Investigation Report

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

NIPSO Reference: 18858

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

I received a complaint from the patient regarding the actions of the Belfast Health and Social Care Trust (the Trust), following elective surgery at Belfast City Hospital (BCH). The patient complained that while under twenty four hour observation following his surgery on 15 January 2016, his pain levels were not adequately monitored, and his bloods were not checked for possible infection. As a result, the patient complained that the Trust failed to identify that he had contracted sepsis prior to his discharge from hospital on 16 January 2016.

Issues of Complaint

I accepted the following issue of complaint for investigation:

> **Issue 1: Did the patient receive appropriate care and treatment from the Trust, following his colonoscopy on 15 January 2016?**

Findings and Conclusion

The investigation of the patient's complaint identified a failure in care and treatment in relation to the Trust's failure to perform an examination of the patient on admission. I am satisfied that this failure caused the patient to experience the injustice of loss of opportunity to be assessed by medical staff against this baseline during his time on the ward.

In addition, the investigation identified a failure in care and treatment in relation to the following record keeping failures:

- Failure of the medical team to record why the patient needed to remain in hospital following surgery, whether he was at risk of specific complications, and to record that this was communicated to the patient
- Failure of the medical team to complete additional admission documentation upon the patient's arrival on the hospital ward
- Failure of the nursing team to record why the patient was administered paracetamol at 06.16hrs on 16 January 2016

- Failure of the nursing team to record what information, pertaining to the patient's care and treatment, was shared with the medical team on 16 January 2016
- Failure of the nursing team to clearly record their names on the patient's nursing records
- Failure of the nursing team to record a nurse's signature on the patient's nursing records at 15.40hrs on 16 January 2016

I am satisfied that the failures in record keeping I identified caused the patient to experience the injustice of uncertainty in relation to the care and treatment he received.

Recommendations

I recommended the Trust:

- Issued the patient with an apology for the injustice of loss of opportunity and uncertainty
- Made a payment of £150 by way of solatium for redress in respect of the injustice I have identified
- Make the Consultant Surgeon aware of the application of GMC Guidance, to ensure that had full regard for it, specifically in relation to the examination and assessment of patients prior to unplanned inpatient admission
- Provided training to all relevant nursing and medical staff on good record keeping to ensure that appropriate records are retained
- Developed an action plan outlining the steps considered in implementing these recommendations.

I am pleased to report that the Trust accepted my findings and recommendations.

THE COMPLAINT

1. The patient complained about the care and treatment provided to him by the Trust following an elective BCH on 15 January 2016. After surgery, the patient was admitted to the hospital ward for twenty four hour observation, before being discharged on 16 January 2016. On 21 January 2016, the patient complained that he was admitted to Antrim Area Hospital (AAH) with a caecal perforation[1], and underwent emergency surgery. He remained in intensive care for nine days, and was fitted with a stoma bag as a result of the perforation.

2. The patient complained that while under twenty four hour observation following his surgery on 15 January 2016, his pain levels were not adequately monitored, and his bloods were not checked for possible infection. As a result, the patient complained that the Trust failed to identify that he had contracted sepsis prior to his discharge from hospital on 16 January 2016.

Issues of complaint

3. The issue of The patient's complaint which I accepted for investigation was:

   Issue 1: Did the patient receive appropriate care and treatment from the Trust, following his colonoscopy on 15 January 2016?

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

[1] The caecum is the beginning of the colon, where the small intestine empties into the large intestine.

- **Nursing (N IPA), MSc, BSc, RGN, Dip** – A colorectal cancer clinical nurse specialist for 15 years, with experience in all colorectal diagnostic and surgical procedures. The N IPA has assisted in the development of diagnostic and post-operative guidelines for this patient group and developed patient information/ education on post-operative care.
- **Surgeon (S IPA), MBBS, FRCS** – A consultant colorectal surgeon since 1998. The S IPA has particular interests in the surgery of intestinal failure, inflammatory bowel disease, abdominal wall reconstruction, and bowel cancer screening colonoscopy.

6. The information and advice which have informed my findings and conclusions are included within the body of my report. The N IPA and S IPA have provided me with 'advice'; however how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

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

8. 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

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

10. The specific standards relevant to this complaint are:

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

- National Early Warning Score (NEWS[3]), Standardising the assessment of acute-illness severity in the NHS, Royal College of Physicians, July 2012 (NEWS Guidance)
- Nursing & Midwifery Council (NMC), The Code, Professional standards of practice and behavior for nurses, midwives and nursing associates, published 29 January 2015 (NMC Code)
- General Medical Council (GMC), Good Medical Practice, published 25 March 2013 (GMC Guidance)

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

[3] The NEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system: respiration rate; oxygen saturation; systolic blood pressure; pulse rate; level of consciousness or new confusion; and temperature.

THE INVESTIGATION

Issue 1: Did the patient receive appropriate care and treatment from the Trust, following his colonoscopy on 15 January 2016?

Detail of Complaint

12. The patient complained about the actions of the Trust following an elective colonoscopy at BCH on 15 January 2016. The colonoscopy was for the removal of a polyp[4] in the caecal pole and was performed under general anaesthetic. Following surgery, the patient was admitted to the hospital ward for twenty four hour observation, before being discharged on 16 January 2016. On 21 January 2016, the patient was admitted to AAH with a caecal perforation[5], and underwent emergency surgery. He remained in intensive care for nine days, and was fitted with a stoma bag as a result of the perforation.

13. The patient complained that while under twenty four hour observation following his surgery on 15 January 2016, his bloods were not re-checked for possible infection. He stated that a Junior Doctor noted his white blood cell count was *'marginally raised'* on this date, and recommended that it was reviewed the next day. However, the patient complained that on 16 January 2016 he was discharged without a blood test being performed.

14. Further, the patient complained that his pain levels were not adequately monitored following his surgery. He complained that his nursing record showed that his pain levels were between 0 and 1, but he believes this was not correct. In addition, the patient disputes the Trust's claim that hospital nursing staff advised him to walk to relieve his pain on the morning of 16 January 2016, as he was very tired after surgery.

15. As a consequence, the patient believes that the Trust failed to diagnose he had contracted sepsis prior to his discharge from hospital on 16 January 2016.

[4] A small growth on the inner lining of the large intestine or rectum.
[5] A hole within the caecum.

Evidence Considered

Clinical Records

16. As part of investigation enquiries, I carefully reviewed the patient's clinical records, between 15 and 16 January 2016. The clinical records, dated 15 January 2016, document:

'15/1/16, [Name] FY1 [Foundation year one Doctor]
21.40 [hrs]

Today's bloods asked to chase…
WCC [White Cell Count] 12.9 (8.5)…

Action
Monitor bloods tomorrow.'

17. In addition, I reviewed the nursing records, dated 15 and 16 January 2016, which document:

'15/1/16 Nursing 20.00 [hrs]
Patient brought from recovery early afternoon approx. 2-3pm…
NEWS satisfactory and recorded…
Aim home in AM [Morning]
Nil complaints voiced [Nurse Signature][6]

16/1/16 Night Duty 02.20
Medications given as per kardex[7]… 1g paracetamol given [at 22.00hrs] for pain with little effect. c/o [complained of] bloating, advised to mobilise, some relieved symptoms. Mobilising to toilet independently. Clinical obs [observations] recorded 4 hourly. Aim home tomorrow. Settled + [and] slept. [Nurse Signature][6]

16/1/16 @ 15.40
Mobile & [and] independent…
Paracetamol given for pain relief.

[6] Note that the nurse's signature is ineligible.
[7] A medical information system used by nursing staff to communicate important information in relation to their patients. It is a quick summary of individual patient needs that is updated at every shift change.

All medication given as per kardex[7].
Clinical observation checked and stable.
For discharge as per ward round, no discharge meds [medications] needed.
Son-in-law collected patient at 12.30 midday. No complaints.
For review in 1 month at [Consultant Surgeon] outpatient clinic. [No Nurse Signature]'

18. I considered The patient's Kardex[7], which records '*Medicine: Paracetamol, Frequency 4° [4 hourly]'*, and details the following administrations:

Date	*15 January 2016*	*16 January 2016*	*16 January 2016*
Time 24hr clock	*22:00*	*06:15*	*10:55*
Dose/ Route	*1g/ PO [orally]*	*1g/ PO [orally]*	*1g/ PO [orally]*
Given by	*LC*	*LC*	*EK*

19. I also considered The patient's NEWS Observation charts for 15 and 16 January 2016:

Date/ Time	***Level of consciousness***	***NEWS Score***	***Pain Score***
15 January 2016			
07.15	*A [Alert]*	*0*	*N/A*
11.30	*A*	*2*	*0*
12.00	*A*	*2*	*0*
12.30	*A*	*2*	*0*
13.00	*A*	*2*	*0*
13.30	*A*	*0*	*1*
17.00	*A*	*0*	*1*
21.30	*A*	*1*	*0*
16 January 2016			
01.05	*A*	*1*	*0*
06.20	*A*	*1*	*0*
09.30	*A*	*0*	*1*

20. In addition, I reviewed The patient's discharge summary from BCH on 16 January 2016, in which the Consultant Surgeon records:

'Due to the size of the polypectomy I kept the patient in hospital overnight.'

21. I considered the *'Consent for Examination, Treatment or Care'* form, reviewed and signed by [the patient] on 15 January 2016, which records the risks associated with [the patient's] surgery:

    'Serious or frequently occurring risks: Bleeding, Pain, Missed Pathology, Perforation'.

Legislation/Policies/Guidance

22. I also considered the NEWS Guidance, in particular the following section which relates to the recording of pain scores:

*'**Pain***

The symptom of pain must be recorded and responded to by the clinical team.

Pain and/or its cause will usually but not always generate physiological disturbances that should be detected by the scoring system for the NEWS… whilst the symptom of pain should be routinely recorded and responded to, it should not form part of the aggregate score for the NEWS. However, to encourage routine recording of pain symptoms, pain has been included as part of the NEWS observation chart…

The NEWS chart also contains dedicated sections to record urine output and pain severity. These do not form part of the NEW score.'

23. In addition, I considered the following section relating to the frequency of monitoring:

*'**Frequency of clinical monitoring…***
The frequency of monitoring should be dictated by the patient's clinical condition and stability…

We recommend that for those in the low-score group, the minimum frequency of monitoring should be 12 hourly, increasing to 4–6 hourly for NEWS aggregate scores of 1–4, unless more or less frequent monitoring was considered appropriate by a

competent or senior clinical decision-maker.'

24. I also considered the NMC Code, in particular Standards 8 and 10:

*'**8 Work co-operatively***

To achieve this, you must…

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff…

8.6 share information to identify and reduce risk…

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need…

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation…'

25. In addition, I considered Standard 21 of the GMC Guidance, which relates to *'doctors registered with the General Medical Council'*:

'21. Clinical records should include:

a. relevant clinical findings

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c. the information given to patients

d. any drugs prescribed or other investigation or treatment

e. who is making the record and when.'

The Trust's Response to investigation enquiries

26. As part of enquiries, the Trust was given an opportunity to respond to the patient's complaint and provide relevant documentation. The Trust confirmed that all of the patient's medical records have been provided to assist with my investigation.

The Junior Doctor's advice to repeat the patient's bloods

27. The Trust was asked to comment on the patient's complaint that following surgery a Junior Doctor's advice to repeat his bloods was not actioned. The Trust confirmed that on 15 January 2016, following the patient's colonoscopy *'blood samples were taken at 17.27hrs'.* These samples were reviewed by a FY1 Doctor at 21.40hrs, *'at which time she documented the results in the patient's notes'.*

28. On review, the Trust stated that an FY1 Doctor noted the patient's white cell count was *'marginally raised',* and recorded an action to *'monitor bloods tomorrow'.* In reference to this note, the Trust said that a *'slight rise in white cell count can be expected post colonoscopy'*. It stated *'when the surgical team reviewed the patient on 16 January 2016, they were satisfied with his clinical status and no further blood tests were arranged'.*

Monitoring of The patient's pain levels after surgery

29. In addition, the Trust was asked to comment on the patient's complaint that there was a failure to adequately monitor his pain levels following his surgery. The Trust stated that the ward nursing records indicate '*that the patient's clinical observations and pain scores were monitored four-hourly in line with the National Early Warning Score (NEWS) policy'.*

30. The Trust was also asked to comment on the patient's complaint that the pain levels recorded in his nursing record were incorrect, as was the note claiming nursing staff advised him to walk to relieve his pain. The Trust stated that *'patients can expect to have some discomfort following a colonoscopy. However, this discomfort normally dissipates within a few hours. Patients' pain levels are assessed using a researched and widely used pain scoring method*

where patients are asked to 'score' their pain level within the numerical range of 0-10, where 0 indicates the patient is not experiencing any pain and 10 indicates that the patient is experiencing the worst pain imaginable.'

31. The Trust stated *'The patient's pain score was assessed every four hours and was recorded to be '0' at 11.30hrs and 13.00hrs on 15 January 2016'.* It confirmed that the patient's pain score rose to '1' at 13.30hrs, and remained at this level when he was reassessed at 17.00hrs. It noted that the patient's pain score was recorded as '0' at 21.30hrs on 15 January 2016, and at 01.05hrs and 06.20hrs on 16 January 2016. The Trust stated that the patient's medicine Kardex[7] indicated he was given one gram of paracetamol orally for pain at 22.00hrs on 15 January 2016, and at 06.15hrs and 10.55hrs on 16 January 2016.

32. In addition, the Trust stated that nursing records indicate that at 02.20hrs on 16 January 2016, paracetamol appeared to be having little effect on the patient's pain. As a result, the Trust stated that nursing staff *'advised him to mobilise'* to relieve some of the symptoms. On review of the notes, the Trust stated *'it is clear that [The patient] experienced sufficient pain during the night to require two repeated doses of paracetamol and that this appeared not to completely relieve his pain'.* The Trust recognised that this did not appear to be reflected in the patient's pain score.

33. On 16 January 2016, the Trust stated that the patient did not advise the medical team during the ward round that he was experiencing pain. The Trust stated that if the patient had made the medical team aware, *'this may have prompted [them] to carry out further assessment, which would have included an examination of his abdomen and possibly a CT scan'.*

Identification sepsis prior to discharge from hospital

34. As part of investigation enquiries, the Trust was also asked to comment on the patient's complaint that its failure to check his bloods and monitor his pain levels, resulted in his sepsis not being detected prior to discharge on 16 January 2016. The Trust stated that there is no recommendation to perform bloods after a colonoscopy, unless there is a specific clinical indication. It stated

that the patient remained clinically stable, the *'slight rise in his white cell count… was not considered clinically significant at that time',* and *'there was no clinical indication that he was septic on discharge.'*

Independent Professional Advice

35. As part of the investigation, I received independent professional advice from the N IPA and the S IPA. Both IPA's considered the care and treatment provided to the patient following his colonoscopy on 15 January 2016. On review, the S IPA also identified a number of omissions in relation to the patient's admission to hospital, which have been detailed below.

Admission to hospital following surgery

36. On 15 January 2016, the S IPA advised that the patient *'underwent [a] colonoscopy under general anaesthetic',* which *'had been arranged because a previous colonoscopy under sedation had not been successful.'* The S IPA noted that there was no documentation in the file in relation to the previous procedure. Prior to the colonoscopy, the S IPA confirmed that the patient completed a consent form with a senior surgical trainee, who explained the *'intended benefits of the procedure… [and] serious or frequently occurring risks.'* The S IPA advised that the consent form was *'appropriately comprehensive.'*

37. The S IPA advised that the patient's operation *'started shortly before 9 o'clock and was finished before 10 o'clock.'* In addition, the S IPA advised that the operation notes recorded that a three centimetre *'polyp was found arising from the appendiceal orifice. An extensive submucosal lift was carried out and the polyp was completely resected.'* The S IPA advised that the operation note recorded that the patient needed 24 hour hospital admission. However, the S IPA advised there was *'no documentation to explain why in-patient hospital care was required.'*

38. In relation to hospital admission, the S IPA noted that it was *'unusual'* for a patient undergoing this procedure at the beginning of the day, to have to stay overnight. The S IPA advised that *'the vast majority of such procedures are carried out as a day case even if they require anaesthetic.'* If there was a

reason that the patient may be at risk of complications, the S IPA advised that this *'should have been clearly documented in the notes and explained to the patient himself. I cannot find any clear documentation regarding the need for an overnight stay or that communication took place to explain to the patient the reason that he needed to remain in hospital.'*

39. The S IPA advised that there was an admission document for the patient, dated 15 January 2016, which was written by a foundation year one trainee. The S IPA advised that this document does not have a time attached to it. As the document does not reference the findings of the patient's surgery on 15 January 2016, the S IPA concluded that it must precede the colonoscopy.

40. In addition, the S IPA advised that there was *'no formal medical clerking documentation regarding [the patient's] condition on admission to the ward… following his colonoscopy.'* However, the S IPA advised that the nursing observation chart *'showed no cause for concern at that time.'* The S IPA also advised that the patient had previously underwent blood tests *'checking his urea and electrolytes and full blood count. Both these investigations had been carried out two days before his attendance for colonoscopy.'*

41. Prior to admission to a ward, the S IPA advised that *'it would be normal practice for a patient's condition to be documented formally.'* The S IPA advised that *'it may be that this was omitted in [the patient's] case because admission documentation had already been carried out prior to his procedure.'* However, the S IPA advised that *'it is not clear, form the hospital documentation, whether it was planned for [the patient] to remain overnight for observation.'* If admission overnight was planned, the S IPA advised that *'I would not expect there to be additional admission medical documentation upon [the patient's] arrival on the ward. Nursing observation and admission notes would have been sufficient. If [the patient's] admission was not planned then I would expect there to be some admission documentation and a record of abdominal examination findings as a baseline upon his arrival in the ward.'*

42. The S IPA was asked if any additional tests or investigations ought to have been performed following the patient's admission. The S IPA advised that *'there*

was no indication for any investigations... [The patient] had normal blood tests from two days prior to his admission. There was no reason to suppose that these tests would have changed significantly.'

The Junior Doctor's advice to repeat the patient's bloods

43. As part of investigation enquiries the S IPA was asked if there was a practice for monitoring a patient's bloods following surgery. The S IPA advised that *'there is no place for routine blood investigations following a colonoscopy even after a polyp has been removed.'*

44. The S IPA advised that the laboratory report records that the patient's blood specimen was received on 15 January 2016 at 17.27hrs, and the request for testing was received at 17.43hrs. The S IPA advised that the results of the blood tests were recorded in the medical records by a FY1 Doctor, at 21.40hrs. The S IPA advised that the time taken to review the blood tests by the FY1 Doctor *'was acceptable. These blood investigations were not required and would not have been expected to show anything untoward.'* In addition, the S IPA advised that it would be standard practice for the laboratory to contact the clinical team caring for the patient had they seen anything abnormal.

45. The S IPA noted that the patient's white cell count was marginally elevated at 12.9, the result was circled, and *'an action plan [was] recorded to monitor blood tests on the following day.'* Following surgery, the S IPA advised that it is normal for there to be a rise in a patient's white blood cell count, and stated that *'is a very non-specific marker for inflammation or infection.'* The S IPA advised that *'a white cell count of 12.9 would not, in isolation, be an indication for further investigation unless the patient had physical signs or other evidence of an ongoing problem.'* The S IPA advised that *'this result would not have been particularly worrying to the team caring for the patient.'*

46. In addition, the S IPA noted that the patient's C reactive protein[8] was *'just outside the normal range'.* However, the S IPA advised that neither the elevated white cell count nor the non-standard C reactive protein '*warranted more than the plan to observe [the patient] overnight. No other action was*

[8] A blood test marker for inflammation in the body.

required at this point.' The S IPA confirmed that no other investigations were indicated on the evening of 15 January 2016.

47. Prior to The patient's discharge, the S IPA advised that there was *'no clear indication'* to undertake blood tests, '*notwithstanding the marginally elevated white cell count.'* The S IPA advised that if the patient was well and symptom free, *'I would not have repeated the full blood count prior to discharge. His satisfactory NEWS physiological observations work [was] reassuring.'* In addition, the S IPA advised that the request to repeat bloods was made by an FY1 Doctor, *'the least experienced medical grade in the hospital service'*. The S IPA advised that *'it would be normal practice'* for the medical team *'to make a judgement about the fitness of a patient for discharge without the need to repeat blood tests.'* On review, the S IPA advised that *'a counsel of perfection would be that the record should have stated why the repeat blood test was not undertaken. However, in the press of business on a busy surgical ward details like this would not be routinely recorded.'*

48. In addition, the S IPA was asked if the blood test had been repeated prior to discharge, what effect would this have had on the patient's care and treatment. The S IPA advised that it would be *'reasonable to conclude that repeat blood tests would have been likely to be more abnormal than those results obtained on 15 January 2016 shortly after the procedure.'* However, the S IPA advised that *'it is my opinion that repeat blood tests were not indicated in the absence of physiological or clinical evidence of concern. This renders the question irrelevant: it is only with hindsight that we know that mildly abnormal white cell count might have been greater than usual significance'* than was apparent to the team caring for the patient.

Monitoring of The patient's pain levels after surgery

49. As part of investigation enquiries, the N IPA was asked to advise on the monitoring of the patient's pain levels following surgery. The N IPA advised that once the patient was fit for discharge from recovery on 15 January 2016, nursing staff assessed him using the National Early Warning Score (NEWS) policy. The N IPA advised that NEWS guidelines suggest that any patient with a score of 1 – 4, *'should be assessed a minimum of 4 - 6 hourly'.*

50. The N IPA advised that The patient was assessed at the following times, between 15 and 16 January 2016, and given the subsequent NEWS and pain scores:

Date/ Time	NEWS Score	Pain Score
15 January 2016		
11.30	2	0
12.00	2	0
12.30	2	0
13.00	2	0
13.30	0	1
17.00	0	1
21.30	1	0
16 January 2016		
01.00	1	0
06.00	1	0
09.30	0	1

51. On review, the N IPA confirmed that the patient's NEWS score was *'assessed correctly'* between these dates.

52. The N IPA also advised that the patient's Kardex[7] recorded that paracetamol could *'only be given every 4 hours.'* The N IPA advised that the patient was given paracetamol at 22.00hrs on 15 January 2016, and at 06.15hrs and 10.55hrs on 16 January 2016. The N IPA confirmed that with a low pain score, *'paracetamol is the standard first choice for pain control'* and it *'is used to treat relatively mild pain.'*

53. The N IPA was also asked to comment on whether further pain relief ought to have been provided to the patient during this time. The N IPA advised that *'there was no evidence that The patient's pain was increasing to more severe pain from mild pain, or that he requested further analgesia to warrant increasing the analgesia.'* However, the N IPA noted that the patient's pain score was 0 at 06.00hrs, suggesting that he had no pain, yet he was given paracetamol 15 minutes later.

54. The N IPA advised that the patient's paracetamol *'was prescribed as an as required drug, therefore the patient will have to request [paracetamol] for it to be given.'* As a result, the N IPA advised that *'a score of 0 suggests [the patient] has no pain therefore you would not administer [an] as required*

paracetamol to manage this.' The N IPA advised that '*pain can start within 15 minutes of assessment, therefore it is difficult to determine if [the administration] was reasonable, however I would expect this to be documented within the notes that his pain score has changed.'* Therefore, the N IPA advised that the pain assessment was either not conducted effectively, or the documentation was incorrect. The N IPA advised that further assessment of this ought to have been performed by the Trust to clarify the reason for the discrepancy.

55. The N IPA also advised that at 02.20hrs on 16 January 2016, the nursing notes record that pain relief was not working, but *'mobilising gave [the patient] some relief'.* The notes record that the patient *'settled and slept after this'*. The N IPA explained that *'during a colonoscopy air is pumped into the bowel to open it. Whilst this is removed during the procedure some of this remains and can cause significant discomfort in the abdomen.'* The N IPA advised that *'mobilising can often help relieve the pain therefore it was appropriate for this to be suggested.'*

56. However, the N IPA advised that the information in relation to the patient's mobilisation was not passed to the medical team on the subsequent ward round. The N IPA advised that although this would not have changed the assessment of the patient overnight, it may have prompted further questions by the medical staff prior to the patient's discharge on 16 January 2016.

57. The S IPA also advised that *'there is no documentary evidence to show that the medical team were aware of [the patient's] pain and [the] paracetamol medication administered to relieve it. Since the doctors did not make any notes concerning the patient's pain it is reasonable to conclude that they were either unaware of it, or felt that it was not worrying.'* The S IPA advised that '*paracetamol is a mild analgesic that is freely available over the counter, I doubt whether its use would have been registered as significant even if it had been brought to the attention of the medical team.'* The S IPA also advised that '*the nursing team would not necessarily bring such routine medication to the attention of the doctors caring for the patient.'* On review, the S IPA advised that *'if the patient was complaining of significant pain then it was the duty of all*

concerned to recognise and respond to this, The nursing and medical teams were both responsible to ensure that his discharge from hospital was safe.'

58. In reference to the Trust's documentation, the N IPA advised that it was difficult to confirm where the nursing team documented their notes, as they were on a separate page to the doctors. The N IPA advised that it would *'be more appropriate if the nurses and doctors wrote within the one set of notes'* to improve communication between the medical teams. In addition, the N IPA advised that *'the doctors then may have been more aware that [the patient's] pain was not controlled with paracetamol if a nurse was not present during the ward round.'* The N IPA also advised that within the nursing notes it is difficult to confirm the name of the nurses assessing the patient, as they had signed but not printed their names.

Identification of sepsis prior to discharge from hospital

59. On 16 January 2016, the S IPA advised that the medical team attended the patient, however the notes did *'not have a time attached to it.'* The S IPA advised that a retrospective nursing entry recorded at 15.40hrs, noted that prior to discharge the patient was using the toilet independently, *'was found to be mobile and independent; able to eat and drink and look after himself. He was therefore allowed home at 12.30pm.'* The S IPA advised that the nursing observation chart showed that the patient's clinical observations *'showed no cause for concern'*, he *'was noted to have an early warning score of 0',* and was not *'suffering from pain at any point.'* As a result, the S IPA advised that the patient *'was therefore allowed home'.* The S IPA advised that there was '*no clear physiological evidence that [the patient] was developing a serious problem prior to discharge from hospital on the 16 January 2016.'*

60. The S IPA was asked if any other examinations, investigations, or assessments ought to have been taken prior to the patient's discharge. The S IPA advised that no abdominal examinations or investigations of the patient were recorded on 16 January 2017. However, the S IPA advised that if the patient was well and symptom free at discharge, then *'no further investigations were required.'*

61. The S IPA noted that the patient stated in his complaint that *'he was suffering from significant abdominal pain after his colonoscopy'* and advised the medical team that he was *'very sore'*. However, the S IPA advised that the nursing observation chart shows *'no evidence that Mr. Jackson was suffering from significant pain... There is no record in the medical notes that the patient was complaining about abdominal pain during his hospital stay.'* The S IPA advised that if the clinical records are accurate, *'the actions of the medical team were reasonable.'*

62. Conversely, the S IPA advised that if the patient's account of events was true, he required examination and investigation, regardless of the minor abnormalities identified in his blood test. The S IPA advised that if this is the case, then *'the team missed an opportunity to assess [the patient's] abdominal pain before he was discharged from hospital. Had they examined his abdomen at this point and discovered he was tender; this would have represented an opportunity to intervene at an earlier stage to manage the perforation of the bowel which we know developed at this time or later. It is reasonable to conclude that [the patient's] abdomen should have been examined'* when he told the medical team that it was *'very sore'.*

63. The S IPA advised that 's*evere abdominal pain following removal of a large caecal polyp would be most concerning. Assessment and investigation to exclude a colonic perforation would be required unless such pain resolved swiftly…. Pain like this is the cardinal sign that he might have been developing a problem which required investigation and treatment.'* Had the patient's pain been apparent, the S IPA advised that *'the clinical team would have undertaken abdominal examination and potentially have been able to act more swiftly.'* The S IPA advised that if there were concerns that the patient was at risk of complications, such as perforation, *'then further investigation by x-ray or CT scan would have been required.'* The S IPA advised that the medical team did not '*appear to have been sufficiently worried that he felt either was needed.'*

64. If the team had been made aware of the patient's pain prior to discharge, and the abdominal examination was performed, the S IPA advised that there would

have been a *'number of potential outcomes',* which would have led to several investigation and treatment paths.

65. As part of enquiries, the S IPA was asked if an x-ray or CT scan had been performed, would it have identified the patient's sepsis. In response, the S IPA advised that *'abdominal x-rays are notoriously difficult to interpret.'* The S IPA advised that *'had the team wished to investigate for a potential problem then CT would have been the imaging method of choice.'* On balance, the S IPA advised that *'it is likely that a CT would have shown evidence of a problem in [the patient's] abdomen had a CT been undertaken prior to his discharge from hospital.'*

66. The S IPA was also asked what effect the identification of the patient's sepsis on 16 January 2016, would have had on his overall care and treatment. The S IPA advised that the patient did not have sepsis on this date. He advised that the issue to determine was whether the patient's perforation, which led to his sepsis, might have been diagnosed at this time. The S IPA advised that *'had a CT shown evidence of a localised perforation then [the patient] would have been treated with antibiotics and intravenous fluids.'* Alternatively, if the CT scan had shown *'evidence of leakage of bowel contents throughout the abdomen then [the patient] would have needed an emergency abdominal operation.'*

67. The S IPA advised that *'earlier surgical intervention may well have resulted in a less severe illness. There is evidence to show that delays in the control of the source of sepsis results in a higher risk of death and poor outcomes from treatment.'* However, the S IPA advised that *'it is quite likely that an operation to manage a perforation of [the patient's] bowel would have resulted in him having an ileostomy… even if the problem had been identified earlier.'* The S IPA advised that *'there is an increased risk of poor healing when bowel is joined together in the presence of contamination and sepsis; hence many surgeons prefer to avoid the risk by formation of a stoma.'*

68. In addition, the S IPA advised that *'it would be legitimate to enquire of the Consultant Surgeon how many large right sided colonic polyps he is*

accustomed to removing endoscopically.' The S IPA advised that *'this is quite a highly specialised area of practice that should only be carried out by someone with demonstrated competence in this field. The risk of bowel perforation is higher for caecal polyps than for lesions in the rest of the colon.'*

The Trust's response to IPA

69. The Trust was given an opportunity to comment on the advice provided by the N IPA and the S IPA in relation to the care and treatment provided to the patient on 15 and 16 January 2016. It stated that the surgical management team, in conjunction with The Consultant Surgeon, acknowledged the findings.

70. In response to the S IPA's question in relation to how many large right sided colonic polyps the Consultant Surgeon had removed endoscopically, the Trust stated that the Consultant Surgeon is *'unable to provide absolute figures for polyp or right sided polyp resection in his practice.'* The Trust stated that the Consultant Surgeon *'is fully trained in the techniques of Endoscopic Mucosal Resection (EMR) and regularly performs such procedures.'* It stated that *'to the best of the [Consultant Surgeon's] knowledge, [the patient is] the only patient who has had a perforation secondary to EMR under his care.'* The Trust stated that the Consultant Surgeon has had *'other perforations as a result of direct scope trauma.'*

71. The Trust stated that *'recognising the difficulty of this case, The Consultant Surgeon asked [an observing Doctor] to be present. He was there throughout.'* It explained that *'[the observing Doctor] is a Consultant Gastroenterologist with a special interest and huge wealth of experience in colonic and oesophageal EMR.'* The Trust stated that [the observing Doctor] *'did not feel there was any adverse event at the time and the Consultant Surgeon believes this is borne out by the post procedure photographs, which show an intact muscularis.'*

72. In addition, the Trust confirmed that the patient was booked into the surgery unit on 15 January 2016 as *'a day case'.* It stated that *'all day cases are reviewed for suitability for discharge with a view to transferring to an inpatient ward if required. Due to the size of the polypectomy, The Consultant Surgeon admitted [the patient] to the main inpatient ward for ongoing observation.'*

73. The Trust also confirmed that a nurse was present on the colorectal ward round on 16 January 2016. It stated that *[ ] was the senior surgical registrar who conducted this ward round. The Consultant Surgeon was not on call this weekend.'*

Analysis and Findings

74. I have investigated the patient's complaint, by carefully examining and testing the care and treatment provided to him by the Trust following his surgery on 15 January 2016. I will consider the issue under the following headings:

    (i) Admission to hospital following surgery;
    (ii) The junior doctor's advice to repeat the patient's bloods;
    (iii) Monitoring of the patient's pain levels after the surgery; and
    (iv) Identification of sepsis prior to discharge from hospital.

(i) Admission to hospital following surgery

75. As part of my investigation enquiries, I reviewed the patient's medical notes on admission to BCH. I note that the patient has not complained about his admission to hospital. However, on review of this documentation I identified that key records were absent. I have set out my findings in relation to this documentation in the subsequent paragraphs.

76. On 15 January 2016, the patient had a colonoscopy under general anaesthetic at BCH. I note the S IPA advised that prior to undergoing the colonoscopy, the patient completed and signed a consent form with a senior surgical trainee, which detailed the *'intended benefits of the procedure… [and] serious or frequently occurring risks.'* I note the risks associated with surgery included *'perforation'.* The S IPA advised that this documentation was *'appropriately comprehensive'.* As per the S IPA advice, I accept that the patient was appropriately advised of the benefits and *'serious or frequently occurring risks'* associated with a colonoscopy prior to his surgery.

77. I note the S IPA advised that the patient's surgery was *'finished before 10 o'clock',* and his operation notes record that *'the polyp was completely resected.'* I note the operation notes record that the patient was admitted to hospital for 24 hour observation. However, the S IPA advised that there is '*no*

documentation to explain why in-patient hospital care was required.' I note the S IPA advised that it was *'unusual'* for a patient having this procedure at the beginning of the day to subsequently stay overnight, as '*the vast majority of such procedures are carried out as a day case even if they require anaesthetic.'*

78. As a result, I note the S IPA advised that it if the patient was at risk of complications during this surgery, it '*should have been clearly documented in the notes.'* The S IPA also advised that '*I cannot find any clear documentation… that communication took place to explain to [the patient] the reason that he needed to remain in hospital.'* I gave regard to Standard 21 of the GMC Guidance, which states that *'clinical records should include… relevant clinical findings… the decisions made and actions agreed, and who is making the decisions and agreeing the actions… [and] the information given to patients.'*

79. I therefore accept the S IPA's advice and consider the failure by the medical team to record adequate details of why the patient needed to remain in hospital, whether he was at risk of specific complications and to record that this was communicated to the patient, contrary to these GMC Guidelines. I note that the patient's discharge summary from the BCH subsequently recorded *'Due to the size of the polypectomy I kept [the patient] in hospital overnight',* and this was confirmed by the Trust.

80. I note the S IPA also advised that there was an admission document for the patient, which was written by a foundation year one trainee, on 15 January 2016. As the document does not reference the findings of the patient's surgery, the S IPA advised that it must precede the colonoscopy. However, the S IPA specified that the document does not have a time attached to it. I consider that it is good practice to include times on the admission documents.

81. In addition, I note the S IPA advised that prior to admission to a ward *'it would be normal practice for a patient's condition to be documented formally.'* The S IPA advised that there was *'no formal medical clerking documentation regarding [the patient's] condition on admission to the ward… following his colonoscopy.'* However, I note the S IPA advised that admission documentation

may have been omitted as documentation was completed prior to the patient's procedure. The S IPA advised that the patient's nursing observation chart *'showed no cause for concern at that time'*, and he had underwent blood tests two days before his colonoscopy. The S IPA advised '*there was no reason to suppose that these tests would have changed significantly.'*

82. As detailed above, the S IPA advised that it was not detailed in the patient's medical notes why he remained in hospital overnight. I note the S IPA advised '*If [the patient's] admission was not planned then I would expect there to be some admission documentation and a record of abdominal examination findings as a baseline upon his arrival in the ward.'* I refer to GMC Guidelines, specifically Standard 15, which states *'if you assess, diagnose or treat patients you must… adequately assess the patient's condition… where necessary examine the patient.'*

83. As the Trust did not respond to the S IPA's comments in relation to the examination, and as there are no contemporaneous records detailing an examination of the patient, I am of the opinion that it is likely an examination was not performed. However, I note that the patient was subsequently reviewed by nursing and medical staff while a patient on the ward.

84. In addition, I refer to Standard 21 of GMC Guidance, which states that *'clinical records should include… relevant clinical findings… the decisions made and actions agreed… any drugs prescribed or other investigation or treatment.'* As per the GMC Guidance, I accept the S IPA's advice that the Trust should have completed additional admission documentation following the patient's transfer to the inpatient ward.

85. As detailed above, I have found a failure in the patient's care and treatment as a result of the Trust's failure to perform an examination of the patient on admission to the ward. I consider that this failure resulted in the patient suffering the injustice of loss of opportunity to be assessed by medical staff against this baseline during his time on the ward.

86. I have also identified failures in the patient's care and treatment as a result of the following record keeping failings:

- The medical team's failure to keep a record of the reason why the patient needed to remain in hospital following surgery, whether he was at risk of specific complications, and to record that this was communicated to the patient
- The medical team's failure to complete additional admission documentation following The patient's transfer to the inpatient ward

87. I consider that the failures in record keeping resulted in the patient suffering the injustice of uncertainty in relation to the care and treatment he received. I will address the issue of remedy at the end of my report.

(ii) The junior doctor's advice to repeat The patient's bloods

88. I note the patient also complained that while under observation following his surgery, his bloods were not re-checked for possible infection. The Trust and the S IPA confirmed that following surgery, the patient's bloods were sent for testing on 15 January 2016 at 17.27hrs. I note the S IPA advised that the blood request was received by the laboratory at 17.43hrs.

89. On review of clinical records, I note the results of the patient's blood tests were reviewed by a foundation year one trainee, at 21.40hrs. The S IPA confirmed that the time taken between the blood test being conducted and the time it was reviewed by the FY1 Doctor, *'was acceptable'.* I also note the S IPA advised that the laboratory would have contacted the clinical team earlier, had it wanted to highlight any abnormalities. As a result of the S IPA's advice, I consider that the testing of the patient's blood was appropriate.

90. I note the FY1 Doctor recorded in the patient's medical notes that his white cell count was marginally elevated at 12.9. As evidenced in the medical notes, the S IPA advised that this result was circled and *'an action plan [was] recorded to monitor blood tests on the following day.'* I also note the S IPA advised that the patient's C reactive protein was *'just outside the normal range.*' However, the S IPA advised that neither of these irregularities '*warranted more than the plan to observe [the patient] overnight. No other action was required at this point.'*

91. In response to investigation enquiries, I note the Trust stated that a *'slight rise in white cell count can be expected post colonoscopy'*. The S IPA confirmed that a rise in a patient's white blood cell count is normal, and advised that it *'is a very non-specific marker for inflammation or infection.'* I note the S IPA also advised that *'a white cell count of 12.9 would not, in isolation, be an indication for further investigation unless the patient had physical signs or other evidence of an ongoing problem… this result would not have been particularly worrying to the team caring for [the patient].'*

92. When asked about the practice for monitoring a patient's bloods following surgery, I note the S IPA advised that *'there is no place for routine blood investigations following a colonoscopy even after a polyp has been removed.'* The S IPA advised that the patient's *'blood investigations were not required and would not have been expected to show anything untoward.'*

93. On review of the available evidence, I accept the S IPA's advice. I consider that in light of the patient's *'marginally elevated'* blood results, the clinical team's decision to observe him overnight, and conduct no further actions at this time was reasonable.

94. The patient also complained that he was discharged on 16 January 2016 without the repeat blood test being performed. I note the Trust stated that on review of the patient prior to his discharge, the surgical team were *'satisfied with his clinical status'* and therefore *'no further blood tests were arranged.'* The S IPA advised that there was *'no clear indication'* to undertake blood tests prior to the patient's discharge, '*notwithstanding the marginally elevated white cell count.'* I note the S IPA advised that if The patient was well *'I would not have repeated the full blood count prior to discharge. His satisfactory NEWS physiological observations were reassuring.'*

95. In addition, I note the S IPA advised that the request to repeat the patient's bloods was made by an FY1 doctor, *'the least experienced medical grade in the hospital service'*. The S IPA advised that the medical team would have made '*a judgement about the fitness of a patient for discharge without the need to repeat a blood test.'* I note the S IPA advised that this *'would be normal*

practice.' As a result, I accept the S IPA's advice and consider that it was reasonable for the senior surgical registrar and the clinical team to discharge the patient based on their clinical judgment, without the need to conduct further blood tests.

96. On review, I also note the S IPA advised that *'a counsel of perfection would be that the record should have stated why the repeat blood test was not undertaken. However, in the press of business on a busy surgical ward details like this would not be routinely recorded.'* I accept the S IPA's advice that this is not always a reasonable practice in a *'busy surgical ward',* and consider that this omission was reasonable.

97. I note the S IPA also advised that if repeat blood tests had have been conducted prior to the patient's discharge, these '*would have been likely to be more abnormal than those results obtained on 15 January 2016 shortly after the procedure.'* However, the S IPA advised that '*it is my opinion that repeat blood tests were not indicated in the absence of physiological or clinical evidence of concern… it is only with hindsight that we know that mildly abnormal white cell count might have been greater than usual significance that was apparent to the team caring for The patient.'*

98. Based on the medical records and S IPA advice, I am satisfied that it was reasonable for the clinical team not to conduct further blood tests, as they had no reason to be concerned for the patient's health prior to discharge. I do not uphold this element of the patient's complaint.

(iii) Monitoring of the patient's pain levels after surgery

99. Following The patient's surgery on 15 January 2016, I note the nursing notes record that he was brought to recovery between 12.00hrs and 13.00hrs. I note the N IPA advised that nursing staff assessed the patient using the NEWS Guidelines, and the nursing records document, *'NEWS satisfactory and recorded'.* On review of the NEWS Guidelines, I note it is suggested that patients with a score of 1- 4 ought to be assessed a minimum of *'4 - 6 hourly'.* I note the patient's NEWS chart records that he was assessed within these

guidelines, and the N IPA has advised that his NEWS score was *'assessed correctly'* between 15 and 16 January 2016.

100. In addition, I note the NEWS Guidelines state that '*Pain and/or its cause will usually but not always generate physiological disturbances that should be detected by the scoring system for the NEWS… However, to encourage routine recording of pain symptoms, pain has been included as part of the NEWS observation chart.'* On review of the NEWS chart, I note that the patient's pain score was recorded at the same time as his NEWS score. It was recorded as '0' at 11.30hrs and 13.00hrs, on 15 January 2016, before rising to '1' at 13.30hrs. The patient's pain level remained at '1' until 21.30hrs, when it was recorded as '0'. I note the patient's pain level was subsequently recorded as '0' until 09.30hrs on 16 January 2016, when it increased again to '1'. On review of the available evidence, I consider the patient's pain scores were recorded within the appropriate timeframes.

101. In reference to pain relief, I note the patient's Kardex[7] records *'Medicine: Paracetamol, Frequency 4° [hourly].'* It details that he was given paracetamol at 22.00hrs on 15 January 2016, and at 06.15hrs and 10.55hrs on 16 January 2016. Therefore, the administration of the patient's medication was within the specified guidelines. I note the N IPA advised that *'paracetamol is the standard first choice for pain control'* and that it '*is used to treat relatively mild pain.'* I note the N IPA advised that *'there was no evidence that The patient's pain was increasing to more severe pain from mild pain, or that he requested further analgesia to warrant increasing the analgesia.'*

102. However, I note the N IPA advised that at 06.00hrs, the patient's pain score was 0, suggesting he had no pain, but he was given paracetamol 15 minutes later. I note the N IPA advised that the patient's paracetamol was prescribed as an *'as required'* drug, therefore it would not have been administered unless the patient required it. The N IPA advised that it is possible the patient experienced elevated pain 15 minutes after his pain score was recorded. However, the N IPA advised that this change ought to have been *'documented within the notes'.* As a result, I note the N IPA has advised that the patient's pain

assessment was either not conducted properly or the documentation was incorrect.

103. On review, I note the Trust stated that *'it is clear that The patient experienced sufficient pain during the night to require two repeated doses of paracetamol and that this appeared not to completely relieve his pain'.* The Trust recognised that the patient's pain did not appear to be reflected in the pain score. On the balance of probabilities, I consider the patient was administered additional paracetamol at 06.15hrs, as he was experiencing pain. However, I am critical of the lack of record keeping detailing why the patient was administered the paracetamol.

104. At 02.20hrs on 16 January 2016, I note the nursing notes record that pain relief was having '*little effect'* on the patient. The notes record that the patient complained of bloating and was '*advised to mobilise'*, which relieved some of his symptoms. Following mobilisation, the nursing notes record that the patient *'settled and slept.'* I note the N IPA advised that '*during a colonoscopy air is pumped into the bowel to open it. Whilst this is removed during the procedure some of this remains and can cause significant discomfort in the abdomen.'* I note the N IPA advised that *'mobilising can often help relieve the pain therefore it was appropriate for this to be suggested.'*

105. As a result of the N IPA advice, I consider the nursing team's instruction for the patient to mobilise was reasonable. However, I note the N IPA advised that the instruction given to the patient to mobilise did not appear to be passed to the medical team on its ward round the next day, as it was not recorded in the medical notes. I note the N IPA advised that although this would not have changed the assessment of the patient overnight, it may have prompted further questions by the medical staff prior to the patient's discharge.

106. In addition, I note the S IPA advised that '*the nursing team would not necessarily bring'* routine pain medication '*to the attention of the doctors caring for [the patient].'* The S IPA advised that *'there is no documentary evidence to show that the medical team were aware of [the patient's] pain and [the] paracetamol medication administered to relieve it. Since the doctors did not*

make any notes concerning the patient's pain it is reasonable to conclude that they were either unaware of it, or felt that it was not worrying.'

107. I note the S IPA advised that *'paracetamol is a mild analgesic that is freely available over the counter, I doubt whether its use would have been registered as a significant event or brought to the attention of the medical team.'* In addition, the N IPA advised that if information in relation to pain medication had been shared *'the doctors… may have been more aware that [the patient's] pain was not controlled with paracetamol if a nurse was not present during the ward round.'*

108. I refer to Standard 10 of the NMC Code, which states that nurses must *'keep clear and accurate notes relevant to your practice.'* It states that nurses must '*identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need'.* I note that the nursing records contain information in relation to the patient's mobilisation, medication and pain levels.

109. I also refer to the NMC Code, specifically Standard 8 *'Work co-operatively'*, which states that nurses must *'maintain effective communication with colleagues', 'keep colleagues informed when you sharing the care of individuals with other health and care professionals and staff'*, and *'share information to identify and reduce risk'.* On a consultant led ward round, the S IPA advised that '*it would be customary for a member of the nursing team'* to be present so that they could *'raise any concerns'* with the medical team. The S IPA also advised that it would be '*unusual for the medical team to consult the nursing records.'*

110. On 16 January 2016, I note the Trust confirmed that a member of the nursing team was present on the colorectal ward round. However, I note that there is no contemporaneous record in the medical records to assist in my consideration of the information provided to the medical staff by the nursing team. Therefore I am unable to make a finding as to whether the nursing team advised the medical team of their instruction to the patient to mobilise, or of the pain medication he was administered.

111. Therefore, as per the NMC guidance, I am critical of the lack of contemporaneous records detailing whether the nursing team shared this information with the medical team on the ward round.

112. I also note that N IPA advised that it was difficult to confirm the name of the nurses assessing the patient, as they had signed but not detailed their names. I gave regard to Standard 10 of the NMC Code, which states that nurses must '*attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.'* I accept the N IPA's advice, and find this failure contrary to the NMC Code.

113. As detailed above, I have identified failures in the patient's care and treatment by the nursing team as a result of the following record keeping failings:

- failure to record why the patient was administered paracetamol at 06.15hrs on 16 January 2016
- failure to record what information related to the patient's mobilisation, medication and pain levels was shared with the medical team on 16 January 2016
- failure to clearly record their names on the patient's nursing records

114. I consider that these failures in record keeping resulted in the patient suffering the injustice of uncertainty in relation to the care and treatment he received. I will address the issue of remedy at the end of my report.

(iv) Identification of sepsis prior to discharge from hospital

115. Prior to the patient's discharge on 16 January 2016, I note the S IPA advised that the medical team attended the patient, but the notes *'did not have a time attached to it.'* I consider that it would be good practice for the nursing team to record this information.

116. Prior to discharge, the S IPA advised that the patient's clinical observations had been taken and they *'showed no cause for concern.'* The S IPA advised that the patient *'was therefore allowed home'.* On review of the nursing notes, I note

that it is recorded that the patient had *'no complaints'* on discharge. In response to investigation enquiries in relation to whether further examinations, investigations or assessments were required prior to the patient's discharge, I note the S IPA advised that if the patient was well and symptom free, then *'no further investigations were required.'*

117. I note the nursing records, which were time stamped 15.40hrs, subsequently record that the patient was *'collected at 12.30 midday'* by his son in law. I gave regard to Standard 10 of the NMC Code, which states that nurses must *'complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event.'* Although the notes were recorded a number of hours following the patient's discharge, I consider that they still comply with the NMC Code.

118. However, I note that a nurse's signature is not recorded in this clinical note. I gave regard to Standard 10 of the NMC Code, which states that nurses must *'attribute any entries you make in any paper or electronic records to yourself.'* I consider that this failure in record keeping resulted in the patient suffering the injustice of uncertainty in relation to the care and treatment he received. I will address the issue of remedy at the end of my report.

119. I note the S IPA advised that the patient did not have sepsis when he was discharged from hospital. The S IPA advised that the issue to determine was whether the patient's perforated bowel, which led to his sepsis, ought to have been diagnosed at this time. Prior to discharge, I note that the patient has complained that he expressed to the medical team that he was *'very sore'.* I note the S IPA advised that if the patient's was experiencing pain, *'the team missed an opportunity to assess [him]'.* The S IPA advised that *'it is reasonable to conclude that the patient's abdomen should have been examined',* as pain '*is the cardinal sign that [the patient] might have been developing a problem.'* The S IPA advised that examination of the abdomen would have led to a *'number of potential outcomes',* involving different investigations and treatment paths.

120. In the Trust's response, I note that the observing Doctor *'did not feel there was any adverse event at the time'* of the patient's colonoscopy, and The Consultant

Surgeon suggested that this is confirmed by the post procedure photographs*, 'which show an intact muscularis.'* In addition, I note the S IPA and the N IPA both advised that the nursing observation chart showed no evidence of the patient '*suffering from significant pain... There is no record in the medical notes that [the patient] was complaining about abdominal pain during his hospital stay.'* In addition, I note the S IPA advised that the medical team did *'not appear to have been sufficiently worried'* that it considered an x-ray or CT scan was required.

121. As a result, the S IPA advised that if the patient's clinical records are accurate, then '*the actions of the medical team were reasonable.'* I note the S IPA advised there was '*no clear physiological evidence that [the patient] was developing a serious problem prior to discharge from hospital on the 16 January 2016.'* However, I also refer to paragraph 106, in which the S IPA advised that *'there is no documentary evidence to show that the medical team were aware of the pain and paracetamol medication administered to relieve' t*he patient's pain.

122. On review of the available evidence, I have been unable to identify contemporaneous records of the patient expressing that he was experiencing pain, or of medical staff identifying that he was in pain. Although I have no reason to doubt that the patient expressed to medical staff that he was experiencing pain, due to the lack of contemporaneous records I am unable to confirm that this is the case.

123. Having carefully considered all the available evidence and the S IPA's advice, I have determined that in this instance I prefer to rely on the contemporaneous evidence available to me. I note the S IPA advised that the nursing observation charts showed no evidence of The patient experiencing pain and the medical team were not 'sufficiently worried' to consider that an x-ray or CT scan was required. In addition, the nursing notes record that the patient had *'no complaints'* on discharge. I therefore consider that it was appropriate for the medical team to discharge the patient without performing further investigations. I do not uphold this element of the patient's complaint.

124. I do acknowledge the S IPA's advice that earlier surgical intervention would have resulted in the patient having *'a less severe illness'.* However, I note that even if the patient's perforation had been identified earlier, *'it is quite likely… that an operation would have resulted in him having an ileostomy.'* I note the S IPA advised that many surgeons prefer to avoid the *'increased risk of poor healing when bowel is joined together in the presence of contamination and sepsis… by formation of a stoma.'*

125. I note the Trust confirmed that The Consultant Surgeon *'is fully trained in the techniques of Endoscopic Mucosal Resection (EMR) and regularly performs such procedures.'* It stated '*to the best of The Consultant Surgeon's knowledge'* this is the only perforation following EMR that has happened under his care. In addition, I note that the Trust stated that The Consultant Surgeon, *'recognising the difficulty of this case'*, invited [an observing Doctor], *'a Consultant Gastroenterologist with a special interest and huge wealth of experience in colonic and oesophageal EMR'* to be present.

126. As a result of the S IPA advice, and given The Consultant Surgeon and the observing Doctor's levels of experience, I consider that it is likely the patient's ultimate outcome would have remained the same, even if further investigations had been completed prior to discharge. In addition, I refer to the *'Consent for Examination, Treatment or Care'* form, which was reviewed and signed by the patient prior to undergoing surgery. I note that perforation is included as a *'serious or frequently occurring risk'.* The S IPA also advised that this form was '*appropriately comprehensive'.* Therefore, I consider that the patient was aware of the potential complications associated with his procedure, prior to undergoing surgery.

CONCLUSION

127. The patient submitted a complaint to me about the actions of the Trust, following an elective colonoscopy at BCH on 15 January 2016.

128. I have investigated the patient's complaint and have found a failure in care and treatment in relation to the Trust's failure to perform an examination of the

patient on admission. I consider that this failure resulted in the patient suffering the injustice of loss of opportunity to be assessed by medical staff against this baseline during his time on the ward.

129. I have also identified failures in the patient's care and treatment as a result of the following record keeping failings:

- Failure of the medical team to record why the patient needed to remain in hospital following surgery, whether he was at risk of specific complications, and to record that this was communicated to the patient
- Failure of the medical team to complete additional admission documentation upon the patient's arrival on the hospital ward
- Failure of the nursing team to record why the patient was administered paracetamol at 06.16hrs on 16 January 2016
- Failure of the nursing team to record what information, pertaining to the patient's care and treatment, was shared with the medical team on 16 January 2016
- Failure of the nursing team to clearly record their names on the patient's nursing records
- Failure of the nursing team to record a nurse's signature on the patient's nursing records at 15.40hrs on 16 January 2016

130. I consider that these failures in record keeping resulted in the patient suffering the injustice of uncertainty in relation to the care and treatment he received.

Recommendations

131. I recommend that the Trust issues the patient with an apology in accordance with the NIPSO guidance for the injustice of loss of opportunity and uncertainty, **within one month** of the date of my final report.

132. In addition, I recommend the Trust makes a payment of £150 by way of solatium for redress in respect of the injustice I have identified. The payment should be made within **one month** of the date of my final report.

133. I consider there were a number of lessons to be learned by the Trust which provides it with an opportunity to improve its services, and to this end I recommend the Trust makes The Consultant Surgeon aware of the application of GMC Guidance, to ensure that has full regard for it, specifically in relation to the examination and assessment of patients prior to unplanned inpatient admission.

134. I also recommend the Trust provides training to all relevant nursing and medical staff on good record keeping to ensure that appropriate records are retained.

135. I recommend the Trust develops an action plan which outlines the steps considered in implementing my recommendations, and provides me with an update **within three months** of the date of the final report. The action plan is to be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/ or self-declaration forms which indicate that staff have read and understood any relevant policies).

136. The Trust accepted my findings and recommendations.

PAUL MCFADDEN
Deputy Ombudsman **January 2020**

Appendices

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.