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

Report Reference: 202003319

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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). The complainant made a complaint about the care and treatment the Trust provided to her late father (the patient) at Causeway Hospital (the hospital) between 12 November and 18 November 2021. The complainant believed the Trust prescribed the incorrect antibiotic to the patient in the Emergency Department (ED). She said the patient developed pressure sores in the ED. She also believed that nursing staff '*neglected*' to sufficiently monitor the patient, who died after removing his oxygen mask. The complainant questioned why the Trust did not commission a Serious Adverse Incident review following the patient's death.

The investigation established failures in care and treatment in that nursing staff did not make a plan of care to include a risk assessment of the patient's skin in the ED. The investigation also found the Trust failed to record its rationale for not reviewing the complaint under its SAI policy.

I recommended that the Trust provide the complainant with a written apology for the injustice caused as a result of the failures in care and treatment I identified. I also made recommendations for service improvements to prevent recurrence of the failings identified.

I extend my deepest condolences to the complainant and her family for the loss of her father.

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 Trust provided to the complainant's late father (the patient) at Causeway Hospital (the hospital) between 12 and 18 November 2021.

Background

2. The patient attended the hospital's Emergency Department (ED) on 12 November 2021 after collapsing at home and experiencing shortness of breath. The patient had a history of COPD[1], Bronchiectasis[2], Korsakoff's syndrome[3] and cognitive impairment.

3. In the ED doctors prescribed amoxicillin[4] for the patient's respiratory issues and admitted him for further treatment. The patient was exposed to a COVID positive patient in the ED, while he was awaiting transfer to a ward. Nurses carried out a skin inspection in the ED and found pressure sores inside the patient's knee and on his left buttock/sacrum[5].

4. The Trust transferred the patient to a medical ward on 14 November, two days after his arrival in the ED. It placed him in a side room as a potential COVID case. He subsequently tested positive for COVID and developed COVID related pneumonia. He remained in the side room.

5. The patient's clinical condition deteriorated, and the Trust placed him on a high flow nasal cannula[6] to maintain his oxygen saturations[7]. A nurse checked the patient on the evening of 18 November and found him unresponsive. A doctor

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[1] Chronic Obstructive Pulmonary Disease: the name for a group of lung conditions that cause breathing difficulties.
[2] A condition in which airways of the lungs remain permanently damaged and widened due to persistent infection. This causes accumulation of excess mucus and bacteria resulting in frequent infections and breathing problems.
[3] A disorder of the central nervous system characterized by amnesia, deficits in explicit memory, and confabulation.
[4] A penicillin antibiotic used to treat bacterial infections, including chest infections.
[5] A single bone comprised of five separate vertebrae that fuse during adulthood. It forms the foundation of the lower back and the pelvis.
[6] A device that delivers extra oxygen through a tube and into a patient's nose. They help people who are having difficulty breathing due to a medical condition or another reason.
[7] The percentage of oxygen in a person's blood. In general a level below 95% is considered abnormal.

pronounced him dead shortly afterwards. The patient had removed his oxygen mask.

Issue(s) of complaint

6. I accepted the following issue(s) of complaint for investigation:

Issue 1: Whether the care and treatment the Trust provided to the patient between 12 November 2021 and 18 November 2021 was reasonable and appropriate and in accordance with relevant policies and guidance. In particular this will consider:

- Appropriate antibiotics administered in the Emergency Department;
- Presence of pressure sores; and
- Monitoring on ward on 18 November

Issue 2: Whether the Trust should have commissioned a Serious Adverse Incident[8] review following the patient's death on 18 November 2021?

INVESTIGATION METHODOLOGY

7. 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.

Independent Professional Advice Sought

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

- A Consultant in Emergency Medicine 2005 to present (ED IPA);
- A Deputy Chief Nurse for an NHS Trust practising since 1995 (N IPA); and

[8] A method of formally assessing significant events, with a view to improving patient care and services. The process involves seeking contributions from all members of the healthcare team and a subsequent discussion to answer why the occurrence happened and what lessons can be learned. Events triggering an SAI can be diverse, include both adverse and critical events, as well as good practice

- A Consultant Physician/Geriatrician working in the NHS since 2011 (G IPA).

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

9. 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[9]:

- The Principles of Good Administration

10. 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 Good Medical Practice, updated April 2014 (the GMC Guidance);
- The National Institute for Health and Care Excellence (NICE) Chronic obstructive pulmonary disease in over 16s: diagnosis and management, updated July 2019 (NICE NG115);
- The National Institute for Health and Care Excellence (NICE) (End of life care for adults: service delivery, October 2019 (NICE NG142);
- The National Institute for Health and Care Excellence (NICE) Pneumonia (hospital-acquired): antimicrobial prescribing, September 2019 (NICE NG139);

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

- Northern Health and Social Care Trust (the Trust) Antibiotic Therapy (First-line Empirical) In Hospitalised Adults, October 2019 (Trust Antibiotic Therapy policy);
- Northern Health and Social Care Trust (the Trust) Policy and Procedures for the Reporting and Management of Adverse Incidents, September 2021 (Trust SAI Policy);
- The Nursing & Midwifery Council (NMC) The Code – Standards of Conduct, performance and ethics for nurses and midwives, October 2018 (NMC Code);
- The Nursing & Midwifery Council (NMC) Future nurse: Standards of proficiency for registered nurses May 2018 (NMC Standards of proficiency);
- Royal College of Emergency Medicine (RCEM) Tackling Emergency Department Crowding, December 2015 (RCEM Tackling ED Crowding);
- Royal College of Emergency Medicine (RCEM) Crowding and its Consequences, November 2021 (RCEM Crowding and its Consequences; and
- Royal College of Physicians (RCP) National Early Warning Score (NEWS)[10]2 Standardising the assessment of acute-illness severity in the NHS, December 2017 (RCP NEWS Guidance).

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

11. 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.

12. 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 complainant did not raise any issues in relation to the

[10] A guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs

draft report's findings, however she noted that for her the report highlighted the '*unacceptable level of care*' the Trust provided to the patient at the hospital. The Trust did not have any comments.

THE INVESTIGATION

Issue 1: Whether the care and treatment the Trust provided to the patient between 12 November 2021 and 18 November 2021 was reasonable and appropriate and in accordance with relevant policies and guidance?

Appropriate antibiotics administered in the Emergency Department

Detail of Complaint

13. The complainant queried the Trust's decision to treat the patient's respiratory symptoms with the antibiotic amoxicillin in the ED. She said she informed ED staff on two occasions '*it was known*' amoxicillin '*would not work*' in the patient's case. She said that had doctors checked the patient's Electronic Care Record (ECR) and viewed his history they would not have prescribed amoxicillin. She believed that if doctors had prescribed a '*strong*' antibiotic the Trust '*may have never*' needed to admit him to a ward. She also queried why there were no respiratory doctors on call on the weekend of the patient's admission.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following:
    - Trust Antibiotic Therapy policy; and
    - RCEM Tackling ED Crowding.

Trust's response to investigation enquiries

15. The Trust stated the following: the patient did not require specialist input on arrival at the ED. Tests in the ED did not show '*anything acute*', or evidence of pneumonia. Doctors '*appropriately*' treated the patient's presenting symptoms with amoxicillin in line with the Trust Antibiotic Therapy policy. Doctors '*would*' have checked the ECR but '*would not have had time*' to check his full history. The patient died from COVID infection on the background of '*severe lung*

disease'. Investigations indicated he had a '*non-bacterial infection*' therefore the choice of antibiotic would not have changed his outcome[11].

16. The hospital is '*small*' and '*peripheral*' with only two respiratory consultants. It was '*not possible*' for the consultants to be on duty every weekend. The respiratory team at Antrim Area Hospital were available on weekends to provide advice if required.

Relevant Trust records

17. I carefully considered the patient's clinical records. A summary of the relevant clinical records is enclosed at Appendix four to this report.

Relevant Independent Professional Advice

ED IPA

18. The ED IPA advised the following the Trust appropriately prescribed amoxicillin for community acquired respiratory infection following the patient's presentation to the ED. The patient had '*severe*' COPD. Treatment of an exacerbation of this condition '*includes*' but is not limited to oral antibiotics. The failure of a previous treatment regime was '*unlikely*' due to the specific antibiotic used, in the absence of '*specific biological sample reports*'. A '*valid*' reason for clinicians to use another antibiotic would have been if the complainant had experienced a '*microbiologically proven respiratory colonisation with an organism known to be resistant to amoxicillin'* and that this information was '*readily available*' to ED staff. Another reason to prescribe an alternative antibiotic would be in the case of an allergy to penicillin. The patient's ECR showed '*no*' antibiotic '*allergies.'* Therefore, ED staff acted appropriately in their decision not to '*deviate*' from the guidance based on the complainant's information.

19. In relation to whether ED staff should have sought advice from the respiratory team, the ED IPA advised: the ED's role is to provide '*timely*' treatment for '*acute, undifferentiated illness and injury*'. The ED team initially assessed and treated the patient. It then concluded he required admission to a ward for

[11] Antibiotics are used to treat or prevent some types of bacterial infection. Antibiotics do not work for viral infections.

further treatment. It would not be '*reasonable*' to expect ED staff to provide '*ongoing care*' to patients who are unable to move to a ward due to capacity reasons. The inpatient team '*should*' make the decision as to whether the patient required additional respiratory input.

G IPA

20. The G IPA advised that a doctor reviewed the patient with input from an '*Acting*' respiratory consultant on 16 November. The '*speed*' of this review and the Trust's management of the patient's condition were '*appropriate*'.

Analysis and Findings

21. The complainant questioned the Trust's choice of antibiotic. She said she made staff aware that amoxicillin '*would not work*' for the patient. I examined the patient's medical records. The triage notes document the patient collapsed at home; he was experiencing confusion and shortness of breath, and his oxygen saturations were low. The ED notes documented the patient's medical history including COPD, Bronchiectasis and Korsakoff's Syndrome. The notes document a working diagnosis of '*IECOPD*' (Infective Exacerbation of COPD)[12]. The notes further document that ED staff gave the patient 1g of amoxicillin approximately two hours after his arrival at the ED.

22. I examined the Trust Antibiotic Therapy policy which states that the '*preferred regimen*' to treat IECOPD is amoxicillin '*1g 8 hourly*' given orally. The policy recommends alternative regimen in cases where a patient has a '*serious penicillin allergy and hypersensitivity*'. I examined the patient's records which do not record an allergy to penicillin. I also examined the patient's ECR records which list his prescribed medications for the previous six months. There is no documentation in the ECR records to suggest '*it was known*' amoxicillin '*would not work*' in the patient's case.

23. The patient's notes do not record any conversations between the complainant and ED doctors; though I have no reason to question the complainant's account. Nevertheless, I note the ED IPA's advice that he would not expect ED

[12] A worsening of the symptoms of COPD such as shortness of breath, caused by an infection.

staff to '*deviate*' from antibiotic policy based on information from the complainant in the absence of a report of a '*microbiologically proven respiratory colonisation with an organism known to be resistant to amoxicillin'*. There is no record of such a report in any of the patient's records the Trust provided to this Office. The ED IPA advised that the role of ED staff is to provide '*assessment and treatment of acute, undifferentiated illness'.* He advised that ED doctors diagnosed the patient with IECOPD and treated him with the recommended antibiotic. There was no indication in the patient's records that this antibiotic would have been unsuitable for him. I accept the ED IPA's advice. Having considered the Trust's guidance, the patient's records and the ED IPA advice, I am satisfied ED staff treated the patient's presenting symptoms with the appropriate antibiotic.

24. The complainant questioned why there were no respiratory doctors on call during the weekend of the patient's admission and why he was not placed under the care of a respiratory team. I note the Trust's response that while the hospital respiratory team were not on call that weekend, other consultants within the Trust were available to provide advice. The ED IPA advised that ED staff decided the patient required admission to an inpatient setting following his diagnosis of IECOPD. The Trust could not facilitate the transfer at that time due to a lack of available beds on the wards. I note his advice that at this point, given the patient's '*situation*' it was the inpatient team's responsibility decide as to whether he required additional respiratory input.

25. I examined RCEM Tackling ED Crowding which states the following: *Patients boarding in the ED are usually the joint responsibility of the clinical team to which they have been referred, and the ED team. Inpatient clinical teams should not avoid taking clinical responsibility for patients who have been referred to them simply because the patients cannot be moved to an inpatient ward*'. I consider that this guidance places more responsibility on the ED team than the ED IPA's advice suggests. However, I note the G IPA's advice that the timing of the respiratory review on the ward on 16 November and the Trust's management of the patient's condition were '*appropriate*'. I examined the patient's notes which document that a doctor reviewed the patient at 10.50 on

15 November. The patient's oxygen saturations were recorded as being at 90%. He also informed the doctor that he felt '*better*' and that '*his chest infection* [had] *gone*'. The patient's condition began to deteriorate on 16 November at which point the doctor reviewing him requested a respiratory review.

26. I acknowledge the complainant's concerns in relation to this matter. The patient had a history of respiratory related issues and required oxygen at home. It is an entirely reasonable expectation on the complainant's part that the respiratory team would review him or provide advice on his admission to hospital. However, having reviewed the guidance, the patient's medical records and considered the ED IPA's advice in the context of the G IPA's advice I am satisfied that the Trust referred the patient for respiratory review/advice at the appropriate time.

27. In summary, I am satisfied that ED staff treated the patient's condition in accordance with its antibiotic policy and there was no indication at that time to refer him to the respiratory team following his presentation to the ED. Therefore, I do not uphold this element of the complaint.

Presence of Pressure sores

Detail of Complaint

28. The complainant said the patient did not have pressure sores prior to his admission to hospital. She said if he developed pressure sores it '*could only have been*' because he remained in the ED '*for 4 days*' without '*assistance for personal care'*.

Evidence Considered

Legislation/Policies/Guidance

29. I considered the following:

- NMC Standards of proficiency; and
- NMC Code

Trust's response to investigation enquiries

30. The Trust stated the following: it would '*refute*' the complainant's '*statement*' the patient developed pressure sores in the ED. ED staff '*felt*' the sore on the sacrum was a '*longstanding injury*'. Nurses provided personal care in the ED and the medical ward.

Relevant Independent Professional Advice

31. The N IPA advised the following: ambulance staff assessed the patient during his transfer to hospital. They did not note the presence of pressure sores but noted that he had been incontinent at some point during the incident. Nursing staff first assessed the patient at 21.00 on 12 November. They carried out the first full skin inspection on 13 November at 10.15. They identified Grade 2 pressure sores[13] on the patient's inner left knee and left buttock/sacrum. Nurses assessed the patient's skin on two additional occasions in the ED and '*acknowledge*[d] *and documente*[d]' the same areas.

32. The N IPA also advised it was possible the patient could have developed pressure sores in the period between his initial assessment and his first full skin assessment. If '*not attended to*' skin can deteriorate within '*3 hours*'. The patient's condition could '*exacerbate*' this process, and anyone with 'multiple co-morbidities is at '*greater risk*' of developing sores. The patient '*could have easily*' developed pressure sores during the time he spent in the ED.

33. The N IPA suggested nursing staff in the ED '*should have*' had a plan of care for the patient given they identified pressure sores on the morning after his arrival in the ED and also due to his extended stay there. The plan should have included carrying out a risk assessment regarding his skin. This could involve a mattress to '*provide pressure relief*'. It could also include a plan to turn the patient, or to '*remind*' him to turn himself. Nurses should also have included a plan for '*dressing*' his ulcers. Failing this ED nurses should have had and recorded a '*recognition of his needs*' and handed this information over to nursing staff caring for him on the ward. As there was no evidence of such

[13] A sore that has broken through the top layer of the skin and part of the layer below. This typically results in a shallow, open wound.

planning in the patient's notes, the N IPA advised the nursing care in this respect was not '*reasonable*'.

Analysis and Findings

34. The complainant told the Investigating Officer that she and her mother cared for the patient at home. She said because of this she '*would have known*' if he had any pressure sores before his admission to the hospital. She said he did not. I note the Trust's statement that nursing staff felt that the sore on the patient's sacrum was '*longstanding*'. I examined the patient's records. The patient report form (PRF) completed by ambulance staff who transported the patient to hospital does not note the presence of pressure sores. I note that when nurses assessed the patient's skin in the ED at 10.15 on 13 November, in addition to the pressure sores, they recorded the presence of bruises on the patient's right leg and buttock which ambulance staff did not record. It is therefore unclear if ambulance staff assessed the patient's skin when they took him to hospital.

35. The records the Trust provided document nurses first assessed the patient's skin on 13 November at 10.15, over 13 hours after he presented to the ED. I note the N IPA's advice that pressure sores can develop within three hours, especially in cases where a patient has a range of co-morbidities, and that the patient could '*easily*' have developed sores in the ED during that time. However, it is unclear from the documentation when these pressure sores developed. There is a clear disparity between the Trust's view that the patient's pressure sore on his sacrum was '*longstanding*' and the complainant's strong view that he did not have any pressure sores when he went into hospital. Given the lack of available evidence, I am unable to conclude if the patient developed sores in the ED.

36. However, I note the N IPA's advice that it would have been appropriate for nurses to carry out a risk assessment of the patient's skin, including a plan of care to reduce the risk of pressure damage once they had documented the presence of pressure sores. I examined the patient's records, and I could not identify any such plan in the nursing notes. I also could not identify any written recognition of the complainant's needs in relation to skincare. Given that the

patient remained in the ED for almost 45 hours, I am concerned that I could not find evidence to show that nursing staff were turning the patient to relieve pressure damage, or documenting how they dressed his wounds.

37. The N IPA referenced the NMC Standards of proficiency which states that nurses should '*demonstrate the ability to accurately process all information gathered during the assessment process to identify needs for individualised nursing care and develop person-centred evidence-based plans for nursing interventions with agreed goals'*. In addition, the NMC Code requires nurses to '*keep clear and accurate records relevant to your practice*'. I cannot conclude from the records whether nurses provided appropriate skin care to the patient in the ED, or how this may have impacted the patient. However, having considered the medical records and the relevant guidance, I accept the IPA's advice that nurses did not provide '*reasonable care*' in their failure to write a plan of care including risk assessing the patient against the possibility of further skin damage.

38. I consider the failure of nurses to write a plan of care including a risk assessment of the patient's skin constitutes a failure in care and treatment. I therefore partially uphold this element of the complaint. I consider that because of the failures identified the patient sustained the injustice of the loss of opportunity to have a plan of care put in place to have his skin appropriately risk assessed in the ED.

Monitoring on the ward on 18 November

Detail of Complaint

39. The complainant said that on the night of 18 November 2021, staff left the patient for a '*prolonged period of time*' without checking him. She said doctors told the family the patient was not expected to pass away on that evening. The patient's sister was sitting outside the patient's room, and a doctor told her to go home. However, staff left him unsupervised, and he pulled off his oxygen mask '*for a drink*'. As the patient lacked capacity, he *forgot* to put his mask on again and sadly subsequently passed away. The patient had pulled off his mask earlier that day and the complainant asked why the Trust did not risk assess him and provide '*1:1*' monitoring. The complainant felt this '*neglect*' by

staff was '*distressing*' as it meant that the family lost the opportunity to see the patient before he died.

Evidence Considered

Legislation/Policies/Guidance

- The GMC Guidance
- NICE NG142;
- The NMC Code; and
- RCP NEWS Guidance

Trust's response to investigation enquiries

40. The Trust stated the following: ward staff did not neglect the patient or leave him unattended for a prolonged period on 18 November. It was not feasible for nurses to care for the patient on a '*one to one*' basis. He was COVID positive and using a high flow nasal cannula (AIRVO) in an enclosed side room. This meant that staff entering the room were at high risk of exposure to COVID. The consultant in charge of the patient's care was '*unaware*' he had removed his mask earlier that day and he appeared '*compliant*' with the oxygen therapy. The Trust also stated even if the patient's sister had stayed outside his room, she '*may not*' have noticed him taking off his mask as she would have to stand up to see him through a small window in the door.

41. The Trust stated the patient had COVID pneumonia, and his oxygen saturations were very low even though he was on '*maximal*' oxygen therapy. He was '*unlikely*' to survive. The Trust discussed this with the family. They wanted the treatment to continue '*in the hope*' the patient would be able to see his wife and the complainant who were at home isolating with COVID. Given his condition, it was '*unlikely*' the patient would have survived more than '*a few minutes*' without his oxygen mask.

Relevant Independent Professional Advice

N IPA

42. The N IPA advised the following: on 18 November the care nurses provided to

the patient was of a '*high standard*' and '*followed*' all the patient's care plans. Nurses '*frequently*' monitored the patient throughout the day in a '*variety of ways*' and '*escalated*' to medical staff when necessary. Nurses took observations on nine occasions on the day '*as per protocol*'. Nurses also checked the patient's AIRVO on five occasions during the day. The N IPA concluded that overall, the frequency with which nurses monitored the patient was '*reasonable*'. She advised that in addition to nursing staff doctors also attended the patient at 18.00 and 18.45.

G IPA

43. The G IPA advised the following: there was no indication for a '*formal*' risk assessment after doctors found the patient had removed his mask on the morning of 18 November. The consultant carried out a ward round with another doctor at 09.45. An entry from the record states '*note events overnight*'. The G IPA would '*expect*' the consultant to have read the previous notes, '*including*' the patient removing his mask. Given that he had previously removed his mask, it was '*predictable*' that he would do so again. It would therefore have been '*best practice*' for doctors to ask nursing staff to monitor the patient more frequently to assess how '*well or how poorly*' he was tolerating his oxygen mask. However, the G IPA advised given the patient's '*very poor*' prognosis, increased monitoring was not '*likely*' to have changed his '*sad outcome*'. Even with one-to-one monitoring it would not have been '*possible*' for ward staff to '*enforce*' the patient to keep his mask in place.

44. The patient's notes from 17 November documented clinicians' plan to '*prioritise*' end of life care if his oxygen levels on maximum AIRVO dropped and his clinical condition deteriorated. This would involve taking him off the AIRVO, switching him to a '*standard*' oxygen mask and allowing his sister to visit him. The patient's oxygen saturations dropped to 56% at 17.00 on 18 November and recovered slowly to 78%. This indicated a '*likely deterioration*' in his condition. The G IPA noted this was a '*potential missed opportunity*' to move him to end of life care and to allow his family to be with him. However, the '*notes suggest*' clinicians regularly reviewed the plan and that the patient was '*comfortable*' and '*happy*' to continue with the AIRVO treatment.

Analysis and Findings

45. The patient's records document that a nurse attended his room at 19.40 on 18 November to check his blood sugar and found he was '*not breathing*'. A subsequent entry noted the nurse found the patient '*with AIRVO mask removed*'. A doctor pronounced him dead at 20.00. The complainant believed the patient's death was caused by insufficient monitoring by nursing and medical staff and a failure by doctors to risk assess the patient after he removed his mask earlier that day.

46. The patient's records document a doctor reviewed him at 06.40 on 18 November and found he had removed his oxygen mask. The nursing records document that following this review nursing staff carried out observations on the patient at 09.00 (NEWS 7), 10.00 (NEWS 4), 14.00 (NEWS 4) and 17.00 (NEWS 9). RCP NEWS guidance states '*We recommend that for patients… the minimum frequency of monitoring should be … 4–6 hourly for scores of 1–4... We recommend that the frequency of monitoring should be increased to a minimum of hourly for those patients with a NEW score of 5-6'.* Nurses checked the patient's AIRVO settings at 08.30, 12.30, 14.30, 16.30 and 17.30. The records also document nurses carried out skin assessments and repositioned the patient at 08.00, 13.00 and 18.00. Therefore, nurses checked the patient on 12 documented occasions after the patient removed his mask on 18 November. I note that in its response to the original complaint, the Trust stated that the nurse-in-charge of the ward carried out a '*visual check*' on the patient at 19.30 who '*had his mask*' on and '*appeared comfortable*'. There is no record of this event in the documentation the Trust provided.

47. The N IPA referenced the NMC Code which requires nurses to '*make sure you deliver the fundamentals of care effectively'* and '*identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.* I note the N IPA's advice that the care nurses provided was of a '*high standard*' and the frequency of the monitoring was '*reasonable*'. Having considered the patient's records and the relevant guidance, I accept the N IPA's advice. I am therefore satisfied that

nurses appropriately monitored the patient in accordance with the guidance.

48. The complainant questioned if doctors should have risk assessed the patient after he was found to have removed his mask on the morning of 18 November. The medical records document that when the doctor entered the room, the patient '*had removed the nebuliser mask then put it on again*'. The consultant in charge of the patient's care stated in the Trust's response to this office she was '*unaware*' the patient had removed his mask. I find this surprising as the consultant and a junior doctor reviewed the patient approximately three hours after this incident. I note the G IPA's advice that she would '*expect*' the consultant to have read the previous entry.

49. The G IPA advised there was no indication for a '*formal*' risk assessment. However, it would have been '*best practice*' for doctors to ask nursing staff to monitor the patient more frequently to assess how he was tolerating his mask. When considering clinical care and treatment, this Office does not apply a 'best practice' or 'gold standard' test. When I consider complaints about clinical care and treatment this Office aims to establish what would have been reasonable and appropriate clinical care and treatment in the situation complained about and to decide whether what actually happened fell short of that. The G IPA advised that the patient's prognosis was '*very poor*' and increased monitoring was not '*likely*' to have changed his outcome. The G IPA further advised it would not have been '*possible*' for ward staff to '*enforce*' the patient to keep his mask in place. I also note the N IPA's advice that nurses were already '*frequently*' monitoring the patient throughout the day. Therefore, while I acknowledge the G IPA's advice that closer monitoring by nurses may have allowed clinicians to better assess how the patient was tolerating his oxygen mask, on balance I am satisfied that it was not likely have changed his outcome.

50. However, the complainant was concerned that she lost the opportunity to see the patient either virtually or in person before he passed away. I examined the patient's medical records which document doctors reviewed him on 17 November 2021 at 15.30. The notes record that if the patient's oxygen levels

dropped any further on maximum AIRVO and he '*deteriorated clinically*', doctors would prioritise end of life care and allow his sister to visit. On the morning ward round at 9.45 on 18 November, the patient indicated that he was happy to continue with current treatment and his sister agreed. He reiterated this at 10.30 the same morning. The records further document that at 17.00 on 18 November the patient's oxygen levels dropped to 56% when nurses repositioned him and '*took a long time*' to return to 78%.

51. I note the G IPA's advice that when the patient's oxygen levels fell on 18 November this was an indication of a '*likely deterioration*' in his condition. It was a '*potential missed opportunity*' to move him to end of life care and to allow his family to be with him. NICE NG142 states that the lead healthcare professional '*should ensure that the person approaching the end of their life is offered opportunities to discuss their existing treatment plans with a healthcare professional. The person's carers and other people important to them should be included in the discussions'.* In addition, the GMC guidance requires doctors to '*work in partnership with patients, sharing with them the information they will need to make decisions about their care, including: their condition, its likely progression and the options for treatment'.* There is evidence the Trust followed this guidance as documented in its discussions with the patient and the family on 17 November and the morning of 18 November.

52. I examined the patient's records which document the consultant made a retrospective note on 19 November detailing her interactions with the patient and his sister on the evening of 18 November. The consultant documented that she saw the patient at 18.00 and 18.45. She noted that at 18.00 he was '*stable*', and his oxygen saturations were between '*78-82%*'. She also documented that when she saw the patient at 18.45 '*he was stable*'. She documented that the patient's sister had been outside the patient's room but went home after the consultant asked her to leave the ward as staff were moving another patient. The consultant noted the patient's sister was *'to be contacted to be with pt if he deteriorated*'. I acknowledge the G IPA's advice that the drop in the patient's oxygen saturations was a '*potential missed opportunity*' to prioritise his end-of-life care and allow his sister to be present.

However, it is evident that the patient's consultant considered him to be stable when she last saw him at 18.45 and at that time his condition had not '*deteriorated*'. On this basis I am satisfied that the Trust acted in accordance with the guidance and the wishes of the patient and his family and that the care and treatment it provided in relation to this issue was reasonable and appropriate.

53. In summary, I am satisfied the Trust's monitoring of the patient on 18 November was reasonable and in accordance with the guidance. I am also satisfied it was reasonable for the Trust to maintain the patient on AIRVO on the evening of 18 November. Therefore, I do not uphold this element of the complaint. However, I fully appreciate how difficult and upsetting it must have been for the patient's family not to have been with him at the time he sadly passed away.

Issue 2: Whether the Trust should have commissioned a Serious Adverse Incident review following the patient's death on 18 November 2021?

Detail of Complaint

54. The complainant said the patient was not expected to pass away on 18 November and as such doctors sent his sister home. She said the patient had pulled off his oxygen mask and because he lacked capacity, he '*forgot*' to put it back on. She said a lack of supervision from ward staff constituted neglect and that the Trust should have treated the patient's death as a Serious Adverse Incident (SAI).

Evidence Considered

Legislation/Policies/Guidance

55. I considered the following :
    - Trust SAI policy.

Trust's response to investigation enquiries

56. The Trust did not address this issue in its response to this office. However, in its response to the complainant's original complaint it stated the following: when

it receives a complaint, the Trust considers whether it should be reviewed under the SAI policy. '*When your complaint was reviewed, it was not felt to require review under the SAI policy*'.

Analysis and Findings

57. I note the only explanation the Trust provided for not reviewing the complaint under the SAI policy was that '*it was not felt to require review under the SAI policy*'. I examined the patient's medical notes and the Trust complaint file, and I was unable to find any evidence the Trust considered whether the complainant's complaint should be reviewed under its SAI policy.

58. I examined the Trust's SAI policy which states an SAI should be considered in '*the unexpected/unexplained death of: - a service user*'. I examined the patient's medical records which document the patient's consultant sent the patient's sister home shortly before his death; she noted the patient '*was stable at that time*'. The records also document Trust's plan on 17 November to switch the patient to end of life care if his clinical condition deteriorated '*to allow sister in to visit*'. It is clear from the patient's notes that clinicians did not expect him to survive his stay in hospital. This is evident from the Trust's plan to switch him to palliative care and by asking him and his family if he wished to continue with oxygen therapy. However, the consultant's advice to the patient's sister to go home, along with her retrospective note documenting that the patient had *'obviously removed his specs leading to his deterioration*' indicates that the Trust did not expect the patient to die on the evening of 18 November.

59. The complainant raised concerns that a lack of supervision from nurses led to the patient removing his oxygen mask and dying unexpectedly. Having reviewed the patient's medical records it is apparent that clinicians did not expect the patient to die on the evening of 18 November. I consider therefore that his death was unexpected and thus constitutes a potential SAI under the Trust's policy.

60. I can find no evidence the Trust considered whether the complainant's complaint should be reviewed under the SAI policy. Given that the patient's

death meets the threshold to be considered as a potential SAI, I would expect the Trust to provide its rationale for not doing so. I am concerned by the lack of evidence of its decision making. I consider its response to the complainant that her complaint '*was not felt to require review'* under the policy to be inadequate and dismissive.

61. The Third Principle of Good Administration 'Being Open and Accountable' requires a public body to state '*its criteria for decision making and give reasons for decisions*.'. I do not consider the Trust meets these standards for the reasons outlined above. I consider that this failure to provide its reasons for not reviewing the complaint under the SAI policy constitutes maladministration.

62. Consequently, I am satisfied the maladministration identified caused the complainant to experience the injustice of upset, frustration, and uncertainty Therefore, I uphold this element of the complaint.

Residual Issue

63. Although the length of time the patient spent in the ED is not a matter the complainant raised in bringing her complaint to me, it is important that I highlight it in this report, particularly as the ED IPA advised that the '*failure of the trust to provide an inpatient bed for the patient in a reasonable timeframe* [was] *a failing of care. There is evidence that ED crowding due to lack of inpatient beds leads to poorer outcomes for patients, included increased mortality'.*

64. I acknowledge the difficulties the Trust faces in moving patients from the ED when there are no available beds on the relevant ward. This highlights the significant pressures experienced in the ED, especially during periods of increased COVID transmission. I also accept the ED IPA's advice that the care ED staff provided '*was of an appropriate standard. The patient was seen and assessed in a timely manner with appropriate care being commenced'.* However, I do not consider it acceptable that a patient must wait almost 45 hours to be transferred to a definitive place of care. The patient waited 10 times longer than clinical guidance recommends before being transferred to the

medical ward. I am concerned that this issue continues to be a feature in complaints to my office. While acknowledging that Trust staff take steps to make patients awaiting admission and their families comfortable, the ED is not an environment designed for a 45-hour stay. It is my expectation that the Trust will give careful consideration to this matter.

CONCLUSION

65. I received a complaint about the actions of the Trust. The complainant raised concerns about the care and treatment the Trust provided to the patient between 12 November and 18 November 2021.

Issue one

66. The investigation established failures in care and treatment in relation to the following matters:

- The failure of nursing staff to write a care plan including a risk assessment of the patient's skin in the ED;

67. I am satisfied the failures in care and treatment identified caused the patient to sustain the injustice of the loss of opportunity to have to have a plan of care put in place to have his skin appropriately risk assessed in the ED.

Issue two

68. The investigation established maladministration in relation to the following matters:

- The Trust's failure to provide adequate reasons or explanations for not reviewing the complaint under its SAI policy.

69. I am satisfied the maladministration identified caused the complainant to experience the injustice of upset, frustration, and uncertainty.

70. I acknowledge how distressing the patient's death was for the family, especially the fact that they did not have the opportunity to be with him when he passed. I appreciate this was a particularly challenging time for hospital staff, patients

and their families because of a renewed outbreak of COVID and the subsequent restrictions. I hope this report addresses the complainant's concerns and goes some way towards reassuring her that the Trust's efforts to treat and monitor the patient were reasonable and appropriate. I extend my deepest sympathies to the family for the loss of the patient.

Recommendations

71. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failures identified within **one month** of the date of this report.

72. I further recommend for service improvement and to prevent future recurrence, the Trust:

- Carry out a random sampling audit of patients' records within the ED from 1 April 2023 to the date of issue of the final report. This is to ensure that patients recorded as having pressure sores who spent in excess of 12 hours in the ED were suitably risk assessed with an appropriate care plan provided. The Trust take action to assess any shortcomings identified;
- The Trust undertakes a review of complaints in relation to Medical Ward 2 for the previous three years. This will concern complaints in which the complainant has requested an SAI following the unexpected death of a patient, or where the events suggest the threshold for consideration as an SAI was met but the Trust has not commissioned one. The purpose is to identify if the Trust provided a rationale when it considered it was not necessary to undertake an SAI. The Trust should take appropriate action to address any identified trends or shortcomings. The Trust ought to include any recommendations identified in its update to this office. The Trust should report its findings to my office.

73. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within three months of

the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies.

74. I am pleased to note the Trust accepted my recommendations.

MARGARET KELLY

NI Public Services Ombudsman

March 2024

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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.