Investigation Report

Investigation of a complaint against Southern Health & Social Care Trust

NIPSO Reference: 201917137

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Listed Authority: Southern Health & Social Care Trust

SUMMARY

I received a complaint about the actions of the Southern Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to the complainant's late husband (the patient). In particular the complainant was concerned about the patient's diagnoses and treatment, at Craigavon Area Hospital (the hospital) emergency department (ED) on 17 and 28 September 2019. The patient sadly passed away 23 June 2021.

The investigation examined the details of the complaint, the Trust's response, and relevant guidance. I also obtained advice from an independent Consultant of Emergency Medicine, to help in my assessment of the care and treatment provided to the patient. The investigation established the Trust staff provided appropriate care and treatment to the patient. However the investigation found a service failure in relation to the ED records detailing the information provided to the patient. This caused the complainant to sustain the injustice of uncertainty.

I wish to acknowledge that although I did not find failures in the patient's care and treatment, this in no way diminishes the distress that the patient experienced on 17 and 28 September 2019.

THE COMPLAINT

1. I received a complaint about the care and treatment the Southern Health & Social Care Trust (the Trust) provided to the complainant's late husband (the patient) in Craigavon Area Hospital (the hospital) Emergency Department (ED) on 17 and 28 September 2019.

Background

2. On 17 and 28 September the patient attended the hospital's ED due to pain and swelling in his left leg on both occasions. During both ED attendances, the patient received blood tests which ruled out Deep Vein Thrombosis (DVT). The Trust referred the patient to a skin specialist who diagnosed a soft tissue infection and received a prescription cream.

3. The complainant raised her concerns with the Trust on 11 May 2020. The Trust provided its final response to the complaint on 5 October 2020.

Issue of complaint

4. The issue of complaint accepted for investigation was:
   Whether the care and treatment the patient received at the Emergency Department of Craigavon Area Hospital on 17 and 28 September 2019 was in accordance with relevant standards and 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 handling of the complaint and the patient's medical records.

Independent Professional Advice Sought

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

   - A Consultant in Emergency Medicine; with 15 years' experience of working within a District General Hospital (ED IPA).

The clinical advice received is enclosed 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 ED IPA provided 'advice'; however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

8. 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. I also refer to relevant regulatory, professional and statutory guidance.

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

- The Principles of Good Administration

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:

- General Medical Council, Good Medical Practice (GMC Guidance) April 2019;
- National Institute for Health and Care Excellence, Venous thromboembolic diseases: diagnosis, management, and thrombophilia testing, NICE guideline 158, June 2012 (NICE NG158);

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

- National Institute for Health and Care Excellence Cellulitis and erysipelas: antimicrobial prescribing, NICE guideline 14, 27 September 2019 (NICE NG141); and
- Southern Trust Deep Vein Thrombosis Protocol, November 2013 (Southern Trust Protocol).

Relevant sections of the guidance considered are enclosed at Appendix three to this report.

10. I did not include all of the information obtained in the course of the investigation in this report. However, I am satisfied that 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. I carefully considered the comments I received from both the complainant and the Trust before I finalised this report. Where appropriate, the comments received have been reflected in changes to the report.

THE INVESTIGATION

Issue: Whether the care and treatment the patient received at the Emergency Department of Craigavon Area Hospital on 17 and 28 September 2019 was in accordance with relevant standards and guidelines.

Detail of Complaint

12. The complainant said Trust staff did not provide her late husband with the appropriate care and treatment. The complainant believed the patient was not properly diagnosed and treated for the pain and swelling in his left leg.

Evidence Considered

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

- The GMC Guidance;
- NICE NG 158;
- NICE NG 141; and
- Southern Trust Protocol.

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

Trust's response to investigation enquiries

14. The Trust explained its staff carried out the appropriate assessments on the patient at the hospital's ED on 17 and 28 September 2019. The Trust explained the patient had blood tests taken and staff performed two Doppler ultrasound scans[2]. The Trust stated these blood tests and ultrasound scans ruled out Deep Vein Thrombosis (DVT)[3], and the Trust treated the patient with an alternative diagnosis (Cellulitis[4]) in the hospital ED. The Trust stated its staff treated the patient appropriately.

15. The Trust explained it referred the patient to a skin specialist within the hospital on 28 September 2018, who agreed with the ED's diagnosis, and the treatment provided. The Trust stated the patient attended the Dermatology[5] Nurse Specialist in April 2019 for this skin condition and was discharged back to the care of his own GP on 28 September 2019.

Relevant Independent Professional Advice

16. The ED IPA provided advice on the care and treatment Trust staff provided to the patient on 17 and 28 September 2019. The ED IPA's full advice is enclosed to Appendix two to this report.

[2] A Doppler ultrasound is a non-invasive test that can be used to estimate the blood flow through your blood vessels by bouncing high-frequency sound waves (ultrasound).
[3] Deep Vein Thrombosis (DVT) a condition in which the blood clots form in veins located deep inside the body, usually in the thigh or lower legs. This can cause pain and swelling in the area.
[4] Cellulitis is a common, potentially serious bacterial skin infection. The affected skin appears swollen and red and is typically painful and warm to the touch. Cellulitis usually affects the skin on the lower legs.
[5] Dermatology the branch of medicine concerned with the diagnosis and treatment of skin disorders.

Analysis and Findings

17 September 2019

17. The patient's medical records document the patient attended ED at 18.34 on 17 September 2019. During this attendance the ED Doctor examined the patient and recorded his clinical findings. The Trust tested the patient's bloods at 19.05 for: a full blood count, urea[6] and electrolytes[7] CRP[8], liver function[9] and d-dimer[10]. Based on the d-dimmer test results, the ED Doctor determined that the patient most likely had DVT. The Trust's medical records document the Trust discharged the patient from ED at 22.10. The Trust gave the patient a follow up appointment to attend the hospital for a Doppler ultrasound scan the following day. This scan was to determine whether the patient had DVT. The medical records do not document whether the Trust explained to the patient the reasons for the treatment and why a follow up appointment was required.

18. The ED IPA advised, *'the initial triage assessment and subsequent clinical evaluation completed in ED are appropriately documented*'. The ED IPA advised there was a delay of over three hours before the ED doctor reviewed the patient. The ED IPA advised whilst the delay was likely to be frustrating for the patient, *'I do not think it impacted on the overall assessment and management during the attendance'*.

19. The ED IPA advised he would have expected the Trust to have informed the patient of why treatment was required, and the reason for the appointment the next day. The ED IPA advised, *'it is impossible to comment on what verbal information, if any, was provided to the patient'*.

[6] Urea is a waste product from the breakdown of amino acids found in proteins.
[7] A group of tests to monitor the levels of major electrolytes in the body like calcium, chloride, magnesium, phosphate, potassium, sodium.
[8] C-reactive protein (CRP) is an annular (ring-shaped) pentameric protein found in blood plasma, whose circulating concentrations rise in response to inflammation
[9] Liver blood tests look at how well the liver is functioning and can indicate whether there is any damage or inflammation inside the liver
[10] D-dimer is one of the protein fragments produced when a blood clot gets dissolved in the body. It is normally undetectable or detectable at a very low level unless the body is forming and breaking down blood clots. Then, its level in the blood can significantly rise.

28 September 2019

20. The Trust's medical records document the patient attended the ED at 18.10 on 28 September 2019 with ongoing pain and swelling in his left leg. The patient also felt generally unwell and had vomited prior to attending the ED. The Trust conducted clinical observations of the patient's heart rate, blood pressure, respiratory rate, temperature, oxygen saturation levels and conscious level.

21. At 23.30 the nurse attended to the patient, and the nurse repeated the previous observations and provided the patient with analgesia. The Trust's medical records document the patient's ultrasound on 18 September was negative for DVT, and he was currently receiving treatment for cellulitis. The ED Doctor examined the patient and recorded the patient's left leg was larger than the right and had dry skin, however the ED Doctor identified that the infection was mild. The patient's blood results documented his white blood cell count was high. Due to the suspected cellulitis which the patient was already receiving treatment for from his GP, the ED Doctor advised the patient to continue with the antibiotics and to take an antihistamine to control the itching. The ED Doctor also advised the patient to raise his leg when seated. The ED Doctor referred the patient to a dermatologist to manage the patient's cellulitis.

22. The ED IPA advised the Trust provided the patient with treatment based on the findings of his clinical assessment and investigation. The ED IPA advised the Trust considered the patient's condition to be cellulitis and *'appropriate treatment for this condition was provided to the patient'*.

23. In response to the draft Investigation Report the complainant said the patient's symptoms were indications that he had circulation issues. I note the Trust conducted two Doppler Ultrasound tests which were negative. I accept the ED IPA's advice that *'the patient received the appropriate tests based on the patient's presentation'*.

24. I recognise the distress the patient likely felt due to the pain and swelling in his left leg, and the frustration over the delays in being seen by medical staff. However, I accept the ED IPA's advice that the Trust provided the correct care and treatment to the patient on 17 and 28 September 2019. I accept the IPA's

advice *'on each occasion investigations were undertaken to determine the most likely condition affecting the patient and further investigations were arranged according to the trust protocols'*.

25. The ED IPA advised there are no notes within the patient's medical records that document a formal discussion between the ED staff and the patient regarding his symptoms and treatment. I note in response to the draft Investigation Report, the complainant said the ED staff did not inform her of the patient's symptoms and treatment.

26. I note the ED IPA's advice, *'I think it would be reasonable to conclude that the doctor gave this information to the patient at the time of discharge'*. However I can see no evidence of this within the clinical records.

27. Overall I remain concerned that the clinical records for both ED visits do not contain documentation of the discussion the medical staff had with the patient about his clinical pathway. I refer to the GMC guidance which requires medical staff to record the information given to patient within their clinical records. I consider this lack of information on both ED attendances a service failure. I am satisfied the absence of these records did not affect the patient's care and treatment. Nevertheless I ask the Trust to reflect on the advice of the ED IPA to remind staff *'to document what information they provide to patients. It should be recorded whether this is written or verbal and who was spoken to.'* I will refer to this in the recommendations of the report.

28. I consider this service failure caused the complainant an injustice of uncertainty about the patient's diagnosis and treatment of his presenting symptoms. I partially uphold this complaint.

29. The complainant did not raise any concerns about the patient's waiting time in the hospital ED. However, I would like to make an observation about the issue the ED IPA raised about the Trust's ED waiting time. The ED IPA highlighted the patient was not assessed by the Doctor until almost seven hours after arrival. The ED IPA advised this does not meet the expected standards for

emergency care. I note the DoH[11] has a target ED waiting time of four hours from attendance to discharge/admittance. The ED IPA advised he did *'not consider the delay affected or altered the treatments provided nor was this detrimental to the patient's condition'*.

30. Despite the ED IPA's advice that these delays did not impact the patient's care and treatment, I consider these delays fell below the expected standard. I acknowledge the number of ED presentations on any given day is unpredictable and staff shortages can cause a delay in administering care. However, I would ask the Trust to reflect on the patient's delay in ED and how this could be improved

CONCLUSION

31. The complainant raised concerns about the care and treatment the Trust provided to her late husband on 17 and 28 September 2019 at the hospital. I am in no doubt the events must have been distressing for the complainant and the patient. However my investigation found no evidence of failing on the part of the Trust in relation to the concerns the complainant raised about the care and treatment the patient received.

32. My investigation found a service failure by the Trust in relation to record keeping.

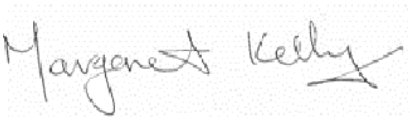
33. The ED IPA made an observation about the patient's ED waiting time. I would ask the Trust to consider how to bring improvements to the hospital's ED waiting times. I would ask the Trust to reflect on the learnings the ED IPA identified for an opportunity to review its staffing model in order to improve ED waiting times.

[11] Department of Health Information Analysis Directorate, Emergency Care Waiting Time Statistics for Northern Ireland July – September 2019, Published October 2019.

RECOMMENDATION

34. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the service failure identified within **one month** of the date of this report.

35. I recommend that the Trust remind ED staff of the importance of record keeping as required by the GMC Good Medical Practice guidance. I would ask the Trust to provide my Office with confirmation that this recommendation has been implemented within **three months** of the date of this report.



MARGARET KELLY **2022**
OMBUDSMAN

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.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.