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

Report Reference: 202002149

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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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Appendix 1 – The Principles of Good Administration

Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 202002149

Listed Authority: Northern Health & Social Care Trust

SUMMARY

I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to her husband (the patient) at Antrim Area Hospital between 11 February 2021 and 1 March 2021.
The complaint concerned particular aspects of the patient's care and treatment, which the complainant believed were inadequate. In particular, the complainant was concerned with aspects of the Trust's decision to discharge the patient on 15 February 2021, the management of the patient's blood glucose and the decision to sedate him when he became agitated. The complainant also questioned the Trust's decision to wait until 22 February to refer the patient to the Mental Health Liaison Service and the appropriateness of its communication with the patient's family.

To assist with the consideration of the issues the complainant raised, I obtained independent professional advice (IPA) from a Consultant Nurse for older people with over 30 years of relevant experience, an experienced Diabetes Specialist Nurse and a Consultant Physician and Geriatrician with over 40 years' experience.

The investigation found the Trust failed to keep adequate records of the patient's food intake for the period between 16 February and 22 February. It also found the Trust incorrectly withheld insulin after the patient experienced an episode of hypoglycaemia on 12 February 2021. These contributed to the patient's erratic blood glucose levels. I concluded these failures led to a loss of opportunity for the patient and caused the complainant to sustain the injustice of uncertainty.

I recommended that the Trust provide the complainant with a written apology for the injustice caused because of the maladministration I identified. I also recommended the Trust ensures it maintains food intake charts when caring for vulnerable, diabetic patients with erratic blood glucose levels and a variable food intake.

THE COMPLAINT

1. The complainant raised concerns about the actions of the Northern Health and Social Care Trust (the Trust) in relation to the care and treatment provided to her husband (the patient) at Antrim Area Hospital (AAH) between 11 February and 1 March 2021.

Background

2. The patient was admitted to AAH via the Emergency Department (ED) on 11 February 2021 with erratic blood sugars. He was transferred from Mid Ulster Hospital (MUH)[1] where he was in a rehabilitation ward recovering from a fractured leg. The complainant had Type 1 diabetes[2] and possible vascular dementia[3]. He had also tested positive for COVID-19 (COVID) on 4 February 2021.

3. The Trust transferred the patient back to MUH on 15 February 2021 following reviews by a Consultant and a Diabetes Nurse Specialist. Upon his arrival at MUH, the GP on call raised concerns that as the patient's blood sugars and the ketone[4] levels in his urine were very high, he may have been suffering with Diabetic Ketoacidosis (DKA)[5]. He was readmitted to AAH via the ED at 23.26 on 15 February. Clinicians in AAH established he was not DKA upon admission.

4. The patient remained in AAH until 1 March 2021. During his admission he developed delirium[6] and nursing staff sedated him on several occasions. The patient's blood sugar levels continued to fluctuate throughout his admission. The Trust referred the patient to a Dietician on 22 February. The patient's blood sugar levels stabilised and the Trust transferred him back to MUH on 1 March.

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[1] A sub-acute hospital where patients are managed by local GPs

[2] A chronic condition where the pancreas produces little or no insulin. This causes increased thirst, frequent urination, hunger, sudden weight loss and weakness

[3] A condition caused by the lack of blood that carries oxygen and nutrients to a part of the brain. It causes problems with reasoning, planning, judgment, and memory.

[4] A type of chemical produced by the liver when it breaks down fats

[5] A condition which causes the blood to become acidic as a result of a severe lack of insulin in the body

[6] A disturbed state of mind characterised by symptoms such as confusion, disorientation, agitation, and hallucinations.

Issue(s) of complaint

5. The issue(s) of complaint accepted for investigation was/were:

Issue 1: Whether the care and treatment provided to the patient by Antrim Area Hospital between 11 February and 1 March 2021 was reasonable and in accordance with relevant standards?

In particular, this will include consideration of**:**

- Discharge from hospital on 15 February 2021;
- Management of blood glucose;
- Requirement to sedate patient;
- Referral to Mental Health Liaison Service; and
- Communications with patient's family.

Issue 2: Whether the complaints handling by the Trust was appropriate?

INVESTIGATION METHODOLOGY

6. 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.

Independent Professional Advice Sought

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

- Consultant Physician and Geriatrician. MB MSc MD FRCP FRCPE FRCPI Dip Card RPMS. A consultant physician for over 40 years and an accredited geriatrician since 2001 (G IPA);
- Consultant Nurse for older people RN, BA(Hons), MSc, PGCert (HE). with over 30 years' experience across acute care, community and care homes (N IPA).

- Nurse Consultant in Diabetes. MSc in Diabetes. A specialist in Diabetes for almost 30 years who has led and developed teams of multidisciplinary diabetes specialist nurses, dieticians and Diabetologists in hospital and community settings. An autonomous practitioner giving advice/guidance to GPs, Practice nurses and Community nurses. (D IPA)

The clinical advice received is enclosed at Appendix three to this report.

8. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'; however how this advice was weighed, 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 which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

   The general standards are the Ombudsman's Principles[7]:
   - The Principles of Good Administration
   - The Principles of Good Complaints Handling

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 Department of Health's (DoH) Guidance in relation to the Health

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

and Social Care Complaints Procedure, April 2009 (the DoH's Complaints Procedure);

- Diabetes UK Evidence Based Nutrition Guidelines for the Prevention and Management of Diabetes, March 2018 (Diabetes UK Nutrition Guidelines for Diabetes);
- The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
- Joint British Diabetes Society for inpatient care (JBDS-IP). The management of hypoglycaemia in adults with diabetes mellitus, May 2018 (JBDS management of hypoglycaemia)National Institute for Care and Excellence (NICE) Clinical Guideline July 2007 CG50: Acutely ill adults in hospital: recognising and responding to deterioration (NICE CG50);
- National Institute for Care and Excellence (NICE) Clinical Guideline CG103: Delirium: prevention, diagnosis and management in hospital and long-term care (NICE CG103);
- National Institute for Care and Excellence (NICE) Clinical Knowledge Summaries (CKS) Delirium: Lorazepam April 2020 (NICE CKS Delirium Lorazepam);
- National Institute for Care and Excellence (NICE) Guidelines NG17: Type 1 diabetes in adults: diagnosis and management August 2015 (NICE NG17);
- National Institute for Care and Excellence (NICE) Guidelines NG97: Dementia: assessment, management and support for people living with dementia and their carers June 2018 (NICE NG97);
- National Institute for Care and Excellence (NICE) Quality Standard: QS24 Nutrition Support in adults November 201) (NICE QS24);
- Northern Health and Social Care Trust (the Trust) Complaints and Service User Feedback Policy and Procedure reviewed September 2018 (Trust Complaint's Procedure);
- Nursing and Midwifery Council (NMC), The Code - Standards of Conduct, performance and ethics for nurses and midwives, March 2015 (NMC Code); and

- Nursing and Midwifery Council (NMC): Future nurse: Standards of proficiency for registered nurses, May 2018 (NMC Standards of proficiency).

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

11. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important was taken into account 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 raised a number of issues. In considering the complainant's points, I decided to seek additional advice from the G IPA and also obtained advice from a Diabetes Specialist Nurse.

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the patient by Antrim Area Hospital between 11 February and 1 March 2021 was reasonable and in accordance with relevant standards?

Discharge from hospital on 15 February 2021

Detail of Complaint

13. The complainant said the patient's capillary blood glucose level (CBG) was 7.7 pre-breakfast on 15 February. She said it had risen to 26.6 when a nurse measured it before lunch on 15 February. The complainant questioned why the Trust discharged the patient to MUH with no evidence of regular glucose monitoring or provision of insulin after his breakfast. She said the Trust failed to explain what happened between the patient's transfer to MUH by ambulance at 15.30 and when clinicians first examined him there at 19.30. The complainant

said the Trust made no attempt to address her question if the patient was in DKA upon arrival at MUH.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following guidance:
    - NICE NG17.

The Trust's response to investigation enquiries

15. The Trust stated the patient '*had four times daily monitoring*' of his CBG. It explained clinicians prescribed insulin '*in accordance with diabetes team recommendations*'. It stated the patient's pre breakfast CBG on 15 February was 7.7 and following this '*he was deemed medically stable*' for transfer to MUH. It stated before it transferred him to MUH the patient's pre-lunch CBG was 26.6. It explained that as the patient was a brittle diabetic[8] a one off elevated CBG reading '*was not alarming*' and clinicians administered insulin as prescribed.

16. The Trust stated it booked an ambulance for 15.30 to transfer the patient to MUH, though it explained transport '*often*' arrived late. The Trust stated the patient arrived at MUH at 17.00. Nursing staff were concerned about his CBG and contacted the on-call GP. The Trust explained the GP advised nursing staff to recheck his CBG in one hour. Following this the GP attended the ward to assess the patient.

17. In relation to the complainant's concern that the Trust had not confirmed if the patient was in DKA while he arrived at MUH, the Trust stated it could not comment on this issue. It explained that the on-call GP felt the patient required a blood gas analysis to determine if he was in DKA. As MUH did not have the facilities to do this the GP arranged to transfer the patient back to AAH for testing. The Trust stated the patient was not in DKA upon arrival at AAH.

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[8] A term used to describe particularly hard to control type 1 diabetes. Sufferers are more likely to experience frequent, extreme swings in blood glucose levels

Relevant Trust records

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

Relevant Independent Professional Advice

19. The G IPA advised the patient was a brittle diabetic and it was '*almost impossible*' to keep his CBG stable. He advised '*this was not a bar*' to the Trust transferring the patient to a step-down facility to monitor his CBG. He further advised staff in MUH had the option to transfer the patient back to AAH if necessary, '*which is what happened*'.

20. I asked the G IPA if the Trust took a CBG reading before it transferred the patient to MUH. The G IPA referred to the patient's diabetic chart for 15 February. He advised the protocol was to record CBG before breakfast, lunch, dinner and bedtime. He advised the Trust '*correctly*' took a reading at 12.00 before the patient's transfer to MUH and there was therefore no requirement to take another reading until 17.00. He advised staff at MUH took and '*duly recorded*' the patient's CBG upon his arrival at MUH. The G IPA further advised the Trust administered all doses of insulin '*correctly*' on 15 February.

21. In relation to the complainant's concern the Trust did not answer her question if the patient was in DKA upon arrival at MUH, the G IPA advised there was no evidence the Trust assessed the patient for DKA there. However, he advised that clinicians carried out a blood gas analysis upon his return to AAH. The G IPA advised the analysis demonstrated that the patient's blood pH[9] was '*perfectly normal*' and his '*bicarb*'[10] was within normal limits. He was therefore not in DKA upon his return to AAH. The G IPA advised that DKA '*will not reverse*' without specific treatment. He further advised the patient did not receive treatment at MUH. On this basis he concluded the patient '*was not in DKA at MUH*'.

[9] The acidity of the blood
[10] Bicarbonate is produced by the kidneys and acts as a buffer to maintain a normal pH. Low levels can be an indicator of DKA.

Analysis and Findings

22. The complainant was concerned that staff at AAH transferred the patient to MUH on 15 February with '*no evidence*' it regularly monitored his CBG or gave him insulin after breakfast. I note the G IPA's advice that the patient's diabetic charts document that staff were monitoring the patient's CBG in accordance with the plan put in place by the hospital's Diabetes Specialist Nurse (DSN)[11]. In addition, he advised that nurses administered a second dose of insulin to the patient at 12.00 prior to his transfer to AAH and there was therefore no requirement to take another reading before 17.00. In her response to the draft report the complainant disagreed strongly with this advice. However, I could not find any indication in the relevant guidance to indicate the Trust's decision was incorrect. Having considered the medical records and relevant guidance, I accept the G IPA's advice the Trust '*correctly*' followed procedure in relation to both issues.

23. The complainant was concerned the Trust failed to confirm if the patient was in DKA when he arrived at MUH on the evening of 15 February. I understand the complainant's concern. I examined the patient's records which document that his CBG and ketone levels were very high when staff measured them in MUH. Both the nursing records from MUH and Northern Ireland Ambulance Service records document a possible diagnosis of DKA. However, I note the G IPA's advice there is no evidence the Trust assessed the patient for DKA in MUH. He also advised that a blood gas analysis carried out in AAH confirmed the patient was not in DKA. The G IPA advised the patient would not have recovered from DKA unless he received specific treatment, therefore he could not have been in DKA prior to being assessed in AAH. I accept the G IPA's advice and I am therefore satisfied the patient was not in DKA when he arrived at MUH. Overall, I am satisfied the Trust regularly monitored the patient's CBG and administered insulin as prescribed. I am also satisfied the patient was not in DKA when he arrived at MUH. Therefore, I do not uphold this element of the complaint.

[11] A trained nurse with special expertise in the care and treatment of diabetes

Management of blood glucose

Detail of Complaint

24. The complainant asked why the Trust waited until 22 February to refer the patient to a Dietician. She noted the Trust's observation that the patient's erratic CBG was related to a '*variable oral intake*' She asked if this was related to a '*failure*' by nursing staff to assist the patient at mealtimes. She also asked if nursing staff adjusted the patient's insulin to compensate for missed meals. The patient said there was '*no evidence*' nursing staff ordered the patient's meals to meet his diabetic requirements. The complainant rejected the Trust's explanation that the instability of the patient's CBG was due in part to COVID.

Evidence Considered

Legislation/Policies/Guidance

25. I considered the following guidance:
    - Diabetes UK Nutrition Guidelines for Diabetes;
    - JBDS management of hypoglycaemia;
    - NMC Code;
    - NMC Standards of proficiency;
    - NICE CG103.

The Trust's response to investigation enquiries

26. The Trust did not directly address why it did not refer the patient to a Dietician until 22 February. It stated a Dietician reviewed the patient on 23 February. It stated the Dietician prescribed food supplements, additional diabetic puddings and suggested nurses encourage the patient to eat and drink little and often.

27. In relation to the complainant's concern that nursing staff did not assist the patient with his meals, the Trust stated it was within '*nursing staff scope of practice*' to provide assistance to patients who '*may require help with feeding'*. In relation to the complainant's question if nurses adjusted the patient's insulin to compensate for variable intake the Trust referred to the Dietician's review which noted nursing staff '*adjusting insulin accordingly as per regime*'.

28. In relation to the complainant's concern there was no evidence nurses ordered the complainant's food to meet his dietary requirements, the Trust stated it provided a diabetic menu for '*all diabetic patients'*. It explained that nurses ensured that patients only received meal options '*suitable to their own needs*'.

Interview with Diabetes Specialist Nurse

29. The investigating officer spoke to the DSN responsible for the patient's care at AAH. He explained he prescribed the patient a set dose of insulin in accordance with his needs at the time. Nurses adjusted the patient's insulin if they felt he did not have enough carbohydrates with a meal, if he skipped a meal, or if his CBG was off baseline by a large margin. However, this would only happen if there was prescriber available in the hospital at the time, so if the patient skipped breakfast and there was no prescriber to speak with, a nurse would have given him the pre-prescribed dose.

Relevant Independent Professional Advice

G IPA

30. I asked the G IPA if it was appropriate for the Trust to wait until 22 February to refer the patient to a Dietician. He advised it was. He explained as the patient was a type 1 diabetic the Trust managed his CBG by adjusting his dose of insulin based on advice from the diabetic team **'***depending on prevailing blood sugar'*. However, the G IPA advised that the patient was not eating properly between 15 and 22 February. He advised when '*standard protocols*' to stabilise CBG by adjusting insulin levels were unsuccessful '*it was reasonable*' for clinicians to seek input from a Dietician.

31. The G IPA advised it '*cannot be said*' the patient's erratic CBG was a result of his diet in AAH. He explained brittle diabetes is often episodic. It '*is almost always*' related to stress and improves when the causative factor is removed.

32. In relation to the Trust's explanation that COVID was a possible contributing factor to the patient's unstable CBG, the G IPA advised evidence existed to support this explanation. The G IPA advised there was evidence of a link between inflammation caused by COVID and raised CBG in patients suffering from diabetes. He referenced an article by Diabetes UK which suggested

COVID may make the '*condition worse*'.[12]

N IPA

33. In relation to the complainant's concern that nursing staff were not ordering food suitable for the patient's diet, the N IPA advised there were no detailed entries relating to food intake in the patient's nursing records before 22 February. She concluded the Trust's records in this respect were '*not adequate*'. However, she advised the nursing records '*consistently identified*' the patient as being diabetic. She also advised that following professional advice on diets is '*part of a nurses* (sic) *role*' in accordance with the NMC Code. She advised therefore that nurses '*should be*' knowledgeable about which foods were appropriate in a diabetic diet. The N IPA referred to the food intake charts after 22 February and advised they indicated when the patient '*consumed all his meal*'. She further advised the Trust provided an '*individualised diet*' in line with the Dietician's recommendations adequate to the patient's needs. She advised the patient gained weight over the period.

34. In relation to the complainant's concern that staff were not assisting the patient to eat at mealtimes, the N IPA referred to the patient's food intake charts from 22 February. She advised that while several of the records note he ate his meal without assistance, most did not comment on whether nurses assisted him. She concluded he ate '*the majority*' of his meals between 22 and 28 February and that assistance was either not required or was '*offered but not recorded'*. As noted above the N IPA advised there were no detailed entries relating to food intake prior to 22 February. She advised the ward round record of 18 February documented that a care assistant was with the patient to '*assist/encourage*' at lunchtime.

35. The N IPA examined the patient's insulin charts and the Diabetes Nurse's instructions. She advised that nurses administered insulin at the '*appropriate times*' following measurement of his CBG levels and in accordance with the instructions from the DSN and medical team.

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[12] https://www.diabetes.org.uk/about_us/news/new-worse-cases-coronavirus

D IPA

36. The D IPA advised the following: because the Trust did not keep food intake charts between 12 February and 22 February, it would not have had '*enough information*' to adjust the patient's insulin doses in accordance with his carbohydrate intake. In order to give the '*correct ratio*' of insulin to the patient's carbohydrate intake, nurses would have to prescribe the insulin dose when the patient was eating his meal. This would be '*impossible to implement*' on a busy ward.

37. The D IPA advised the Trust's approach to administering insulin meant the patient's insulin dose was therefore '*independent*' of his carbohydrate intake. This could have contributed to his erratic CBG levels. The D IPA advised that if the DSN wanted to manage the patient's diabetes based on his carbohydrate intake, the Trust '*should have*' implemented a food chart from 12 February.

38. The D IPA advised the patient's erratic CBG would also have been impacted by nurses '*incorrectly*' omitting Levemir[13] following an episode of hypoglycaemia[14] on 12 February. Omitting Levemir because of hypoglycaemia causes erratic CBG '*for up to 18 hours*'. 'Evidence' of the effect of the omission could 'be seen' on 13 February when the patient's CBG rose to 26.2 at lunch and further increased to 27.8. The D IPA also advised that the DSN's advice for nurses to prescribe additional Fiasp[15] at lunchtime if the patient was hyperglycaemic was contrary to the JBDS management of hypoglycaemia guidelines. She advised over-correction can trigger a further episode of hypoglycaemia. She advised this further contributed to the patient's erratic CBG.

Analysis and Findings

39. The complainant raised several concerns relating to the Trust's management of the patient's blood glucose. I examined the patient's clinical records and it is

[13] A type of long-acting insulin used to treat patients with diabetes by keeping blood sugar levels under control.
[14] a clinical syndrome present when the blood glucose concentration falls below the normal fasting glucose range
[15] A fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour,

evident the Trust did not keep food intake charts prior 22 February. While the N IPA advised nurses were aware the patient was on a diabetic diet, I note the Dietician's assessment that the patient's food intake was '*variable*' prior to 22 February due to his refusal to eat meals and this '*likely exacerbated*' his erratic CBG. I note the G IPA's advice that it was reasonable for clinicians to refer the patient to a Dietician when existing methods to manage his blood sugars were unsuccessful.

40. However, I note the Diabetes Nurse Specialist's advised that while the insulin doses nurses gave to the patient depended on his CBG reading, they were also dependent to how much carbohydrate the patient consumed during a meal. I note the N IPA's advice that the patient's food intake charts before 22 February were '*not adequate*'. In her correspondence with the Trust, the complainant said the patient's CBG levels were '*entirely dependent on a careful monitoring of food intake*'. The patient's records demonstrate an awareness among nursing and medical staff that he was missing meals and his intake was '*variable*'. However, the lack of food intake charts for the period prior to 22 February makes it impossible to determine how nursing and medical staff adjusted the patient's insulin dose in relation to this variable intake.

41. Irrespective of this, I note the D IPA's advice that the lack of food charts meant that nurses would not have had '*enough information*' to give the patient the '*correct ratio*' of insulin to his carbohydrate intake. This meant that his insulin dosage was '*independent*' of his carbohydrate intake and would have contributed to his erratic CBG. In addition, I note D IPA's advice that the patient's erratic CBG was further impacted by nurses' '*incorrect*' decision to withhold Levemir on 12 February and the DSN's advice to prescribe additional Fiasp at lunch if the patient was hyperglycaemic.

42. JBDS management of hypoglycaemia states '*DO NOT omit insulin injection if due (However, insulin regimen review may be required)'.* It also states '*DO NOT treat isolated spikes of hyperglycaemia with 'stat' doses of rapid acting insulin. Instead maintain regular capillary blood glucose monitoring and adjust normal insulin regimen only if a particular pattern emerges*'.

43. Standard 6 of the NMC Code requires nurses to '*maintain the knowledge and skills you need for safe and effective practice*'. Standard 8 of the NMC Code requires nurses to *'work with colleagues to preserve the safety of those receiving care'*. In addition, Standard 10 of the NMC Code states that nurses are required to: '*keep clear and accurate records relevant to your practice'*...

44. In relation to the period following 22 February, I note the N IPA's advice the Trust provided an '*individualised diet*' in accordance with the Dietician's recommendation. I note further the N IPA's advice that the food intake charts indicate if the complainant ate a full meal. In addition, I accept the N IPA's advice that nurses administered insulin at the '*appropriate times*' following measurement of CBG levels.

45. I note the complainant's concern nurses were not assisting the patient with his meals which may have been the reason for his reduced food intake. The lack of information in the patient's records prior to 22 February means I am unable to make a finding on this issue. However, the patient's records document his nursing care plan specifies he '*may require some assistance*' with eating and for nurses to '*encourage intake*'. The N IPA also advised the ward round notes from the 18 February record that a care assistant was with the patient to '*encourage/assist*' him to eat his lunch. Finally, the Dietician's assessment documented the patient '*can refuse meals.'* In relation to the period after 22 February the N IPA advised the food charts indicate the patient ate the '*the majority*' of his meals with or without assistance and that his weight increased after 22 February. Therefore, while I cannot conclude if nurses assisted the patient with his meals on every occasion he required it, I accept the N IPA's advice the Trust provided a diet that was '*adequate for his needs*' after 22 February.

46. In summary, I am satisfied that from 22 February nursing staff provided the patient with an adequate and appropriate diet and administered insulin in accordance with the guidance from the relevant specialists. I was unable to determine if nurses gave the patient the necessary help to eat his meals, however, I accept the N IPA's advice that he ate the '*majority*' of his meals

between 22 February and 28 February. I therefore consider there is no indication the patient suffered detriment in relation to this issue.

47. Finally, I accept the N IPA’s advice that the Trust’s record keeping in relation to food intake was *‘not adequate*’ before 22 February. The records document the patient’s CBG was unstable during this period, and I acknowledge and accept the G IPA’s advice that several factors may have caused this instability. However, I also considered the D IPA’s advice that because nurses were not documenting the patient’s carbohydrate intake, they would have been unable to accurately adjust his insulin dosage. This contributed towards the patient’s erratic CBG, as did the Trust’s decision to withhold Levemir on 12 February and the DSN’s advice to prescribe additional Fiasp to the patient’s lunchtime dose when he was hyperglycaemic. The Trust ‘*should have*’ introduced food charts on 12 February. I accept the D IPA’s advice. Having considered the medical records, the relevant guidance and the D IPA’s advice, I am satisfied the Trust’s decision to withhold the patient’s Levemir after an episode of hypoglycaemia, to prescribe additional doses of Fiasp when he was hyperglycaemic, in addition to its failure to appropriately monitor the patient’s carbohydrate intake and adjust his insulin accordingly constitutes a failure in care and treatment. In its response to the draft report the Trust stated ‘*JBDS guidelines are used, but clinical picture at the time will supersede guidelines*’, however it did not clarify how this applied to the report’s findings. I am therefore satisfied my original finding was correct. I therefore partially uphold this element of the complaint.

48. I am satisfied that as a result of the failures identified the patient sustained the loss of opportunity to have his carbohydrate intake appropriately monitored and to have his CBG stabilised in a timely fashion. In addition, I am satisfied these failures caused the complainant to sustain the injustice of uncertainty of how the Trust managed the patient’s CBG prior to 22 February.

Requirement to sedate patient

Detail of Complaint

49. The complainant questioned the Trust’s decision to sedate the patient on four occasions during his stay in AAH. She said she did not accept the patient

required sedation of any kind as he had been in hospitals continuously since December 2020 and was not sedated until he arrived at AAH. The complainant asked if the patient's refusal of meals because he was sleepy was due to the Trust's use of sedatives. She believed the patient presented as '*unsettled*' due to the '*total failure*' of nurses to address his dietary requirements resulting in erratic CBG. She described the decision to sedate the patient as '*lazy nursing*'.

Evidence Considered

Legislation/Policies/Guidance

50. I considered the following guidance:
    - NICE CG50;
    - NICE CG103;
    - NICE CKS Delirium: Lorazepam; and
    - NMC Code;

The Trust's response to investigation enquiries

51. The Trust stated that it commenced the patient on behavioural charts on 17 February. It explained staff recorded the patient as being unsettled '*on a number of occasions*'. The Trust stated it did not prescribe regular sedation during his inpatient admission. However, the patient's records showed a pre-admission prescription for oral lorazepam[16] to be administered *'as required*'. The Trust stated staff used verbal de-escalation techniques '*in the first instance*'. However, staff administered the sedative when they felt the patient was '*a risk to themselves or others*'.

52. The Trust stated delirium is common among patients in acute settings, '*especially those who have known* (sic) *history of dementia*'. The Trust stated that in addition to the patient's possible dementia, '*multiple recent*' hospital transfers and a COVID infection contributed to his delirium.

Relevant Independent Professional Advice

53. The N IPA reviewed the patient's medical records and advised that nurses

[16] A drug of the benzodiazepine group, used to treat anxiety, sleep disorders and severe agitation.

sedated the patient due to '*acute agitation*' and restless behaviour. She advised the patient's behaviour could have led to '*injury or self-neglect*'. She advised that nurses administered lorazepam in accordance with the guidance in place at the time and it was appropriate for them to do so.

54. The N IPA advised there was a possibility the patient's erratic CBG contributed to his delirium. However, she clarified he had other risk factors including COVID and dementia. She advised that in her opinion the patient's unsettled behaviour resulted from a '*mix of factors*, *principally delirium on a background of dementia*'. The G IPA also advised that there was a '*variety of reasons*' why elderly patients developed delirium in hospital.

55. The N IPA advised she could not find a '*direct correlation in the records'* between the Trust's use of sedatives and '*next day sleepiness*' in the patient. She advised that his delirium was '*most likely*' the cause of his sleepiness.

56. In relation to the complainant's concern that nurses' use of lorazepam to manage the patient's agitation was '*lazy*' and did not address his underlying condition, the N IPA disagreed. She advised nursing staff provided regular one to one care, or close supervision throughout the patient's stay at AAH. She advised that nursing records indicated staff recognised and monitored the patient's unsettled behaviour and escalated their concerns to medical staff. The N IPA advised that '*non-pharmacologica*l' interventions by nursing staff '*greatly exceeded*' the use of medication to settle him. She concluded there was '*no evidence*' nurses used lorazepam to calm a patient who was agitated due to what the complainant believed was their '*failure*' to manage his CBG.

Analysis and Findings

57. In relation to the complainant's belief the patient became unsettled due to his erratic CBG, I note the N IPA advised this may have been a contributary factor to his delirium. However, both IPAs advised there is a variety of factors which cause delirium in an elderly patient. In the patient's case the N IPA advised his dementia and COVID may have been factors. I note the N IPA advised that in her opinion the patient's agitation was due principally to '*delirium on a background of dementia*'. I accept the N IPA's advice. Therefore, while I

acknowledge there is a possibility that the patient's unstable CBG may have contributed to his agitation, I am satisfied there were several other factors that may have caused it. In her response to the draft report the complainant noted the patient did not have a formal diagnosis of dementia at the time he was in AAH. I sought additional advice from the G IPA who advised that the Trust managed the patient on the basis that he '*probably*' had dementia. On this basis it was '*reasonable*' for the Trust to conclude that dementia was a contributing factor to the patient's delirium. In addition, I examined the patient's medical records which document the patient's continuing confusion and lack of understanding after clinicians considered his delirium had resolved.

58. The complainant asked if the report took into consideration if the patient's agitation was caused by the fact he was hungry. I acknowledge the complainant said the patient told her several times he was hungry; however, this is not reflected in the patient's notes. In addition, I note the patient regularly refused meals during the period he had delirium. I acknowledge and accept the complainant's view however it is not supported by the patient's clinical records.

59. The N IPA advised that the patient's delirium caused him to become sleepy and miss meals; she concluded the records did not indicate a '*correlation*' between the use of sedatives and his subsequent refusal of meals I accept the N IPA's advice.

60. I examined the patient's records which document numerous occasions where nurses describe him as being '*unsettled*' or '*agitated*'. I note the N IPA's advice that nurses acted appropriately and in accordance with the guidance by using lorazepam to sedate the patient when he was acutely agitated as he could have put himself at risk. I note nurses used lorazepam to sedate the patient on four occasions between 12 February and 28 February. The N IPA also advised the number of '*non-pharmacological*' interventions by nursing staff '*greatly exceeded*' their use of sedatives. In addition, she also advised that nurses regularly gave the patient one to one care or close supervision and escalated the patient to medical staff when they had concerns. I accept the N IPA's advice there is no evidence of '*lazy nursing*' by staff in AAH. In summary, I am

satisfied that the Trust's use of sedatives was appropriate and necessary and I do not uphold this element of the complaint.

Referral to Mental Health Liaison Service

Detail of Complaint

61. The complainant asked why the patient's consultant did not request Mental Health Liaison Service (MHLS) input into the patient's care until 22 February. The complainant asked if the Trust requested this in advance of a meeting with the complainant on 23 February.

Evidence Considered

Legislation/Policies/Guidance

62. I considered the following guidance:
    - NICE CG103;
    - GMC Guidance;

The Trust's response to investigation enquiries

63. The Trust stated the patient's delirium had several contributing factors including recent hospital moves, his recent COVID infection, as well as a '*history of cognitive impairment*'. It stated it was common among patients with dementia to experience delirium in an acute medical setting. It explained the patient was on an *'older person ward*' and as such the ward staff were '*very skilled in delirium management*'.

64. The Trust stated it commenced the patient on behavioural charts[17] on 17 February. It stated it addressed '*potentially modifiable contributing causes to his delirium*'. It explained the consultant reviewed the patient's behavioural charts and referred him to MHLS for '*further assessment*'.

Relevant Independent Professional Advice

65. The G IPA advised that an elderly patient '*is especially prone*' to delirium in

[17] A chart used to record the number of times a specific behaviour is happening. It helps to identify when a behaviour occurs during the day and when or whether different interventions are effective in reducing the behaviour.

hospital for many reasons as the Trust '*correctly stated*'. The G IPA advised treating clinicians were '*right*' to observe the patient before referring to MHLS. He explained this was because some of the potential causes of delirium were reversible and in elderly patients sometimes '*took longer to resolve*'. Therefore, it was appropriate for clinicians to wait for a possible resolution of these causes before taking any further action.

Analysis and Findings

66. I note the complainant's concern the Trust should have referred the complainant to MHLS in a timelier fashion. She asked if her imminent meeting with the Trust on 23 February prompted it to seek MHLS input on 22 February. I considered the Trust's response which stated it addressed '*potentially modifiable contributing causes to his delirium*'. The Trust neither explained how it addressed the contributing causes or clarified why it waited until 22 February to seek input from MHLS. I consider the Trust's response to be vague and dissatisfactory.

67. However, while the Trust's response fails to address the patient's concerns the G IPA advised that it '*correctly*' identified that the patient's delirium was caused by several factors, including probable dementia and frequent changes of location. He also advised while some of the underlying causes of the delirium are reversible, they often take time to resolve. The G IPA advised that for this reason the Trust's watch and wait approach before involving MHLS was '*right*' and '*appropriate*'. I accept the G IPA's advice.

68. In addition, I reviewed the patient's medical records which document the Consultant's plan to refer the patient to MHLS when she reviewed him at 11.45 on 22 February. By her own account the complainant did not ask for a meeting with the consultant until '*3.26pm*' on 22 February when she called the ward to speak to the Consultant. On this basis I do not consider the Consultant's decision to seek input from MHLS was prompted by the prospect of a meeting with the complainant. I am therefore satisfied that the Trust referred the patient to MHLS at an appropriate time and I do not uphold this element of complaint.

Communication with family

Detail of Complaint

69. The complainant said that the Trust's communication with the family was '*totally inadequate*'. She highlighted her unsuccessful attempts to contact the patient's Consultant on 22 February to get an update on the patient's condition. She said the Trust's apology failed to explain the lack of contact from the Consultant. She also believed the Family Liaison Service's communication with the family was inadequate.

Evidence Considered

Legislation/Policies/Guidance

70. I considered the following guidance:
    - GMC Guidance
    - NMC Code;

The Trust's response

71. The Trust stated the Ward sister apologised to the complainant by telephone and in person for the delay in contacting her about a meeting with the Consultant to discuss her issues with the complainant's care. The Trust explained the Consultant asked the Ward sister to call the complainant to advise her of the meeting, but due to '*conflicting priorities*' she could not do so immediately.

72. The Trust stated it recognised the importance of communication. It stated that it apologised if the efforts it made to communicate with the complainant '*seem to have failed at times*.'

Relevant Independent Professional Advice

G IPA

73. I asked the G IPA if the Trust's efforts to communicate with the Trust were adequate. The G IPA referenced the patient's notes and advised he had '*no concern*' regarding this issue. He said there was '*ample*' evidence in the notes that the Trust '*consistently maintained*' adequate and reasonable

communications with the patient’s family.

N IPA

74. The N IPA also advised there was ‘*ample*’ evidence in the patient’s records that the Trust communicated with the patient’s family most days. She advised that the Trust regularly provided updates to the complainant and concluded their actions in this respect were ‘*reasonable*’.

Analysis and Findings

75. I sympathise with the complainant’s frustration over her inability to get an update on the patient’s condition from his consultant on 22 February. I note the complainant’s belief the Trust failed to explain the lack of communication from the patient’s consultant. I consider this was an extremely trying time for the complainant. The patient was a vulnerable individual with complex health issues. The complainant had several concerns about his care and treatment and was limited in how often she could see him due to visiting restrictions in place at the time. I consider that in these circumstances good communication from the hospital was extremely important. In my view the communication from the Trust on 22 February was sub-optimal. I note that in its final response to the complainant on 23 August 2021, the Trust apologised to the complainant for its ‘*failure to communicate adequately*’ with her.

76. However, I do not consider that the Trust failed to explain to the complainant why the Consultant did not contact her on 22 February. It explained that the Consultant asked the Ward sister to arrange a meeting with the complainant. The Ward sister acknowledged she did not contact the complainant immediately due to ‘*competing priorities*’. I consider this is a reasonable explanation. I note the Ward sister apologised twice to the complainant for the communication breakdown. In view of this, I consider that the Trust has addressed its failings and apologised to the complainant for them.

77. The complainant also highlighted what she believed was ‘*inadequate communication*’ from other members of staff including the Family Liaison

Service. The G IPA advised that he had '*no concern*' regarding the communication which was '*consistently maintained*' and '*reasonable*'. I note the N IPA's advice echoed that of the G IPA. I accept both IPAs' advice. Therefore, I do not uphold this element of the complaint. In her response to the draft report the complainant strongly disagreed with the finding in relation to this issue. I re-examined the patient's records and I consider when there was clear evidence that the Trust's communication with the complainant was below an acceptable standard it apologised to her. I also note both IPA's unequivocal view that communication was reasonable. Therefore, while I acknowledge the complainant's view, I am satisfied my original finding was correct.

Issue 2: Whether the complaints handling by the Trust was appropriate?

Detail of Complaint

78. The complainant said she was '*entirely dissatisfied*' with the Trust's response to her complaint. She said that several issues she raised '*remained unanswered*'. While not specifically raised in her complaint to this office, the complainant also expressed her dissatisfaction to the Trust over its response times to her complaint.

Evidence Considered

Legislation/Policies/Guidance

79. I considered the following policies;
    - DoH's Complaints Procedure; and
    - Trust's Complaints Procedure.

The Trust's response to investigation enquiries

80. The Trust stated it received emails of complaint from the complainant on 16 February, 23 February, 24 February and 1 March. It stated it received letters from the complainant on 23 March and 14 April querying when she would receive a response to her complaint. The Trust stated it issued its initial response on 26 April. It stated it received a follow-on complaint on 19 May, which it acknowledged on 20 May. It stated the complainant sent letters on 28

June and 29 July asking when the Trust would respond. The Trust stated it sent its final response on 23 August 2021.

Analysis and Findings

81. I examined the Trust's responses to the complainant on 26 April and 23 August 2021 and I acknowledge the complainant remains deeply unsatisfied with these responses. I note it provided her with the patient's medical records. As indicated in the issues addressed above, the records fall below the required standard at times and I consider this may have contributed to the complainant's dissatisfaction with its response. However, I examined the complaint file and I am satisfied the Trust made reasonable attempts to answer the complainant's questions where possible. Therefore, I do not uphold this issue of complaint.

82. Although the Trust's delay in responding to her complaint is not a matter the complainant raised in bringing her complaint to me, it is important that I highlight it in this report. The complainant submitted several complaints to the Trust between 16 February and 1 March 2021. She asked the Trust to consider her complaint of 1 March in conjunction with her previous complaints. The complainant contacted the Trust again on 23 March and 14 April asking when she could expect a response. There is no evidence in the complaints file that the Trust responded to either of these requests. The Trust sent out its initial response to the complainant on 26 April. Following the complainant's follow-on complaint to the Trust on 19 May, she sent letters on 28 June and 29 July requesting updates. The Trust issued its final response on 23 August 2021.

83. The Trust's Complaints Procedure states that when it receives a complaint the complainant *'should normally be issued with a written response within 20 working days*'. It further states if the response is likely to be delayed, the relevant investigator should notify the Complaints department '*so that the complainant can be advised of the reason for the delay*'. I consider that it is unacceptable the complainant had to write to the Trust on four occasions asking when she could expect a response to her complaint.

84. The Trust agreed to a face-to-face meeting with the complainant on 24

February 2021 to discuss the concerns she had raised '*both formally and informally*'**.** When the complainant asked for the Trust's minutes of the meeting, it responded that it did not take minutes as it '*was not arranged as a formal complaint meeting*'**.** I refer to the Trust's Complaints Procedure which states '*Where meetings do take place, these should be recorded and shared with the complainant within 10 working days for approval*.'

85. The First Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned'*. It is my expectation that the Trust will give careful consideration to this matter and of the need to remind relevant complaints staff of the requirement to make a record of meetings with complainants. It should also remind complaints staff of the importance of meeting response times and where this is not possible to update the complainant, provide reasons for the delay and indicate when they can expect a response.

CONCLUSION

86. I received a complaint about the actions of the Trust. The complainant raised concerns about the care and treatment the Trust provided to her husband, the patient. The complainant also had concerns about the Trust's handling of her complaint.

Issue One

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

- The failure to keep food intake charts between 16 February 2021 and 22 February 2021; and
- The failure to appropriately monitor the patient's carbohydrate intake and adjust his insulin accordingly.

88. I am satisfied that the failures in care and treatment identified caused the patient to sustain the injustice of the loss of opportunity to have his carbohydrate intake appropriately monitored and to have his CBG stabilised in

a timely fashion. I also concluded this caused the complainant to sustain the injustice of frustration. The investigation found the Trust's decision to discharge the patient on 15 February, its use of sedatives, its referral to MHLS on 22 February and its communication with the patient's family were all reasonable and appropriate.

Issue two

89. The investigation found the Trust made reasonable efforts to answer the patient's questions.

Recommendations

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

91. I further recommend for service improvement (and to prevent future recurrence)

- The Trust reminds relevant staff of the importance of maintaining accurate and complete food intake charts when caring for vulnerable diabetic patients with variable oral intake
- The Trust carries out a random sampling audit of vulnerable, diabetic patients on Ward B2 from 1 January 2023 to date. This is to ensure that patients' food intake is being appropriately monitored and the relevant charts completed as necessary.
- The Trust carries out a random sampling audit of the diabetic charts of patients in Ward 2B from 1 January 2023 to date. This is to ensure nursing staff have not withheld a patient's Levemir following an incident of hypoglycaemia.

92. I recommend that 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. That action plan should be supported by

evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

93. I am pleased to note the Trust accepted

94. I note the D IPA also made a number of recommendations at the end of her advice. These included

- The Trust use preprinted insulin correction dosing;
- Nursing staff should not omit insulin following hypoglycaemia;
- The Trust introduce closer f Multi-disciplinary Team working to improve patient outcomes; and
- The Trust redesign and update its '*outdated*' diabetes monitoring charts.

In its response to the D IPA recommendations the Trust explained its monitoring charts and prescription charts would be '*superseded*' with the introduction of a new administrative system in November 2024. It also stated that nurses '*should know*' not to omit insulin following hypoglycaemia. On this basis I added an additional recommendation at paragraph 91 that the Trust should carry out an audit of patients' diabetic charts to ensure nurses were not omitting insulin following an episode of hypoglycaemia.

Margaret Kelly

Ombudsman
April 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 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 2 PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law 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 learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing 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.

2. 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 where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. **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.

4. **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 and actions 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

5. **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.

6. **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 learning from complaints.

- Regularly reviewing the lessons to be learnt from complaints.