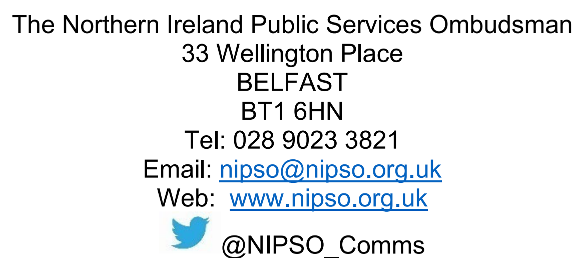
Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Northern Health & Social Care Trust

NIPSO Reference: 202000508



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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust) in relation to the care and treatment the Causeway Hospital staff provided to the complainant's late mother (the patient).

The complainant was unable to visit her mother due to COVID-19 restrictions and relied on telephone calls. She complained that it was difficult to speak to a doctor and the standard of communication when she did caused her upset and uncertainty about her mother's health and plan of care. I also considered that delay in returning the complainant's telephone calls caused her uncertainty and upset about her mother's condition and I upheld this element of the complaint.

The complainant also said that the Trust failed to adequately explain the patient's diagnoses and treatment in the written responses to her complaint. I concluded that the Trust might have avoided the escalation of the complaint to NIPSO had the Trust provided a more detailed response to the complainant at the outset. This failing caused the complainant ongoing uncertainty about whether the patient received appropriate medical care. I therefore upheld this element of the complaint.

I considered the care and treatment provided to the patient was, in the main appropriate, reasonable and in accordance with relevant standards, guidance and practice. However, I found the Trust ought to have performed two diagnostic tests on the patient upon her admission to ensure the Trust had a full picture of the patient's health position. Whilst I found these tests not being performed did not impact upon the patient's care and treatment, I found it caused the complainant uncertainty and frustration as to the patient's condition and diagnoses. I also found the Trust ought to have carried out an assessment for oxygen therapy before discharge or expedited the referral that was already in place. I considered that this failing delayed the patient receiving palliative oxygen therapy for symptom relief and caused the complainant the upset of witnessing her mother's ongoing respiratory distress. I upheld this element of the complaint.

In addition to the injustices outlined in the paragraphs above, I found the failings

identified caused the complainant to take the time and effort to bring this complaint to my Office.

I recommended that the Trust provides the complainant with a written apology for the injustice caused as a result of the failures. For service improvement in complaints handling and to prevent future recurrence, I recommended that the Trust shares the learning from this report with those in the Acute Services Complaints Office who were involved in the complaint resolution process.

THE COMPLAINT

1. I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust) in relation to the care and treatment the Causeway Hospital (CH) staff provided to the complainant's late mother (the patient).

Background

2. The patient was 79 years old and had a history of Sarcoidosis[1], Mitral stenosis[2] and interstitial lung disease[3]. She was admitted to the CH via ambulance as an emergency on 31 May 2020 with shortness of breath and severe back pain. CH discharged her on 5 June 2020 with a primary diagnosis of Congestive Cardiac failure (CCF)[4], type two respiratory failure[5] and community acquired pneumonia (CAP).

Issues of complaint accepted for investigation

3. **Issue one: Whether the diagnosis, treatment and follow up were appropriate?**
   Issue two: Whether medical staff communicated appropriately with the patient and the complainant about her mother's diagnoses and treatment?

INVESTIGATION METHODOLOGY

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

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[1] Sarcoidosis is a condition that causes small patches of red and swollen tissue, called granulomas, to develop in the organs of the body.
[2] Narrowing of the mitral valve of the heart.
[3] a group of conditions that result in inflammation and scarring of the lung.
[4] A progressive heart disease that affects pumping action of the heart muscles and causes fatigue and shortness of breath.
[5] Type 2 respiratory failure is defined as a patient having a raised carbon dioxide level in their arterial blood ($PaCO_2$ above the normal range of 4.6-6.1KPa[5]).

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from an independent professional advisor (IPA) a respiratory consultant since 2015 with the following qualifications: MBBS, MRCP, PhD.
   I enclosed the clinical advice received at Appendix four to this report.

6. I included the information and advice that informed my findings and conclusions within the body of this report. The IPA provided 'advice'; however how I weigh this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

7. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those that 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[6]:
    - The Principles of Good Administration
    - The Principles of Good Complaints Handling

8. I referred to specific standards and guidance, that applied at the time the events occurred, which governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint. These are:
   - The General Medical Council's (GMC) Good Medical Practice, updated April 2019 (the GMC Guidance);
   - The Nursing and Midwifery Council's (NMC) Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates, March 2015 (NMC Code);

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

- Appendix Two - Community-Respiratory-Team-Operational-Policy-HSCT201363
- Appendix Three - Home Oxygen Service Assessment and Review (HOSAR) NHSCT/20/1462;
- The HSC Guidance in relation to the Health and Social Care Complaints Procedure, 2019 (HSC Guidance);

9. I did not include all of the information obtained in the course of the investigation in this report, but I am satisfied that I took into account everything that I considered to be relevant and important in reaching my findings.

10. 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 gave careful consideration to the comments I received before I finalised this report.

THE INVESTIGATION

Issue one: Whether the diagnosis, treatment and follow up were appropriate?

Detail of Complaint

11. The complainant questioned the patient's diagnosis of CCF. She asked why no referral was made to the cardiac consultant who was working in the same hospital for confirmation of the diagnosis and treatment while she was an inpatient. These events happened during a period when outpatient clinics were cancelled due to COVID pressures. She said that the cardiac consultant subsequently informed her at a consultation on 10 August 2020 that the patient did not have CCF.

12. The complainant also remained dissatisfied about the explanations the Trust provided for the patient acquiring type 2 respiratory failure.

13. The complainant did not believe that the x-ray showed that her mother had CAP because there was ‘no lobe collapse or consolidation’ on the x-ray.

14. She complained that the CH did not arrange a home oxygen assessment.

Evidence Considered

Legislation/Policies/Guidance

15. I attached extracts from the GMC Guidance at Appendix three to this report.

The Trust’s response to investigation enquiries

16. I attached extracts from the Trust’s letter of 30 June 2021 to NIPSO at Appendix five to this report.

17. The Trust provided detailed explanations for the diagnoses of CCF, Type 2 respiratory failure and CAP. The Trust also explained why no in-patient oxygen assessment was carried out.

Relevant Independent Professional Advice

18. The IPA detailed the patient’s medical history as follows:
‘The patient had a past medical history of sarcoidosis, complicated by pulmonary fibrosis[7] and traction bronchiectasis[8]. Her diagnosis of sarcoid had been made in 1983 and her care was transferred to Antrim Area Hospital in 2017. She had also been diagnosed with atrial fibrillation (AF)[9] in 2019 for which she was on warfarin and she had had a previous tissue (porcine) aortic valve replacement in 2013. The patient had mild mitral stenosis, hypertension and previous rheumatic fever. The patient had also been investigated in 2019 by the neurologists for dissociative episodes[10]. The patient was

[7] A lung disease that occurs when lung tissue becomes damaged and scarred.
[8] irreversible dilation of the bronchi resulting from airway damage due fibrosis
[9] Irregular heartbeat
[10] problems with memory, identity, emotion, perception, behaviour and sense of self

immunosuppressed for her sarcoid on mycophenolate mofetil and prednisolone[11].'

The diagnosis of congestive cardiac failure (CCF)

19. The IPA advised clinicians noted that symptoms and signs of CCF, including breathlessness, ankle swelling and fatigue, were present in the patient on admission to the CH on 31 May 2020 and *'it would be reasonable to treat as acute or decompensated heart failure with diuretics'.*

20. The IPA advised that clinicians treated the patient appropriately with intravenous diuretics and she responded well.

21. The Investigating Officer asked the IPA if the cardiac consultant's letter 20 August 2020 to the respiratory consultant supported or contradicted the diagnosis of CCF on 1 June 2020. The IPA advised *'Overall, the cardiology consultant has documented that she thought that the patient's deterioration was mainly due to her respiratory function, but there had been some cardiac component. In summary, this letter dated 20.8.20 supports the diagnosis of heart failure which contributed towards the patient needing to be admitted to hospital and does not contradict it.'*

22. The IPA advised '*The medical team could have arranged for the patient to have a BNP[12] and ECHO (echocardiogram[13]) during her admission, which would have given weight to her diagnosis, and in turn satisfied the complainant who has questioned the diagnosis of CCF'.*

23. The IPA added *'Although the ED clerking had proposed a BNP to be measured on admission, I am not able to see this result. It may not have been possible to do these depending upon lab facilities at the hospital for the BNP and the impact of COVID on the ECHO facilities'.*

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[11] Drugs to reduce the activity of the body's immune system
[12] It is a blood test which measures the hormone B-type natriuretic peptide and should be measured if the diagnosis of heart failure is uncertain.
[13] An imaging test using ultrasound to monitor the heart's mechanical function.

24. The Investigating Officer asked the IPA what the BNP value on 9 June 2020 indicated. She advised that '*an elevated value of >1000 would support a diagnosis of (acute) heart failure/CCF alongside the relevant clinical findings. It should however be noted that AF can also lead to an increase in BNP'.*

The diagnosis of CAP

25. The Investigating Officer asked the IPA to explain what the chest x-ray on 31 May 2020 showed. She advised *'this would suggest the patient had radiologically an element of pulmonary oedema with significant pulmonary fibrosis from her sarcoid. The interpretation was noted to be limited but no lobar collapse or consolidation was present. Patients with pneumonia do not always have lobar changes (i.e. an entire lobe affected), changes of consolidation can also be focal, patchy or distributed widely throughout both lungs. If the patient had a small area of the lung affected, it might have been difficult to see the consolidation on the patient's CXR as the interpretation was limited. Therefore pneumonia (or CAP) could not be excluded on the basis of this CXR report alone'.*

26. The IPA also advised *'It was reasonable to have treated the patient for an infection (or community acquired pneumonia/CAP) as she was at a high risk of developing an infection because of her immunosuppression and it could not be excluded from the chest x-ray report'.*

27. The IPA advised the patient was treated with the antibiotics amoxicillin and clarithromycin, and given oxygen therapy. This is in line with the British Thoracic Society (BTS) recommendations on how to treat CAP. Her immunosuppressant drugs were appropriately withheld whilst she was on the antibiotics and she received a higher dose of steroids during her admission. The IPA advised that this was appropriate treatment for CAP.

The diagnosis of type 2 respiratory failure

28. The IPA provided an explanation of the types of respiratory failure. She advised type 2 respiratory failure is defined as a patient having a raised carbon dioxide

level in their arterial blood. She advised that the patient was identified as having acidosis[14] and correctly diagnosed with type 2 respiratory failure.

29. The IPA advised *'Type 2 respiratory failure can also occur as a result of pulmonary oedema[15] and it can occur as a result of being given a high dose of morphine. The patient had both pulmonary oedema and had received a high dose of morphine, and therefore this might be considered the more likely explanation as to why the patient developed type 2 respiratory failure. This is on a background of the patient having impaired lung function from her pulmonary fibrosis'.*

30. The IPA advised the patient was treated appropriately with oxygen therapy in line with BTS recommendations. *'The BTS recommendation is if a patient is a known CO_2 retainer, their oxygen saturations are targeted at 88-92%. It was noted in ED that this patient was a CO_2 retainer from her blood gas result and as a result the patient's oxygen saturations were targeted appropriately'.*

The lack of referral to cardiology during this admission

31. The IPA advised that **t**he patient had a history of atrial fibrillation but did not present with this on admission. She advised that an electrocardiogram (ECG[16]) performed on 31 May 2020 indicated that the patient was not having an acute cardiac event or heart attack. The IPA advised *'she did not have an acute coronary syndrome such as a myocardial infarction as she had a normal troponin[17] blood test and she had no new changes on her ECG.'*

32. The IPA further advised *'the patient responded well to the treatment of diuretics and NIV. She had a relatively short admission and was noted to be keen to go home on 5.6.20. The patient was admitted during the first wave of the COVID pandemic and was immunosuppressed; it was therefore in her best interests to avoid a prolonged admission and potential contact with COVID patients'.*

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[14] Respiratory acidosis is a state in which decreased ventilation Increases the concentration of carbon dioxide in the blood and decreases the blood's pH

[15] Lung congestion resulting from fluid re-distributing to the lungs causing respiratory failure.

[16] ECGs are machines used by medical professionals to measure a heart's electrical activity.

[17] A troponin test measures the levels of troponin T or **troponin I proteins** in the blood which are released when the heart muscle has been damaged, such as occurs with a heart attack.

33. The IPA advised a BNP test and an echocardiogram may have given a better indication as to whether an inpatient cardiology review was required or not. She added *'I consider the cardiology team would not have changed her inpatient management as she received appropriate treatment during her admission. The cardiology consultant was informed of the patient's admission when the patient was discharged home'.*

Not assessing for oxygen therapy before discharge

34. The Investigating Officer asked the IPA if clinicians ought to have assessed the patient for home oxygen before discharge from the CH on 5 June 2020. The IPA advised *'The patient's oxygen saturations were noted to be 91% on room air on 5.6.20. It was noted in the medical notes on the consultant ward round on 5.6.20 that the patient's oxygen levels were observed to reduce significantly on mobilising and she was already waiting for a community ambulatory oxygen assessment…the patient should have been considered for an oxygen assessment before discharge from Causeway Hospital due to her low saturations on mobilising. If an oxygen assessment was not thought appropriate, then reasons for this should have been more clearly documented in the medical notes. A blood gas on the day of discharge would have facilitated this process…this oxygen assessment might have included expediting the already arranged assessment for ambulatory oxygen or arranging a new assessment for palliative oxygen'.*

35. The IPA also advised *'on discharge from Antrim Area Hospital (the patient's second hospital admission), the patient's saturations were noted to be 95% on room air and therefore she did not meet the criteria for long term oxygen therapy (LTOT), as documented by the respiratory nurse in the medical notes. She was in the end prescribed oxygen for palliative purposes, i.e. for symptom relief'.*

36. Prior to discharge a spinal referral had been made and the patient was discharged to the care of her GP pending this review. The IPA advised *'in my opinion, the patient was given appropriate care for her osteoporotic spinal changes as the patient was mobilising, was pain free, had no focal neurology*

and the team had referred her for specialist input. In addition, there would be local guidelines that GP would usually follow for the management of osteoporosis in the community'.

37. The IPA concluded that *'the medical management of this patient was to the standards expected; the diagnoses were correct and the patient received appropriate care.'*

Analysis and Findings

38. The investigation of this issue of complaint seeks to determine whether the patient's diagnoses, treatment and follow up were appropriate and to provide the complainant with information to aid her understanding of how the Trust managed the patient's medical issues.

The diagnosis and treatment of CCF

39. As the IPA advised, the patient had multiple medical problems prior to admission including AF, hypertension and valve disease which are risk factors for heart failure. She presented at the CH with symptoms of breathlessness, ankle swelling and fatigue, which the IPA explained are the main symptoms of CCF.

40. The IPA referred to the cardiac consultant's clinic letter dated 20 August 2020 and advised *'The cardiology consultant documented that the higher dose of diuretic had helped with the patient's symptoms during her admission and that admission chest x-ray had findings of fluid overload. In the clinic the patient had mild ankle swelling. These comments support a diagnosis of heart failure'.*

41. I accept the advice of the IPA that the patient was correctly diagnosed with CCF based on the symptoms the patient presented with within the context of the patient's medical history. I also accept the IPA's further advice that the Trust treated the patient appropriately with diuretics and NIV - and that the patient responded well to both.

The diagnosis of CAP

42. The IPA advised the chest x-ray made was difficult to interpret '*due to extensive fibrotic changes present within both lungs which limit interpretation'*. The IPA advised '*there was no obvious lobar consolidation on the report*'. Nonetheless, the IPA advised the Trust could not exclude the presence of pneumonia. I accept the IPA's advice in this respect, and also accept the IPA's further advice that it was *'reasonable'* for the Trust to have treated the patient for CAP, given '*she was at a high risk of developing an infection because of her immunosuppression and it could not be excluded from the chest x-ray report'*. I further accept the IPA's advice that clinicians treated the patient appropriately for CAP with antibiotic medication.

The diagnosis of type 2 respiratory failure

43. The IPA explained the diagnosis of type 2 respiratory failure. The IPA agreed with the Trust's explanation that this was likely due to a combination of factors including '*significant lung disease, fluid on her lungs, administration of morphine for back pain in the ambulance along with oxygen administration'*. I accept the IPA's advice that oxygen therapy was provided appropriately to target an oxygen saturation of 88-92%.

The lack of referral to cardiology during this admission

44. The Trust stated the patient's ECG did not suggest the need for any urgent cardiology intervention. The IPA agreed that the ECG indicated the patient was not having an acute cardiac event or heart attack.

45. The IPA also advised the ESC recommends diagnostic tests such as BNP and ECHO in patients who present with acute or decompensated heart failure upon admission as an inpatient – and that the Trust did not perform these tests upon the patient's admission. The IPA advised that '*if these tests were done, then the results of them may have given better indication as to whether an inpatient cardiology review was required or not'.* On foot of this advice, I consider the Trust ought to have performed these tests on the patient upon her admission to ensure it had a more complete picture of the patient's condition and potential diagnoses. I consider this to be a failing on the Trust's part regarding the care and treatment it provided to the patient.

46. However, I also note the IPA's advice that *'the cardiology team would not have changed her inpatient management as she received appropriate treatment during her admission.'* I also note the IPA's advice that the cardiology consultant was informed of the patient's admission at the time of discharge and that this clinician subsequently consulted with the patient on 10 August 2020.

47. I accept the advice of the IPA that referral to the cardiology team before discharge would not have changed her inpatient management. Therefore whilst I found there to be a failing in terms of the diagnostic tests not being carried out on admission, I am satisfied there was no injustice to the patient as a result of this failure, or as a result of the patient's subsequent wait to see the cardiologist. However, I found this failure did cause the complainant to sustain the injustice of uncertainty regarding the patient's cardiac health.

Not assessing for oxygen therapy before discharge

48. The IPA advised that the Trust ought to have checked the patient's blood gas due to her low saturations on mobilising and considered an oxygen assessment before discharge. The clinician noted the patient was already waiting for a community ambulatory oxygen assessment. The IPA advised that the clinician should have clearly documented in the medical notes the reasons for not carrying out an oxygen assessment. I accept the advice of the IPA that the extant referral for a community ambulatory oxygen assessment could have been expedited or a new assessment for palliative oxygen arranged. In the event, the patient received an oxygen assessment following a subsequent hospital admission to a different hospital under the Trust's remit on 12 June 2020. It is noteworthy that the patient refused to be returned to CH, as she had lost confidence in it. The Trust subsequently provided the patient with provision for home oxygen on 23 June 2020.

49. I consider this to be a failing in the care and treatment the Trust provided to the patient that caused the patient to sustain the injustice of loss of opportunity to receive palliative oxygen therapy for symptom relief at an earlier time. The patient also sustained the injustice of uncertainty regarding management of her

ongoing symptoms and treatment options, as well as upset at the delay she experienced. The failing also caused the complainant to sustain the injustice of upset at having to witness her mother's continued respiratory distress, and frustration regarding feeling unheard in the process.

50. In terms of communication between the Trust and the community respiratory team regarding oxygen assessment, I note the IPA's advice that it was '*not clear*' the patient's medical notes whether the Hospital staff '*informed the community respiratory team of the patient's admission and subsequent discharge*' – but that the Trust's response to the internal complaint sets out the Trust '*verbally informed*' the community team. I also note the complainant's position that this verbal communication was instigated by a conversation she had with a staff member from Antrim Area Hospital. Whilst it cannot be determined from the evidence available exactly what prompted the verbal communication, I consider the communication that did eventually take place ought to have been reflected in the patient's medical notes. I consider this to be a failure in record keeping, contrary to the GMC Guidance regarding the importance of clinicians keeping clear and accurate record-keeping. This failure caused the complainant to sustain the injustice of uncertainty and frustration regarding the patient's treatment.

51. To conclude, I partially uphold issue one of the complaint – on the basis that whilst the medical management the Trust provided to the patient was to an appropriate standard, there was a lack of assessment for oxygen therapy prior to discharge, and a failure to perform recommended diagnostic tests which impacted upon the overall care and treatment provided to the patient. There was also a failure in record-keeping regarding the subsequent communication between the Trust and the community respiratory team.

Issue two: Whether medical staff communicated appropriately with the patient and the complainant about her mother's diagnoses and treatment?

Detail of Complaint

52. The complainant was unable to visit due to COVID restrictions and depended on phone calls. She was dissatisfied with delays in returning her calls and the standard of communication from the medical staff. She complained that nurses were able to provide some information but were not able to answer all her questions '*hence the need to speak to a doctor*'.

53. She complained that, having spoken to a doctor on 1 June 2020, she was unable to speak to a doctor again until 5 June 2020. She first complained to the Trust about this by email on 5 June 2020, stating '*Can you honestly tell me if this was your mother who you were told at the beginning of the week that the Dr didn't know if she would make it through the day, that you would be satisfied with this?'*

54. She also complained that the Trust's written responses to her complaint did not provide her with answers to her questions.

Evidence Considered

55. I considered the patient's medical records and shared these with the IPA.

56. The nursing record shows that a nurse had a *'lengthy discussion'* with the complainant at 19:00 on 4 June 2020 and '*answered all her questions'.* The complainant said that calls on this date took place at 10:25 14:00 and 17:25 – and that any record of a call at 19:00 may have been written retrospectively – but that it wasn't '*lengthy*'. The nursing record shows a nurse telephoned the complainant on the morning of 5 June 2020. The nurse explained to her that the patient was agitated and asked her to telephone her mother. The nursing records document that the complainant did so. A further record at 18.30 documents '*[complainant] very concerned that doctors had not contacted her. Spoke with* ██████ *- to finish looking at patients. Continued to update [complainant]'*.

57. I attach extracts from the GMC Guidance at appendix three. Paragraph 33

states *'You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support'.*

The Trust's response to investigation enquiries

58. I attach extracts from the Trust's response to investigation enquiries at Appendix five. The IPA also provided advice regarding the quality of the Trust's responses to the complainant on 22 July and 22 October 2020 and to NIPSO on 30 June 2021.

59. The Trust explained that '*an email complaint was received on 5 June 2020 at 12.37. The Complaints Manager advised the complainant by return email that she was looking into her concerns at 12.59 and advised her by telephone at 13.08 that [the respiratory consultant] would call her that afternoon'.* The complainant challenged some of these times. The complainant outlined a nurse called her initially at 07:30, and after that call she immediately called the patient. The complainant said she subsequently called at 09:45 and at 11:00. The complainant denied she spoke with a doctor at 13:00, stating that she called again at 16:00 and spoke with a doctor at 16:10, rather than at 18:30.

60. The Trust subsequently explained that the respiratory consultant in charge of the patient's care was attending to a patient on the ward and was unable to make the call therefore she asked one of her team to do so. The Trust accepted that Covid restrictions and no visiting created difficulties in communicating with relatives.

Relevant Independent Professional Advice

61. The Investigating Officer asked the IPA to consider how well the respiratory consultant explained the patient's diagnoses, treatment plan and prognosis to the complainant on 1 June 2020. The IPA advised the consultant recorded he '*spoke with the daughter over the phone and updated her on the patient's*

condition and plan of management'.

62. She further advised *'it is a short entry and I would have expected more specific points with regards to what the patient was being treated for, how the patient was being treated, how long the patient would likely be in hospital and what the outcome might be. Therefore, this communication seems inadequate if the aim of the conversation was to fully update the complainant on all the aspects of her mother's care'.*

63. The IPA advised *'the patient's main symptom was breathlessness and the complainant perceived that oxygen would improve this. Oxygen treatment is for low blood oxygen levels and has not been proven to have 'any consistent effect on the sensation of breathlessness in non-hypoxaemic[18] patients [BTS guidance]. It appears that at no point was this explained to the patient or the complainant'.*

64. The IPA noted that '*the ED clerking had proposed a BNP to be measured on admission'* but it is not recorded that this was done. I accept the advice of the IPA that a BNP and ECHO, while not essential at that time given that the focus was on treating the CCF, *'would have given weight to her diagnosis, and in turn satisfied the complainant who has questioned the diagnosis of CCF'.*

65. The complainant rang the ward three times seeking information about the patient on 4 June 2020. The IPA advised that this is not recorded in the medical notes - *'The only mention of the complainant wishing to speak with the medical team is in the nursing notes. The nursing notes document that a nurse updated the complainant on her mother's condition with a 'lengthy discussion' on 4.6.20 at 1900, but the complainant was not 'not happy' that a doctor didn't ring her back'.*

66. The IPA also advised *'Perhaps the nursing staff should have left a written message for the team to ring the complainant back so that there was no doubt the [message] was passed on'.*

[18] Hypoxaemia is low blood oxygen

67. The following day, 5 June 2020, the complainant rang back twice in the morning but was not able to speak to the consultant. The notes record a SHO spoke to her at 13:00. In the IPA's opinion, the SHO gave the daughter information she wanted to know in a way she understood and met the GMC standard of communicating effectively.

68. It is recorded at 17:10 that another SHO rang the complainant on 5 June 2020. The IPA advised *'the SHO updated the complainant on the key points of her mother's management and progress. The SHO appeared to have answered her questions in a way in which she understood as the daughter 'was appreciative' and 'had no further questions'.* In the IPA's opinion, this also met the GMC communication standard.

69. The IPA highlighted the impact of COVID on communication as follows: *'relatives were not allowed to visit hospitals and medical staff were under enormous strain. It would simply not have been possible to call every patient's relative regularly whilst still being able to carry out medical duties. Relatives were predominantly called if patients were deteriorating and this was not the case for this patient; the patient was improving with the treatment she received'.*

70. In relation to the clinical decisions, the Investigating Officer asked the IPA to consider the Trust's written responses to the complainant dated 22 July 2020 and 22 October 2020. The IPA considered the letter of 22 October 2020 in which the Trust provided further explanations to those offered in its first letter of 22 July 2020. I considered the IPA's advice under the same headings used in issue one for clarity.

The diagnosis of CCF

71. The IPA advised *'the Trust explain in the letter of 22 October 2020 that the patient was treated for heart failure as she presented with shortness of breath, the doctor heard crackles when listening to her chest and the patient had pulmonary oedema on her CXR. The Trust also explain shortly after her first admission, the patient had a raised BNP which supports the diagnosis of heart*

failure. This is a reasonable explanation explaining why the patient had been treated for CCF.'

The diagnosis of CAP

72. The IPA advised *'the Trust explain in this letter that as the CXR could not exclude areas of 'consolidation' and the patient had increased inflammatory markers, the patient was treated for a chest infection with antibiotics. This is a reasonable explanation, although perhaps the Trust should have used the term 'CAP' to satisfy the complainant'.*

The diagnosis of type 2 respiratory failure

73. The IPA advised *'the Trust explains that because the patient had type 2 respiratory failure, she required non-invasive ventilation. There is no explanation as to what type 2 respiratory failure is to the complainant, nor what the purpose of NIV is. This was not a good enough explanation to explain why the patient was in type 2 respiratory failure'.*

Not assessing for oxygen therapy before discharge.

74. The IPA advised *'the Trust explain further what an ambulatory oxygen assessment involves and how the patient's referral was triaged as non-urgent and delayed due to the COVID pandemic. In my opinion, this is a good explanation as to what ambulatory oxygen assessments involve.*
It might have been useful to explain as well to the complainant why the patient did not need an urgent oxygen assessment and more specifically why it was felt the patient did not need an oxygen assessment before discharge.
In this letter to the complainant, the Trust do however explain that the medical team made a verbal request to the respiratory nurse for the community team to review her at home post discharge. This review took place on 11.6.20'.

The lack of referral to cardiology

75. The IPA referred to the Trust's letter dated 22 July 2020 to the complainant which explained that the respiratory consultant did not ask for a cardiology review as this is not necessary in all patients who present with CCF and her most recent ECHO result from her cardiology review '*did not suggest the need*

for any particular cardiology intervention'. The IPA advised *'Whilst this is likely an appropriate clinical reason, the Trust could have explained in this letter a little more about the type of heart failure the patient had and how the cardiology team would have unlikely changed her inpatient management.'*

76. The IPA also referred to the Trust's letter to NIPSO dated 10 June 2021 and advised that all the responses were reasonable. She concluded that *'none of the letters from the Trust contain miscommunication, falsehoods, or contradictions with regards to the patient's conditions'.*

77. The IPA concluded *'There appears to have been a breakdown in communication between the medical team and the complainant. Although the patient seemingly had capacity and so could have updated her daughter as well, the complainant was looking for reassurance that her mother had received appropriate medical care and ultimately felt she did not get this reassurance both during her admission and afterwards in the letters she received from the Trust'.*

Analysis and Findings

78. Paragraph 33 of the GMC guidance requires doctors to *'be considerate to those close to the patient and be sensitive and responsive in giving them information and support'.* The NMC Code requires nurses to '*communicate clearly*' and to '*keep clear and accurate records relevant to your practice*'.

79. The complainant did not believe that the Trust upheld these standards of communication.

Communication with complainant

80. The medical records show the respiratory consultant in charge of the patient's care telephoned the complainant on 1 June 2020. He recorded that he updated her '*on the patient's condition and plan of management'* and told her that she '*is currently being treated actively and she is showing some improvement'.* The complainant's comment that the *'Dr didn't know if she would make it through the day'* on 1 June 2020 suggests that the consultant conveyed to the

complainant that the patient was seriously ill and that the complainant understood.

81. However, the IPA advised that the entry was *'short'* and not adequate *'to fully update the complainant on all the aspects of her mother's care'.* The IPA provided examples of further information that the consultant could have provided to the complainant which would have helped with communication about the patient's condition.

82. The IPA advised that the nursing notes record the complainant telephoned on 4 June 2020, asking to speak to a doctor. The complainant's telephone calls on 4 June 2020 are recorded only in the nursing notes and not in the medical records. It is therefore unclear whether nursing staff passed on the complainant's enquiries to the medical team, therefore I cannot conclude that they were. I accept the IPA's advice that the nursing staff should have left a written message for the team to ring the complainant back so that there was no doubt that the messages were passed on to medical staff.

83. It was the following afternoon, 5 June 2020, after the complainant rang again twice, before a doctor retuned her call. This meant that the complainant had not spoken to a doctor since 1 June 2020, when she was informed that her mother was seriously ill. The nursing notes record several conversations with nursing staff, however the complainant said the nurses were not able to answer all her questions. The patient was due to be discharged that day, therefore speaking to a doctor was important to the complainant.

84. In respect of 1 June 2020, having considered the IPA's advice, I find the respiratory consultant's update to the complainant that day failed to meet the standard of communication required in the GMC Guidance, set out above.

85. In respect of 4 June 2020, having considered the IPA's advice, I find the content of the nursing notes regarding any potential communication between nursing staff and the patient's doctors regarding the complainant's calls failed to

be sufficient to meet the standards of record-keeping and communication required by the NMC Code.

86. In respect of 5 June 2020, having considered the IPA's advice, I am satisfied the communication between the patient's doctors and the complainant was sufficient to meet the standards required by the GMC Guidance.

87. I consider the failings identified caused the complainant to sustain the injustice of uncertainty and upset about her mother's condition. I therefore uphold this element of the complaint.

Written responses to complainant 22 July and 22 October 2020

88. The Trust wrote to the complainant on 22 July 2020 in response to the complaint. The IPA identified deficiencies in the Trust's explanations about CCF, type 2 respiratory failure, and oxygen therapy.

89. The Trust wrote to the complainant again on 22 October 2020 and provided further information. The IPA advised that the Trust could have provided a better explanation of type 2 respiratory failure and the reason why the patient did not need an oxygen assessment before discharge.

90. I accept the IPA's advice that '*the Trust could learn from the limited number of issues in respect of communication, identified above'*. In the IPA's opinion the Trust provided satisfactory explanations to NIPSO's investigation enquiries in its response of 30 June 2021. This leads me to conclude that escalation of the complaint to NIPSO may have been avoided had the Trust provided a similarly detailed response to the complainant on 22 July and 22 October 2020.

91. The HSC Guidance in relation to the Health and Social Care Complaints Procedure 2019 requires the Trust to provide appropriate and proportionate responses to complaints it receives. Responses must be '*clear, accurate, balanced, simple, and easy to understand*', and should '*address the concerns expressed by the complainant and show that each element has been fully and fairly investigated*'. Taking the IPA's advice into consideration, I consider the

Trust failed to adhere to this Guidance in respect of the abovementioned aspects of its letters dated 22 July and 22 October 2020. As such, I consider the Trust failed to adhere to the first Principal of Good Administration, 'getting it right', which requires a public authority to comply with its own published policies and procedures. The Trust also failed to adhere to the second Principal of Good Administration, 'being customer focused' in terms of the level of detail provided to the complainant in aspects of those responses.

92. These failings constitute maladministration, which caused the complainant to sustain the injustice of uncertainty regarding whether the patient had received appropriate medical care. Furthermore, the failing caused the complainant to take the time and effort of bringing this complaint to my Office. I therefore uphold this element of the complaint.

CONCLUSION

Care and treatment

93. I received a complaint about the actions of the Trust in relation to the care and treatment of a patient in the CH. The complainant is the patient's daughter. The complainant was dissatisfied with delays in returning her calls and the standard of communication from the medical staff. She also said that the Trust failed to adequately explain the patient's diagnoses and treatment in the written responses to her complaint.

94. I considered whether the care and treatment provided to the patient were appropriate, reasonable and in accordance with relevant standards, guidance and practice.

95. I accept the conclusion of the IPA that, with the exception of the lack of assessment for oxygen therapy before discharge *'the medical management of this patient was to the standards expected; the diagnoses were correct and the patient received appropriate care'.* Whilst it was found that diagnostic tests such as BNP and ECHO would have added weight to the diagnosis of CCF, it was also found that the Trust failure to perform these tests did not ultimately alter the management of the patient.

96. I consider the failing regarding oxygen therapy caused the patient to sustain the injustice of loss of opportunity to receive palliative oxygen therapy for symptom relief at an earlier stage – as well as upset at the delay she experienced. This failing also caused the complainant to sustain the injustice of upset in terms of having to witness her mother's ongoing respiratory distress. The failing in respect of the diagnostic tests caused the complainant to sustain the injustice of uncertainty regarding the patient's condition These failings also caused the complainant to take the time and effort of bringing this complaint to my Office. I uphold this element of the complaint.

Communication

97. I also considered whether communication with the complainant met relevant standards.

98. I accept the advice of the IPA that the pressures of the COVID pandemic meant that doctors in a busy respiratory ward had to prioritise telephoning relatives of those patients whose condition was deteriorating over those who were improving, as this patient was.

99. The Trust explained that Covid restrictions and a prohibition on visiting created difficulties in communicating with relatives, therefore *'the Trust developed the use of the Family Liaison Service to assist ward staff in providing ongoing updates in relation to patients' condition and also assisting where possible to promote the use of our virtual visiting'* (see appendix five). Had that initiative been in place in June 2020, it would undoubtedly have improved the complainant's experience.

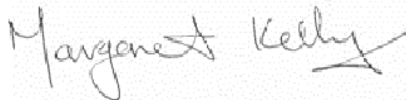
100. As well as tardiness in returning the complainant's calls, I found that the Trust did not adequately explain the patient's diagnoses and treatment, firstly in phone calls with the complainant and then in the written responses to her complaint. I consider that these failings caused her the injustice of uncertainty and upset about her mother's condition. These failings also caused the complainant to take the time and effort of bringing this complaint to my Office. I uphold these elements of the complaint.

Recommendations

101. 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 failures identified within **one month** of the date of the final report.

102. I welcome that the Trust introduced the Family Liaison Service to assist with communication with relatives. I further recommend that the Trust provides me with a copy of the current policy in place for communicating with relatives during those periods when visiting is curtailed or prohibited. The Trust should provide this within **one month** of the date of the final report.

103. For service improvement in complaints handling and to prevent future recurrence, I recommend that the learning from this report is shared with the staff in the Acute Services Complaints Office who were involved in the resolution of this complaint. Staff should also be reminded of the Principles of Good Complaint Handling which I attached at Appendix two to this report.



MARGARET KELLY
OMBUDSMAN
18 January 2023

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.