Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Northern Health & Social Care Trust

NIPSO Reference: 202000487

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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.

Case Reference: 202000487
Listed Authority: Northern Health & Social Care Trust

SUMMARY

This complaint is about care and treatment provided to the complainant's late mother at Antrim Area Hospital. The patient was transferred to a side room on another ward on 27 June 2019. The complainant was concerned staff did not administer fluids to the patient or appropriately monitor her for 24 hours following her transfer. She also raised concerns about staff's communication with her during that time.

The investigation found the patient's recorded fluid intake for 27 June 2019 was below the recommended level. It did not find any evidence to suggest that nursing staff took action to help the patient increase her fluid intake. The investigation identified it was unlikely this had a long lasting effect on the patient's health. However, it established the reduced fluid intake likely caused her discomfort.

The investigation found the decision not to attach the patient to a cardiac monitor appropriate. However, it identified one occasion where nursing staff did not take the patient's clinical observations in accordance with relevant guidance. It also identified that nursing staff failed to deliver fundamental aspects of the patient's care for a period of approximately five hours. It concluded that staff denied the patient access to basic nursing care during that time.

The investigation identified concerns with nursing staff's communication with the complainant. It found they did not inform the medical team of the complainant's request to speak with a doctor. The investigation recognised the upset and uncertainty the failures caused the complainant at an already distressing time.

The investigation found the record keeping for this case of a poor standard. It found that not completing these records led to staff denying the patient the opportunity for other clinicians to consider information about her care and treatment. I recommended the Trust apologise to the complainant for the failures identified. I also recommended actions for the Trust to undertake to prevent the failures recurring.

THE COMPLAINT

1. This complaint is about care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's mother (the patient) in June 2019. It was also about its communication with the complainant.

Background

2. The patient had a history of end stage heart failure and aortic stenosis[1]. After becoming unwell with an infection on 24 June 2019, the Trust admitted the patient to Antrim Area Hospital. The patient was immediately started on the Sepsis Six Pathway[2].

3. The cause of the patient's infection was identified and she was transferred to a side room on ward A1 on 27 June 2019. The complainant's concerns relate to care and treatment provided to the patient in the 24 hours following her move to ward A1. The patient remained in hospital until she was well enough for discharge on 11 July 2019. She sadly died in her nursing home six weeks after her discharge from hospital.

Issues of complaint

4. I accepted the following issues of complaint for investigation:

   Issue 1: Whether Antrim Area Hospital staff provided appropriate care and treatment to the patient on 27 and 28 June 2019.

   Issue 2: Whether the communication between Antrim Area Hospital staff and the complainant on 27 and 28 June 2019 was appropriate and in accordance with relevant guidelines.

INVESTIGATION METHODOLOGY

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

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[1] When the heart's aortic valve narrows.

[2] A set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement, and urine output monitoring, to be initiated within one hour.

Independent Professional Advice Sought

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

    - A consultant physician for over 40 years and an accredited geriatrician for 20 years (G IPA); and
    - A senior nurse practitioner with 20 years nursing and managerial experience across both primary and secondary care (N IPA).

    I enclose the clinical advice received at Appendix two to this report.

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

Relevant Standards and Guidance

8. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional and statutory guidance.

    The general standards are the Ombudsman's Principles[3]:

    - The Principles of Good Administration
    - The Principles of Good Complaints Handling

9. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

    The specific standards and guidance relevant to this complaint are:

    - The General Medical Council's (GMC) Good Medical Practice, as

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

updated April 2014 (the GMC Guidance);

- The Nursing and Midwifery Council's (NMC) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, updated October 2018 (NMC Code);
- National Institute for Health and Care Excellence's (NICE) Chronic heart failure in adults: diagnosis and management, NICE Guideline 106, September 2018 (NICE NG106);
- National Institute for Health and Care Excellence's (NICE) Intravenous fluid therapy in adults in hospital, Clinical Guideline 174, updated May 2017 (NICE CG174);
- National Institute for Health and Care Excellence's (NICE) Sepsis: Recognition, diagnosis and early management, NICE Guideline 51, updated September 2017 (NICE NG51);
- The Royal College of Nursing (RCN) and the National Patient Safety Association's (NPSA) The Hospital Hydration Best Practice Toolkit, Factsheet 3.1 Hydration and Healthy Aging, October 2007 (RCN and NPSA's Hydration Guidance); and
- The Royal College of Physician's (RCP) National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS, updated December 2017 (RCP's NEWS Guidance).

I enclose relevant sections of the guidance considered at Appendix three to this report.

10. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important 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 Antrim Area Hospital staff provided appropriate care and treatment to the patient on 27 and 28 June 2019.

Detail of Complaint

12. The complainant said staff failed to administer fluids for the patient following her transfer to ward A1 after 13:00 on 27 June 2019. She also said staff failed to appropriately monitor the patient.

13. The complainant said the uncertainty surrounding her mother's care caused her to become anxious, especially as her father was also unwell at the time.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following guidance:
    - The GMC Guidance;
    - The NMC Code;
    - NICE NG106;
    - NICE CG174;
    - NICE NG51;
    - The RCN and NPSA's Hydration Guidance; and
    - The RCP's NEWS Guidance.

The Trust's response to investigation enquiries

Fluid intake

15. The Trust explained staff recorded the patient's fluid intake throughout her stay in AAH. It said staff prescribed and administered IV fluids when the patient was drowsy. It explained that following the patient's transfer to ward A1, she '*had an ice lolly at 12:30 and had mouth care at 18:00 but was drowsy at that time'.*

16. The Trust said medical staff prescribed the patient IV fluids at 23:55 on 27 June 2019. It explained nursing staff started these fluids at 01:00 on 28 June 2019. The Trust said the records document the patient '*had an oral intake of 500 mls during the day and continued with IV fluids as prescribed*'.

Monitoring

17. The Trust explained that staff decided before transfer that cardiac monitoring for the patient '*was not clinically indicated*'. It said staff used other equipment when recording observations. It explained the patient '*did not require continual monitoring*'.

18. I referred the Trust to a gap in the patient's clinical records between 12:30 on 27 June 2019 and 01:00 on 28 June 2019. The Trust explained the reasons for this are '*not clear*'. It provided details of the patient's observations recorded on 27 and 28 June 2019. It explained the records evidence that staff repositioned the patient at 17:00 and 22:00. It also said staff administered aztreonam[4] and furosemide[5] for the patient at 14:00, and linezolid[6] at 22:00.

Relevant Trust records

19. I enclose a summary of the relevant records at Appendix four to this report.

Relevant Independent Professional Advice

G IPA

20. A Consultant Geriatrician (G IPA) provided advice on the care and treatment medical staff provided to the patient on 27 and 28 June 2019. I enclose the advice the G IPA provided at Appendix two to this report.

N IPA

21. A senior nurse practitioner (N IPA) provided advice on the care and treatment nursing staff provided to the patient on 27 and 28 June 2019. I enclose the advice the N IPA provided at Appendix two to this report.

The complainant's response to the draft report

22. The complainant explained she accepted the finding that cardiac monitoring of the patient was not clinically indicated. However, she said the Trust did not explain this to her. She also said that doing so would have helped ease her anxiety, as she did not know the patient was only receiving palliative care for her heart condition.

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[4] An antibiotic used primarily to treat infections.
[5] A loop diuretic medication used to treat fluid build-up.
[6] An antibiotic used for the treatment of infections caused by Gram-positive bacteria that are resistant to other antibiotics.

23. The complainant referred to the observations nursing staff took of the patient. She expressed her view that, on the basis of the information in this report, these observations '*could not be trusted'*.

Analysis and Findings

Fluid intake

24. The complainant raised concerns about the patient's fluid intake from lunchtime on 27 June 2019 to the early hours of 28 June 2019. The patient's records document her fluid intake for 27 June 2019 as just 580ml. This is below the 1.6 litres the RCN and NPSA's Hydration Guidance recommends.

25. The N IPA advised that as the patient was drowsy at times, nursing staff should have encouraged her to take fluids. She said staff can use red mugs or jugs to show the patient needed additional assistance with fluid intake. She also advised staff could have asked the patient's family to encourage her to take fluids. However, there is no evidence in the records to suggest that nursing staff took action to help the patient increase her fluid intake. The Trust said the records document the patient took an ice lolly. However, I note it was the complainant (rather than nursing staff) that fed the patient the ice lolly when she realised staff had not administered any fluids.

26. In these circumstances, patients often require assistance with mouth care. The N IPA advised that while this was the case with the patient, the records do not contain an oral assessment or mouth care plan. The records document that staff administered mouth care once during this period (the patient refused a second attempt). However, I am unable to determine if the level of mouth care administered was appropriate due to the absence of an assessment and plan.

27. The NMC Code identifies hydration as one of the fundamental aspects of nursing care and it states that staff should assist those patients who have difficulty drinking. Section 1.2 of this Code also requires staff to deliver the fundamentals of care effectively. Based on the information available, I cannot be satisfied that nursing staff did everything within their remit to ensure the patient took sufficient fluids on 27 June 2019. I consider this a failure in the

patient's care and treatment. The N IPA advised it unlikely the patient's poor fluid intake had a long lasting effect on her health. However, I consider it likely it caused her discomfort. This is especially as she was unable to ask for water herself at that time. Based on the evidence available, I uphold this particular element of the complaint.

28. I also acknowledge the impact the failings had on the complainant. Her concern at the time is clear as she took it upon herself to encourage her mother to take an ice lolly. This caused the complainant further concern and uncertainty, as she did not know what effect this could have on her mother.

29. I also have concerns about the poor standard of records covering this period. This is in addition to the missing oral assessment and mouth care plan. I note the Trust said its staff recorded the patient's fluid intake throughout her admission. However, I note the N IPA's advice that the patient's fluid balance records for 27 June 2019 are incomplete. Therefore, the patient's overall fluid balance for this period is unknown.

30. Section 1.2.2 of NICE CG174 requires staff to fully and accurately complete fluid balance records. Furthermore, standard 10 of the NMC Code requires nursing staff to create and retain appropriate records. I consider that by failing to complete the fluid balance records, staff did not act in accordance with this guidance. The absence of complete records limits the amount of information available for those staff involved in the patient's future care. I consider this failure denied the patient the opportunity for staff to consider important information regarding her oral intake when deciding on her care and treatment. I refer to further concerns regarding record keeping later in this report.

31. The complainant raised a further concern regarding the prescription and administration of IV fluids for the patient on 27 June 2019. The records document medical staff prescribed IV fluids at 23:55 that night. The G IPA advised that based on the patient's clinical history, the medical staff's prescription was appropriate. I note nursing staff administered the fluids approximately an hour later, which the N IPA advised was timely. I accept their

advice and consider the staff's actions in this instance appropriate. I do not uphold this particular element of the complaint.

Monitoring – medical care

32. The complainant queried why staff did not attach the patient to a cardiac monitor following her transfer to ward A1 on 27 June 2019. The Trust said cardiac monitoring for the patient '*was not clinically indicated*'. The G IPA considered this decision appropriate. He noted the patient received palliative care for her end stage heart failure. Therefore, cardiac monitoring would not lead to her receiving treatment for the condition. I accept his advice.

33. The complainant also said staff did not attend to the patient for five and a half hours following her transfer to ward A1 on 27 June 2019. I note the patient's records did not contain a medical evaluation between 12:30 on 27 June and 01:00 on 28 June 2019.

34. The G IPA explained that medical staff will not usually make a note if there is no relevant information to add during that period. He did not identify any relevant medical updates during the time specified. Therefore, he considered the absence of a medical entry appropriate. I accept his advice. I hope this reassures the complainant that medical staff provided appropriate care to the patient during this time.

Monitoring – nursing care

35. The records also do not contain a nursing evaluation between 12:30 on 27 June and 01:00 on 28 June 2019. The N IPA considered this concerning and advised the records evidence that staff did not deliver the fundamental aspects of nursing care during this time.

36. The first issue the N IPA identified was the absence of a documented handover of the patient to ward A1. I cannot determine from the records whether staff provided a verbal handover of the patient. However, a documented handover would have contained vital information for staff who later became involved in the patient's care following her transfer. I consider that by not documenting this handover nursing staff failed to act in accordance with sections 10.1 and 10.2

of the NMC Code. I also consider it a failure in the patient's care and treatment. I am satisfied the absence of a documented handover denied the patient the opportunity for staff to consider this information when deciding on her future care and treatment.

37. The complainant was concerned that staff did not attend to the patient for over five hours following her transfer to ward A1. The Trust explained that nursing staff provided clinical care to the patient periodically between 14:10 and 22:10 on 27 June 2019. This included taking the patient's clinical observations, repositioning the patient, and administering medication.

38. I accept the records evidence that staff provided this care. However, the N IPA said the records do not document that staff attended to the patient's nutrition, hydration, comfort, or hygiene needs. I find this concerning. The NMC Code identifies these as fundamental aspects of care and states that staff must deliver this care effectively. However, I cannot find any evidence to suggest that staff considered these aspects of care for the patient on 27 June 2019. By not doing so, I consider staff failed to act in accordance with sections 1.2 and 1.4 of the NMC Code. I also consider it a failure in the patient's care and treatment. I am satisfied this led to staff denying the patient the opportunity to access basic nursing care during this time.

39. I also considered the patient's NEWS staff recorded on 27 June 2019. The records document the patient scored 6 at 14:10. The RCP NEWS Guidance states that within this parameter, staff should perform observations hourly and escalate to the medical team. However, staff did not repeat the NEWS until more than three hours later (17:30). Also, there is no evidence in the records to suggest nursing staff referred the patient to a doctor for review.

40. The N IPA advised a '*competent clinical decision maker*' can change the frequency of NEWS observations. However, the records do not document a decision to change the frequency, or a reason for doing so. Therefore, I cannot see any reason why staff delayed taking the patient's clinical observations by more than two hours, and did not refer the patient to a doctor. By failing to do so, I consider staff failed to act in accordance with RCP NEWS Guidance.

41. I note the N IPA's advice that the patient's NEWS decreased when a nurse next checked her observations. Therefore, she did not consider the delay negatively impacted the patient's clinical status. However, the guidance is in place to ensure that staff check patients for clinical deterioration and escalate when necessary. I consider staff denied the patient the opportunity to have her observations taken in accordance with the guidance, especially given her increased risk of clinical deterioration at that time.

42. While the complainant may not have been aware of the nursing staff's obligations, she identified a shortfall in the care provided. I consider this caused her concern and uncertainty, especially as doctors earlier informed her of the patient's poor prognosis. I hope this report helps address some of the concerns she may still have about her mother's fluid intake and monitoring.

Issue 2: Whether the communication between Antrim Area Hospital staff and the complainant on 27 and 28 June 2019 was appropriate and in accordance with relevant guidelines.

Detail of Complaint

43. The complainant said she asked a nurse if she could speak to a doctor to obtain an update on the patient's condition following her transfer on 27 June 2019. However, she said a nurse told her the doctors were busy and not available to speak to her.

44. The complainant said that before she left the hospital that evening, she raised her concerns about the care provided with the Ward Sister. She explained she also asked the Sister why staff did not encourage the patient to drink water. The complainant said the Sister '*blatantly lied'* to her, as she told her the patient was unconscious and could not drink.

45. The complainant, who was already anxious due to both parents being ill, explained the staff's actions caused her further anxiety and uncertainty.

Evidence Considered

Legislation/Policies/Guidance

46. I considered the following guidance:
    - The GMC Guidance; and
    - The NMC Code.

The Trust's response to investigation enquiries

Request to speak to a doctor

47. The Trust explained that six doctors were on duty in ward A1 on 27 June 2019. It explained the ward was at '*maximum capacity of 32 patients, with 4 new patients transferred to Ward A1 that day*'. The Trust said medical staff informed the complainant of the patient's condition prior to her transfer. It explained staff had '*no new information*' to tell her. The Trust said staff provided regular updates to the complainant after this.

48. The Trust explained the records do not refer to the complainant's request to speak to a doctor. However, it acknowledged staff may not have documented it. The Trust further explained staff updated the complainant before the end of visiting time on 27 June 2019, and advised they would contact her if the patient's condition changed.

The Ward Sister's involvement

49. The Trust explained the Ward Sister recalled that staff in reception asked her to speak with the patient's relative. However, '*she could not recall the specifics of the conversation'*. The Trust explained the Ward Sister took a '*personal note'* of the discussion. However, she did not formally document it '*as she was of the opinion that the matter was resolved to [the complainant's] satisfaction*'.

50. The Trust further explained the Ward Sister said she spoke to nursing staff about the complainant's concerns. It said the Sister again did not record this discussion, as she felt she resolved the matter.

Relevant Trust records

51. I enclose a summary of the relevant records at Appendix four to this report.

Relevant Independent Professional Advice

G IPA

52. A Consultant Geriatrician (G IPA) provided advice on the care and treatment medical staff provided to the patient on 27 and 28 June 2019. I enclose the advice the G IPA provided at Appendix two to this report.

N IPA

53. A senior nurse practitioner (N IPA) provided advice on the care and treatment nursing staff provided to the patient on 27 and 28 June 2019. I enclose the advice the N IPA provided at Appendix two to this report.

The complainant's response to the draft report

54. The complainant explained that the patient's named nurse only introduced herself after the complainant enquired who was caring for the patient.

55. The complainant said she did not understand how the Ward Sister believed she resolved the matter to the complainant's satisfaction. She explained that following their conversation, she informed the Ward Sister she remained dissatisfied. She also said that in response, the Ward Sister provided to her a leaflet about how to submit a formal complaint to the Trust.

56. The complainant referred to the Trust's view that doctors provided her regular updates after 27 June 2019. She explained they only did so after she raised her concerns. The complainant referred to the diagnosis of the patient's bacterial infection on 27 June 2019, which the medical team did not update her on. She said doctors could have provided this information to inform her of the risk of infection.

Analysis and Findings

Request to speak with a doctor

57. The clinical records do not document the complainant's request to speak to a doctor. Therefore, there is no evidence to suggest she made the request. However, the records demonstrate the complainant was very involved in her mother's care throughout her admission. They also evidence that she regularly requested updates from staff. Therefore, on the balance of probabilities, I am

satisfied the complainant did seek an update on the patient's condition on 27 June 2019.

58. The records do not evidence that the nurse asked one of the doctors to update the complainant following her request. I acknowledge a doctor may not have been available to speak to the complainant. However, I accept the N IPA's advice that regardless, the nurse should have informed the medical team of the complainant's request and documented it in the records. I also acknowledge the team may not have had an update on the patient's condition to share with the complainant. However, I consider that even informing her there was no change in her condition would likely have helped with the complainant's uncertainty at that time.

59. I note the N IPA's advice that if a doctor was not available to speak to the complainant, nursing staff should have reassured her they were providing appropriate care to the patient. However, the records do not evidence they did so. While not documented in the records, I note from the written complaint the Sister later told the complainant that nurses administered IV fluids to the patient. However, the records document that staff administered fluids around 01:00 on 28 June 2019. This was at least 12 hours after the patient's transfer. I consider it likely that by this time the lack of communication had already caused the complainant distress.

60. Section 5 of the NMC Code requires nurses to share information with those close to the patient (where the law allows). Section 8 requires nurses to work in cooperation with their colleagues and maintain effective communication. Section 10 requires nurses to keep clear and accurate records. I consider that by not recording the patient's request and passing it on to the medical team, and by not providing reassurance to the complainant, nursing staff failed to act in accordance with these sections of the NMC Code. I uphold this element of the complaint.

61. I do not consider these failings impacted nursing staff's care and treatment of the patient. However, I recognise the effect the situation likely had on the complainant. I am aware both of the complainant's parents were unwell at that

time. She explained she felt she could not leave her mother (to care for her father) until she was satisfied she was receiving appropriate care. The clinical records also evidence that earlier on 27 June 2019 doctors informed the complainant of the patient's poor prognosis. Based on the evidence available, I am satisfied the staff's actions caused the complainant further distress and uncertainty. It is clear from the records that staff were aware of the complainant's situation. However, I see no evidence to suggest they considered this when sharing information with her.

The Ward Sister's involvement

62. The complainant raised concern that the Ward Sister '*lied*' to her about the patient's inability to take fluids. The Trust explained the Sister recalled that the discussion occurred. However, she could not recall what information she shared with the complainant. It also said she did not document a note of the discussion in the patient's records.

63. In the absence of a record, I am unable to confirm what information the Sister shared with the complainant. Therefore, I cannot determine that the information she provided was appropriate and reflective of the patient's condition at the time.

64. The N IPA advised that in accordance with Section 10 of the NMC Code the Sister should have documented the discussion in the patient's clinical record. I do not consider the failure to retain this record impacted the patient's care and treatment. However, the absence of a complete record prevents me from establishing what information the Sister provided to the complainant and whether this was reflective of the condition of the patient. I consider the absence of this record a service failure.

CONCLUSION

65. This complaint is about care and treatment provided to the patient in June 2019 following her transfer to ward A1 in the AAH. It was also about communication with the complainant. I uphold elements of the complaint for the reasons outlined in this report. I also found the record keeping for this case of a poor

standard and identified a service failure relating to the creation and maintenance of records.

66. I recognise the impact the failures had on both the patient and the complainant. I especially recognise the distressing situation the complainant was in with both parents being unwell at the same time. I note the patient's health improved on this occasion and she was discharged two weeks after these events. However, I am aware the patient again became unwell and sadly passed away in August 2019. I offer through this report my condolences to the complainant for the loss of her mother.

Recommendations

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

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

    ii. The Trust shares this report with staff involved in the patient's care and asks them to reflect on the failures identified.

68. I further recommend the Trust provides training to relevant staff within **three months** of the date of my final report. It should provide evidence to confirm completion of the training and that it used the findings in this report as a training tool for staff. The training should incorporate:

    i. The importance of creating and retaining contemporaneous records in accordance with Standard 10 of the NMC Code;

    ii. The importance of documenting a handover to staff when a patient transfers to a different ward;

    iii. The importance of recording patients' fluid balance in accordance with NICE CG174;

    iv. The importance of undertaking clinical observations in accordance with the RCP Guidance;

    v. Actions they can take to assist patients with their fluid intake;

    vi. The importance of passing on a person's request to speak with a doctor and documenting it in the records; and

vii. The importance of reassuring the person close to the patient when a doctor is not available to speak to them.

69. I also recommend the Trust undertake an audit using a random sample of nursing records. The Trust should report its findings to my office within **three months** of the date of the final report. The audit should assess if the records contain:

    i. Completed oral assessments and mouth care plans; and
    ii. Clinical observations undertaken, and patients escalated to the medical team, in accordance with RCP Guidance.

70. I note the Trust implemented its own Food and Drink Strategy 2018 to 2021 to ensure it delivers in full the recommendations outlined in the Department of Health's Promoting Good Nutrition: A strategy for Good Nutritional Care for Adults in Care Settings in Northern Ireland. Elderly patients are particularly vulnerable to the effects of dehydration and inadequate fluid intake is a serious safety concern. Therefore, if it has not already done so, I further recommend the Trust implements a specific hydration action plan to improve the delivery of hydration care to patients. The Trust should provide evidence it implemented this action plan within **seven months** of the date of the final report.

71. It is evident from my reading of the records how involved the complainant was in the patient's care and how she strived to speak for her mother when she was unable to herself. I hope this report goes some way to address the complainant's concerns about the care her mother received in June 2019.

MARGARET KELLY
Ombudsman **July 2022**

Appendix 1

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.