Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 19274

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.

TABLE OF CONTENTS

Page

SUMMARY

I received a complaint about the care and treatment provided by the medical team on the fractures ward of the Royal Victoria Hospital to the complainant's late mother (the patient) between 5 and 23 December 2013. The complainant also said that the clinical team from the fractures ward did not communicate appropriately with her family.

In considering the complaint I established that it was appropriate for the patient to be initially treated on the fractures ward due to her presenting with a neck of femur fracture. The level of oxygen administered to the patient while she was on the fractures ward was reasonable. I also established that the consent for the patient's surgery was undertaken in accordance with relevant guidelines. However, the investigation established areas where the patient's care and treatment fell below the appropriate standard. I considered that she ought to have been transferred to a respiratory ward post-surgery when her respiratory failure became the most significant concern. I also established that the communication with the complainant while her mother was on the fractures ward was not appropriate. Furthermore, I established that the complainant was not appropriately involved in decisions when her mother lost capacity post-surgery.

I recommended that the Trust apologise to the complainant for the failings identified. I would also have made a recommendation in relation to the Trust's NIV policy. However, the Trust confirmed that a review of the policy was undertaken and a revised policy is now in place. I was pleased to note that the Trust accepted my findings and recommendations.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust) regarding the care and treatment provided to the complainant's late mother by the clinicians of the fractures ward of the Royal Victoria Hospital (RVH) between 5 and 23 December 2013. The patient had a fall at home on 3 December 2013 and was taken by ambulance to Antrim Area Hospital (AAH) the following day. She was transferred to the RVH in the early hours of 5 December 2013 and was admitted to the fractures ward for treatment.

2. The complainant said that her mother remained on the fractures ward despite experiencing respiratory difficulties. She complained about the level of oxygen administered to her mother and that the medical team from the fractures ward did not communicate appropriately with her or her family while her mother was being treated on the ward.

3. The patient was transferred to the care of a respiratory consultant on 23 December 2013. She was discharged from the RVH on 30 December 2013 and passed away at her home on 4 January 2014.

Issues of complaint

4. The issues of complaint accepted for investigation were:

Issue 1: **Whether the patient received appropriate care and treatment on the fractures ward of the Royal Victoria Hospital between 5 and 23 December 2013?**

Issue 2: **Whether the communication with the patient, the complainant and her family was reasonable during the patient's admission to the fractures ward?**

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

- A Consultant Trauma and Orthopaedic Surgeon with over 15 years' experience in clinical orthopaedics (O IPA);
- A Consultant Physician for over 30 years and an accredited geriatrician for 18 years (OG IPA);
- A Consultant in internal and respiratory medicine at a large university teaching hospital for 15 years (R IPA); and
- A critical care nurse for 14 years (N IPA)

7. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs 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

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

The general standards are the Ombudsman's Principles[1]:

- The Principles of Good Administration

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

- 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.

The specific clinical and operational standards relevant to this complaint are:

- The British Thoracic Society's (BTS) Guideline for Emergency Oxygen Use in Adult Patients, 2008 (the BTS guideline for emergency oxygen use);
- The British Thoracic Society's (BTS) Guideline for Non-invasive Ventilation in Acute Respiratory Failure, March 2002 (the BTS guideline for use of NIV);
- The British Orthopaedic Associations Care of Patients with Fragility Fracture [also known as the Blue Book II], 2007 (the Blue Book);
- The Belfast Health and Social Care Trust's Policy on The Use and Management of Non-Invasive Ventilation in Adults for Acute Type II Respiratory Failure in a Hospital Setting, June 2013 (the Trust's NIV policy);
- The Belfast Health and Social Care Trust's Policy for the Prescription and Administration of Emergency Oxygen in Adults, Version 2, April 2012 (the Trust's emergency oxygen policy);
- The National Institute for Health and Care Excellence's (NICE) Chronic obstructive pulmonary disease in adults, quality standard, 2011 (the NICE guidelines for COPD);
- The National Institute for Health and Care Excellence's (NICE) Clinical Guideline 101: Management of chronic obstructive pulmonary disease in adults in primary and secondary care (partial update), June 2010 (NICE CG101);
- The Department of Health's (DoH) Comprehensive Critical Care: A review of adult critical care services, May 2000 (the DoH review of critical care);

- The Belfast Health and Social Care Trust's Policy for Measuring and Recording Physiological Observations, August 2011 (the Trust's policy for recording observations);
- The General Medical Council's (GMC) Confidentiality: Working with doctors working for patients, October 2009 (the GMC guidelines on confidentiality);
- The General Medical Council's (GMC) Consent: patients and doctors making decisions together, 2008 (the GMC guidelines on consent);
- The General Medical Council's (GMC) Good Medical Practice, April 2013, (GMC Good Medical Practice); and
- The Belfast Health and Social Care Trust's Policy to be Followed When Obtaining Consent for Examination, Treatment or Care in Adults or Children (the Trust's policy on obtaining consent).

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

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

THE INVESTIGATION

Issue 1: Whether the patient received appropriate care and treatment in Ward 5F (Fractures) of the Royal Victoria Hospital between 5 and 23 December 2013

Detail of Complaint

12. The patient had a fall at home on 3 December 2013 and was taken by ambulance to AAH the following day. She was transferred to the RVH in the early hours of 5 December 2013 and was admitted to the fractures ward for treatment. In particular, the complainant was unhappy that her mother

remained on the fractures ward despite experiencing respiratory difficulties. She also complained about the level of oxygen administered to the patient.

Evidence Considered

Legislation/Policies/Guidance

13. I refer to the following legislation policies and guidance which were considered as part of investigation enquiries:

    i. I considered the following sections of the BTS guideline for emergency oxygen use:
        - Oxygen prescription;
        - Oxygen administration; and
        - Monitoring and maintenance of target saturation.

    ii. I considered the following sections of the BTS guideline for use of NIV:
        - Summary of recommendations: setting up an acute NIV service.

    iii. I considered the following section of the Blue Book:
        - Six standards for hip fracture care.

    iv. I considered the following sections of the Trust's NIV policy:
        - Background;
        - The use of non-invasive ventilation (NIV) in Acute Type II Respiratory Failure;
        - Protocol for non-invasive ventilation in patients with hypercapnic respiratory failure;
        - Signs and symptoms of acute respiratory distress; and
        - Patient transfer.

    v. I considered the Trust's emergency oxygen policy. In particular, paragraphs 4.1, 4.6, 4.7, and 4.10 of the guideline.

    vi. I considered the following sections of the NICE guidelines for COPD:
        - Quality statement 6: Emergency oxygen during an exacerbation; and
        - Quality statement 7: Non-invasive ventilation

vii. I considered the following sections of NICE CG101:

- Key priorities for implementation; and
- Use non-invasive ventilation

viii. I considered the DoH review of critical care. In particular, paragraphs 15 and 35 of this guideline.

ix. I considered the Trust's policy for recording observations. I identified the following relevant extract:
'*Physiological abnormality is associated with adverse patient outcome. Track and trigger scoring systems have been designed to identify and monitor ward patients who are, or who may become unwell. Physiological 'track and trigger' systems rely on periodic observation of selected basic physiological signs (tracking) with predetermined calling or response criteria (trigger) for requesting the attendance of staff who have specific competencies in the management of acute illness and/or critical care'*.

The Trust's response to investigation enquiries

14. In relation to the complaint that the patient remained on a fractures ward with no specialist respiratory input, the Trust explained that '*the RVH Trauma and Orthopaedic Service has a medical team, led by a Consultant Physician who specialises in Acute Orthomedicine. This team is experienced in the treatment of pre and post-operative patients admitted to the fracture wards. These patients often have co-morbidities and complex medical conditions including respiratory conditions as in the patient's case'*.

15. In response to the complaint regarding the care and treatment, the Trust explained that '*on 5 December 2013, an arterial blood gas was ordered in view of the patient's history of significant chronic obstructive airways disease (COPD). [The patient's] underlying COPD was later confirmed on the Autopsy Report...the patient's baseline arterial blood gas test was satisfactory on room air and no oxygen therapy was administered at that time. It is important to note*

that a patient's oxygen saturations will vary considerably during their stay in hospital, especially when they have advanced COPD, had emergency hip surgery and developed chest sepsis like the patient'.

16. The Trust further explained that '*at various stages, a patient may require additional oxygen support or none at all. Some patients, like [the patient], can become sensitive to oxygen therapy. This is why we monitor such patients closely and use arterial blood gases to titrate therapy[2]. This was done on a regular basis throughout [the patient's] stay in hospital. The Trust has confirmed that on 14 December 2013, [the patient] was administered five litres of oxygen to provide nebulised treatment[3]. However, as outlined in the previous independent respiratory review…of the patient's care, consequently her inspired oxygen was reduced, which was the appropriate action to take following monitoring of the patient's blood gas analysis'*.

17. The Trust further explained that '*throughout 15 December and 16 December 2013, as per Dr A's statement, the patient's oxygen saturation levels were not stabilising. Input and advice was provided by medical teams from Respiratory, Cardiology and the Critical Care Outreach Team and a joint decision was taken to transfer the patient to the acute medical ward for advanced respiratory support. On 23 December 2013 discussion took place with [Dr A] and [Dr B], and [Dr B] took over the patient's care'*.

18. The Trust was asked to explain the role of the Critical Care Outreach Team (CCOT) within the RVH. It explained that the CCOT is '*made up of Registered Nurses'*. Its objectives are '*early identification of acutely ill patients in order to avert admissions (prevent readmission) to critical care; early and appropriate action in unstable patients to prevent their condition deteriorating and facilitating earlier admission/readmission in cases where ICU/HDU [intensive care unit/high dependency unit] management is required; provide a patient centred service; follow up of identified patients discharged from critical care;*

[2] The process of adjusting the dose of a medication for the maximum benefit without adverse effects.
[3] A nebuliser converts a solution of a drug into a fine spray.

and the sharing of critical care skills and knowledge with ward staff caring for deteriorating patients'.

19. The Trust further explained that '*the CCOT is activated as a response to the National Early Warning Score (NEWS) on the observations chart as follows; Patients who trigger 5 or more, or 3 for one parameter on the NEWS chart should be referred to the ward medical staff and outreach simultaneously by the ward staff. Patients who do not trigger on the NEWS chart but who staff are concerned about may also be referred'*.

20. In relation to the trial of NIV for the patient, the Trust explained that '*the CCOT nurse was on the ward with the year 2 Foundation Doctor and discussed the trial of Non Invasive Ventilation with the doctor, based on the Arterial Blood Gas. The medical registrar was contacted and reviewed the patient'*. In relation to the recommendation for the patient to be transferred to a respiratory ward made by the CCOT, the Trust explained that '*this recommendation for transfer to an area suitable for patients receiving Non Invasive Ventilation was made by CCOT in keeping with Trust policy "The Use and Management of Non Invasive Ventilation in Adults for Acute Type II Respiratory Failure in a Hospital setting". This was supported by the medical staff*'.

21. The Trust was asked if it follows a policy on early recognition and rescue of deteriorating patients. It explained that '*the patient's physiological observations were recorded on a National Early Warning Score (NEWS) chart. This is a track and trigger scoring system designed to identify and monitor ward patients who are, or may become unwell. The NEWS is based on a simple aggregate scoring system in which physiological parameters (respiratory rate, heart rate, systolic[4] and diastolic[5] blood pressure, level of consciousness, oxygen saturation and temperature) are measured and a score is allocated. With the early warning score system each vital sign is allocated a numerical score from 0 to 3, on a colour coded observation chart (a score of 0 is most desirable and a score of 3*

[4] The first number on a blood pressure reading. It measures the pressure in the blood vessels when the heart beats.
[5] The second number on a blood pressure reading. It measures the pressure in the blood vessels when your heart rests between beats.

is least desirable). These scores are added together and a total score is recorded which is their early warning score. A trend can be seen whether the patient's condition is improving, with a lowering of the score or deteriorating, with an increase in the score. Care can be escalated to senior medical staff as appropriate. There is clinical guidance for staff on the back of the NEWS chart, on actions that should be implemented for each individual patient's score, from 0 being no action to be taken, to a score of 7 and above requiring high risk and urgent review'.

22. In relation to learning identified from the complaint, the Trust explained that '*named consultant will be discussed with the patient and relatives when they are being admitted to the ward and this discussion will be documented in the nursing notes. Due to the number of changes and rotation of nursing staff in the fracture wards, a team approach to the delivery of care has been adopted at present to improve continuity of patient care and communication to patients and relatives. However, the named nurse model is currently under review. The Trust values feedback from patients and relatives as this enables us to improve our services. Learning is shared from our complaints through revalidation, multi-disciplinary audit meetings and clinical governance processes'*.

The Trust's records

23. The patient's clinical records provided by the Trust were carefully considered.

24. The Trust also provided a report it commissioned for its investigation into the complaint. The investigation was undertaken by a Consultant Respiratory Physician (CRP) from another Health and Social Care Trust in Northern Ireland. In the report, the CRP explained that he did not have any '*direct working links with the wards where the patient was looked after or with the doctors who were treating her'*. The CRP explained in his report that the patient had '*significant COPD prior to her admission with a fracture. This can be seen from previous CT scans and lung function tests that she had'*. He further explained that it was '*not surprising that she [the patient] suffered from pneumonia as a post-operative complication and she would have been very prone to developing this condition as a result of her previous lung problem'*.

25. The CRP explained that '*post-operatively…it was clear that she [the patient] had deteriorated and she was commenced on supplementary oxygen. At that stage her arterial blood gas measurements confirmed that she had Type II respiratory failure with respiratory acidosis and her oxygen levels were too high. Consequently, her inspired oxygen was reduced which was the appropriate first step in managing this problem and in addition to reducing her inspired oxygen concentration the target for her oxygen levels was set at 88-90% which is in keeping with the BTS Acute Oxygen guidelines'*. The CRP further explained that '*this action resulted in a further improvement in her arterial blood gas measurements but since there was not enough of an improvement, she was given a trial of non-invasive ventilation. Again, this would be in keeping with the guidelines for management of Type II respiratory failure…but she found this treatment difficult to tolerate and ultimately it was abandoned*'.

26. The CRP explained that the patient had '*frequent measurements of her arterial blood gases and the pattern that emerged was that she was very sensitive to increases in her oxygen therapy which again would be consistent with severe underlying COPD. During this period, the steps taken to try and maintain adequate oxygenation were appropriate and the monitoring of the effect of this treatment was also appropriate'*.

27. The CRP further explained that '*it is true to say that at the time of her initial deterioration, the administration of 5-litres of oxygen via nasal cannula was reasonable but nevertheless contributed to her Type II respiratory failure at that time. However, this was recognised very quickly and corrected. I do not believe that it was in any way a causative factor in her subsequent death. I believe the in-hospital management was appropriate'*.

Relevant Independent Professional Advice

28. As part of investigation enquiries, the advice of an Ortho-geriatrician physician was obtained (OG IPA).

29. The OG IPA agreed that it was appropriate for the patient to be admitted to the fractures ward upon her arrival to the RVH. He further agreed that it was

appropriate for the patient to return to the fractures ward following her surgery on 7 December 2013.

30. The OG IPA was asked if the patient was reviewed by a respiratory specialist once her SATS[6] levels started to fluctuate on 11 December 2013. He advised that '*oxygen saturations (SATS) are liable to vary especially in the patient with COPD, as [the patient] was. It is within the competence of a generalist doctor to understand/interpret and manage SATS. [The patient] was being looked after by the medical/orthogeriatric team on the fracture ward following hip surgery. That was perfectly in order. And the care cannot be faulted. There was no need to involve a respiratory specialist at that stage'*.

31. The OG IPA was asked if the decision to administer five litres of oxygen to the patient on 14 December 2013 was appropriate. He advised that '*the expectation in managing the oxygenation status is to keep the SATS from dropping below 88-92%. Increasing the inspired oxygen to 5 litres / minute is entirely appropriate. And it can be managed on any ward including a fracture ward in hospital. This is in keeping with guidance from the British Thoracic Society (BTS). Her blood gases showed improvement when it was repeated at 2155 hrs on 14/12/13. When she became tachypneic (= increased rate of respiration) it was because she had developed likely chest infection (pneumonia). Her heart rate and white blood cell count had increased, suggesting probable infection. BUT [his emphasis] there is evidence also that the infection was getting under control because the CRP[7] [C-reactive protein] was coming down and the chest x-ray showed improvement too on 15/12/13'*.

32. The OG IPA advised that there was no requirement at that stage for the patient to be reviewed by a respiratory specialist. He advised that '*there were no real concerns and the team that was looking after her have demonstrated clearly that her care was as per textbook…there is no evidence that her management was in any way compromised by being on the fracture ward under the care of the medical/orthogeriatric team. There is no requirement to transfer care to the respiratory team when the care being provided was perfectly all right. Besides it*

[6] Oxygen saturation measures the percentage of oxygen present in the blood.
[7] A high level of CRP in the blood is a marker of inflammation.

is well recognised that frequent moves by post-operative patients can by itself cause/aggravate delirium[8]'. The OG IPA advised that it was appropriate for the clinical team to continue treating the patient with oxygen therapy at that stage. He advised that '*the patient had background COPD. It is perfectly reasonable to expect her to be on oxygen in order to maintain her oxygen SATS in the range of 88-92%. This is in keeping with BTS guidelines*'.

33. The OG IPA advised that the decision to start the patient on a trial of non-invasive ventilation on 15 December 2013 was '*reasonable and appropriate'*. In relation to the absence of a respiratory specialist review, he advised that a '*respiratory review was not necessary at that stage...she was seen by the medical registrar while she was still on the orthopaedic ward. At 0035 hrs on 16/12/13, having considered the options, it was decided that it was best for the patient to remain under the care of the orthopaedic team. And given the fact that she was an orthopaedic patient it was correctly stated that that team would have to decide the ceiling of care… the patient was duly seen by the Respiratory Nurse Specialist (RNS) on the same day, 16/12/13. The RNS did not recommend transfer of care on that day after reviewing the patient'*.

34. The OG IPA was referred to the decision to transfer the patient temporarily to the Acute Medical Unit (AMU) on 15 December 2013 for the NIV trial. He advised that '*it was appropriate for NIPPV [NIV] to be carried out where the right facilities were to hand. That was customary procedure at the Trust and perfectly acceptable'*. The OG IPA further advised that '*the transfers to and return from AMU is not precisely stated in the notes…it appears that she tolerated NIV for 7 hours but then felt claustrophobic. The entry by the Staff Doctor on 16/12/13 says he noted the events that weekend. The entry on 16/12/13 says she was sent to AMU for NIPPV and was returned to fracture ward. So one can deduce she returned on 16/12/13*'.

35. The OG IPA was referred to an entry in the patient's clinical records made by the CCOT. The record documented a recommendation for the patient to be transferred to a ward for respiratory support. The OG IPA advised that '*it is not*

[8] A condition that starts suddenly in someone who is unwell and results in confused thinking and reduced awareness of the environment.

evident from the notes that this was immediately taken on board by the medical team in that she was not promptly transferred to a respiratory ward...she was however then seen by the RNS [respiratory nurse specialist] on 16/12/13 itself. The RNS did not suggest transferring care to the respiratory ward and wrote instead that she would refer the patient to community respiratory team and district nursing for on-going chronic disease management on discharge. In fact, the RNS did not think that she would need NIV again on the night of 16/12/13'.

36. The OG IPA was referred to the complaint that the patient's care ought to be transferred to a respiratory specialist earlier than 23 December 2013. He advised that '*management post-operatively was being adequately carried out by the medical/orthogeriatric team. Their decisions were evidence based and as per accepted protocols and hence cannot be faulted. There is evidence that the CCOT and RNS had previously been involved in her care. There is an entry on 17/12/13 suggesting respiratory review. Accordingly she was seen by the RSN that same day at 1030 hrs and she did ask for a respiratory review on this occasion. The respiratory Specialist Registrar saw her promptly within 20 minutes at 1050 hrs. He had discussed with the consultant who was content with providing "advise (sic) on ventilator issues as long as is necessary but not for take over care at present." Therefore the respiratory team were consulted earlier than 23/12/13 but did not feel that her care needed to be transferred to themselves when they were contacted on 17/12/13'*.

37. In relation to the overall care and treatment of the patient during her stay on the fractures ward between 5 and 23 December 2013, the OG IPA advised that '*records show that the medical care was entirely reasonable, appropriate and in keeping with the Blue Book and appropriate standards'*.

38. As part of investigation enquiries, the advice of an independent respiratory physician was also obtained (R IPA).

39. The R IPA was referred to the clinical record, dated 17 December 2013, which documents that a Specialist Registrar (respiratory) discussed the patient with Dr B, a Respiratory Consultant following his review. In response, the R IPA referred to the BTS guideline for the use of NIV. He advised that '*the local*

Trust policy for the use of NIV states that patients are treated with NIV in designated areas which at the RVH are wards 5E/5F (respiratory) and wards 7B/7C (AMU). According to the records, [the patient] was moved to the AMU on 15 December 2013 to start NIV. I am not able to determine from the records if/when she was transferred back to the orthopaedic ward. If [the patient] received NIV on the Orthopaedic ward then this is in contravention to the Trust policy and to the BTS guidance'.

40. In relation to the decision for the patient to remain on the fractures ward, the R IPA advised that '*it is not clear why [Dr B] advised on 17 December 2013 that [the patient] stay under the orthopaedic team. The over-riding threat to [her] life at that time was lung failure due to pneumonia and COPD which was proving difficult to treat with NIV. It is usual practice for Respiratory physicians to take over the care of these patients. The records state that on the 23 December 2013, Dr A agreed with Dr B that Dr B would take over care of the patient'*.

41. The R IPA concluded that the patient '*developed post-operative pneumonia which together with her COPD led to lung failure. NIV appears to be [have] been delivered in an inappropriate location and not under a respiratory team, which represents a failing in care. There was an opportunity for the patient to be reviewed by a medical member of the ITU [intensive therapy unit[9]] team to determine if the treatment could be given on HDU [high dependency unit] or ITU. This did not happen and represents a failing in care. The care of [the patient], and the communication with her daughter would be (sic) have been improved if she had been on a respiratory ward under a respiratory team. However I do not see any evidence that this contributed to her demise once she left hospital'*.

42. In relation to learning, the R IPA advised that the Trust ought '*to consider updating the NIV policy to ensure that it reflects current guidance, including the 2017 NCEPOD report…in terms of which patients receive ward based NIV and who should be referred to HDU/ITU for NIV treatment'*. The R IPA also advised that the Trust ought '*to consider updating the NIV policy to ensure that all*

[9] Also referred to as intensive care units (ICU).

patients started on ward based NIV are taken over by a respiratory consultant the next working day'.

43. As part of investigation enquiries, the advice of an independent Critical Care Nurse was also obtained (N IPA).

44. In relation to the care and treatment the CCOT provided to the complainant, the N IPA advised that '*the care provided by the CCOT was brief. [The patient] was supported by the team whilst receiving Non Invasive Ventilation in order to correct her type 2 respiratory failure. The critical care outreach nurse ensured referral to [an] appropriate respiratory specialist nurse was made for further management of her respiratory needs. Outreach did not review once the patient was stable and nursed in an appropriate ward'*.

45. The N IPA advised that *'the CCOT would have become involved in the care of the patient potentially for several reasons:*
    - *There was a noted deterioration in oxygen saturations, which was becoming difficult to manage despite appropriate attempts.*
    - *There would have been an increase in the patients National Early Warning Score, which as part of a deteriorating patient policy would have ensured a referral should be made to the CCOT.*
    - *The ST6[10] doctor […] suggested a trial of Non Invasive Ventilation which is part of the CCOT role (ward nurses are not trained in the use of NIV this is a specialised role).*
    - *The orthopaedic staff may have wanted extra support and guidance to help manage the patient's condition.*
    - *CCOT also respond to gut feeling'*.

46. In relation to the trial of NIV started for the patient, the N IPA advised that the '*CCOT would respond to a request for a trial of NIV and if indicated would commence treatment. This would only be considered following discussion with a doctor, review of the patient and review of blood gases. It would appear that*

[10] Speciality Registrar.

routine practice was followed when treating the patient. The critical care outreach nurse would try to remain with the patient during this trial to ensure the patient can tolerate NIV or until they are moved to a more appropriate area'.

47. In relation to the CCOT's recommendation made on 16 December 2013 for the patient to be transferred to a ward for respiratory support, the N IPA advised '*this recommendation was appropriate and is based on proposals firmly established from the Department of Health document Comprehensive Critical Care- A review of Adult Critical Care Services (2000). The guidelines have remained unchanged and all CCOT adhere to this document. The focus remains on the needs of the patient ensuring they receive the right care regardless of location and at risk patients are moved to an appropriate area of safety as soon as possible'*.

48. In relation to the CCOT's overall care provided to the patient, the N IPA advised that it '*was reasonable and appropriate and in accordance with National Institute for Health and Care Excellence [NICE] (CG101 2010) guidance'*. She further advised that it was '*appropriate and well managed. The CCOT reviewed the patient regularly, ensured the patient was moved to an appropriate ward and referred to a specialist respiratory nurse to continue the care of the patient'*.

The complainant's response to a draft copy of the report

49. A draft copy of this report was shared with the complainant and she provided her comments. She believed that the medical team administered 10 litres of oxygen to her mother rather than the maximum of five litres recorded. She explained that a cardiologist in the hospital informed her that this amount would have been 'deadly' to her mother.

50. The complainant also referred to the level of oxygen administered to her mother given her low body mass index (BMI). She commented that there was a '*failure to monitor the correct level [of oxygen] given, taking into account her weight and height…her weight was 5 ½ stone on admittance and 5 stone on death'*.

51. The complainant explained that her mother was not monitored while she was

on the Fractures ward. She also explained that she informed the medical team on 21 December 2013 that her mother was hypoxic[11]. However she was left in the room without any intervention.

Further Independent Professional Advice received

52. Further advice from the Ortho-geriatrician physician (OG IPA) was obtained following receipt of the complainant's comments on a draft copy of this report. The OG IPA advised, '*in adults, oxygen is prescribed based on blood oxygen saturation measured by a small device called a pulse oximeter applied to the fingertip or by arterial level of oxygen in the blood. The aim is to keep the saturation levels at 94-98% or 88-92% depending on whether the patient has COPD or not. Inspired oxygen administered is increased or decreased to attain the desired target oxygen saturation. Body weight or BMI do not come into the reckoning and is irrelevant because treatment/prescription is based on achieving the correct oxygen saturation in a given patient'*.

Analysis and Findings

Decision to treat the patient on the fractures ward

53. The complainant was unhappy about the decision to treat her mother on a fractures ward despite her experiencing respiratory issues. I note from the clinical records that the patient had a neck of femur fracture which required surgery. She was transferred from the AAH and admitted to the fractures ward at the RVH on 5 December 2013 to undergo the required surgery. I further note that she returned to this ward following her surgery. I note that the Blue Book states that *'all patients with hip fracture should be admitted to an acute orthopaedic ward within 4 hours of presentation*'. Having considered the guidelines, I accept the OG IPA's advice that '*it was appropriate for the patient to be admitted to the fractures ward…upon her arrival to the RVH'*. Furthermore, I accept the OG IPA's advice that '*it was appropriate for the patient to return to [the fractures ward] following her surgery on 7 December 2013'*.

[11] Hypoxia is a condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level.

54. I note that the Blue Book states that *'all patients presenting with a fragility fracture should be managed on an orthopaedic ward with routine access to acute orthogeriatric medical support from the time of admission*'. Having reviewed the patient's clinical records, I note that she remained on the fractures ward under the care of her surgeon. I further note that Dr A, a consultant in ortho-medicine, also treated her during her stay on the fractures ward. Having considered the guidelines stated in the Blue Book, I accept the OG IPA's advice that '*there is no evidence that her management was in any way compromised by being on the fracture ward under the care of the medical/orthogeriatric team*'. I consider that the decision to continue treatment of the patient following her surgery, with Dr A's input, was reasonable, appropriate and in accordance with relevant guidelines.

55. The complainant said that her mother continued to be treated on the fractures ward despite experiencing respiratory issues following the surgery. Furthermore, she complained that a respiratory consultant did not take charge of her care and treatment until two weeks after she started to experience difficulties [23 December 2013]. I note from the patient's clinical records that she was trialled on NIV on 15 December 2013. I further note that the Trust's NIV policy recommends that the patient ought to be referred to the Acute Team Medical Registrar and the Respiratory Nurse. It also states that patients ought to be '*treated with NIV in **designated areas'** [emphasis in policy]*, which are the AMU and respiratory wards.

56. I note that the trial of NIV was commenced following the Acute Team Medical Registrar's review. I also note that the CCOT monitored the trial at ward level. I further note that the patient was temporarily transferred to the AMU to facilitate this trial and she was referred to a respiratory nurse by the CCOT. Having reviewed the Trust's NIV policy and the patient's clinical records, I consider that the decision to transfer the patient to the AMU to facilitate this trial was appropriate.

57. I note that the patient was subsequently returned to the fractures ward further to her having difficulty tolerating the NIV treatment in the AMU. However, the records document that the patient was administered NIV again while remaining

on the fractures ward following a review by the respiratory team on 17 December 2013. I note that the respiratory team agreed to manage the patient's ventilator use but not take over her care at that stage.

58. I note the BTS guideline on the use of NIV, which states that '*NIV can be provided in a number of locations including the ICU, a high dependency unit (HDU), or a respiratory ward*'. I further note the Trust's NIV policy, which states that NIV ought to be administered in '*designated areas'*, which does not include the fractures ward. Having reviewed the relevant guidelines and the patient's clinical records, I accept the R IPA's advice that *'the over-riding threat to [the patient's] life at that time was lung failure due to pneumonia and COPD which was proving difficult to treat with NIV. It is usual practice for Respiratory physicians to take over the care of these patients…NIV appears to be [have] been delivered in an inappropriate location and not under a respiratory team, which represents a failing in care*'. I consider that the respiratory team ought to have transferred the patient to an appropriate ward to administer the NIV and manage her respiratory failure, in accordance with relevant guidelines. However, the team did not transfer the patient, nor did they take over her care at this stage. **Therefore, I uphold this element of the complaint.**

59. In relation to the impact this failing had on the patient, I accept the R IPA's advice that there is no '*evidence that this contributed to her demise once she left hospital'*. Therefore, I am unable to conclude that the decision not to transfer the patient to a respiratory ward from 17 December 2013 contributed to the deterioration in her health. However, I consider that the patient experienced injustice as a consequence of this failing. I consider that the patient experienced the loss of opportunity for her respiratory failure to be treated on a specialist ward from 17 December until 23 December 2013.

60. I note that in her response to a draft copy of this report, the complainant explained that her mother was not monitored while she was on the Fractures ward. I note from the clinical records that arterial blood gas analyses were regularly undertaken, as well as medical observations. Therefore, I consider that the patient was monitored during her time on the Fractures ward.

61. The complainant also explained that she informed the medical team on 21 December 2013 that her mother was hypoxic. However, she was left in her room without any intervention. The clinical records do not document this particular interaction. I note that the clinical records, dated 21 December 2013, document that the patient experienced respiratory difficulties and was treated with NIV. I also note that she was reviewed by two doctors and a chest physiotherapist, who documented that the patient improved following the NIV treatment. Based on the records available, on the balance of probabilities, I consider that the medical team intervened when the patient experienced respiratory concerns on 21 December 2013.

The level of oxygen administered to the patient

62. The complainant said that the medical team administered an excessive level of oxygen to her mother while she was on the fractures ward. I note from the clinical records that the patient was administered five litres of oxygen on 14 December 2013. I note in her response to a draft copy of his report, the complainant explained that she believed her mother was administered 10 litres of oxygen rather than the five litres recorded. I am unable to find a reference to this level of oxygen being administered to the patient. Furthermore, I am unable to find a record of the comment the complainant said that a cardiologist made to her about the level of oxygen being '*deadly*' for her mother. Based on the evidence available, I consider that the patient was not administered more than five litres of oxygen during her stay in the RVH at one time.

63. I note that the NICE guidelines for COPD recommends that *'people receiving emergency oxygen for an acute exacerbation of chronic obstructive pulmonary disease (COPD) have their oxygen saturation levels maintained between 88% and 92%'.* In relation to the level of oxygen administered to the patient, I note that neither the Trust's emergency oxygen policy nor the BTS guidelines (as referred to by the OG IPA) recommend a particular level of oxygen to be administered to patients. However, both the policy and the guidelines state that *'oxygen should be prescribed to achieve a target saturation of…88–92% hypercapnic respiratory failure*'. The policy also states that '*patients with COPD*

and other risk factors for hypercapnia who develop critical illness should also be given high concentration oxygen therapy whilst awaiting immediate medical review and pending the results of urgent blood gas results'.

64. I note from the clinical records that the medical team's plan was to maintain SATS levels for the patient at 88% to 92%. However, the records document that the patient's SATS level was at 96% and 97% in the days following her surgery. I note that the medical team reduced the oxygen level administered to the patient following the results of an arterial blood gas analysis, which showed increased levels of carbon dioxide in her blood. I note from the clinical records that her SATS level reduced to 90% following this action, which is within the target range. I further note that the medical team continued to monitor the patient's SATS and changed the level of oxygen administered to achieve the target SATS level required.

65. I note the CRP's report of his investigation into the treatment provided to the patient in which he explains that '*the administration of 5-litres of oxygen…was reasonable'*. I also note the OG IPA's advice that *'the expectation in managing the oxygenation status is to keep the SATS from dropping below 88-92%. Increasing the inspired oxygen to 5 litres / minute is entirely appropriate'.* I note that in her response to a draft copy of this report, the complainant raised concerns with her mother's low BMI and the level of oxygen administered to her. However, I also note the OG IPA's advice that *'body weight or BMI do not come into the reckoning and is irrelevant because treatment/prescription is based on achieving the correct oxygen saturation in a given patient'.* Having reviewed the BTS Guideline, I accept the advice provided by the OG IPA. I consider that the medical team's decision to administer five litres of oxygen to the patient at that time was reasonable, appropriate and in accordance with relevant guidelines.

66. I note that the CRP considered that the level of oxygen initially administered to the patient [five litres] '*contributed to her Type II respiratory failure at that time'.* However, I also note that the CRP explained that the clinical team took steps to '*try and maintain adequate oxygenation'* and that the '*monitoring of the effect of*

this treatment was also appropriate'. Having reviewed the clinical records and the independent professional advice provided to me, I consider that the administration of this level of oxygen to the patient did contribute to her respiratory failure. However, I also consider that this was recognised by the clinical team and appropriate action was taken in accordance with the BTS Guideline. I accept the OG IPA's advice that '*the overall management of oxygen and respiratory care cannot be faulted'.* **Therefore, I do not uphold this element of the complaint.**

Issue 2: Was the communication with the patient, the complainant and her family reasonable during the patient's admission to Ward 5F (Fractures)?

Detail of Complaint

67. The complainant said that the family were not asked for their consent nor informed that their mother was to undergo surgery. Furthermore, she complained that the family were not informed that the patient experienced three instances of atrial fibrillation[12] (AF) or that she was diagnosed with Type II respiratory failure. She also complained that a doctor did not speak with the family until 12 December 2013 despite their requests to speak with a doctor for the six days previous.

Evidence Considered

Legislation/Policies/Guidance

68. I refer to the following legislation policies and guidance which were considered as part of investigation enquiries. I have highlighted the relevant extracts as follows:
    i. I considered the GMC's guidance on consent. I identified the following relevant extracts:

    'Partnership…

    6. If patients are not able to make decisions for themselves, the doctor

[12] A heart condition that causes an irregular and often abnormally fast heart rate.

must work with those close to the patient and with other members of the healthcare team. The doctor must take into account any views or preferences expressed by the patient and must follow the law on decision-making when a patient lacks capacity.

Reasons for not sharing information with patients

13. No one else can make a decision on behalf of an adult who has capacity. If a patients asks you to make decisions on their behalf or wants to leave decisions to a relative, partner, friend, carer or another person close to them, you should explain that it is still important that they understand the options open to them, and what the treatment will involve…

Sharing information…

21. You should check whether a patient needs any additional support to understand information, to communicate their wishes, or to make a decision. You should bear in mind that some barriers to understanding and communication may not be obvious; for example, a patient may have unspoken anxieties, or may be affected by pain or other underlying problems. You must make sure, wherever practical, that arrangements are made to give the patient any necessary support. This might include, for example: using an advocate or interpreter; asking those close to the patient about the patient's communication needs; or giving the patient a written or audio record of the discussion and any decisions that were made.

Advance care planning

57. If a patient: …b. has a condition that will impair their capacity as it progresses, such as dementia…you should encourage them to think about what they might want for themselves in the event that they cannot make their own decisions, and to discuss their wishes and concerns with you and the healthcare team…

59. You should approach such discussions sensitively. If the patient agrees, you should consider involving other members of the healthcare team, people who are close to the patient or an advocate…

Part 3: Capacity issues

The legal framework

62. …In Northern Ireland, there is currently no relevant primary legislation; and decision-making for patients without capacity is governed by the common law, which requires that decisions must be made in a patient's best interests…'.

ii. I considered the GMC's guidance on confidentiality. I identified the following relevant extracts:

'[Standard 9]: When disclosing information about a patient, you must…

c. get the patient's express consent if identifiable information is to be disclosed for purposes other than their care or local clinical audit, unless the disclosure is required by law or can be justified in the public interest…

[Standard 10] When you are satisfied that information should be disclosed, you should act promptly to disclose all relevant information…

[Standard 24]: Seeking a patient's consent to disclosure of information shows respect, and is part of good communication between doctors and patients…

[Standard 64]: You should establish with the patient what information they want you to share, who with, and in what circumstances. This will be particularly important if the patient has fluctuating or diminished capacity or is likely to lose capacity, even temporarily. Early discussions of this nature can help to avoid disclosures that patients would object to. They can also help to avoid misunderstandings with, or causing offence to, anyone the patient would want information to be shared with'.

iii. I considered the GMC's Good Medical Practice. I identified the following relevant extract:

'[Standard 33]: You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support'.

iv. I considered the Trust's policy for obtaining consent. I identified the following relevant extract:

'What consent is – and isn't

…Where an adult lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, ***no-one else can give consent on their behalf*** *[emphasis in policy]. However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable advance directive'*.

The Trust's response to investigation enquiries

69. In relation to the complaint about the clinicians' communication with the family, the Trust explained that it is '*very sorry that [the complainant] felt that communication regarding the care and treatment of her mother was unsatisfactory and we understand how this caused the family further anxiety and uncertainty regarding her treatment plan'*. The Trust explained that the clinical records detail that a doctor (Dr C) spoke with the complainant on 12 and 16 December 2013. It explained that Dr A also spoke with the complainant on 16 December 2013. In relation to her complaint that she was not informed that her mother's was to undergo surgery, the Trust explained that it '*apologises that the complainant was not present for her mother's consent for surgery'*.

70. The Trust explained that '*all documented conversations with [the complainant] have been recorded in the patient's inpatient notes…nonetheless, there are occasions, during a patient's care in which more informal conversations take place with relatives that are not documented'*. It further explained that '*there is currently no Belfast Trust policy on "keeping family members informed of their relatives' condition whilst in hospital*"'.

The Trust's records

71. The patient's clinical records provided by the Trust were carefully considered.

72. I considered the patient's records of her admission to hospital. The records document that the patient consented to information being shared with her next of kin [the complainant]. The patient's Plan of Care, written on 6 December

2013, documents that medical staff ought to '*liaise with family'*. The records also document that the patient requested that information required for her admission be obtained from the complainant.

73. I also considered the minutes of a meeting held with the Trust and the complainant in December 2014. In relation to the issue of consent for the patient's surgery, the minutes stated that the '*[Clinical Director, Trauma and Orthopaedics] explained the normal process of consent. If a patient is not capable of consenting, the medical staff would sign the form. He added that many relatives cannot sign on behalf of the patient. A mini mental score would be completed to assess the patient's understanding and capability. [The complainant] said that her mum would have agreed out of respect for doctors as she was old school'*.

74. I further considered the letter the Trust sent to the complainant in response to her complaint. The letter stated that '*you [the complainant] also expressed your concern at the communication from [Dr A] and [Dr C] and I apologise for the anxiety this caused. The [Clinical Director, Trauma and Orthopaedics] has already provided feedback to his colleagues regarding communication, respect and dignity'*.

Relevant Independent Professional Advice

75. As part of investigation enquiries, the advice of an orthopaedic surgeon was obtained (O IPA). The O IPA was referred to the complaint that the patient's family were not informed of her surgery. He advised that '*there is no documentation in the notes that there was any discussion held with the family members of the patient regarding her upcoming surgery. I could not also see any documentation that any effort had been made to contact [the patient's] family prior to her surgery. There is a note on 12th December 2013 that the patient's daughter had been trying to speak to the doctors and she was upset that nobody had spoken to her about her mum. Therefore, it is most likely that the patient's family members were not informed of her upcoming surgery'*.

76. The O IPA was asked if the patient had the mental capacity to consent to her own surgery. He advised that '*the patient's medical records indicate that she had GCS of 15/15 at the time of admission and she was alert and oriented. This would indicate that she was able to communicate well and was fully within her senses and did not demonstrate any signs of dementia…it would be considered good medical practice (irrespective of her early dementia), to inform her family regarding her medical condition and imminent surgery*'.

77. The O IPA was asked if the complainant or a member of her family ought to have been asked for their consent for their mother to have the surgery. He advised that *'according to English law, no one can give legally valid consent to medical treatment on behalf of another adult. As per rules of consent to medical treatment in [Northern] Ireland, "at present, no-one outside the courts can consent to treatment on behalf of an incapacitated adult. However, treatment can – and should – be given if the patient's doctors, in consultation with the patient's relatives and carers, conclude that it is in the patient's best interests." Therefore, either the patient should have been consenting for her own surgery, which she did in this case, or the doctors should have taken this decision in her best interest. However, it would be good practice to discuss this with her family if she was unable to consent herself*'.

78. The O IPA advised that '[*the patient] was able to consent for her own surgery and therefore was alert and oriented. Under the circumstances, there is no obligation on part of the medical team to contact her family to inform them of her surgery, unless the patient specifically requests for this to happen. However, it would be considered as good medical practice for the treating team to inform the patient's family of her surgery unless she had specifically requested for this not to happen'*. He further advised that '*it is the responsibility of the treating team to inform the family. This could be anyone from the senior medical team to the junior medical team. Once the family were informed, they would most likely wish to speak to the relevant medical personnel and that person should then make themselves available to speak to the family'*.

79. The O IPA was referred to the clinical records, which document that a mini mental score (MMS) of 3/10 was obtained from the patient on 8 December

2013. He advised that this test '*is a set of ten questions designed to give the examiner a rough idea of the mental state of the patient. Each question correctly answered scores one point. A score of 6 or less suggests delirium or dementia, although further and more formal tests are necessary to confirm the diagnosis… this acts as a rough guide to the medical team regarding a patient's cognitive status and a score of 3 would indicate patient is unable to retain or process information pertinent to her treatment'*. He further advised that '*an MMS score of 3/10 would indicate that the patient was not in a position to make sound judgement regarding her treatment at that stage and her medical team would need to take action in her best interests based on their own judgement. The team should ideally involve the patient's family in the decision-making process, given that the patient was unable to do this for herself at that time'*.

80. The O IPA was referred to the complaint that the family were not informed that the patient experienced three occurrences of AF or that she was diagnosed with Type II respiratory failure. He advised that '*medical notes indicate there was a discussion with the patient's daughter and Dr C on 12/12/13 but this does not clarify whether daughter was told of the multiple AF and Type 2 respiratory failure. Next documented discussion with daughter by [Dr C] on 16/12/13 wherein a detailed discussion was had but exact contents not all documented'*.

81. The O IPA was also referred to the complaint that a doctor did not speak to the family until 12 December 2013. He advised that '*there is a note on 12th December 2013 from nurses as well as [Dr C] separately that the patient's daughter was unhappy as she had been had been trying to speak to the doctors and nobody had been informing her as to what's happening with her mum*'. The O IPA further advised that '*the medical notes do not document any discussion with the family till 12/12/ 13. There is a note on 12th December 2013 from nurses as well as [Dr C] separately that the patient's daughter was unhappy as she had been had been trying to speak to the doctors and nobody had been informing her as to what's happening with her mum. Therefore it appears that the patient's family were not spoken to by a doctor till this time'*.

The O IPA advised that '*someone from the medical team should have spoken to the patient's family prior to her surgery and certainly prior to December 12th'*.

82. The O IPA advised that '*it is extremely important to keep family informed regarding a patient's treatment and in particular any surgery that a patient is required to undergo, even more so if the surgery is happening on an urgent basis. I cannot satisfy myself in the above case that this had happened or that reasonable steps had been taken to inform the patient's family of her imminent surgery. [The patient] could have developed complications during or following her surgery and therefore it was important to keep the family aware of this at all times. Irrespective of a patient's mental capacity or physical condition, unless the patient had indicated at some stage when they were fully alert and oriented that they did not wish to keep their family informed, it is the duty of the treating team to keep the family regularly informed of a patient's progress as per the Good Medical Practice guidelines'*.

83. As part of investigation enquiries, the advice of an ortho-geriatrician was obtained (OG IPA). The OG IPA was referred to the complaint that the family were not informed that the patient was to undergo surgery. He advised that '*the team should have informed the NOK [next of kin]…there is no record of communication with NOK re the planned surgery. [The patient] was found capable of giving consent and had duly consented. This has been properly documented. So the operation was legal. It would have been good practice to keep NOK informed. There is no record that this happened. BUT again, after her mother being brought to hospital following a fall at home, one would have assumed that NOK would be on the ward chasing up for news regarding her mother. [The complainant] did say on 12/12/13 that she was trying to contact the doctors. Yet she would have been able to get news from the nurses on the ward. They could have given her some information or pointed her in the right direction and they would normally also [have] found a doctor who could talk to her. If NOK had approached the nursing team, asking for information or asking to talk to the doctors, I would have expected mention of this in the nursing record. The nursing record does not document any encounters / interactions with [the complainant] or any others of her family prior to 12/12/13'*.

84. The OG IPA agreed that the medical team had a duty to inform the patient's family of the surgery. He advised that '*it should not be done without their knowledge. Medical records do not provide evidence that the family were contacted prior to surgery. However, I am willing to put the onus equally on the family in that one would expect them reasonably to make contact with the hospital or medical or nursing staff regarding the progress of or plans for her treatment following the fall at home'*.

85. The OG IPA was asked if he considered that the patient had the mental capacity on 5 December 2013 to provide her consent for the surgery. He advised that '"*Form 1 Consent for examination, treatment or care" was administered to the patient by a consultant orthopaedic surgeon. On its first page…are stated the tests of mental capacity. Going by that consent form, I take it that the consultant was not remiss in administering and obtaining consent when she lacked capacity to do so….I have to therefore accept that she had the capacity because the form is signed by the consultant orthopaedic surgeon as the "responsible healthcare professional" and I take it that means that in his opinion she was competent at the time'*.

86. The OG IPA agreed that the medical team ought not to have obtained the family's consent for the patient's surgery. He advised that '*in the case of a patient who has mental capacity, only the patient can give consent. There are no circumstances that the family can give consent on behalf of an adult with capacity…when the patient is not capable of giving consent by lack of capacity it is open to the clinician to act in her best interests and perform the necessary procedure/operation. Consent of NOK/family is not required even though it would be good medical practice to keep them in the loop regarding treatment of their mother'*.

87. The OG IPA advised that the mini mental score obtained (MMS) is the '*abbreviated mental test score (AMTS) and it [a score of 3/10] suggests the presence of delirium or dementia. I agree that further tests are required if one were required to make a definitive, formal diagnosis of delirium or cognitive impairment…I agree that the patient was probably suffering from a state of*

confusion/ delirium/ cognitive impairment. Communication would need to be had with NOK. This was to be [the complainant'].

88. The OG IPA further advised that '*AMTS only points to a state of confusion or cognitive impairment. No specific action is called for except awareness of the patient's mental state. If there was a question of consent being required, should she not have capacity, the medical/surgical team would have to act in her best interests, keeping her daughter informed re the situation/decisions. Yet, it must be noted that she may have capacity to consent even though she may be confused. The doctor who administers the consent form [for the surgery] has to satisfy himself that the patient has the capacity to consent. If she were to develop any deterioration or improvement, the base line AMTS of 3/10 would indicate if the score had changed in either direction'.*

89. The OG IPA was referred to the complaint that the family were not informed that the patient experienced three instances of AF and was diagnosed with Type II respiratory failure. He advised that the '*ECG taken on 8/12/13 is reported in the notes as being in normal rhythm. [The patient] was not continuously in atrial fibrillation (AF) after it first developed possibly on 11/12/13. AF can sometimes be provoked by chest infection, which is what the patient developed post-operatively. On 13/12/13 ECG was said to be in normal rhythm. It remained so on 14/12/13. On 15/12/13 she was back in AF. As she was flipping between AF and normal rhythm, the condition is called paroxysmal atrial fibrillation[13] (PAF). Type 2 respiratory failure (T2RF) was diagnosed when the arterial blood gas shows low oxygen concentration and high carbon dioxide in the blood T2RF occurs commonly in patients with COPD and was unrelated to the hip surgery*'.

90. The OG IPA further advised that '*it was necessary to update [the complainant] being her mother's NOK concerning her progress following surgery and other related health matters. the complainant met [Dr C] on 12/12/13. At that time she mentioned she was having PAF and possible chest/urinary sepsis. [Dr C] was correct in telling the daughter concerning her mum's health. The note states the*

[13] PAF occurs when a rapid, erratic heart rate begins suddenly and then stops on its own within 7 days.

complainant had power of attorney. It does not specify if it covers health as well as finances[14]. At that point the complainant was keen to take her mother home and was not keen for her to have rehabilitation following hip surgery. [Dr C] did not tell her that she had T2RF [Type II respiratory failure]'. The OG IPA advised that *'as the patient was in a state of confusion the team should rightfully have discussed matters concerning her mother's health and progress after operation etc. with the complainant in her position as NOK. Inexplicably, this does not appear to have occurred'.*

91. The OG IPA was referred to the complaint that a doctor did not speak with the family until 12 December 2013. He advised that '*according to the notes, [the] first discussion with a doctor is documented on 12/12/13. There is no record of any earlier discussion with a doctor. On 11/12/13 the dietitian writes about her conversation with the patient's daughter at 1520 hrs…there is the note of 12/12/13 that [the complainant] was "unhappy" that she had been asking to talk to doctor. [Dr C] has noted "I was unaware of this". It is not immediately clear as to when and from whom [the complainant] had sought information'*. The OG IPA further advised that '*it is a fact that there is no record of such [a] conversation prior to 12/12/13. As [the complainant] is next-of-kin then the onus is on the medical/surgical team to keep her informed…the medical team were wrong if they had not spoken with [the complainant] as her NOK'*. In conclusion, the OG IPA advised that the *'lack of communication with the NOK was an inexplicable lapse'*.

92. The OG IPA was asked if the medical team's communication with the patient was appropriate. He advised that '*I have had sight of the consent form and in the Trauma Coordinator check list has a tick against consent which confirms suggests consent had have been obtained from the patient. The notes concerning the consent for surgery specifically states what exactly was explained to the patient about the operation and the risks and possible complications'*.

[14] Power of attorney for health is not relevant in Northern Ireland.

Analysis and findings

93. The complainant said that the medical team failed to communicate effectively with her and her family about her mother's care and treatment. In particular, she complained that the medical team failed to inform the family that the patient was to have surgery and they failed to obtain their consent for the surgery. She also complained that the family were not informed that their mother experienced three instances of atrial fibrillation (AF) and Type II respiratory failure following her surgery. She further complained that a doctor did not provide her with an update on her mother's care and treatment until 12 December 2013. This was a week after the patient's admission to the RVH.

Communication with the patient's family prior to surgery (7 December 2013)

94. I considered the complaint about the medical team's failure to obtain consent for the patient's surgery from the family. I note that consent for surgery was obtained from the patient on 5 December 2013 and she underwent the surgery on 7 December 2013. I also note the GMC's guidance on consent, which states that '*no one else can make a decision on behalf of an adult who has capacity*'. It also states that *'in Northern Ireland, there is currently no relevant primary legislation; and decision-making for patients without capacity is governed by the common law, which requires that decisions must be made in a patient's best interests'*. Furthermore, I note the Trust's policy for obtaining consent, which states *'where an adult lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves,* ***no-one else can give consent on their behalf*** *[emphasis in policy]'.* I note that there is no evidence in the patient's clinical records to suggest that she lacked the mental capacity prior to her surgery to provide consent.

95. Having reviewed the patient's clinical records and relevant guidance, I accept the O IPA's advice that '*either the patient should have been consenting for her own surgery, which she did in this case'.* I also accept the OG IPA's advice that '*there are no circumstances that the family can give consent on behalf of an adult with capacity*'. I consider that the surgical team's decision to obtain consent from the patient, rather than from the complainant or her family, was

reasonable, appropriate and in accordance with relevant guidelines. **Therefore, I do not uphold this element of the complaint.**

96. The complainant also said that her family were not informed that their mother was to undergo surgery on 7 December 2013. In relation to this element of the complaint, I considered Standard 33 of the GMC's Good Medical Practice, which states that '*you must be considerate to those close to the patient and be sensitive and responsive in giving them information and support'*. I also considered the GMC's guidance on confidentiality. I note that Standard 9c states '*get the patient's express consent if identifiable information is to be disclosed for purposes other than their care or local clinical audit'.* I also note Standard 64 of this guidance, which states that '*you should establish with the patient what information they want you to share, who with, and in what circumstances'*. I note that it is documented in the patient's clinical records that she consented to information being shared with her next of kin [the complainant]. I further note that the patient's Plan of Care, written on 6 December 2013, documents that medical staff ought to '*liaise with family'*. It is also documented that the patient requested that information required for her admission be obtained from her daughter. Based on the information documented in the patient's clinical records, I am satisfied that she provided her consent for information relating to her care to be shared with the complainant as her daughter and next of kin.

97. I note from the patient's clinical records that there is no evidence to suggest that the upcoming surgery was discussed with the complainant prior to it taking place. I accept the O IPA's advice that '*I cannot satisfy myself in the above case that this had happened or that reasonable steps had been taken to inform the patient's family of her imminent surgery'.* Therefore, I consider that the medical team treating the patient failed to inform her daughter that she was to undergo surgery.

98. In relation as to whether or not this was reasonable, I note the O IPA's advice that '*the patient could have developed complications during or following her surgery and therefore it was important to keep the family aware of this at all times'*. However, I consider that this information ought only to have been

shared following consent from the patient in accordance with the GMC's guidance on confidentiality. I have already established, in paragraph 90 of this report, that I am satisfied that the patient provided consent for her care to be discussed with the complainant as her daughter and next of kin. Therefore, I consider that in this instance, the medical team treating the patient ought to have informed the complainant of her mother's upcoming surgery. **I uphold this element of the complaint.**

Communication with the patient's family following her surgery

99. I note from the clinical records that an abbreviated mental test score (AMTS) of 3/10 was obtained from the patient on 8 December 2013 (the day following her surgery). I note the O IPA's advice that '*further and more formal tests are necessary to confirm the diagnosis [of delirium]'*. There is no evidence in the clinical records to suggest that additional tests were undertaken to confirm that the patient did not have the mental capacity to make decisions about her care. However, I am satisfied, based on the AMTS obtained, that the patient's mental capacity was under question following her surgery.

100. I considered that neither the complainant nor her family were informed that their mother experienced three instances of AF and that she was diagnosed with Type II respiratory failure. I note the OG IPA's advice that the patient experienced '*paroxysmal atrial fibrillation (PAF)'*. I further note the record of the discussion between Dr C and the complainant that occurred on 12 December 2013. The records document that Dr C '*explained situation yesterday [11 December 2013]. PAF + sepsis ?urine ?chest'*. I accept the OG IPA's advice that *'at that time she [Dr C] mentioned she [the patient] was having PAF and possible chest/urinary sepsis. Dr C was correct in telling the daughter concerning her mum's health'.* Therefore, I consider that the complainant was informed by Dr C that her mother experienced PAF (intermittent AF).

101. In relation to the patient's diagnosis of Type II respiratory failure, I note the OG IPA's advice that this was diagnosed '*when the arterial blood gas shows low oxygen concentration and high carbon dioxide in the blood'.* I note from the clinical records the arterial blood gas analysis taken on 14 December 2013 was

the first documented record of increased carbon dioxide in the patient's blood. I would have expected that if this information was shared with the complainant, the discussion would have been documented in the clinical record. However, the clinical records do not provide evidence that the complainant was informed that her mother had respiratory failure. Therefore, I accept the OG IPA's advice that *'[Dr C] did not tell her [the complainant] that she [the patient] had T2RF [Type II respiratory failure]'.*

102. I also considered the complaint that a doctor did not provide the complainant with an update on her mother's health until 12 December 2013. This was one week after the patient was admitted to the RVH. I note that the Trust explained that there may be occasions '*in which more informal conversations take place with relatives that are not documented'*. However, it also explained that the clinical records only document discussions between Dr C and the complainant on 12 and 16 December 2013, and between Dr A and the complainant on 16 December 2013. Therefore, on the balance of probabilities, I am satisfied that a doctor did not speak to the complainant prior to 12 December 2013. I note from the clinical records that the complainant informed the medical team on 12 December 2013 that she had requested to speak with a doctor for six days. However, I also note that these requests are not recorded in the clinical records prior to 12 December 2013. Therefore, I am unable to conclude whether or not the complainant made the repeated requests referred to.

103. In relation as to whether or not this delay in communication with the complainant was reasonable, I considered Standards 6 and 21 of the GMC's guidance on consent. Standard 6 states that *'if patients are not able to make decisions for themselves, the doctor must work with those close to the patient and with other members of the healthcare team'.* Standard 21 states that *'you should check whether a patient needs any additional support to understand information, to communicate their wishes, or to make a decision…this might include, for example:…asking those close to the patient about the patient's communication needs…'.* I accept the OG IPA's advice that *'as the patient was in a state of confusion the team should rightfully have discussed matters concerning her mother's health and progress after operation etc. with the*

complainant in her position as NOK. Inexplicably, this does not appear to have occurred'.

104. I consider that the clinicians treating the patient failed to meet Standards 6 and 21 of the GMC guidance on consent. Given the AMTS obtained on 8 December 2013, the patient's mental capacity was clearly under question following her surgery. Furthermore, it has already been established that the patient previously provided her consent for information to be shared with the complainant as her daughter and next of kin. Therefore, I consider that the medical team ought to have informed the complainant of her mother's diagnosis of respiratory failure. I also consider that they ought to have involved the complainant in the decision making surrounding the care and treatment of the patient post-surgery in accordance with Standards 6 and 21 of the GMC guidance on consent. There is no evidence to suggest that the medical team considered the patient's mental state and took the appropriate steps when making decisions on her treatment. **I uphold this element of the complaint.**

105. I consider that the complainant experienced the injustice of uncertainty and upset as a result of the ineffective communication from the clinicians treating her mother.

CONCLUSION

106. I investigated a complaint about the actions of the Trust regarding the care and treatment provided to the complainant's late mother by the medical team on the fractures ward of the RVH between 5 and 23 December 2013. The complainant also said that the clinical team from the fractures ward did not communicate appropriately with the patient's family.

107. I have not found a failure in care and treatment or maladministration in respect of:

i. The Trust's decision to admit the patient to the fractures ward;
ii. The level of oxygen administered to the patient as part of her treatment on the fractures ward; and
iii. The failure to obtain consent from the complainant or her family for the patient to undergo surgery.

108. The investigation established failures in the medical team's communication with the patient's family in respect of:
i. The decision not to transfer the patient to an appropriate ward from 17 to 23 December 2013 to manage her respiratory failure;
ii. The failure to communicate effectively with the complainant, as next of kin, during her mother's stay on the fractures ward; and
iii. The failure to involve the complainant in the decision making regarding the care and treatment of the patient following her surgery when the AMTS obtained suggested she was suffering from delirium.

109. I am satisfied that the failures identified in this report caused the patient the injustice of the loss of opportunity for her respiratory failure to be treated on a specialist ward from 17 until 23 December 2013. Furthermore, I consider that it caused the complainant to experience the injustice of uncertainty and upset as a result of the lack of communication from the clinicians treating her mother.

110. I shared a draft copy of this report with the complainant and she responded with her comments. I carefully considered the comments made by the complainant. I have not found any new evidence that would cause me to reconsider my findings and conclusions in this case.

111. I also shared a draft copy of this report with the Trust. In its response, the Trust explained that it had reviewed and updated its Non-Invasive Ventilation (NIV) policy. I note that this was implemented in August 2019. I welcome this learning and review already undertaken by the Trust.

Recommendations

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

i. The Trust provide the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the uncertainty, concern and upset caused to her as a result of the failures in communication identified.

113. I further recommend that within **three months** of the date of this report:

i. The findings of this investigation, in relation to communication, ought to be shared with the medical and nursing teams on the fractures ward. This is so that they can reflect on their practice in order that communication can be improved.

114. The Trust accepted my findings and recommendations.

PAUL MCFADDEN
Acting Ombudsman **March 2020**

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.