier intervention with supplemental feeding would have had a dramatic effect on the outcome. However there certainly had been some delays in addressing her nutritional needs and these could have been picked up at an earlier stage in her final illness'.*

58. I asked the CP IPA if administration of the drug Glandosane might have enabled the patient to eat more comfortably. The CP IPA advised '*Glandosane is an artificial saliva preparation and it is used for the treatment of dry mouth. It is part of a number of measures that can help patients with dry mouth for which there can be many causes. This includes regular oral moistening with mouth care which the patient appears to have had. It has no other indications for any role in improving swallowing or the comfort of swallowing. It has no role in this. It would not have allowed [her] to eat more comfortably as the fundamental problem in her case was the she was suffering from a poor and unsafe swallow. It is clearly documented on the 24 May 2014 that the intended reason for prescription of Glandosane was for comfort'.*

59. The CP IPA also advised *'Glandosane was prescribed on 24 May 2014 in the 'as required section' for comfort measures*, *however this date was added at a later time'.* The CP IPA also advised *'it appears to have been administered on only one occasion on 28 May 2014 at approximately 15.00'*. The CP IPA also highlighted the *'signatures of the prescriptions for Glandosane on 24 May 2014 and 28 May 2014*, *do not seem to be clear and it is impossible to ascertain the name of the prescribing doctor clearly. It would be expected good practice that a doctor's name would be clear and legible with a signature for all drug prescriptions'.*

60. The CP IPA advised '*whilst Glandosane was administered and signed for on 28 May 2014, it is initialed by the individual dispensing the drug but it is not clear who this has been'. Whilst this is accepted practice that the dispensing of a drug would be indicated by an individual's initial only, however there does not seem to have been a record of full name and signature of this individual to identify their identity in other parts of the clinical documentation – this is often done by a list of individuals in a patient's records who would be writing in clinical case notes so that signature abbreviations and initials used when signing for medication dispensed could be identified – I cannot see this record*

of documentation'.

The Nursing IPA

61. I also asked the Nursing IPA about the administration of Glandosane. The Nursing IPA advised '*Glandosane should only be administered when needed and at the dose stated. It works by moistening and lubricating the mouth and throat and thus could be swallowed accidentally which may be uncomfortable for [the patient] who had a poor swallow reflex'.* The Nursing IPA *states 'the nursing record with regards to the administration for Glandosane, are in line with NMC Standards for Medicines Management (2010). This was an 'as required' spray and it should be clearly documented on a prescription chart when it has been administered'.*

ANALYSIS AND FINDINGS

I shall consider my findings under the following sub-headings:

i. Modification of Diet and SALT Referral

62. I established that the patient's medical team modified her diet to thickened fluids on 8 April 2014. I examined the Trust's response to my enquiries and note the Trust did not have a policy that required them to consult and engage with the SALT in advance of adjusting a patient's diet. I established the Trust made a SALT referral on 9 April 2014 and she was assessed by SALT on the 15 April 2014, some four working days later. I established that the SALT recommended a thickened liquid diet also which was not at variance with the recommendation made by the clinical team on 8 April 2014. The Trust has explained that '*it is the role* of *medical staff to assess if a patient requires a modified diet as part of their medical management plan. Following medical assessment, a referral to Speech and Language Therapy (SALT) is normal practice; however medical staff are qualified to alter a patient's diet without*

SALT authorisation'.

63. I accept the Dietician IPA advice that it was appropriate for the patient's medical team to modify her diet on 8 April 2014. I note the Trust were not required to engage and consult with the SALT in advance of modifying her diet and therefore I consider the clinical team's decision to modify the diet prior to a SALT assessment to have been reasonable and with the patient's immediate welfare at its focus. Also, I consider that there was no requirement to consult with the patient or her family prior to making this decision. There is evidence that the decision was appropriately communicated to her and her family. The complainant has noted in her letter of complaint dated 27 April 2015 to the Trust '*A nurse in 2 North suggested an assessment by SALT so they thickened Mum's drinks and recommended soft food meantime'* and makes several references to subsequent discussions with nurses and care assistants about her mother's diet. **Therefore, I do not uphold this element of the complaint.**

64. I note the patient's medical team had raised concerns regarding the safety of her swallow. A telephone referral was made to SALT from Ward 2 North on 9 April 2014 and the record notes that she was '*currently eating/drinking*'. I consider that this was inaccurate and misleading. However this was followed by a written referral dated the same day. The written referral indicates '*soft diet/thickened fluids at present*'. I note that the Trust informed the complainant in June 2015 in response to her complaint '*unfortunately the speech and language therapy team were not aware that interim management of your mother following the receipt of referral had been thickened liquids. This new clinical information would have altered the speech and language therapy team response time to see her*'. This suggests that the written referral was either not received promptly or not appropriately triaged by SALT. I note that SALT provides a five day week service only, therefore the referral prior to a weekend meant that the assessment took place six days after referral.

65. Therefore, I agree with the Dietician IPA that '*a SALT opinion should have been*

sought sooner as there are variations within consistencies of thickened fluids depending on the patient's swallowing ability'. The GMC Guidelines on Good Medical Practice: paragraph 15 (b) states '*If you assess, diagnose or treat patients you must promptly provide or arrange suitable advice, investigations or treatment where necessary*'. I consider the misleading information provided to SALT in the verbal referral and the resulting delay in the SALT assessment was a failing. I find the Trust failed to adhere to the GMC guidelines in this regard and that this constitutes a failure in care and treatment. I consider the failure to correctly triage the SALT referral, compounded by the additional two day delay because there is no weekend service, caused the patient and the complainant the injustice of uncertainty and concern about the appropriate consistency of the patient's diet. **I uphold this element of the complaint.**

66. I note that the Trust informed the complainant on 20 June 2016 that '*as part of the triage process at the point of referral, nursing staff are advised that it is their responsibility to inform the SALT service if eating/drinking status changes for the patient while he/she remains on waiting list for SALT assessment'.* I welcome this improvement.

ii. Dietician Review and Artificial Feeding

67. I established during the investigation that the patient had dietician reviews and assessments carried out approximately eighteen times between 15 April 2014 and 28 May 2014. I accept the advice of the Dietician IPA that the dietician reviews, assessments and recommendations were carried out in accordance with NICE guidance for Nutrition Support in Adults (2006). I note between 15 April 2014 and 8 May 2014 the Dietician team had highlighted on five occasions to the medical team that she was not meeting her nutritional requirements and that artificial feeding should be considered. I also established that the medical team did not attempt artificial feeding until 8 May 2014, approximately 16 days after the dietician team had initially recommended artificial feeding. I accept the CP IPA advice that during this period, there was evidence on both clinical and

dietician notes that the patient's oral nutritional intake was inadequate and was resulting in the deterioration of her nutritional status and significant weight loss.

68. I note that the patient's medical team made a number of attempts to NG feed her between 8 May 2014 and 14 May 2014. I also note that she was commenced on TPN on 12 May 2014. However, this was temporarily ceased to allow further attempts at NG feeding whilst under sedation. However, the attempts to NG feed whilst was under sedation proved unsuccessful and TPN feeding was again recommended on 14 May 2014 until 29 May 2014.

69. The Dietician IPA has noted that by the time TPN feeding started, the patient had *'been nearly a month with minimal nutrition'*. I accept the advice of the CP IPA that there was a delay by the medical team to implement the recommendations made by the dietician team. I note the CP IPA advice that she was without adequate nutrition between 7 April 2014 and 12 May 2014 which was more than a month prior to the medical team commencing TPN feeding. I note that the Dietician notes and records were maintained separately to the clinical notes and as a result were not readily available for other members of the multidisciplinary team to review.

70. In considering a finding on this issue of complaint I have had regard to the General Medical Council (GMC) Good Medical Practice Guidelines 2013, paragraph 15 (b) which states you must "*promptly provide or arrange suitable advice, investigations or treatment where necessarily".* I note Paragraph 16 (c) of that guidance also states that "*in providing clinical care you must: provide effective treatments based on the best available evidence"'.* I have also considered relevant NICE Guidance, Nutrition Support for Adults (2006), sections 1.2, 1.7 and 1.8 (paragraph 15 refers). I consider the Trust's delay in providing adequate nutrition to the patient, without recording the rationale for not doing so, failed to meet NICE guidance and GMC guidelines on applying knowledge and experience to practice. I accept the IPAs' advice that there were

missed opportunities between 7 April 2014 and 12 May 2014 for the patient's medical team to consider the dietician team's repeated requests to consider artificial feeding and ensure adequate nutrition was provided earlier. I am critical of the Trust's delay in their consideration to artificially feed the patient which I find led to a further delay in the Trust commencing the patient on TPN feeding.

71. The first Principle of Good Administration "Getting it right" – 'A*cting in accordance with the law and with regard for the rights of those concerned'* – explicitly creates an expectation that public authorities will have regard to published standards such as the GMC Guidelines on Good Medical Practice and NICE guidelines. The Principles of Good Administration are the general standards which I will apply in any complaint, however those standards are informed by specific standards and principles that apply to a particular aspect of care. Therefore, I consider that the five core standards, of the Patient and Client Experience Standards 2009, of 'Respect, Attitude, Behaviour, Communication, Privacy and Dignity' are relevant in this case. These also reflect the human rights principles of fairness, respect, equality, dignity and autonomy (FREDA). The CP IPA advised it '*is difficult to say whether earlier intervention in terms of artificial feeding would have altered the outcome for [the patient]',* however, she '*was malnourished at the time of her death'.*

72. The DHSSPS publication 'Promoting Good Nutrition, a Strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016' begins with a quotation from Florence Nightingale in 1898 "*Every careful observer of the sick will agree in this, that thousands of patients are starved in the midst of plenty, from want of attention to the ways which make it possible for them to take food."* I consider this to be particularly pertinent in this case. I consider that, as a result of the delays in the patient receiving adequate nutrition, the Trust had insufficient regard for her human rights, and, in particular, her dignity, during the final weeks of her life.

73. I consider it a significant failing in care and treatment that the Trust did not consider the recommendations made by the dietician team to commence artificial feeding earlier. I also consider the delay by the Trust in providing adequate nutrition to be a failure to adhere to GMC guidelines. The CP IPA advised, and I accept, that the patient was in poor health and that her poor nutritional state was only one of many factors contributing to her death. I am mindful as noted by the CP IPA that she had a number of significant health problems during her final admission, including severe infection with pneumonia and urinary infection, pressure ulcers, dehydration, and acute kidney failure. Also she had recent surgery for a hip fracture. However, I consider the loss of opportunity, discomfort and distress that inadequate nutrition afforded to the patient to be an injustice. I also consider the complainant to have suffered the injustice of, upset and distress at the Trust's delay in providing adequate nutrition to her mother. **I therefore uphold this element of the complaint.**

iii. **Administration of Glandosane**

74. I accept the CP IPA advice that Glandosane is an artificial saliva which is used in the treatment of dry mouth. I established that the patient was suffering from a poor and unsafe swallow and therefore accept the advice of the CP IPA that Glandosane would have had no indications for any role in improving her swallowing or the comfort of swallowing. I also established that her prescription on 24 May 2014 for Glandosane, was prescribed in the 'comfort only' section of her prescription chart. I accept the advice of the CR IPA that it was the Medical Registrar's intention that the prescription of Glandosane was for comfort only. There is no evidence that Glandosane was required by the patient from 24 May 2014 until it was administered on 28 May 2014. I also accept the advice of the Nursing IPA that Glandosane was administered on 28 May 2014 in accordance with the NMC Standards for Medicines Management. **Therefore, I do not uphold this element of the complaint.**

75. However, I note the CP IPA highlighted that the prescribing signatures for

Glandosane were not clear. GMC Guidelines on Good Medical Practice: paragraph 19 states *'documents you make (including clinical records to formally record your work) must be clear accurate and legible'.* I find the prescribing doctor's failure to adhere to the GMC guidelines on recording actions and treatment clearly, accurately and legibly, to constitute maladministration. **I do not consider the patient to have suffered an injustice in this instance and therefore I do not uphold this element of the complaint.** However, the Trust should remind clinical staff of the importance of ensuring that clinicians' full names and signatures are made known within patient records.

Issue Two Was the nursing care and treatment provided on the ward appropriate and reasonable?

Detail of the complaint

76. The complainant confirmed that her mother's medical team had commenced a trial of NG feeding on 8 May 2014. However, after a number of unsuccessful attempts to NG feed her mother, her medical team had agreed on 8 May 2014 with the complainant and her mother that no further attempts of NG feeding were to take place unless her mother was sedated. The complainant complained that a nurse attempted to feed her mother on 14 May 2014 without sedation. She has recorded in the detail of her complaint to the Trust a conversation with a nurse who, the complainant states, explained that she proceeded with the NGT without sedation on the morning of 14 May 2014 as '*she could not sedate mum without [the doctor's] permission'.* The complainant stated that it was inappropriate and unreasonable for the nurse to have ignored the wishes of her mother and the instructions of her medical team, causing her great discomfort and potentially jeopardising three further attempts under sedation later that day.

Evidence Considered

i. Policies/Guidance

77. I considered the following extracts from the NMC – Standards of Conduct Performance and Ethics for Nurses and Midwives (2008) to be relevant:
Paragraph 1 – 'you must treat people as individuals and respect their dignity'.
Paragraph 24 – '*you must work co-operatively within teams and respect the skills, expertise and contributions of your colleagues'.*
Paragraph 42 – '*you must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been'.*
Paragraph 43 – '*You must complete records as soon as possible after an event has occurred'.*

ii. The Trust's response to investigation enquiries about a nurse NG feeding the patient without sedation

78. In response to enquiries, the Trust confirmed to me that the medical notes state '*NG tube insertion is to be done under sedation as per nutrition round patient to have NGT under sedation. Patient agreeable'.* The Trust also referred to the medical notes on 14 May 2014*, 'note discussion yesterday (i.e. 13 May 2014) NG vs TPN. Family very keen to attempt NG tube with sedation. Patient refused without sedation after it was attempted this am'*. On enquiry a doctor stated '*my recollection of this case is limited. The note states that NG insertion was attempted 'this morning' and so refers to the morning of 14th May. I do not believe I attempted the insertion without sedation that morning and do recall making 3 attempts later that day with sedation'.* The Trust referred to the record and stated '*it is noted that on 14 May 2014, 18.00 hours NG tube insertion attempted with Midazolam (sedation) by 3 times ... FY2 same unsuccessful, not for further tries'*. The Trust confirmed that a Staff Nurse and the patient's daughter were present when the sedation was given and the three attempts made by the doctor. The Investigating Officer interviewed the Staff Nurse on 17

October 2017 but unfortunately she could not recall providing care and treatment to the patient or her subsequent interaction with her daughter on the morning of 14 May 2014.

79. The Trust was asked on a number of occasions by the Investigating Officers to address the specific complaint that the nurse attempted NGT on the morning of 14 April 2014 without sedation, which had not at that stage been prescribed. The Trust's reply on 21 September 2017 states *'We are unable to find any entry in either the medical or nursing notes which notes the name of who attempted to insert the NG tube'* and that '*The staff nurse responsible for [the patient's] care on the morning of 14 May 2014 has left the Trust. Attempts to contact her have been unsuccessful so we are unable to provide any further information'*.

iii. The patient's medical notes and records

As part of my investigation, the patient's medical notes and records were examined. The relevant extracts have been highlighted in the subsequent paragraphs in this report.

80. The dietician record on 9 May 2014 states '*nursing staff reported to me at the end of yesterday Dr ... indicated for potential NG feeding – he is to discuss with family. Medical Notes indicate attempted to pass NG tube last night, not successful, patient has stated she does not want this'.*

81. The dietician record on 13 May 2014 states '*Dr … suggested reattempting NG tube feeding under sedation and patient agreeable'.* The medical record on 13 May 2014 also states '*as per Nutrition round, patient to have NG feeding under sedation, patient agrees'* and the nursing record of 13 May 2014 states '*for NG tube insertion in AM'.*

82. On 14 May 2014, the medical record states '*patient refused NG without sedation after it was attempted this am'* and *'will attempt further NG tube*

insertion ... this afternoon with sedation'. I note also the following entry on the nutritional care plan on 14 May 2014, '*As per medical notes yesterday NG tube feeding to be attempted under sedation this morning'.* '*spoke with staff Nurse … NGT was attempted this am by ward (with no sedation used*)' The note continues '*No sedation prescribed yet on kardex A/W Dr … W/R re decision re further NGT attempt'* and *'spoke with daughter … who is extremely concerned re mum's nutrition upset that NGT was attempted W/O sedation'.*

iv. The Independent Professional Advice

83. The Nursing IPA advised it had been documented within the medical and dietician records that an attempt had been made to NG feed the patient without sedation on the morning of 14 May 2014. However, the Nursing IPA could find no record on the nursing notes that an attempt had been made to NG tube feed her without sedation that day. The Nursing IPA advised '*it is expected good practice and in line with national guidance to keep clear accurate records as soon as possible after an event has occurred and to document that the patient has given verbal consent'*.

84. The Nursing IPA advised '*it was not reasonable the nurse did not record the attempt made to NG tube feed [the patient] without sedation'.* The Nursing IPA also advised '*the nurse should have checked [the patient's] medical notes and had a clear understanding of the plan of care before attempting NG tube insertion'.* The Nursing IPA advised '*the plan, as agreed by all parties (including the patient herself) was to attempt NG feeding with sedation. To attempt without was against the plan and there is no record that the patient consented to this'.*

ANALYSIS AND FINDINGS

85. The investigation has established that the patient had agreed with her medical team and family on 13 May 2014 that she did not want NG feeding to be attempted without sedation. Upon examination of the dietician notes I established that it was recorded on 14 May 2014 that 'the ward' had attempted that morning to NG feed her without sedation. The nurse who attempted this has been identified by the complainant. However, no record was made of this attempt in the nursing notes and the nurse has no recollection of the events of the morning of 14 May 2014. I accept the advice of the Nursing IPA that the nurse should have checked the patient's medical notes prior to attempting to NG feed. I consider that had the nurse reviewed these notes, she would have been aware of the agreed plan of care and what the patient had consented to. I also accept the advice of the Nursing IPA that to attempt NG tube feeding without sedation was against the plan. I note also that there is no record that the patient knew that the attempt was being carried out without sedation or that she gave informed consent to this.

86. The Trust failed to respond initially to enquiries from the complainant and my Investigating Officers about the attempt at NGT on the morning of 14 May 2014 and has belatedly informed me that the nurse responsible for the patient's care on that day has left the Trust and cannot be contacted. It is regrettable that an opportunity to clarify this has been missed. I am however satisfied from the complainant's detailed account and the available records, including the entry 'p*atient refused without sedation after it was attempted this am'* that an attempt had been made to NG feed without sedation on the morning of 14 May 2014. I accept the IPA advice that to do so was not with informed consent. I have considered the medical notes and the detail of the complaint in this regard. The complainant in her correspondence with both the Trust and my office has been consistent and firm that the NGT was attempted without sedation by the nurse and that she apologised to the complainant for this. The Investigating Officers

interviewed the nurse as part of my investigation, who did not deny this but indicated with the passage of time that she could not recall these events.

87. I have had regard to the NMC Code; Standards of Conduct Performance and Ethics for Nurses and Midwives 2008, which states in its preamble '*The people in your care must be able to trust you with their health and wellbeing. To justify that trust, you must make the care of people your first concern, treating them as individuals and respecting their dignity*'. I am critical of the Trust going against the wishes of the patient and her plan of care as agreed by her and her medical team the day before. I consider that this failure to adhere to the plan of care was not in line with good nursing practice as detailed in the NMC standards and constitutes a failure in care and treatment. **I therefore uphold this element of the complaint.**

88. I consider the patient to have suffered the injustice of upset, distress and discomfort at having NG feeding attempted without sedation, having clearly articulated the day before that she did not want it. I consider that failings such as this can lead to a lack of confidence on the part of the patient and relatives about the adequacy of care and treatment being provided to their loved ones and concern that their loved ones wishes are not being adhered to.

89. I note that I have been presented with no evidence that would lead me to question the patient's mental capacity to make an informed decision regarding her plan of care, particularly about only allowing NG tube feeding whilst under sedation. Furthermore when reflecting on the human rights principle – the right to private and family life, I consider the FREDA principles of fairness, respect, equality, dignity and autonomy are particularly important in this case. Private life covers more than physical privacy and includes issues such as personal choices. An integral aspect of the right to private and family life is the right to protection of one's physical and psychological integrity. Measures that affect physical integrity or mental health may constitute a violation of the right to private and family life if they are carried out against a person's will. In this case,

the patient had capacity to make a personal choice not to have an NG tube inserted without sedation. I therefore consider that the nurse, in attempting to insert an NG tube without sedation, had insufficient regard for the patient's rights and did not adhere to the FREDA principles of respect, dignity and autonomy.

90. I am concerned that the Nursing IPA could find no record within the nursing notes of the attempt to NG tube feed the patient on 14 May 2014. Paragraph 42 of the NMC standards of conduct performance and ethics for nurses and midwives states '*nurses must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been'.* Paragraph 43 also states '*nurses must complete records as soon as possible after an event has occurred'***.**

91. I consider the failure to record that an attempt was made to NG tube feed on the morning of 14 May 2014 without sedation to be inappropriate and unreasonable and not in line with good nursing practice. I also consider the failure in record keeping to be contrary to NMC standards and to constitute maladministration. Lack of appropriate records will necessarily limit the availability of crucial information to any additional clinicians who would become involved in the patient's care and treatment. I have considered the detail of the complaint. In particular that a nurse undertook the NGT without sedation on the morning of 14 May 2014. On the balance of probability, I find that the nurse undertook this intervention. I consider the patient to have suffered the injustice of pain and discomfort during the attempt to insert an NG tune without sedation. I also consider the complainant to have suffered the injustice of uncertainty and frustration as a result of the incomplete record and subsequent confusion and misinformation about what care and treatment her mother was afforded on the morning of 14 May 2014. **Therefore, I uphold this element of the complaint**.

CONCLUSION AND RECOMMENDATIONS

92. The complainant complained to my office about the nutritional care and treatment and nursing care and treatment her mother had received in Craigavon Area Hospital. In reaching my conclusion I have carefully considered all of the issues in the complaint. I have also considered the Trust's responses, the patient's medical notes and records and the advice of a number of IPAs. In considering the injustice experienced by the complainant and her mother, I have taken into account her letter of complaint where she has described the upset and distress her mother and her family experienced in the last weeks of her mother's life.

93. I have also considered the principles enshrined in the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) and the European Social Charter (ESC). The ESC enshrines the right to the protection of health and contains specific provisions relating to older people. The right to health is intrinsic to the right to life (article 2 of the ECHR) and the right to private and family life (article 8 of the ECHR). This guarantees physical and psychological integrity and prohibits non-consensual medical treatment. I consider that in attempting to insert a NG tube without sedation against the patient's stated wishes and in failing to address her nutritional needs in a more timely manner, the Trust did not have sufficient regard for her rights.

94. I note that the patient's health had been declining for a number of years and that upon admission to the hospital, her condition was complex with a number of co-morbities. These included severe infection with pneumonia and urinary infection, pressure ulcers, dehydration, and acute kidney failure as well as recent surgery for a hip fracture. I also note from the notes and records that the clinical team had been open with the family that the prognosis for their mother was poor. Based on the clinical advice, I conclude that, given these significant co-morbities and frail health, earlier intervention may not have prevented the sad outcome of the patient's death. However I consider that appropriate and

timely intervention may have alleviated her discomfort and distress in the last weeks of her life. I am mindful also of the distress of her family who witnessed their mother dying in a malnourished state. I note that the complainant seeks an improvement in patient care. I sincerely hope that, on reading my findings and recommendations, the complainant and her family will be reassured that their main issues of concern have been carefully and fully investigated, and further that the Trust will have learned important lessons from this complaint to the benefit of patient experience in the future.

95. From my investigation of the complaint I have found failures in care and treatment with regard to the triaging of the SALT referral, failure to provide adequate nutritional care and treatment to the patient, and failings with regard to some aspects of nursing care and treatment. I have also identified instances of inadequate record keeping which constitutes maladministration. I consider that the Trust had a number of opportunities to provide adequate and timely nutritional care and treatment to the patient. In this respect her medical team failed to supplement her nutrition at an earlier stage. I am satisfied that, as a result of these failings, she suffered the injustice of loss of opportunity, upset, distress and discomfort. I am also satisfied that the complainant and her family suffered the injustice of upset, distress, uncertainty and frustration in dealing with these issues. **I uphold these issues of complaint.**

96. By way of remedy I recommend the Trust apologises to the complainant and her family for these failings. I recommend the Trust provides a payment of £750 as a solatium in respect of the injustice identified. The payment should accompany the letter of apology and be issued within one month from the issue of my final report.

97. I also recommend that the Trust provides me with an action plan within three months specifying how the failings identified in this report will be shared with the medical and nursing teams involved in the patient's care. The Trust's discussion with these teams should focus on learning and improvement,

highlighting the importance of good communication and record keeping.

98. I also recommend the Trust includes in the action plan it proposes to remind the medical team, particularly when care is shared among a number of professionals, of the importance of coordinating recommendations and communications from all health professionals when devising a patient's plan of care, including those of the Dietician. The Trust should also ensure that the agreed plan of care is readily available to all medical and nursing staff and remind staff that they must consult the plan and adhere to its requirements before treating a patient.

99. I have observed that the main dietetic notes are held separately from the clinical and nursing notes and that this may have been a factor which contributed to the failings I have identified in this case. I therefore ask the Trust to report to me on progress towards the goal of maintaining a single patient record for all patients in Northern Ireland.

MARIE ANDERSON
Ombudsman **July 2018**