Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 14634

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

The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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EXECUTIVE SUMMARY

I received a complaint about the actions of the South Eastern Health and Care Trust (the Trust) in relation to the care and treatment of the complainant's mother in the Ulster Hospital, Dundonald (UHD) between August 2013 and April 2014. The patient passed away in April 2014 aged 84.

Issues of Complaint

I accepted the following issues of complaint for investigation:

- The care and treatment provided to the patient in Ward 24 of UHD.
- The care and treatment provided to the patient in the Renal Unit of UHD.

The complainant, who jointly raised the complaint with her husband, also raised a complaint about the care and treatment the patient received while a patient in Domnall Independent Care Home (Case reference 17241) and regarding the actions of the Belfast Health and Social Care Trust (Case reference 16708). I have investigated and reported on these complaints under the respective case numbers.

Findings and Conclusion

I have investigated this complaint and have found a failure in the patient's care and treatment in relation to the following matters:

- A failure to receive her insulin medication at the correct time and a failure to check blood glucose levels when it was administered
- A failure in record keeping with regard to insulin
- A failure to assess the patient's stump wound every day
- A failure with regard to the NMC Code, 'Make the care of people your first concern', (Part 1 - You must treat people as individuals and respect their dignity. Part 3 - You must treat people kindly and considerately.)
- A failure to have regard to the rights of the patient and her family to participate in the decision to place an NFR Order

I am satisfied that the failures in care and treatment I have identified caused the complainants to experience the injustice of distress, uncertainty and anxiety with

regard to the treatment received by the patient.

Recommendations

I recommend that the complainants receive a written apology for the distress, uncertainty and anxiety caused to them as a result of the failures in care and treatment identified. I also recommend that the Trust should make a payment of £500, in solatium, to them.

THE COMPLAINT

1. This complaint centred around the care and treatment received by the late mother, the patient, of one of the complainants, from the Ulster Hospital, Dundonald (UHD). The patient suffered from long standing, poorly controlled, type 2 diabetes requiring insulin. She had a history of end stage renal failure (chronic kidney disease stage 5) and had been on dialysis from September 2005. She had peripheral vascular disease and a recent below left knee amputation. She also had a history of hypertension, high cholesterol, renal anaemia and hypothyroidism.

2. The patient was admitted to Ward 24 of the UHD on 9 August 2013 and was discharged to Domnall Independent Care Home (Domnall) on 10 September 2013. She was assessed at the UHD neurovascular clinic on 20 September 2013 following a presumed TIA (Transient Ischaemic Attack[1]) and she subsequently suffered a stroke on 18 October 2013. Following this stroke, the patient was readmitted to UHD where she remained until she passed away in April 2014 at the age of 84. During this whole period of time the patient received dialysis, usually three days per week, in the Renal Unit of UHD.

Issues of complaint

3. The issues of complaint which were accepted for investigation were:

- Issue 1: Whether the care and treatment provided to the patient in Ward 24 of UHD was reasonable and appropriate?
- Issue 2: Whether the care and treatment provided to the patient in the Renal Unit of the UHD was reasonable and appropriate?

4. The complainants provided a comprehensive narrative of the care and treatment which the patient received in UHD and raised multiple points and questions which they considered should be answered during the course of this investigation. I refer to Article 30(6) of the above Order which states that 'the procedure for conducting an investigation is to be such as the Ombudsman considers appropriate in the

[1] A brief interruption of the blood supply to the brain, which causes temporary impairment of vision, speech, sensation or movement

circumstances of the case'. The investigation focuses on the care and treatment received by the patient covering the broad areas of concern raised by the complainants, rather than focusing on the multiple and numerous individual queries which were raised. Also in relation to my findings and conclusions I note that aspects of their complaint, covering many areas of the patient's care, relates to the content of conversations which occurred with various members of Trust staff and the matters that they allege were communicated to them. When communications are undertaken in the absence of contemporaneous notes or recordings I am unable to conclude as to the content and tone of the discussion.

5. This complex investigation has focused on the issues of complaint in relation to the following aspects of the patient's care.

Care and Treatment provided on Ward 24

(i) Failing to administer insulin
(ii) Dietetics
(iii) Wound Care
(iv) Nursing care

the patient's care and treatment in UHD Renal Unit

(i) Stroke Awareness
(ii) Mr A's (Consultant Nephrologist) conduct
(iii) Insertion of NFR (Not for Resuscitation) into the patient's medical records.

INVESTIGATION METHODOLOGY

6. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainants. This documentation included the patient's GP and Trust medical records for the relevant period. A copy of this draft report has been shared with the Trust, relevant clinical staff and the complainants for comment.

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

Nursing – Consultant Nurse for older people in a NHS Trust. She has clinical experience across acute care and care homes including expertise in caring for frail older people with complex needs.

Wound Care – Physiotherapy Team Lead in Vascular and Surgery. She has experience in the rehabilitation of amputees and those with complex wounds.

Tissue Viability Nurse –Tissue Viability Nurse Specialist, RGN, MA in Health Care Law. She currently works as a Tissue Viability Nurse Specialist and has over twenty years' experience in this role both in the community and acute setting.

Diet – Senior Dietitian, MNutr (Master of Nutrition 2010). She is a specialist dietitian with experience managing both adult and pediatric patients providing a range of oral, enteral and parenteral nutrition support and therapeutic diets.

Nephrology – Bachelor of Medicine and Bachelor of Surgery, FRCP. He has been a consultant nephrologist for over 5 years and is the clinical lead for transplantation and nephrology in a NHS Trust.

Stroke – Consultant Stroke Physician. He has been a consultant stroke physician for more than 15 years, working in a large stroke centre. He has considerable clinical experience in all aspects of stroke management including acute assessment, TIA

(transient ischaemic attack) clinics, assessments for thrombolysis or thrombectomy and stroke rehabilitation. He is lead clinician for audit and research in a stroke service. He has published research on the diagnosis, risk assessment and prognosis of TIA.

I received clinical advice to assist my investigation of this complaint.

8. The information and advice which have informed my findings and conclusions are included in this report. The IPAs have provided me with 'advice'. However how I have weighed this advice, within the context of this particular complaint, taking into account the Trust and its clinician's responses, is a matter for my discretion.

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

10. The general standards are the Ombudsman's Principles[2]:

- The Principles of Good Administration
- The Principles of Good Complaints Handling
- The Public Services Ombudsmen Principles for Remedy

11. The specific standards are those which applied at the time the events occurred and which governed the exercise of the professional judgment of the Trust staff whose actions are the subject of this complaint.

12. The specific standards relevant to this complaint are:

(i) British Association of Chartered Physiotherapists in Amputee Rehabilitation (BACPAR) – Guidance for the multidisciplinary team on the management of post-operative residuum oedema in lower limb amputees

(ii) Nursing and Midwifery Council Standards for Medicine Management 2007

(iii) NMC Record Keeping, Guidance for Nurses and Midwives (2009)

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

(iv) NMC Code: Standards of conduct, performance and ethics for nurses and midwives (2008)

(v) Chandra, Schulz, Lawrence BMJ 1999, 16th and 19th Report of the UK Renal Registry

(vi) UK National Clinical Guideline for Stroke (4th Edition)

(vii) SEHSCT Incident Reporting Policy, Medicines Policy, Standards for Medicine Management (2007)

(viii) Wardlaw J. BMJ 2004; 328: 655-656

I refer to relevant extracts of these documents, which are reproduced in this report.

13. I have not included all of the information obtained in the course of the investigation in this report. However, I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

THE INVESTIGATION

14. The complainants raised concerns about a number of aspects regarding the care and treatment received by the late the patient on Ward 24 at UHD. These are considered at numbers (i) – (iv) under the following headings

(I) – Failure to administer Insulin

15. They complained that one of them found an abandoned insulin pen on the patient's locker on 9 September 2013 when she visited her at 20.00 that evening.

16. They complained that the Trust was neglectful regarding this incident which posed a danger to the patient, other patients and visitors on the ward. They also questioned the consequences to the patient not receiving her insulin dose at this time.

17. I have considered the following evidence:

(i) Notes of meeting held on 18 December 2014 with the complainants and Trust staff

(ii) The relevant Trust correspondence with them relating to their complaint

(iii) Relevant statements and recollections from staff involved

(iv) The Trust's Medicine Policy September 2011

(v) I have also considered NMC Standards for Medicines Management (2007) – Standard 2.10 – 'You 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 the medicine.'

a. Standard 14 – registrants must not prepare substances for injection in advance of their immediate use or administer medication drawn into a syringe or container by another practitioner when not in their presence'.

b. I refer also to NMC Record Keeping, Guidance for Nurses and Midwives (2009) - Standard 4 'Your records should be accurate and recorded in such a way that the meaning is clear'. Standard 8 'Records should identify any risks or problems that have arisen and show the action taken to deal with them'.

18. I refer to the Subcutaneous Insulin Prescription and Diabetes Control Sheet dated 9 September 2013. This evidences that the patient received dialysis in the morning. It shows four readings for capillary blood glucose and records insulin as being given at 17.45.

19. During meetings and correspondence with the complainants, the Trust stated that an insulin pen, once administered, should be routinely locked in the medication drawer. The Trust has accepted that on this occasion this did not occur. It is not disputed by the Trust that insulin was not administered at the appropriate time nor was the pen locked within the drawer. The Trust stated that this was totally unacceptable practice and has apologised emphatically for the incident and for any distress caused. It has been confirmed that relevant Trust staff had been made aware of the seriousness of the incident. Further, the relevant nurse undertook update training on the administration of medicines and had a note placed on her personnel file to record that this incident had occurred.

20. In order to assess the treatment provided to the patient by nursing staff, I obtained independent expert advice. The Nursing IPA advised that in this case,

although the insulin injection was prepared in the presence of another practitioner, there was a failure to make an accurate and contemporaneous record of the administration of insulin. This action fails the standard of practice required of a registered nurse. From her examination of the documentation the Nursing IPA stated that her conclusion was that the patient did not receive her insulin appropriately on this occasion. The appropriate procedure ought to have been for the nurse or nurses responsible for checking the insulin to have both also checked the patient and confirmed administration of the insulin at the prescribed time and to make a clear and contemporaneous record of their actions. The Nursing IPA stated that it is unacceptable practice to leave a prepared medication on top of a patient's locker and to sign for a treatment as having being given when in fact it has not been administered.

21. The Nursing IPA advised that the records do not indicate when the insulin was administered, although it was prescribed and signed for at 17.45. (The complainants state that it was administered at 20.15). The Nursing IPA has advised that blood glucose should have been checked before administration and while this reading was recorded as being 12.8 at 17.45, there is no record of blood glucose being checked again before 20.15. The patient's records evidence that blood glucose was monitored at 21.29 and the reading at that time was 13. The Nursing IPA stated that there is no evidence that this measurement was taken at the appropriate time to coincide with insulin administration. The Nursing IPA has concluded that when the nursing staff discovered the insulin syringe as a result of one of the complainant's intervention, the insulin was administered at that time but that the blood glucose was not checked immediately beforehand. This is poor practice that could have potentially placed the patient at risk of hyperglycaemia (an abnormally high level of glucose in the blood).

22. The Nursing IPA advice was shared with the Trust. In response the Trust accepted the Nursing IPA's comments and considered her comments to be fair.

Analysis and Findings

23. The complainants raised the issue of the 'neglectful abandonment' of an insulin injection and of the danger that this posed to the patient and to others on the ward. They stated that this issue was raised by them at the time (9 September 2013). However, they did not make a formal complaint until 3 April 2014. I note that 9 September 2013 was the last full day that the patient spent at UHD as she was discharged on 10 September 2013 to Domnall.

24. I have considered the relevant documentation, medical records and correspondence about this issue of complaint. With the passage of time, it is not possible to be certain about the sequence of events which occurred or to provide an exact reasoning as to why the patient did not receive her diabetes medication at the correct time. Having said that it appears that blood tests had been taken and insulin prepared and the details recorded by two nurses at 17.45. The insulin pen was left by a nurse on top of a locker and not administered. The nurses went on a break and it was not until one of the complainants (the patient's daughter) visited at 20.00 that the insulin pen was noted. She stated that she brought this to the staff's attention and the insulin was administered at approximately 20.15.

25. The Nursing IPA has stated, and I concur, that it is unacceptable practice to leave a prepared medication on top of a patient's locker and to sign for a treatment as having being given when it has not been administered. The patient's medical records evidence that she received an insulin injection at 17.45. The investigation has revealed, and the Trust now accepts, that the medication was not administered until at least 20.15. Furthermore it appears that the medication was administered at this time without the patient's blood glucose levels having been checked immediately beforehand. This practice, which falls below the NMC standard for Medicines Management (2007), standard 14 and could have potentially placed the patient at risk of an abnormally high level of glucose in her blood. There is however no evidence that the patient suffered any adverse consequences as a result of this failing and she was discharged to Domnall the following day.

26. I consider the events of 9 September 2013 with regard to the administration of the patient's insulin medication to represent a failure in her care and treatment. The patient did not receive insulin at the correct time and when it was administered blood glucose levels were not checked immediately beforehand, which is contrary to NMC Standards for Medicines Management (2007), Standards 2.10 and 14. I also consider there to have been a failure to adhere to the NMC Record Keeping, Guidance for Nurses and Midwives (2009) in that Standards 4 and 8 were not adhered to. (Paragraph 17) and I consider this to represent a failure in the care and treatment afforded to the patient. NMC guidance is clear with regard to the basic principles of good record keeping. A failure in maintaining accurate and contemporaneous records impedes the thorough, independent assessment of care provided to patients. I also consider that maintaining accurate and appropriate records affords protection to clinicians involved in providing patient care by providing a clear record of their actions and the treatment provided. This was a significant failing in record keeping in this case. The IPA advice is clear that this failure caused no detriment to the patient. However, the patient was placed at risk of an abnormally high level of glucose in her blood. The incident caused injustice to the complainants of upset, worry and uncertainty as to the care and treatment received by the patient.

27. I note that in correspondence with the complainants and during the course of meetings as part of the HSC local resolution process, the Trust has accepted that what occurred with regard to the provision of insulin on this date was unacceptable practice. The Trust and the staff nurse involved offered apologies to the complainants for this incident. The Trust also stated that following the formal complaint made to it in April 2014, staff were interviewed, training was recommended and a member of staff had a note placed on their personnel file. I welcome the fact that the Trust acknowledged this failing. The Trust has reflected on and learned from this complaint. This is an important part of the Principles of Good Complaints Handling. I expect that the Trust will also have considered the learning points identified by the Nursing IPA to improve its patient services.

(II): Dietetics

28. The complainants raised concerns that the patient was provided with an inappropriate diet while a patient in UHD and that this was detrimental to her

wellbeing.

29. In particular they complained that the patient did not receive a diet appropriate to a patient with a renal condition and that she received a 'free diet' instead. They complained also that the Trust informed them that any change in diet was intended to promote wound healing. They believe however that the patient's wound deteriorated during this time. They also state that the Trust informed them that the patient's diet was changed to a correct diet one week prior to discharge to Domnall. This statement is considered by them to be untrue and they believe that when the patient was discharged to Domnall her diet was still incorrect.

30. I have considered correspondence relating to this issue of complaint, including a record of a meeting on 6 July 2015 attended by the complainants and Trust dietitians.

31. I refer to the following relevant extracts from the patient's dietary records:
9 August 2013 – 'Spoke to patient re meals. Appetite very poor. Reviewed diet.'
15 August 2013 – 'review visit. Main issue is high blood sugars which make wound healing more difficult and increases thirst, ….Dr will increase insulin'
22 August 2013 – 'patient eating as she would at home in terms of volume'
27 August 2013 – '…spoke to patient and daughter. They had been very concerned about high potassium on Thursday. I explained possibly due to high blood sugars….daughter queried if should be on 'renal diet', however patient already knows renal diet and is choosing appropriately, reluctant to restrict diet further. Wound healing well.'
4 September 2013 – 'Pt agreed to c/o renal menu, will arrange. ..Plan 1. Fortisip compact 2. Renal menu'

11 September 2013 – 'transferred to Domnall Care Home on 10/9/13. Contacted staff nurse in Domnall. Explained diet advice sheet and fluid allowance…'
12 September 2013 – '..from Domnall phoned. Explained (word unclear) of diet'.

32. In response to investigation enquiries the Trust stated that the patient was regularly reviewed by Renal Dietitians to whom she was known. A recommendation

of a ‘free diet’ was made on 9 August 2013, which removed the usual restrictions associated with renal care and was aimed at increasing food choice and intake. The Trust stated that due to the patient’s clinical condition at the time, her assessed nutritional requirements, poor appetite and stump wound, the food she was encouraged to take was appropriate.

33. The Trust stated that dietary requirements to promote wound healing included adequate protein and energy intake whilst monitoring potassium and phosphate levels. The Trust confirmed that monitoring of the patient’s food intake and blood results were specifically related to her clinical condition and her dietary treatment was adjusted accordingly during her admission. Usual renal diet was reinstated to a potassium level (exceeding 6.0) in combination with the improved dietary intake and supplement drink.

34. The Trust stated that the dietary treatment discussed with the patient included the change in her usual diet to the type of foods she was being encouraged to eat to promote wound healing and to avoid malnutrition. The patient was self-restricting reduced potassium fruits and avoiding fruit juice, which was not unusual for a renal patient on a ‘potassium restricted’ diet for some time. The Trust also stated that a dietitian discussed this change with both the patient and her daughter on 27 August 2013 as they were concerned that the patient was not on a ‘renal menu’ and an explanation provided for the decision.

35. The Dietitian IPA advised that the patient was known to the renal dietetic team at UHD prior to her admission to Ward 24 UHD, as she was in receipt of regular dialysis. Prior to her admission, she was following a diabetic and low potassium diet on advice of the renal dietitians when seen on the renal unit. She was also prescribed oral phosphate binder medications with meals to help control phosphate levels in her blood.

36. The Dietitian IPA advised that the patient was a patient in UHD from 9 August 2013 following a below the knee amputation to 10 September 2013. During this admission, the renal dietitians continued to review her regularly (12 direct patient contact reviews on Ward 24 and Renal unit) together with a number of biochemistry

reviews and liaison with nursing staff. On admission the patient's dietary intake and appetite was very poor. The dietitian calculated a nutritional deficit or around 1000kcal and 40g protein, which is significant. At this time, the patient's blood potassium levels were in the normal range, and the clinical priority at the time was to encourage wound healing following her amputation.

37. The Dietitian IPA advised that wound healing is a multifactorial process, of which diet (in particular dietary protein) is important. Poor nutrition and inadequate protein intake can delay wound healing. High protein foods include meat, eggs, pulses and dairy/milk products. Milk, however, also has a high potassium content. Renal patients, who have had high blood potassium levels, will often be advised to restrict the amount of potassium in their diet to control blood potassium levels. As part of this, patients are educated and advised to avoid/restrict high potassium food and drinks such as milk/milk products.

38. The patient's blood potassium levels were in range, and her dietary intake poor. The Dietitian IPA advised that, in light of this presentation, the Trust dietitian, correctly identified the clinical priority at the time was to improve her nutritional intake to encourage wound healing and recovery from her surgery. As part of this, the patient was encouraged to increase the number of milk based foods to improve her dietary protein intake, and the dietary potassium restriction was temporarily relaxed. There is evidence that potassium levels were closely reviewed by the renal dietitians and the medical team. The patient was having milk puddings and drinking milk, along with oral nutritional supplements in order to increase her dietary and protein intake, which was acceptable and clinically justified. The Dietitian IPA found no evidence that the patient was given unsuitable foods.

39. The Dietitian IPA advised that the renal dietitians closely monitored the patient's dietary intake and bloods results. They correctly identified when the patient's dietary intake was improving and nutritional supplements were appropriately reduced. After reviewing the patient's biochemistry record, it was noted that she had a slightly raised potassium level of 5.9mmol/l on 22 August 2013. The renal dietitian appropriately reduced the patient's oral nutritional supplements and discussed this with the renal team. At this point raised potassium levels were felt to be due to high

blood sugars, and the renal physician felt that potassium levels would reduce with insulin, used to correct the raised blood sugars.

40. The Dietitian IPA advised that there is a record of a discussion with the Trust dietitian, the patient and her daughter on 27 August 2013. The dietitian had reassured the patient and her daughter that the raised potassium level was likely to be due to raised blood sugars. It is documented that the patient's daughter had queried whether she should be placed on a renal diet. The renal dietitian reassured the patient's daughter that the priority was to encourage wound healing and not unnecessarily restrict the patient's diet which may be detrimental to the wound healing process. On 27 August 2013 the records show that the patient's daughter would bring in suitable sandwiches for the patient to support this high protein diet. The patient's blood potassium levels then returned to normal, until 3 September 2013 when they were raised at 6.2mmol/l. On 4 September 2013 the renal dietitian again reviewed the patient, and assessed correctly that her dietary intake had much improved, and as a result her dietary potassium intake had increased.

41. The Dietitian IPA advised that in view of the patient's improved dietary intake, the renal dietitian appropriately reinstated the renal diet (low potassium) advice, in order to help manage blood potassium levels. The biochemistry records evidence that the Dietitian IPA advised that the patient's potassium levels then remained within the normal range until April 2014. It is appropriate for dietitians to temporarily relax dietary restrictions, such as potassium restrictions, when there is a greater clinical priority to improve overall dietary intake. The IPA advised that where such changes are regularly reviewed, as in the case of the patient, this is clinically acceptable. The Dietitian IPA advised that the patient was not provided with inappropriate food or dietary advice during her admission to UHD from August 2013 to September 2013.

42. In relation to the phrase 'free diet', the Dietitian IPA advised that this is a locally used term amongst renal teams to indicate that a dietary potassium restriction is relaxed. This allows the inclusion of milk-based foods into a patient's diet. The Dietitian IPA advised that the renal dietitian clearly documented the nutritional care plan and discussed this with ward staff in order to avoid any confusion. The patient required a high protein diet to encourage wound healing. The Dietitian IPA advised

that, in the presence of poor dietary intake and blood potassium levels within the normal range, it was appropriate to relax the usual dietary potassium restriction to allow more milk-based foods to increase protein intake**.**

43. The Dietitian IPA further advised that it was reasonable and appropriate to make changes to the patient's diet between 9 August and 3 September 2013. As documented in the detailed dietetic notes and thorough dietetic assessments on admission to UHD in August 2013, the patient's initial dietary intake was inadequate. The dietitian appropriately advised dietary modifications including high protein advice and oral nutritional supplements, to meet the nutritional deficit. As her nutritional intake improved, and the dietitian felt the patient was meeting her nutritional requirements, the oral nutritional supplements were appropriately reduced. The IPA Dietitian has confirmed that the dietitian correctly requested regular diabetic nurse reviews in order to manage the patient's blood sugar levels. The dietitian appropriately relaxed, and then later reinstated the patient's dietary potassium restriction in response to her changes in clinical condition. The Dietitian IPA concluded, and I concur, that the dietetic input to the patient's care and treatment at UHD was thorough and documentation excellent.

44. When asked as part of investigation enquiries whether it was reasonable and appropriate to change the patient's diet for wound healing, the Dietitian IPA advised that there is extensive evidence in the literature and clinical guidelines to highlight the importance of good nutritional care in wound healing. This is particularly important to ensure nutritional adequacy and protein intake. I note that the tissue viability nurse (TVN) was also involved in the patient's care and liaised with the renal dietitians. There is clear evidence that the dietitians correctly identified a nutritional deficit in total calories and protein and made changes to the patient's diet to account for this. The inclusion of high protein foods, nutritional supplements, ensuring good diabetic blood sugar control and reviews by medical team and diabetes nurse specialists were appropriate in the circumstances.

45. The Dietitian IPA advised that the patient was discharged to Domnall on an appropriate diet for her clinical condition. She was following a 700ml oral fluid restriction as advised by the managing renal team, and a diabetic and renal diet

avoiding high potassium sources. Normal blood potassium levels evidence that the patient was compliant with this advice and receiving suitable nourishment. There were two telephone calls from the renal dietitians to Domnall on 11 and 12 September 2013 to discuss the patient's nutritional needs on discharge. This was followed up with written information being sent to Domnall Care home (dated 11 September 2013)

46. The Dietician IPA advised that the patient continued to be regularly reviewed by the renal dietetic team at UHD throughout her time in Domnall, and during her later re-admission to UHD in October 2013. In her opinion, the Dietitian IPA advised that the patient was not provided with an incorrect diet or dietary advice during her admission to UHD. She was regularly reviewed by the renal dietitians, and dietetic assessments were thorough with excellent documentation. Dietary changes were clinically justified to reflect changes in the patient's clinical condition and were appropriately monitored by the renal dietitians.

47. In assessing the care provided to the patient, I obtained the advice of a Nephrology IPA who also advised on the patient's diet. He advised that the renal dietitian inputted considerable effort into the patient's care and explained that renal dietetics can often seem confusing. While a diabetic renal diet is extremely restrictive, there are occasions when several of these restrictions may be relaxed due to necessity. For example in an elderly patient with poor nutrition and poor wound healing a calorie and protein intake may be of great importance. The Nephrology IPA advised that there is evidence of this being considered by the renal dietitian and explained that while it may appear that clinicians are contradicting themselves and others, they are in fact tailoring their advice to the presenting clinical scenario.

48. As part of the investigation, the Dietitian IPA advice was shared with the Trust for comment. In response the Trust accepted the Dietitian and Nephrology IPA's comments. It stated that it was delighted that the excellent care provided to the patient by the Renal Dietitians was recognised. The Dietitian IPA had also complimented the relevant staff on their excellent documentation in this case.

Analysis and Findings

49. The complainants made a complaint about the Trust's diet management and the advice and foods that the patient received in UHD. They complain that the term 'free' diet was not adequately explained to them and contend that the patient received an incorrect diet. This diet was detrimental to her wellbeing and when discharged to Domnall the patient's diet remained incorrect. They also complain that although the rationale for UHD's actions were to promote wound healing, the condition of the patient's wound deteriorated while she was a patient there. The Dietitian and Nephrology IPA advice I have received regarding this element of this complaint are in agreement that the care and treatment received by the patient concerning her dietary requirements was clinically justified and appropriate to changes in her clinical condition. I accept this advice and consequently do not consider that there was a failure in the treatment received by the patient with regard to this aspect of her care.

50. It is evident from the records that, following a dietetic assessment on admission to UHD on 9 August 2018, the patient's appetite was poor. At this time her assessed dietary requirement was for 1900kcal and 68g of protein. However, it was estimated that her intake was 900kcal and 28g of protein. The Dietician IPA has stated that this was a significant shortfall in the patient's nutritional needs. In these circumstances a 'free' diet was recommended for the patient. Prior to this time the patient's dietary requirements had been tailored to her diabetic and renal conditions with particular emphasis being placed on potassium levels. The Dietitian IPA has advised that renal patients are often advised to restrict or avoid high potassium food and drink products such as milk or containing milk. This is the type of dietary plan that the patient and her family would have been familiar with prior to her admittance to UHD on 9 August 2013.

51. Due to the patient's clinical presentation of inadequate dietary intake on admission to UHD and the need to promote wound healing for her recently below knee amputation, a modification of diet was decided upon. This involved relaxing previous restrictions on potassium and allowing the introduction of a higher protein intake to increase milk based foods in the patient's diet. I am satisfied that this relaxation of dietary restrictions was based on her clinical needs and introduced in

the patient's best interests. Prior to this decision being made, clinical staff ensured that the patient's potassium levels were within range and over the following days and weeks there was a continuous assessment of blood results. The Dietitian IPA advice noted that potassium levels had slightly increased on 22 August 2013. At that time the patient was assessed by the dietitians and renal physicians and it was determined that the raised potassium levels were due to high blood sugars. It was considered that the raised potassium would reduce with insulin being used to correct the raised sugars. With this treatment, her blood levels, for both sugar and potassium, returned to normal. When increased potassium blood levels were again detected on 3 September 2013, it was determined that as the patient's dietary intake had sufficiently improved. Therefore, she was appropriately reinstated on the low potassium advice. The Dietitian IPA noted that the patient's potassium levels then remained within the normal range until April 2014.

52. In light of the evidence and based on the IPA advice, I conclude that the assessment and treatment of the patient's dietary requirements were entirely appropriate and well managed. The Dietitian IPA has complimented the UHD assessments and treatment which the patient received during this time. She has particularly commented on the high standard of record keeping in relation to this element of the patient's case. I agree with the Dietitian IPA's assessment of how the patient's complex dietary needs were managed while a patient in UHD. I consider that given the patient's multifaceted medical conditions, balanced decisions had to be made with competing priorities regarding the patient's complex dietary needs. When admitted to UHD on 9 August 2013, the most important priority was to improve the patient's nutritional deficiency and to attempt to improve the chances of her amputation wound healing. It was for this reason that the patient's renal diet with its restrictions on potassium intake was temporarily relaxed. The Dietitian IPA has advised that sugar and potassium levels in the patient's blood were 'constantly monitored'. There is evidence of close cooperation between dietitians and physicians in relation to her dietary care needs. A review was undertaken when potassium levels rose again in early September 2013. As the patient's dietary intake had improved at this time her renal diet with potassium restriction was reinstated. Both of the IPAs stated that it is appropriate for dietitians to temporarily relax dietary restrictions, where there is greater clinical priority, as in this case.

53. The complainants stated that when the patient was discharged to Domnall in September 2013, she was placed on an incorrect diet for her condition. The patient, when discharged from hospital, was following an oral fluid restriction as advised by the managing renal team, and a diabetic and renal diet avoiding high potassium sources. Blood potassium levels indicate that the patient was compliant with this advice. The renal dietitians were also in telephone contact with Domnall on 11 and 12 September 2013 to discuss the patient's nutritional needs on discharge. Further information was provided to Domnall, dated 11 September 2013. I accept the Dietitian IPA advice that on discharge from UHD the patient was placed on an appropriate diet for her condition. Further, that she continued to be regularly reviewed by the renal dietetic team throughout her time in Domnall. I therefore do not uphold this element of Mr and Mrs Hassan's complaint.

54. The complainants also stated that while they were informed that any change in the patient's diet was intended to promote wound healing, the wound continued to deteriorate during this time. A high protein or moderate diet alone will not guarantee wound healing. The provision of correct nutrition is only one of a number of factors which provide the optimum conditions under which wound healing can occur. Many wounds, for various reasons, for example the position of the wound site or the overall general health and condition of the patient, are difficult to treat or are resistant to healing. I have considered the patient's wound treatment. I accept the advice of the IPA that the patient's diet was specific to her needs and was properly adjusted for clinically justified reasons with a view to assisting wound healing and recovery from surgery.

55. The complainants made a complaint in relation to the use of the term 'free diet', describing the explanation they received as being ridiculously deceptive and unreliable for a minor change to a complex diet. The Dietitian IPA has advised that the term 'free diet' is a locally used term amongst renal teams to indicate that a dietary potassium restriction is relaxed, to allow the inclusion of milk-based foods into a diet. I have concluded that a change in the patient's diet was appropriate, properly documented and made for well-founded clinical reasons. It is evident that this term was confusing to the complainants. At the meeting held on 6 July 2015

between the complainants and Trust dietitians, it was acknowledged by Trust staff that language that professional staff use among themselves and different terms can be confusing to laypeople. The Trust's Lead Dietitian agreed at this meeting to raise this issue with her staff and that a learning point would be reinforced regarding the term 'free diet'. The Lead Dietitian said that she would also raise this point at the dietitian's regional group meetings. I welcome this recognition on the part of the Trust on the importance surrounding the language used in providing explanations to patient's relatives. I consider this recognition and the subsequent explanation provided to the complainants to represent good practice in complaints handling.

(III): The care and treatment of the patient's wound

56. The complainants stated that the patient's amputation wound was inadequately cared for.

57. They complained about the adequacy of the patient's wound care. They were concerned that the patient's stump wound should have had its dressing changed on a daily basis and it was inappropriate and unsuitable for the Trust to place the patient into a ward which had inexperienced staff in the care and treatment required for patients with an amputation. They claim that the patient should have been accommodated on a surgical ward in UHD.

58. They also complained about iodine dressings becoming dislodged from the patient's wound and falling onto the ground. They complained whenever the TVN instructed the removal of the shrinker sock, this had been initially refused by Nursing staff even though the patient was complaining about pain in the region of this stump wound.

59. They complained about records indicating blackness on the amputation wound measuring at 10cms by 5cms but Trust staff on ward 24 recording the area as only half this size at 5cms by 5 cms.

60. I have considered the following extracts from the patient's clinical records:
21 August 2013: 'new sock arrived for patient, dressings due right foot tomorrow'
22 August 2013: 'compression bandage applied to stump as requested'

27 August 2013: 'has been wearing stump shrinker loose over past 3-4/7, dressing removed (Tubifast), and placed shrinker firmly over the limb, advised NS and patient of correct use'
3 September 2013: Necrotic area on wound, urgent TVN referral and vascular opinion

61. In response to investigation enquiries the Trust stated that it was satisfied that Wound Management and Pressure Area Care was appropriate.

62. The Trust stated that during the patient's admission from 9 August 2013 to 10 September 2013, the wound was assessed and redressed on eight occasions and on a further 12 occasions the wound was assessed and the dressing changed. It stated that during this period there were four occasions when wound care was not carried out on the planned date. I was provided with an explanation for each of these occasions and note that on three of the four occasions wound care was carried out the following day. On the fourth occasion wound care had been planned for 17 August 2013. However the records evidence that the wound had been assessed and the dressing changed on 16 August 2013. The patient was next assessed and the dressing on the wound changed on 19 August 2013.

63. The Trust stated that on admission to Ward 24, the patient expressed her desire to regain her independence and mobility and was keen for a prosthetic limb to be fitted. In preparation for this a shrinker sock is used to control swelling, promote healing and assist in shaping the stump. In preparing the patient for the fitting of the shrinker sock, it was applied loosely to the stump on 22 August 2013 and following further physiotherapy assessment on 27 August 2013 it was applied firmly over the stump. Written advice was received from the Regional Disablement Service on the correct use of a shrinker sock.

64. On 3 September 2013 the nurse assessing the wound noted a new area of necrosis. An urgent medical review was undertaken and plans were put in place for an urgent vascular and TVN assessment. The TVN advised the sock should be

removed and noted no exudate[3], bad smell or infection. The vascular assessment was of a necrotic superficial eschar[4] measuring 5cm x 5cm, the rest of the wound was dry and healing. There appeared to be a haematoma[5] underneath but there was no active infection or cellulitis. The Trust stated that the development of a haematoma is a recognised possible postoperative complication of amputation.

65. The Trust stated that throughout the admission nursing staff undertook to monitor and record the patient's pain on a daily basis, encourage her to express when she was in pain and administer and monitor the effectiveness of pain killing medication. It stated that if there was no pain relief or the patient expressed increased pain the medical officer was asked to review.

66. In considering the adequacy of the patient's wound care, the advice of three IPA's was sought. From a Nursing IPA, from a TVN nurse and from a Physiotherapy IPA. A summary of each advice is provided below.

The Nursing IPA Advice

67. The Nursing IPA advised that she had examined the records relating to two wounds; the stump wound and the right toe and heel wound. She advised that the stump wound specifies the primary dressing and there are ongoing detailed wound progress continuation sheets referring to the wounds, and specifying when there was podiatry involvement. The IPA advice is that records that refer to the amputation wound include appropriate measurements that provide an objective evaluation and identify changes in the wound status. A pain assessment in relation to the wound site is included with each entry. Adjustments to the dressing regime are recorded in response to change and there is a detailed Tissue Viability Assessment/ Evaluation that specifies the management plan.

68. The Nursing IPA advised that these records suggest that wound monitoring was

[3] ooze
[4] dry scab of dead skin
[5] A localised collection of blood, usually clotted – a severe bruise

appropriate, that changes were identified in a timely way and referral for specialist opinion was appropriately made and advice acted on. The Nursing IPA concluded that wound care was appropriately documented and reflected reasonable and appropriate practice

The TVN IPA Advice

69. The TVN IPA provided a chronology of events relating to care of the wound. I have appended this in appendix four to this report.

70. Overall the TVN IPA concluded that the wound care provided by the TVN was reasonable and appropriate and that the referral to her and her assessment was timely and appropriate.

71. The TVN IPA advised that the documentation evidenced that the nursing team on the ward were managing the wound appropriately initially as it was a closed surgical wound that did not require much input. The patient was also assessed on a regular basis by the renal team who also assessed the wound. The wound dressing was observed on a regular basis and was often dry, free from ooze and intact and therefore left in place. From 13 August 2013 onwards, pain became an issue and there were early indications in the following days that the wound site was deteriorating.

72. The TVN IPA advised that modern wound management and wound dressings allow for less frequent change of dressings. Frequent changes of dressings can reduce the temperature of the wound bed and can allow bacteria to enter the wound when it is open. The indication for changing the dressing is usually based on an assessment of the dressing and the patients surrounding skin. If a dressing is clean and intact with no evidence of fluid leaking, then there is no reason that the dressing would need changed daily. The TVN IPA noted that the patient had regular reviews by the medical team and wound assessment plans. Further, there was a wounds care plan instigated when the surgical wound deteriorated.

73. In relation to descriptions of the wound sizes in the patient's medical records relating the new necrotic area the TVN IPA advised that the nursing notes recorded

this as 2 x 5cm on 2 September 2013. At that time, the medical team recorded it as 8 x 5cm and on 3 September 2013 the TVN recorded it as 10 x 5cm. On the same day the vascular surgeon recorded it as 5 x 5cm. The TVN IPA advised that measurement of a wound is an approximate measurement due to the fact that the whole wound is much longer than the segment being measured.

74. The TVN IPA advised that the use of a shrinker sock is not related to wound care. A shrinker sock is used post amputation to reduce swelling to the area and is an aid in keeping the shape of the limb for future prosthetic fitting. In this case it was appropriate for a shrinker sock to be considered. However, the sock ought to have been removed when the patient complained of pain. The sock should feel firm and supportive but not tight or painful. The TVN IPA advised that while there was a link in time between the introduction of the shrinker sock and the deterioration to the wound, there is also evidence following the initial surgical procedure that there was bruising to the stump which could have been an earlier indicator of a haematoma. Haematomas can develop a couple of weeks post-surgery and therefore it is difficult to ascertain whether the application of the shrinker sock exacerbated the development of the haematoma by causing pressure to the area or whether this would have occurred anyway as a result of the surgery. The TN IPA had advised that wound management itself of the stump would not have contributed to the development of a haematoma.

75. Overall the TVN IPA advised that the standard of wound care provided was reasonable. There was no evidence that the wound was not appropriately managed or reviewed. The TVN IPA noted that wound assessments were completed at regular intervals and pain and nutritional assessments were completed. The referral in this case to a TVN was appropriate and within a timely manner. There is evidence that the patient was regularly assessed by the medical and renal teams who also reviewed and commented on the condition of the wound.

The Physiotherapy IPA Advice

76. The Physiotherapy IPA commented on the physiotherapy care and treatment provided in UHD. On 27 August 2013 the Trust physiotherapist checked the stump and found there to be no redness or seeping from the wound and the stitches to be

in place. The physiotherapist removed the tubifast and then placed the stump shrinker firmly over the limb. The Physiotherapy IPA explained that it is common practice not to have dressings such as tubifast underneath a stump shrinker as should they wrinkle, this can then cause areas of increased pressure.

77. The IPA was asked whether it was appropriate to apply a sock shrinker to the wound at this time. The Physiotherapy IPA advised that the wound progress sheet records that the dressings on 25 August 2013 were bloodstained, slightly red and discoloured on the right side. The next wound progress entry on the 28 August 2013 reports the same findings. However the Physiotherapy IPA advised that wounds, especially in patients with diabetes, can change on a day to day basis.

78. The Physiotherapy IPA advised that if the patient's wound was blood stained, red and discoloured then it would have been advisable to remove the shrinker to minimise pressure on the wound. If the redness and seeping was minimal it would have bene appropriate to keep the shrinker on but with regular checks of the wound to check that there was no further deterioration. She advised that there is no universal opinion as to when, while a wound is healing, a stump shrinker should be used. However, as the physiotherapist involved reported that the dressings had no seeping and the wound had no redness and based on this assessment, it would appear that the limb was suitable for application of a shrinker sock.

79. The Physiotherapy IPA further advised that the stump shrinker was correctly removed after discovery of the necrotic area. Guidelines for use of a stump shrinker state that if it becomes painful then it should be removed immediately. However, as the patient reported pain before the stump shrinker was applied, it would be difficult to attribute the pain to stump shrinker rather than ongoing stump pain.

80. The Physiotherapy IPA advised that from the clinical notes the following was not clear:

(i) Which day the stump shrinker first was applied to the patient
(ii) Who first applied the stump shrinker to the patient
(iii) Which day the stump shrinker advice sheet was placed in the notes
(iv) Whether the patient was given a copy of the stump shrinker advice sheet

81. In conclusion the Physiotherapy IPA advised that:

(i) It was difficult to advise on the application of the stump shrinker on 27 August 2013 and whether this was appropriate as the only documentation of the wound on that day is that of the physiotherapist. That is because appropriate advice was given to the staff regarding the correct application.

(ii) When it was noted that the wound was necrotic it was appropriately escalated to both the TVNs and vascular surgeons

(iii) Documentation of when the stump shrinker was first applied was absent

(iv) The wound care charts are not always clear if they are referring to the stump wound or the 2 wounds on the patient's right foot.

82. As part of the investigation, a copy of the Nursing IPA, TVN and Physiotherapy advice with the Trust. In response the Trust accepted the Nursing and TVN's comments. The Trust generally agreed with the Physiotherapy IPA advice. However, the Trust reverted on the point made by the Physiotherapy IPA that it was difficult to comment if the assessment of the wound made on 27 August 2013 was accurate. The Trust stated that there was no evidence that this statement was inaccurate. The information the Physiotherapist recorded on 27 August 2013 related to the appearance of the patient's surgical wound on that day. There is no record in the nursing notes, the multidisciplinary notes or the TVN record relating to the wound appearance on that day.

83. The Trust stated that the Physiotherapy IPA concluded that 'documentation of when the stump sock was first applied appears to be absent'. The Trust stated that patient records on 27 August 2013 record that a stump shrinker had been worn for 3 to 4 days. Multidisciplinary team notes on 22 August 2013 record that a compression bandage was applied by a member of the nursing team. As this 'bandage' was handed over as requested by a member of the Limb Fitting Team (as evidenced by the telephone number in the notes). The Trust stated therefore that it could be surmised that this is evidence of the first application of the stump shrinker as referred to in the remainder of the patient's notes.

Analysis and Findings

84. The patient underwent a below knee amputation (BKA) of her left leg in the Royal Victoria Hospital (RVH), Belfast on 2 August 2013. She was discharged from the RVH on 9 August 2013 and admitted to Ward 24 of UHD on the same day. The stump wound was reviewed and redressed in the RVH on 8 August 2013, before transfer to UHD. The wound was then assessed and redressed on eight occasions in UHD between 9 August 2013 and 10 September 2013. During this period the wound was also assessed and the dressings changed on a further 12 occasions. Each of the IPA's engaged to provide advice on this element of the complaint. The Nursing, TVN and Physiotherapy IPAs have all concluded that the care and treatment provided to the patient with regard to wound care was reasonable and appropriate. I have read their advice and the Trust's responses to same. I concur with these assessments and consider that overall the care and treatment to the patient's stump wound was reasonable and appropriate. There are a number of factors to this element of the complaint, I shall consider each in turn.

85. The complainants stated that the patient ought not have been nursed on this ward as they stated that staff were inexperienced in wound care. The IPA advices indicate that staff on the ward appropriately managed the wound. When the patient arrived at UHD, this was a relatively recent wound with the amputation having occurred just the previous week. At that early stage, the wound required little care and being a closed wound, it required just a simple dressing for protection. At this time, the wound was observed regularly by nursing staff and it was mostly dry, free from leakage and intact. The wound dressing was generally left intact. The Nursing IPA has confirmed that there were ongoing detailed wound progress continuation sheets maintained, adjustments to the dressing regimes were recorded and there were detailed tissue viability assessments and evaluations carried out. I accept the Nursing IPA's advice that the records completed indicate that overall the wound monitoring by nursing staff was appropriate and that timely referral for specialist opinion was identified and made when required. There is no evidence to indicate that the wound was mis-managed and irrespective of which ward the patient was treated on, the TVN IPA has advised that the standard of wound care provided was overall reasonable. I agree with this assessment. **I do not uphold this element of the**

complaint.

86. The complainants stated that the patient's wound dressings ought to have been changed daily. The advice from the TVN IPA states that this was not required. She states that today's wound management, given improvements in modern wound dressings, has developed to allow for less frequent wound dressing changes. The TVN IPA has explained that frequent changes of dressings allow the wound bed to cool which can be detrimental to the healing process and also that frequent changes can allow bacteria to enter the site, which would be an obvious source of infection. If modern dressings are clean, free from ooze and intact, there is no need for them to be changed on a daily basis. I have carefully considered advice regarding wound dressings. **I do not uphold this element of the complaint.**

87. I note by letter to the complainants dated 4 June 2015 the Trust stated 'having discussed your mothers case with our colleagues in the Regional Amputee Unit, we now know that the stump wound should have been assessed on a daily basis. I would apologise on behalf of the team for this shortfall in this area of your mother's care.' I note this statement states that the wound be assessed on a daily basis not that the dressing be changed daily. I welcome this recognition on the part of the Trust and the learning that it has derived as a result of the complaint made by the complainants. I consider this recognition and the subsequent apology to them to represent good procedure on the part of the Trust. To reflect on and learn from complaints reflects the Principles of Good Complaints Handling in that omissions are acknowledged and learning derived from these situations. However I consider the Trust's acceptance that the patient's stump wound was not assessed on a daily basis, and its acceptance that it should have been, to represent recognition of a failure in the patient's care and treatment in this regard. I consider that it would have caused the injustice to the patient of not having her stump wound assessed every single day. I also consider that it caused them the injustice of uncertainty, anxiety and upset over the care and treatment that the patient received with regard to stump care. Nonetheless while I have found a failing in this aspect of the patient's care I am satisfied that the overall wound management was satisfactory.

88. The complainants asserted that the shrinker sock was applied to the patient's

wound at an inappropriate time, causing pain and eventually leading to a haematoma. The TVN IPA has advised that the use of a shrinker sock is not related to wound care. A shrinker sock is used after an amputation to reduce swelling to the area and is used to keep the shape of the reduced limb for a future prosthetic fitting. I note that the patient had expressed her desire to have a prosthetic limb fitted and to regain some of her mobility.

89. The TVN IPA has advised that from 13 August 2013 onwards, pain became an issue and there were early indications in the following days that the wound site was deteriorating. I note that in the clinical records the patient's pain levels varied. On 14 August 2013 it was noted that she had described her pain level to a doctor as being 7/10 at times. The patient was prescribed regular analgesia and over the next number of days pain was described as variable or as not being present at all. The Physiotherapy IPA has stated that it was unclear to her on what date the shrinker sock was fitted. However an examination of the records evidences that it was applied on 22 August 2013. I note an entry in the Multidisciplinary Care Instruction and Treatment Plan documentation at 2.00pm on 22 August 2013 'Compression bandage applied to stump as requested (handed over this am)', the shrinker sock having been delivered the previous day. In the following days there is no record of the patient complaining of pain. On 27 August 2013 it is noted that the shrinker sock was 'removed at present'. By 27 August 2013 the patient's status has improved to the extent that the possibility of her being discharged back to Domnall was being considered. By 1 September 2013 the patient's notes were stamped as being medically fit for discharge. However on 3 September 2013 it was noted 'nursing staff observed eschar on wound site, not noted before……necrosis?'

90. The complainants believed that the shrinker sock was applied at an inappropriate time and led to the development of a haematoma. I have determined that the shrinker sock was first applied on 22 August 2013. The Physiotherapy IPA has advised that there is no universal opinion as to what point during wound healing a stump shrinker sock should be started. However based on her assessment of the records she was of the opinion that the patient's limb was suitable for application of the shrinker sock at this time. The TVN IPA advised that while the application of the shrinker sock and changes to the wound may have happened at around the same

time, it is impossible to establish a causal link. She advised that there is evidence that following the amputation there was bruising to the stump which could have been an early indicator of a haematoma. Further, haematomas can develop weeks post-surgery. Therefore it is difficult to ascertain whether the application of the shrinker sock exacerbated the development of the haematoma or whether this would have occurred anyway as a result of the surgery. The TVN IPA advised that the wound management itself of the stump would not have contributed to the development of the haematoma. With regard to the periodic removal of the shrinker sock, I note its removal on a number of occasions, for example on both 27 and 29 August 2013. Based on the independent medical advice which I have received, **I do not uphold this element of this complaint.**

91. As referenced in a previous paragraph, eschar and potentially necrosis[6] was first noted at the amputation site on 3 September 2013. The complainants have queried the presence of the TVN and a specialist from the RVH on that day. I note that once the change to the wound was noted on 3 September 2013, an urgent tissue viability referral was made together with a telephone call to the vascular team at the RVH where the amputation had taken place. The potential discharge to Domnall was also cancelled on that day. This is the reason for the presence of the TVN and RVH specialist on that day. I consider these actions to have been an appropriate escalation to the changes in the patient's wound. The patient was not experiencing any new pain or other issues. **I therefore do not uphold this element of this complaint.**

92. The complainants also raised concerns about discrepancies in the recorded dimensions of the wound at different times. The TVN IPA has advised measurement of a wound is an approximate measurement due to the irregular nature of any wound and the fact that the whole wound is much longer than the individual segments being measured. I note the TVN IPA advice that the nature and appearances of wounds can change from day to day especially in diabetic patients. Variations in subjective recorded wound dimensions, which are approximations, do not invalidate the overall advice which I have received, that the overall wound care received by the patient

[6] The death of tissue cells

was reasonable and appropriate. I do not uphold this element of the complaint.

(IV): Nursing care provided to the patient at UHD

93. The complainants stated that the standard of nursing care at UHD was not to their expectations and was inadequate.

94**.** I have considered the letter from the Trust to the complainants dated 4 June 2015 **–** 'Charge Nurse Kendall would accept that here were shortcomings in the communication with your family during your mothers stay in ward 24…….he also apologises to you for inappropriate comments made by some staff on the Ward. These were unprofessional and not acceptable…..There is no excuse for any staff member who is rude, abrupt, impolite or unwelcoming to patients or their visitors…'.

95. In response to the investigation, the Trust considered that it had acted in the patient's best interests at all times and that it had provided her with high quality and appropriate care.

96. In order to assess the adequacy of nursing care, I obtained independent professional advice. The Nursing IPA reviewed all nursing records completed at UHD for the patient while a patient in Ward 24. These included the nursing document 'Assessment and Plan of care Adult In-patients' which covers nursing care needs assessment across the domains of medicines management, social circumstances, family needs, safety and mobility, communication, breathing, cardiovascular, nutrition and hydration, elimination, personal hygiene, dressing, skin care and wounds, pain, working and recreation, emotional and psychological needs, spiritual and cultural needs, and self-image. The Nursing IPA noted that information within these plans is brief and consists mainly of ticked boxes. However, the information spans the breadth of potential needs and all domains have been addressed. The Nursing IPA advised that this is an acceptable assessment document. There are documented risk assessments, including infection control, CJD (dementia), MUST (nutrition), Braden (pressure ulcer) with body map noting skin damage and amputation. The prevention/ management plan, falls risk and moving and handling assessments are completed. The Nursing IPA advised that these assessments are complete and are reasonable and appropriate for the patient's

needs.

97. The Nursing IPA also reviewed the records of care delivery on the 'multidisciplinary care instruction and treatment plan'. This includes the nursing entries relating to care given and covered care planning, wound care, insulin administration, moving and handling, fluid restriction, and constipation management. A care instruction specific to personal hygiene / washing and dressing specifies an individual care plan including observation of the patient's fistula, washing and dressing and maintenance of independence. This has been evaluated daily except for four days. I note the recorded entries briefly state that assistance was provided by nursing staff, a typical entry being 'full bed bath this am' (14 August 2013) and 'assistance of one given with personal hygiene needs' (31 August 2013). Other care plans cover wound care and pain, with regular evaluations recorded. The Nursing IPA advised that the multi-professional communication sheets for this period include additional nursing entries that refer to care provided, for example 'no management issues. Care continues as planned' (18 August 2013), 'settled and slept for periods. Complaining of pain in leg – paracetamol given at 22.00' (20 August 2013).

98. The Nursing IPA advised that these entries, while brief, suggest that the nursing care was planned and evaluated, and was reasonable and appropriate for the patient's needs. The Nursing IPA's overall conclusion was that while there were errors in the insulin administration (identified previously), the subsequent nursing care, wound care and medicines administration are appropriately documented and reflect reasonable and appropriate practice

99. As referenced previously the Nursing IPA advice was shared with the Trust for comment. In response the Trust accepted the Nursing IPA's comments and considered her comments to be fair.

Analysis and Findings

100. In considering the concerns raised about nursing care, I note that in a letter of complaint to this office, they stated that they found the staff on Ward 24 to be extremely unapproachable, abrupt, impolite and unwelcoming to both the patient and

relatives. In previous letters to the Trust relating to this aspect of their complaint, I note that they complained that on many occasions the patient's medication was left on a napkin for her to take rather than being placed in her hand. This proved difficult due to the patient's poor eyesight. I note that during the local resolution stage of the complaints process, on 4 June 2015, the Trust wrote to them apologising for this and other incidents. I also note that the Trust apologised for inappropriate comments made by some staff on the ward and for a shortcoming in communication with the complainants, calling these failings unprofessional and unacceptable.

101. In respect of the matters complained of concerning staff attitudes, I welcome the apologies made by the Trust to the complainants and consider this to represent good procedure on its part. As referenced earlier in this report to reflect on and learn from complaints reflects the Principles of Good Complaints Handling in that omissions are acknowledged and learning derived from these situations. However while I note and welcome the apologies already given, I also consider these to be a recognition and acceptance on the part of the Trust that there had been shortcomings in this aspect of the patient's care. I consider this to be contrary to the NMC Code, Make the care of people your first concern, parts 1 and 3 (Part 1 - You must treat people as individuals and respect their dignity. Part 3 - You must treat people kindly and considerately.) I consider these shortcomings to constitute a failure in the care and treatment afforded to the patient. I consider that this would have caused the injustice of upset to the patient as she was not treated with the respect and courtesy that is due to her as a patient of the Trust. I also consider it to have caused them the injustice of upset and frustration over the care and treatment that the patient received while a patient of the Trust.

102. I have also considered how the patient's nursing records and care plans were completed. The Nursing IPA advised that the care plans and assessments covering all aspects of the patient's care and treatment addressed all the domains of care. She also noted that all risk assessments were completed and the documentation evidenced that the patient's care planning was reasonable and appropriate for her needs. The Nursing IPA's overall conclusion was that although there was an error in insulin administration on 9 September 2013, the subsequent nursing care, wound management and medicines administration were appropriately documented and

reflect reasonable and appropriate practice. Based on the available evidence (records) and the IPA advice, **I concur with this assessment and consequently find no failing in the Nursing documentation completed on the patient's care and treatment.**

The Patient's Care

103. The complainant's raised issues of concern around the care and treatment provided to the patient in the Renal Unit of UHD. I have included the issue of stroke awareness in this section of the report. The issues complained of are considered under numbers (v) – (vii) under the following headings.

V: Stroke awareness

104. They complained that the Trust ignored numerous TIAs which were clear symptoms of indicators that the patient had sustained a potential stroke.

105. They also complained that the Trust discharged the patient to a private nursing home on 18 October 2013. They believe that it was inappropriate to transfer the patient to the nursing home at that time and that her health care was compromised as a result. They complained that Trust staff were inattentive towards the stroke symptoms she presented. This was so despite a widespread publicity campaign (FAST)[7] to raise stroke awareness.

106. The patient had been discharged from UHD to Domnall on 10 September 2013. On 20 September 2013, the patient was brought into the Emergency Department of UHD from Domnall with a history of speech difficulties (expressive dysphasia) for 30 minutes which had spontaneously resolved. A diagnosis of a TIA was made. The ABCD2 score (a risk stratification score for TIA) was recorded as 4 and the patient was referred to the Neurovascular Clinic where she was examined on 25 September 2013. At the clinic, the diagnosis of TIA was confirmed and Aspirin 75mg once daily was changed to Clopidogrel 75 mg. Other medication including Atorvastatin 20mg once daily were continued. It was noted that the patient had a 'poor functional status and multiple co-morbidities' and she would not be a candidate for carotid

[7] Face numbness, arm drooping, speech difficulty, time to call ambulance)

endarterectomy[8]. Therefore, a carotid duplex ultrasound was not done. The patient was discharged back to Domnall early on the morning of 21 September 2013.

107. At a dialysis session on 18 October 2013, notes from the haemodialysis department record that the patient had left sided facial numbness and left upper limb numbness and a stroke was suspected. The onset of this was probably two days previous. It was considered by xxxx that admission or tests were not necessary and the patient was discharged back to Domnall.

108. On 21 October 2013, the patient was readmitted to hospital with worsening left sided weakness and a right hemisphere ischaemic stroke was diagnosed. A CT brain scan showed bilateral ischaemic[9] changes. The patient remained an inpatient in UHD until her death in April 2014

109. I have considered the following clinical records in chronological order:

Domnall Resident Progress Report

20 September 2013 (19.47) – '[the patient] verbalises and the daughter noticed that she had slurred speech' (04.01) Diagnosis of possible TIA which has resolved itself…[patient] returned to Domnall at 04.30 assisted to bed….'

Haemodialysis Worksheet

110**. 18 October 2013** - 11.10 Phone call from daughter. Raised concern about [patient] 'not being herself', tingling sensation on arms and felt strange on face yesterday evening. Raised concern to Domnall staff…..advised that we will assess patient upon arriving to the unit and if needed will ask MO to assess.

111. (JSM) ATSP, C/O left sided facial numbness and L arm – symptoms for the last 2 days. Probable CVA. No swallowing difficulties. Patient is in SR and is on aspirin. Currently in NH following L BKA. No indication for acute admission.'

112**. UHD record** (18 October 2013) – '84 year old female sudden onset expressive dysphasia …. Denies chest pain/paraesthesia/LOC spontaneously resolved…obs stable, alert, appears well…'

[8] An operation to remove the lining of an artery restoring normal blood flow.
[9] Insufficient blood supply to an organ or tissue

(04.15) – D/c family keen to get patient home. Venflan removed, ass X 2 to chair and wheeled out to car. Assisted into car by family and nurse.'

Domnall Resident Progress Report (19 October 2013)
113. '4.30pm received a phone call from the Dialysis Unit advised that [patient] has left side body weakness including facial, for further observation over the weekend and to monitor again on Monday'

114**. 21 October 2013** – 'Spoke to daughter, [patient] will be admitted to UHD for CT scan due to left side weakness'.

UHD Patient Record
115. **21 October 2013 – '**Seen by Stroke team, admitted to Ward 23. CT brain done post dialysis'

116. In response to investigation enquiries, the Trust stated that the patient attended A&E on 20 September 2013 following an episode of speech disturbance. A neurovascular assessment was requested and the patient further attended on 25 September 2013 with her daughter. The patient was reported as being bright, alert and fully orientated. An examination of speech, cranial nerves and limbs revealed no residual deficit. The history described by the patient and her daughter was considered to be in keeping with a period of expressive dysphasia consistent with a diagnosis of TIA. This clinical opinion and a plan of care and treatment were discussed with the patient and her daughter and FAST advice was given. However, no routine review was considered necessary.

117. The Trust stated that on Friday 18 October 2013 the patient's daughter contacted the Renal Unit concerned that her mother was not 'being herself'. The patient reported tingling sensations on her arms and her face felt strange. The patient's daughter was advised that as her mother was to attend the Renal Unit that day she would be assessed upon arrival.

118. The Trust stated that an assessment was carried out by a Consultant Nephrologist, Mr A. The clinical assessment was that the patient had been

experiencing an evolving stroke over a number of days for which there was no treatment. The Trust stated that there was no clinical indication for lysis[10] and it has not been proven that there is a clinical benefit for lysis in haemodialysis patients due to high risk of bleeding. The Trust stated that admitting the patient would not have been in her best interests. This was explained fully to the patient and the complainants at the time.

Independent Professional Advice

119. The Consultant Stroke Physician (CSP IPA) advised that the assessment and documentation in the A&E department on 20 September 2013 was in keeping with guidelines and established good practice. The ABCD2 risk score was applied appropriately. The guideline states that patients with suspected TIA who are at high risk of stroke (that is an ABCD2 score of 4 or above) should receive aspirin or Clopidogrel and a statin. The patient had been prescribed these drugs and they were to be continued. She was, quite appropriately, referred to the neurovascular (TIA) clinic in keeping with established good practice.

120. The CSP IPA advised that it was appropriate to discharge the patient back to the nursing home on 20 September 2013 as she was on the necessary preventive drugs and admission of TIA patients is usually not necessary, given that neurovascular clinics have been widely established. An admission to hospital of patients with a TIA is necessary only in certain circumstances (such as extreme high risk or crescendo TIAs) and these did not apply to the patient at that time. The CSP IPA advised that a nursing home would be considered a place of relative safety in comparison to patients who live alone.

121. The CSP IPA advised that the only deviation from guidelines in this instance was that the patient was seen in the neurovascular clinic four days later. The guideline states that patients with suspected TIA who are at high risk of stroke (e.g. ABCD2 score of 4 or above) should be seen in a TIA clinic within 24 hours of onset of symptoms to enable measures for secondary prevention and specialist assessment and investigation. However the CSP IPA advised that the 4 day delay in

[10] Mechanical disruption of cell membranes

assessment by the neurovascular clinic could not have been foreseen by the A&E department. In practical terms, the CSP IPA concluded this omission did not have any detrimental effect as the patient was already on secondary prevention (aspirin and atorvastatin) and she did not suffer any adverse consequences before she was seen in the neurovascular clinic.

122. The complainants asserted that the patient's subsequent stroke ought to have been predicted by the Trust before it occurred on 20 October 2013. However, the CSP IPA advised that on 18 October 2018, it was considered that the patient had suffered a stroke (CVA) but did not need an acute admission or a brain scan.

123. The CSP IPA advised that this is not in line with established medical practice or guidelines in use in 2013. The relevant guidelines clearly state that stroke is a medical emergency and if outcomes are to be optimised, there should be no delay in accessing treatment. The 2012 National guidelines for stroke make the following recommendations which are pertinent to this case:

- Brain scans are needed in all patients with a suspected stroke and these should be done as soon as possible.
- All patients should have immediate access to a stroke physician to ensure patients get access to appropriate medical interventions.
- All patients with acute stroke should be admitted directly to a stroke unit.

124. The CSP IPA advised that although the patient was already quite disabled and had several concurrent medical problems, the outcomes of all patients (regardless of age, comorbidity or stroke severity) are improved by specialist stroke care on stroke units[11]. The patient would not have been suitable for thrombolysis (clot busting treatment) because of the uncertain time of the stroke onset and the risk of bleeding, but would definitely have needed a fairly urgent CT brain scan mainly to exclude a brain haemorrhage (patients with serious renal problems on dialysis have a high risk of haemorrhage) and to ensure that Clopidogrel could be continued safely. A swallow screening assessment by a stroke trained clinician is the recommended

[11] Stroke Units Trialists Collaboration 2009, 2013.

method to ensure that a patient who has had a stroke can swallow safely[12]. Impairment in swallowing following a stroke can lead to pneumonia. Although the eventual outcome for the patient may not have changed, her treatment was not in keeping with established good practice as she was denied an immediate stroke specialist assessment and possible admission to a stroke unit.

125. However the CSP IPA confirmed that thrombolysis or clot busting treatment, was not suitable for the patient for the following reasons:

(i) The exact time of onset of her symptoms is not clearly documented but the stroke symptoms were present for about two days as stated in the notes from 18 October 2013. As stated in the National Stroke Guidelines 2012, for people over the age of 80 years, the thrombolysis treatment has to be given within three hours of stroke onset (established practice in 2013 and at the present time is to use it within 4.5 hours of onset of symptoms).

(ii) The patient had severe renal disease and was on haemodialysis. Such patients have a greater tendency to bleed in the brain as a side effect of thrombolysis. However, being on haemodialysis is not an official contraindication to thrombolysis. Many stroke specialists use a lower dose of the clot-busting drug Alteplase when treating patients on dialysis.

126. In relation to the extent and adequacy of communication with the family, the CSP IPA advised that there is a single record from 6 December 2013 which documents a detailed discussion about several aspects of the patient's care including stroke care. The documentation states that the family were advised that even if the patient had presented earlier/at onset of stroke symptoms, a significant change in drug selection would not have occurred. The CSP IPA advised that this is factually correct. However, it is not the whole answer as even if the patient was not considered suitable to receive thrombolysis (assuming she had presented within 3 hours of onset of stroke symptoms), the discussion does not reflect the fact that she would have missed the other benefits of stroke unit care by not being admitted as soon as possible after the stroke. The record also states that the family were advised

[12] National Guideline, 2012

that drugs that reduce the risk of stroke could not eliminate stroke risk completely. The CSP IPA agreed with this statement.

127. Overall the CSP IPA advised that the assessment of the TIA on 20 September 2013 in A&E was appropriate, treatment was given and referrals made. The CSP IPA noted the four day delay in assessment at the Neurovascular clinic. However, he stated that such delays are very common in hard pressed stroke services all over the UK. The CSP IPA was satisfied that no harm was done as the patient was already on preventive tablets and did not have any further TIAs or strokes while waiting for the neurovascular clinic. In the neurovascular clinic, a decision was taken not to perform a carotid duplex ultrasound scan as the patient was felt unsuitable for carotid intervention. Most stroke physicians would agree with this assessment. However, there is no mention of a brain scan during this assessment. It is established practice to offer some form of brain imaging (either CT or MRI scan) in most patients seen in neurovascular clinics with transient hemispheric symptoms (symptoms that are potentially due to ischaemia to the brain). The CSP IPA advised that a scan of this type provides useful information about previous strokes and excludes a bleed or other pathology which can cause similar symptoms.

128. The CSP IPA advised that returning the patient to Domnall on 18 October 2013 without a stroke review, brain scan or advice from a stroke specialist was inappropriate. This clinical decision is not in keeping with established practice. The evidence, in his view, is unequivocal; all stroke patients (regardless of age, stroke severity and comorbidities) require an urgent stroke specialist review, an urgent brain scan as soon as possible and admission to stroke unit if appropriate. This policy has evidenced improved outcomes for stroke patients. A swallow assessment by a trained stroke clinician is also recommended as part of a stroke assessment. That is because a stroke can often cause difficulty swallowing which in turn can lead to pneumonia. The CSP IPA advised that local policies should enable any clinician in any department of the hospital who treats a patient with suspected stroke to access specialist stroke advice (often via stroke specialist nurses or on call doctors) or follow standard pathways of stroke care.

129. The CSP IPA advised that the statement made by the Trust that ‘the patient

would not have met the criteria for FAST' is over simplistic and factually inaccurate. He also noted that a stroke specialist did not appear to have responded to the family's complaints or been involved in an assessment. The CSP IPA advised that it is possible that had the patient been seen by a stroke specialist, she might have been admitted to a stroke unit on the 18 October 2013. Although the eventual outcome may not have been any different, appropriate clinical management in keeping with established practice would have given her the best possible chance of recovery from the stroke.

130. As part of investigation enquiries, the CSP IPA and Stroke Physician advice was shared with the Trust and Dr Smith. In response the Trust stated that its Emergency Department Team had no further comments to make other than that at the time of the patient's admission Ward 24 did provide stroke input as it historically did have stroke beds.

131. A Consultant in the Renal Unit stated that he had concerns about the Emergency Department and Renal comments from the stroke specialist. He stated that while in an ideal world, the patient may have been admitted to the stroke unit on Friday 18 October 2013, in reality he had the choice of sending the patient to the Emergency Department after her dialysis where she may have been admitted medically over the weekend or returned to the nursing home. It was and remains his opinion that discharging the patient back to the nursing home with the proviso that she could be readmitted over the weekend if clinical change occurred was a reasonable opinion. He stated that as the patient was a high dependency patient whom he knew would be coming back on Monday 21 October 2013 when she would be reassessed. An urgent brain scan on Friday 18 October 2013 would not have altered the patient's management. He also stated that he was aware that the patient's life expectancy was severely limited and that a wait and admission from the Emergency Department was probably not in her best interests. He stated that he made this decision in good faith having looked after the patient for a very long time. He commented also that 'we provide good care for our patients and this episode has been extremely upsetting for myself and renal staff.'

132. The Trust's Associate Clinical Director for Elderly Services stated that he

considered the stroke specialist's opinions are largely appropriate. However he commented also on the statement that 'it is established practice to offer some form of brain imaging (either CT or MRI scan) in most patients seen in Neurovascular clinics with transient hemispheric symptoms…'. The Associate Clinical Director stated that the Stroke IPA confirmed that the 2012 UK National Guidelines are the appropriate guidelines. However, he pointed out that these guidelines do not stipulate that most of these patients ought to have such imaging. The guidelines state that those in whom vascular territory or pathology is uncertain need brain imaging. The Associate Clinical Director stated that therefore the patient's neurovascular clinic was consistent with the national guidelines.

133. The Trust's Associate Clinical Director for Medical Specialties, commented that the renal electronic notes confirm that the Consultant in the Renal Unit assessed the patient including swallow. There was an active decision not to admit. Therefore, as stated before, this was a very reasonable decision and taken with the patients best interests central. He further stated he accepted that a CT scan was not done and that technically guidelines may not have been followed. However the Associate Clinical Director for Medical Specialties stated that guidelines are guidelines and when it is deemed not to be in the patient's best interests to follow them then this is correct. Overall he stated that the Trust accepts all of the CSP IPA medical report except that relating to admission and the need for a CT scan. The admission of the patient was considered, she was examined, including her swallow, and an active decision was taken not to admit her. He further stated that there was no evidence that this decision had any adverse effect on the patient or her outcome.

134. Having considered the Trust response to this aspect of the complaint, I asked the CSP IPA for his further comments. I was advised that he stood by his original advice which was based on relevant guidelines and established good practice current at the time when the events took place.

Analysis and Findings

136. The complainants are unhappy with the actions of the Trust following the attendance of the patient at UHD on two occasions, in September 2013 and October

2013. On 20 September 2013 the patient was noted to experience a period of 30 minutes speech difficulty while a patient at Domnall. They consider on this occasion, that following a brief stay in UHD when a TIA was diagnosed, the patient was inappropriately discharged back to Domnall. The complainants also consider that a hospital setting was more appropriate for observation and continuing treatment rather than discharge back to a nursing home. They similarly consider that when the patient experienced left sided facial weakness on 18 October 2013, she ought to have been kept in hospital for treatment rather than having to be readmitted three days later and being diagnosed with a stroke. I shall consider each occasion in turn.

137. On 20 September 2018, I note that the patient was taken to UHD Emergency Department following a 30 minute episode of speech difficulties at Domnall. The speech difficulty was noted to have resolved itself and was diagnosed as having been caused by a TIA. The CSP IPA has advised that the assessment of the TIA on 20 September 2013 in the Emergency Department was appropriate, treatment was given and referrals made. I have considered the CSP IPA advice and accept this assessment. The patient was correctly appraised using the ABCD2 score. Her score using this tool suggested that she should be treated with an antiplatelet medication and a statin. The patient was already taking this medication and its use was therefore continued. The patient was also correctly referred for further assessment to a neurovascular clinic. I note the four day delay in arranging this appointment. However, I find no failing of the Trust in this regard. The CSP IPA has advised that such delays are very common in hard pressed stroke services all over the UK. I recognise the resource pressures currently experienced within all areas of health care. I note that during this four day time period the patient was receiving the correct medication and that she suffered no further TIA's before the date of her clinic review. The CSP IPA advised that it was appropriate, due to her condition that a carotid duplex ultrasound scan was not carried out but he did make reference to a failure to carry out a brain scan. I shall return to this issue later in this report.

138. The question arises as to whether or not the patient ought to have remained in hospital for further monitoring on 20 September 2013 or whether discharge was appropriate. The CSP IPA was clear in his advice. Upon discharge the patient was receiving the appropriate medication and had been correctly referred to the

neurovascular clinic. At the time it was considered that there was no more practical treatment which the patient could receive as an in-patient. The CSP IPA advised that a nursing home is considered to be a place of relative safety, compared to a patient being discharged to home. Therefore, in these circumstances a discharge to a nursing home was therefore appropriate. I have considered the available evidence and the IPA advice and agree with his assessment.

139. The patient attended for dialysis from the nursing home on 18 October 2013. At this time, it was noted that the patient had left side face numbness extending to her left arm. It was also noted that she experienced these symptoms for two days. The complainants stated that the patient ought to have been admitted to hospital rather than being discharged. Further, that she ought to have received further treatment at this time as an in-patient. They believe that had the patient received treatment at this time she would not have went through the trauma of being discharged only to be admitted to UHD three days later on 21 October 2013.

140. The clinical records evidence that the patient was diagnosed as having had a probable stroke or CVA[13]. It was determined that as she had no swallowing difficulties and was already receiving correct medication, there was no indication for acute admission to hospital. The complainants stated that the patient was not treated according to what they understood to flow from the FAST campaign concerning strokes which had been widely advertised. They are concerned that the patient ought to have been treated with clot busting drugs to combat the stroke or at least to alleviate its effects. The CSP IPA has advised that the use of these drugs would not have been suitable for use on the patient for two reasons. Firstly, the symptoms of a stroke had been present for possibly two days and the use of clot busting treatment [14] ought to only be used in patients over 80 within hours of the onset of symptoms. The second reason was that the patient had severe renal disease and was on dialysis and the use of clot busting drugs in such patients increases the risks of bleeding on the brain. The CSP IPA advises that the patient was not suitable for clot busting treatment. I accept this and find no failing on the part of the doctor in this regard.

[13] Cerbrovascular accident or stroke
[14] Thrombolysis

141. The CSP IPA has advised that the patient ought to have received a fairly urgent CT or MRI scan to exclude a brain haemorrhage and to ensure that medication could be continued safely. The CSP IPA has advised that the 2012 Guidelines in place at the time recommended that a brain scan be carried out as soon as possible after the event and that a swallow screening assessment by a stroke trained clinician also be carried out. In this case I note that it was recorded in the medical notes that the patient displayed 'no swallowing difficulties'. I am therefore satisfied that some assessment of her swallow capacity took place. A CT brain scan was not undertaken on 18 October 2013. However this was carried out on 21 October 2013, three days later.

142. The question arises as to whether the patient ought to have been admitted to UHD on 18 October 2013 to enable further assessment of her condition. The CSP IPA advice, which I received is clear, 'all stroke patients (regardless of age, stroke severity and comorbidities) require a stroke specialist review, an urgent brain scan as soon as possible and admission to a stroke unit if appropriate'. In its response to the CSP IPA advice Mr A provided reasoning behind the decision not to admit the patient on 18 October 2013 (a Friday). He stated that this was an 'active' decision not to admit, in that it had been thought about but was considered clinically, not to be in her best interests. The Trust restated its view that discharge to a nursing home is considered to be to a place of safety where medical care is available. It was noted that as a high dependency patient the patient was due to return to hospital on the following Monday (21 October 2013) when she could be reassessed. The patient could have been admitted to UHD over the weekend had her condition deteriorated during this time. Further Mr A, given his knowledge of the pressures on the Emergency Department, stated that the alternative to discharging the patient would have resulted in the patient having to wait for an indeterminate time in the Emergency Department before admittance to a hospital bed. This wait, following a session of dialysis, on an already weak and tired patient was not considered to be in the patient's best interests from a clinical perspective. Mr A stated that the decision to discharge the patient on 18 October 2013 was made by him in good faith, he had been caring for the patient for a long time and who knew her renal history and other medical conditions.

143. When considering complaints about the clinical care and treatment received by a patient, I aim to establish whether, overall, good, appropriate clinical care and treatment has been applied in a given situation. If there is a relevant standard or guidance and the clinical decision, action or judgement does not appear to have been in line with it, I will consider what evidence there is to support the decision/action. In deciding whether good clinical care and treatment has been provided, I will consider the explanations of the clinicians and the hospital trust and balance this against the relevant standards and guidance.

144. I have considered carefully Mr A's reasoning behind the decision to discharge the patient back to her nursing home on 18 October 2013 and not to admit her to the Emergency Department of UHD at that time. I have come to the conclusion that this decision was made in good faith, on good clinical grounds and it was considered at the time, medically, to be the patient's best interest. I note that there was no adverse impact caused to the patient as a result of this. I appreciate that at times clinicians have to make difficult, finely balanced decisions for their patients taking multiple and complex factors into account. I note that Mr A and his staff had been treating the patient for a number of years. Mr A was fully aware of her history and was providing her with ongoing care. Mr A was concerned about the impact on her health of a potentially long wait in the Emergency Department. I also note the points made by Mr A regarding the possibility of re-admittance over the weekend. These were factors which he took into account. The patient received a brain scan upon admittance to UHD three days later, on 21 October 2013. I have also taken into account the comments of the CSP IPA that this delay may not have altered the patient's eventual outcome. I make no finding of a failure of care and treatment by Mr A or his staff in this regard.

(VI): The conduct of Mr A

145. The complainants have criticised the conduct of Mr A and also the decision to terminate dialysis treatment for the patient.

Evidence considered

146. I refer to the following as part of the investigation of this complaint.

Multi Professional Progress Sheet

7 November 2013- 'Meeting with daughter and son, updated on current situation…Discussed ongoing RRT[15]…explained likelihood that that her condition will deteriorate in near future (by further stroke/sepsis) and that if significant decline in health may need to review appropriateness of RRT….family v keen on option of d/charge. I explained now has v high care needs + this will be difficult …'

23 December 2013 – '[Patient] stated she was tired and wanted to return to the ward. Dialysis discontinued at her request…'

31 March 2014 – Patient unresponsive. UF[16] stopped Fluid returned.O2 10 litres in place. Slow to regain consciousness again. Requesting off dialysis. Consulted with Mr A…

'Have spoken to daughter and brokerage. There is still no capacity for an overnight call in pts area (sons home) she is 1st on waiting list for when one becomes available.'

1 April 2014 – 'attended for dialysis this am which wasn't successful …[patient] not tolerating dialysis….'

'[Patient] had a further attempted HD session this am. Shortly after commencing treatment she became unresponsive. Blood pressure dropped. Treatment was discontinued and patient resuscitated.

Phoned the patient's NOK – [daughter] at 2.15pm and explained above. She is very reluctant to accept that her mother is dying and further dialysis treatment is not possible….'

2 April 2014 – (10.00) **'**Had to return prematurely from renal dialysis past 2 occasions because of low BP. Renal consultants have now decided she should not be given further dialysis and Mr A is meeting with her daughter this am…. Survival without dialysis will be v short (probably < 1/52). Pall care is appropriate at present.' (10.50) I agree with decision not to continue HD. the patient has been on dialysis for 10 years >, this is the maximum survival one could hope for at this age on HD. For weeks/months it has been clear that there was a very low chance of continuing HD

[15] Renal replacement therapy
[16] Ultrafiltration

as an outpatient. However now the patient has reached the point where her body cannot withstand the dialysis process'.
(11.30) 'I have just met with the patient family and explained the decision to stop further dialysis treatment. I have also explained this to [patient] and she understands the consequences of this decision + reason for it. Please ensure palliative care is in place to manage as best as possible the patient's end of life care…'

147. In response to investigation enquiries Mr A stated that when the patient died aged 84, she had survived 8.5 years receiving dialysis therapy. When the patient commenced dialysis in 2005 her life expectancy would have been 2.5 years. Mr A stated that the patient had done extremely well and had survived with a good quality of life until the amputation in August 2013. As her comorbidity was poor her estimated survival rate following this procedure was one year. When she subsequently suffered a stroke the patient's life expectancy was even further diminished. Mr A stated that the patient's prolonged survival was a testament to the excellent care that she received.

148. Mr A stated that he would never undertake to withhold or stop lifesaving treatment if it was in the patient's best interest. In all cases, including this case, decisions are discussed with consultant colleagues, the multidisciplinary teams involved in the patients care, in addition to the patient (where appropriate) and the immediate family. Mr A stated that it was important to note that in this case he did not withdraw/stop dialysis treatment. The patient was unable to tolerate further dialysis and only at that stage did he inform the family that the patient's death was imminent. When the patient lost consciousness early into dialysis treatment for the second consecutive day (31 March 2014 and 1 April 2014), it was very clear that she could no longer tolerate dialysis. At that time Mr A had a meeting and spoke to the family and to the patient. It was his impression, and that of his colleagues and of the multi-disciplinary team at that time, that the meeting was conducted in a caring professional manner and that the family were satisfied with both its content and communication during the meeting and at the patient's bedside.

149. Mr A also stated that he would have been delighted if the patient had been fit to return home. However, he noted that her rehabilitation potential was severely limited

by her multiple comorbidities and likely further deterioration of peripheral vascular disease affecting her surviving right leg. Mr A concluded his response by stating that at all times caring for the patient, he did so in a caring and professional manner with her best interests always primary in his actions. He stated that he was open, transparent, courteous, sensitive and professional in his interactions with the patient and her family.

Independent Professional Advice

150. In order to assess this issue of complaint, independent professional advice was sought. The Nephrology IPA provided a chronology of the patient's treatment.

151. The Nephrology IPA advised that Mr A provided the patient care and treatment to a reasonable standard. He advised that the patient was 84 at the time of her death and had been on dialysis from 2005. He advised that this is an exceptionally long dialysis career despite the multiple comorbidities which existed and the recent amputation. The Nephrology IPA advised that the one year mortality rate for dialysis patients undergoing a lower limb amputation is in excess of 50%. The patient's course was also complicated by sepsis and the non-healing of the surgical wound. In April 2014 the patient had become undialysable with profound intradialytic hypotensive [17]episodes which rendered her unconscious.

152. The Nephrology IPA explained that the purpose of chronic dialysis is to enable people with end stage renal failure to exist at home and to come into hospital thrice weekly for an arduous outpatient process to clean the blood. The benefits of dialysis are often finely balanced against its downsides. He compared it to palliative chemotherapy and advised that chemotherapy would not be offered if the effects of chemotherapy were worse than the effects of not having chemotherapy. To add context the Nephrology IPA advised that the prognosis of the average patient on dialysis is as bad, or worse, than the prognosis of the average patient with malignancy. It was the opinion of the Nephrology IPA that had the renal team continued to attempt to dialyse the patient then she would ultimately (and in the very near future) have suffered a cardiac arrest and died on the dialysis machine. This

[17] Intradialytic hypotension (low blood pressure) is a serious and frequent complication of hemodialysis

outcome would have been unfair to the patient, her family and the medical and nursing team looking after her. He advised that the patient had done extremely well during her dialysis experience to out-survive nearly every single patient of equivalent age and comorbidity contemporaries who commenced dialysis at the same time. The Nephrology IPA advised that by April 2014, the patient was no longer able to benefit from dialysis and there was no reasonable prospect of returning to being an out of hospital dialysis patient.

153. The Nephrology IPA advised that the evidence indicates that Mr A communicated with the family about the medical condition and long term prognosis of the patient. Overall he could see nothing to indicate that the dialysis provided to the patient was anything other than of the highest quality. The Nephrology IPA commented on the number of dialysis treatments received by the patient, particularly during December 2013 and his examination as to whether or not the extent of dialysis received was reasonable and appropriate for her condition. The Nephrology IPA advised that the patient received a higher than average number of dialysis sessions during this period in an attempt to optimise her condition regarding fluid and uraemia.[18] More frequent dialysis facilitates more gradual fluid removal. The Nephrology IPA advised that the frequency of dialysis that the patient received during December 2013 cannot be seen as anything other than a combination of clinical expediency and trying to give her the best chance to get better. When it became clear that increased frequency had not resulted in sustained clinical improvement, she reverted to her normal dialysis schedule. This was an entirely and reasonable strategy.

154. Overall the Nephrology IPA advised that he could see no basis for a complaint levelled against Mr A, the Renal Unit or the appropriateness of providing ongoing dialysis. He did not believe that the care the patient fell below a reasonable standard.

155. The Trust welcomed the Nephrology report with regard to the renal issues

[18] The presence of excess urea and other chemical waste products in the blood.

Analysis and Findings

156. The complainants stated that the patient was removed from dialysis treatment prematurely stating that it was unjustified and that this in effect hastened her death. They complained about the method of communication both from Mr A and other staff members stating that it was uncaring and unsympathetic. The Nephrology IPA has provided advice on the standard of care regarding the dialysis which the patient received. I shall comment on this in the succeeding paragraphs. Much of the complaint from the complainants in relation to the renal unit relates to the communication between them and members of the Trust staff and concerns their recollection of conversations which took place. I am unable to conclude on the content of unrecorded conversations. I am aware that at times of heightened stress such as the illness of a loved one, in a life threatening situation, it is difficult to absorb and reflect on information at such stressful times. I note that there is no written contemporaneous evidence in the medical records to assist me in my consideration of some of the verbal comments which the complainants allege were made. Without independent corroboration, I am unable to decide and assess what was communicated during this discussion.

157. The Nephrology IPA advises that the dialysis provided to the patient was of the highest quality. He commented on the fact that she had survived on dialysis for such a long time (from 2005 to 2014) and that she had survived nearly all of her contemporaries who had commenced dialysis at the same time. This is evidence of the high standard of care which she had received. I accept this advice and note the mortality statistics quoted by the Nephrology IPA. In particular I have considered the statistic that the prognosis of the average patient on dialysis is as bad as or worse than that of the average patient with malignancy. I am satisfied that the comorbidities which the patient suffered from, which included heart disease, peripheral vascular disease, diabetes, obesity, but in particular the recent amputation and wound problems had weakened the patient's strength. This had resulted in a reduction in her ability to tolerate dialysis. The evidence for this is the fact that she had been rendered unconscious during two dialysis sessions in quick succession. I note that the complainants state that the patient had experienced episodes similar to this in the past and recovered. However I accept the advice of the Nephrology IPA that at

the relevant time when the patient's dialysis was stopped, she was undialysable. The likelihood was that if dialysis continued, she would suffer from a heart attack and die on the dialysis machine in the very near future. This is a particularly stark statement. I wholly agree that this would not have been in the patient's best interests, the staff involved interest or that of her family. Regretfully, the patient was no longer capable of being treated effectively through dialysis. The effectiveness of dialysis had gradually reduced in the face of the comorbidities from which she suffered, to the extent that it had become unsustainable. I accept the advice of the Nephrology IPA. In conclusion, I am satisfied that the decision to cease dialysis treatment for the patient was reasonable, appropriate and in her best interests, and that of her family.

158. The complainants raised concerns about Mr A's negativity and consider that the meetings which were held concerning the patient's possible return home were deceitful and pointless. The Nephrology IPA has considered this issue and concluded that with the overall deterioration in the patient's condition and the reducing effectiveness of dialysis, it was highly unlikely that she would be well enough again to have been treated as an outpatient. I have considered all of the evidence and have reflected on the sad circumstances of this case. I note the difficulty in arranging a discharge for the patient due to the very high health care needs that she required, was pointed out to the family on 7 November 2013. I also note the difficulty in securing an adequate social care package to include night time cover for the patient. The Trust have acted appropriately in this regard and I do not consider that meetings held to discuss the patient's future care were deceitful. As the Nephrology IPA has stated any brief windows of opportunity to discharge the patient while she was fit were missed not through deceit but through the challenges in arranging a suitable care package given her complex needs.

159. The complainants raised concerns over the 'negativity' of Mr A and complained that he terminated dialysis for unjustifiable and premature reasons. I have concluded that the dialysis for the patient ceased for valid clinical reasons at a time when her body could no longer tolerate this treatment. I am also satisfied from an examination of the clinical records that this decision was not taken by Mr A alone. This was a multi-discipline decision taken by a number of doctors and the renal team as a whole. I appreciate that the complainants remain of the view that the message

communicated by Mr A on 1 and 2 of April 2014 was a 'negative' one, in that he was explaining the inevitability of the patient's death. I note that Mr A both telephoned and met with the family to communicate this message. The complainants consider that Mr A informed them of the patient's prognosis in an unsympathetic and uncaring manner. I acknowledge that this was a difficult time for them. I accept they held a deep, continuing belief that the means of communication was unsympathetic. However, I am unable to conclude this in the circumstances. Overall the Nephrology IPA advised that he could see no basis for the complaints against Mr A. **I accept this advice and do not uphold this element of the complaint.**

7: Not For Resuscitation

160. The patient's medical notes on 21 October 2013 contained a reference 'Patient is NFR' [19]. I sought independent medical advice on the appropriateness of this decision in the circumstances.

161**.** I have considered the following guidance**: '**Decisions Relating to Cardiopulmonary Resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing' (The Joint Statement)**.** This joint statement was published in the Journal of Medical Ethics in 2001. The following extracts from this statement are relevant to my investigation of this complaint. *'These guidelines should, therefore, be viewed as a framework providing basic principles within which local policies on CPR attempts may be formulated…'*

Section 3 of the joint statement entitled 'Essential aspects of decision making' states: *'…ideally, decisions about whether to attempt to resuscitate a particular patient are made in advance as part of overall care planning for that patient, and, as such, are discussed with the patient along with other aspects of future care…'* This section also states that a DNACPR order *'should be made only after the appropriate consultation and consideration of all relevant aspects of the patient's condition.*

These include:

[19] This is a patient management tool which reflects a clinical decision taken that CPR is not to be attempted in relation to a particular patient

- *the likely clinical outcome, including the likelihood of successfully restarting the patient's heart and breathing, and the overall benefit achieved from a successful resuscitation;*
- *the patient's known, or all ascertainable, wishes;*

The views of all members of the medical and nursing team, including those involved in the patient's primary and secondary care and, with due regard to patient confidentiality, people close to the patient, are valuable in forming the decision…'

162. Section 5.1 outlines *'any discussions about whether to attempt CPR, and any anticipatory decisions, should be documented, signed and dated in the patient's record.'* Further, section 6 states *'relatives and others close to the patient should be assured that their views on what the patient would want will be taken into account in decision making but they cannot insist on treatment or non-treatment.*
Section 8 states: *'…it is good practice to involve people close to patients in decisions…it is important to be clear that the information sought from people close to patients is to help ascertain what the patient would have wanted in these circumstances, as opposed to what those consulted would like for the patient or what they would want for themselves if they were in the same situation'*
Section 11 records that *'the overall responsibility for decisions about CPR and DNAR orders rests with the consultant or GP in charge of the patient's care.'*
Section 12 entitled 'Recording and communicating decisions' notes *'communication of decisions to the patient and people close to the patient is also a part of this process…unless the patient refuses, decisions should also be communicated to the patient's family and others close to the patient. The usual rules of confidentiality apply.'*

Clinical records

163. A document first completed at 23.15 on 21 October 2013 and countersigned at 10.15 on 22 October 2013 by two separate consultants states that 'a decision has been taken that the patient….is not for cardiopulmonary resuscitation (CPR). A box is then ticked which states CPR is unlikely to be successful due to 'end stage renal disease on dialysis, vascular multiple comorbidities'. The sections of this document to give details of any discussion with the patient and the family have been left blank.

21 October 2013 – Assessment and Plan of Care Adult In-Patients. Section headed Resuscitation Order. After question 'On admission is there a DNAR[20]Order signed by a Doctor' is followed by a box ticked yes. The section headed 'patient history' contains the sentence 'Patient is NFR'

22 October 2013 – Multi-professional progress sheet notes 'NFR'

Trust Response

164. The Trust did not comment on this section of the Nephrology IPA report.

Independent Professional Advice

165. The Nephrology IPA advised that it was appropriate that a 'No Further Resuscitation' be recorded on the patient's notes on 21 October 2013. He also advised that it could be argued that this should have been in place long before. The patient had been admitted to hospital on this date with a cerebrovascular incident and had a score on the Glasgow Coma Score indicating that she had reduced consciousness. The Nephrology IPA advised that the patient was not suitable for admission to the ICU, which would be the destination of choice for patients who have survived a cardiopulmonary resuscitation attempt. He advised that it would have been entirely inappropriate to attempt to resuscitate the patient in anything other than highly selective circumstances. This would not apply in the circumstances of general ill health, deterioration and decline.

166. The Nephrology IPA also advised that it was also reasonable that the medical staff did not consult with the family immediately before placing the NFR on the patient's medical notes on 21 October 2013. He advised that an NFR is a medical decision. Resuscitation is a medical intervention. Neither a patient nor a patient's relative can insist on receiving clinically inappropriate treatment. At the time of completion the patient was acutely unwell with reduced consciousness and so it was reasonable not to consult her. While it is good practice to inform the family of the decision, especially when a patient lacks capacity, the Nephrology IPA advised that there is no requirement that this is done contemporaneously, especially as in his

[20] Do Not Attempt Resuscitation

case if it is done late at night.

Analysis and Findings

167. I note that a NFR order was placed on the patient on the night of 21 October 2013, a number of hours after her admission to UHD with suspicion of a stroke. I note the reasons given for this order and accept the advice of the Nephrology IPA that the decisions to place a NFR order was appropriate and reasonable in the circumstances of the patient's condition. I also accept the advice of the Nephrology IPA that neither the patient's consent nor that of her family was required for this order to be put in place at this immediate time as this is a clinical decision to be taken in the circumstances prevalent at the time.

168. However following examination of the clinical records, I note that there is no evidence of a discussion with either the patient or family members at which the NFR order was explicitly referred to or discussed. The medical records make clear that the patient's daughter was present on the ward on a number of occasions after 21 October 2013 but the subject was not discussed. A meeting with the family was held on 7 November 2013 and at that meeting the patient's condition was discussed and the possibility of deterioration in near future, either by a further stroke or sepsis, was also discussed. There is no evidence of an NFR being referenced. Over the period following this meeting there is no evidence that the placement of a NFR order was discussed with the patient or her family.

169. Having considered this matter and in light of the contents of the guidance contained within the Joint Statement, I consider there to be a failure to have regard to the patient's right, and that of her family, to be involved in this decision. There is no evidence of lack of capacity. In the first instance it would have been appropriate and reasonable to have specifically informed the patient of the decision to apply the NFR order. If the patient had lacked capacity then the families' views would be relevant and necessary before a decision was made. The Joint Statement outlines the importance of discussions of such decisions with the patient and families. From the records, it is clear that clinical staff were aware of the patient's continuing serious

clinical condition. Good clinical practice in these circumstances required a full and documented discussion and explanation with the patient in order to seek her views.

170. The Trust is obliged to have regard to the human rights of the patient and her family in the context of the delivery of care and treatment. The Participation Principle is a key tenet of the Human Rights Based approach to patient care. I consider that the patient and her family ought to have been involved in the decision of the imposition of a NFR Order. The failure to do this does not reflect good clinical practice and fails to respect the patient's rights. The Trust failed in this regard to have regard to the rights of the patient and her family. I consider this failure to have caused the patient and her family the injustice of loss of opportunity to contribute to the decision regarding the placement of a DNR Order.

CONCLUSION

171. A complaint was made to me about the actions of the Trust regarding the care and treatment received by the late mother of one of the complainants. This has proved to be a complex and lengthy investigation which has involved the engagement of multiple independent medical advisors. Having carefully and thoroughly considered the records, considered the medical advice and noted the circumstances of this case, I have found instances of failures in the care and treatment received by the patient. **There are elements of this complaint which I have not upheld.**

172. I shared a copy of a draft investigation report into this complaint with the complainants and with the Trust. The Trust accepted my findings and conclusions and had no further comment to make. The complainants provided detailed and extensive comments on the content of the draft report and expressed their disappointment at some of my findings. They are particularly disappointed with regard to my conclusion regarding the discharge of the patient on 18 October 2013 from UHD. I have given their comments on this issue and all of their further comments, my most serious consideration. I recognise that they may not totally accept all of my conclusions in their entirety but I wish to assure them that I have

reached them only after the fullest consideration of all the facts and all of the evidence obtained in this case. Overall, save for minor amendments, I have not changed my findings and conclusions.

173. I have investigated this complaint and have found a failure in the patient's care and treatment in relation to the following matters:

(i) A failure to receive her medication at the correct time and a failure to check blood glucose levels when it was administered
(ii) A failure in record keeping with regard to insulin
(iii) A failure to assess the patient's stump wound every day
(iv) A failure with regard to the NMC Code, 'Make the care of people your first concern', (Part 1 - You must treat people as individuals and respect their dignity. Part 3 - You must treat people kindly and considerately.)
(v) A failure to have regard to the rights of the patient and her family to participate in the decision to place an NFR Order

174. I am satisfied that the failings I have identified caused the complainants to experience the injustice of distress, uncertainty, anxiety and a loss of opportunity with regard to the treatment received by the patient.

Recommendations

175. Irrespective of the apologies already given to the complainants concerning some of the matters complained of, I recommend that they receive a further written apology in accordance with NIPSO 'Guidance on issuing an apology', dated June 2016, for the distress, uncertainty and anxiety caused to them as a result of the maladministration and failures in care and treatment identified in this report. I also recommend that the Trust should make a payment of £500, in solatium, to them.

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.