Investigation of a complaint against the Western Health and Social Care Trust

Report Reference: 202001908

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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 concerning the care and treatment the Western Health and Social Care Trust (the Trust) provided to the complainant's daughter (the patient) in September 2021 following an attendance at the Emergency Department (ED) of Altnagelvin Hospital.

Following my investigation, which included the receipt of Independent medical advice, I found a significant delay in the medical review of the patient following the allocation of a triage category of 2, failure to evidence that consideration had been given to the potential of a sedative being given to the patient, a failure in the lack of evidence to show if an ECG was reviewed prior the medical review, a failure to medically review the patient in a timely fashion and a failure in the calculation and recording of NEWS scores. I recognised that the events the complainant occurred during a period of time when the Health Service throughout Northern Ireland was experiencing pressures dealing with the consequences of the Covid-19 pandemic which had effects on all areas of health provision. While accepting the pressure on services may have affected the time for review it is important that standards of clinical practice are maintained and that patients and their families are shown empathy and compassion in circumstances that are difficult for everyone.

While I have identified a number of areas where improvements could be made I accepted the independent medical advice received which was that the plan to conduct an ECG and then to observe was generally appropriate and reasonable for the presenting condition.

One of the more concerning aspects of this complaint was the experience of the complainant trying to deal with the difficult and erratic behaviour of the patient in the open 'majors' area and staff offered no assistance. I consider that in this respect the Trust did not have appropriate regard for the patient's human rights.

I welcome that the Trust accepted that this was not an appropriate response and apologised to the complainant following its consideration of the complaint.
I recommended that the Chief Executive of the Trust offer an apology to the complainant for the failings identified and that these failings be reflected upon by the relevant medical staff.

THE COMPLAINT

1. This complaint concerned the care and treatment the Western Health and Social Care Trust (the Trust) provided to the complainant's daughter (the patient) in September 2021 following an attendance at the Emergency Department (ED) of Altnagelvin Hospital.

2. The complainant attended the ED of Altnagelvin Hospital with the patient who had taken an overdose of quetiamine on 7 September 2021. The complainant said that over the following hours there was a lack of medical intervention by the Trust and she also complained about the attitude of staff. She believed the patient was treated 'appallingly 'and that there was 'no nursing, no compassion and no empathy shown.

Issue(s) of complaint

3. I accepted the following issue of complaint for investigation:

   Whether the care and treatment the Trust provided to the patient on 8 September 2021 was appropriate, reasonable and in accordance with relevant standards.

INVESTIGATION METHODOLOGY

4. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant medical and clinical documentation together with its comments on the issues the complainant raised.

Independent Professional Advice Sought

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

   - A duel trained consultant working in emergency and acute internal medicine at a regional trauma centre.

6. 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

7. 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[1]:

   - The Principles of Good Administration

8. 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);
   - Royal College of Physicians – Generic Medical Record (June 2015)(RCP Guidance)
   - Nursing and Midwifery Code of Conduct (2022) (NMC Code)

9. I did not include all information obtained during the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

10. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. Both accepted the reports conclusions.

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

THE INVESTIGATION

Whether the care and treatment the Trust provided to the patient on 8 September 2021 was appropriate, reasonable and in accordance with relevant standards.

In particular, the following were considered:

- **Lack of medical intervention**
- **Lack of help with the patient and**
- **Incorrect Glasgow Coma Scale (GCS) recordings.**

Detail of Complaint

11. The complainant said that after midnight on 8 September 2021, the patient phoned her and stated that she was 'feeling low'. The complainant immediately went to the patient's house where it transpired that she had taken an overdose. The complainant drove her to the ED at Altnagelvin hospital. At that stage the patient was 'still relatively coherent' but she relayed to her mother that she was having difficulty breathing. The complainant said that between 00:30 and 09:00 the patient had her blood pressure taken twice and a heart trace carried out but that there was no further medical intervention from the Trust. Over the following hours the patient became erratic, and the complainant had to restrain her while staff 'looked on'. The complainant believed her daughter was treated 'appallingly 'and that there was 'no nursing, no compassion and no empathy shown'.

Evidence Considered

The Trust's response to investigation enquiries

12. In response to investigation enquiries the Trust's Acting Service Manager for Unscheduled Care (ASMUC) and a Consultant in Emergency Medicine/Clinical Lead (CEM) stated that the patient arrived at the ED at 00.30 on 8 September 2021, following which she was triaged, and initial observations taken. An ECG was carried out at 01:49 which was reviewed and documented as normal with no evidence of worrying changes due to overdose. The ASMUC added that

Nursing observations [2](NEWS) were carried out which were acceptable ranging between 0 and 2. Unfortunately, the patient was not seen by any members of the medical staff until 08:24.

13. The CEM accepted that this was an excessive waiting time to be seen and stated that although an apology was provided for in the Trust's response to the complaint, he felt that it required a significant apology for the delay in medical review.

14. In responding to the complaint that after the patient became incoherent and began to lash out, members of the nursing staff watched on and did not provide any assistance, the ASMUC apologised that the complainant and her mother did not receive the assistance that she felt necessary at the time. He also confirmed that the patient was allocated to the seating area at the Majors 1 area which is mainly used for patients for whom they are unable to provide a curtained cubicle, as this allows the patient to remain visible to the nursing team caring for them. The ASMUC stated that the curtained cubicles which might have afforded some privacy were all in use with other patients, and despite review, one did not become free until 13:50 (13hrs 20 min after registration).

15. Concerning the accuracy of clinical notes, the Trust stated that when the patient was seen by one of the ED registrars at 08:24 her [3]Glasgow Coma Scale (GCS) was formally assessed at 11/15. This is consistent with what the complainant said as being the patient's varying level of alertness during the stay in ED. The observation chart filled out by the nursing team uses the Awake, Verbal, Pain, Unresponsive (AVPU) scale which is an estimation of the GCS and not a formal score. The Trust stated that the level of alertness was

[2] NEWS (National Early Warning Score) is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients. The total possible score is on a rising scale, the higher the score the greater the clinical risk. Higher scores indicate the need for escalation, medical review and possible clinical intervention.

[3] The GCS is a clinical scale used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients. The highest score (full consciousness) is 15, and the lowest (lack of consciousness) is 3

acceptable for observation and the patient did not require any airway protection or intervention at any time.

16. In conclusion the Trust stated that whilst the ED is under sustained pressure, with high number of attendances and long waits to be seen, the experience of the patient and the complainant was unsatisfactory.

Relevant Independent Professional Advice

17. Whilst part of the complaint concerned the attitude of staff on the night of 8 September 2021, I obtained independent medical advice on the care provided given the records available and the Trust's acceptance of the inappropriateness of the attitude and behaviour of staff to the patient, I asked the IPA to focus on the appropriateness of the medical treatment the patient received during this time. The IPA provided a timeline of events and stated that '*The patient involved in this case is a 22-year-old female who attended Altnagelvin Hospital (AH) on 8 September 2021 at approximately 0030. Her mother, who is the complainant, was in attendance. It is noted that the patient has a history of depression, personality disorder and a previous overdose. The patient had attended the AH ED once in the last six months. On this occasion, the medical reason for attending the emergency department was due to an alleged overdose of Quetiapine 3g (100mgx 30) at 00:00.*

18. The IPA advised the patent *'did not have any significant medical condition that required treatment or intervention, therefore nothing significant was omitted'.* He did, however, suggest that he was unable to ascertain if the ECG taken at 01:49 had been reviewed prior to the medical review at 09:05 and suggested that controlling the patient's delirium with sedation may have resulted in a much better experience for the patient and her mother. The IPA also advised that '*It would have also been best practice to have conducted a cursory medical review to ensure the patient wasn't developing more serious side effect of the Quetipine overdose that wasn't immediately obvious due to her mental state at the time*.'

19. Identifying any learning/service improvements to be taken from this complaint, the IPA advised that '*Ideally, it should be documented if a patient is being allocated to an area as a result of capacity pressures as opposed to the presenting complaint or clinical condition. This makes it easier to defend the reasoning why such decisions are made. Results which are reviewed should have clear documentation when and by whom the review took place.*
One suggestion to aid compliance with the RCP requirement of good record keeping, is to employ a computerised system that allows you to record the notes directly onto the Electronic Patient Records (EPR). While fully appreciating that this is not currently available at all Trusts, it is an IT solution that all Trust's should be planning to provide in the near future'.

20. Concerning conduct and communication the IPA advised that '*the emphasis of the complaint is in relation to the perceived unprofessional conduct and lack of communication between relative and staff. The Trust have acknowledged this in their response and apologised, stating that it was unacceptable and detailed remedial actions they have taken'*.

21. The IPA summarised his advice '*The patient presented with a deterioration in their mental health and a subsequent quetiapine overdose. The patient was allocated to the waiting room to wait for her medical review. The Complainant's letter seems to focus more on conduct and communication concerns as opposed to the patient's medical care. On review of the documentation contained, the Trust acknowledges errors and omissions in this respect and has apologised accordingly. From a medical perspective the patient was managed safely, had regular nursing contact, had appropriate investigations, was referred to the appropriate specialty for ongoing observation and had a review by the mental Health Liaison Team prior to discharge'.*

Analysis and Findings

22. This complaint was, in the main concerning, the attitude of staff when the complainant and the patient attended ED following an overdose. The complainant considered the patient had been treated '*appallingly*' receiving *'no nursing, no compassion and no empathy'*. In her initial letter of complaint to the

Trust the complainant said that *'between 00.30 am and 9;00 (the patient) had her blood pressure taken twice and a heart tracing carried out and there ended all medical intervention. Over the next hours (the patient) became completely incoherent she lashed out, tried to pluck imaginary objects out of the air, attempted to climb over furniture, crawl under furniture, attempted to leave the waiting area and at times just lay face down on the floor, I wrestled with (the patient) while wearing just night clothes while a waiting room of people watched on'.* I shall comment on this issue at a later stage of this report.

23. In relation to the actual medical treatment, I accept and agree with the IPA advice which I received. This is that overall, the patient was safely managed with regular nursing contact (in the sense that observations were regularly taken) and had appropriate investigations carried out. She was referred to the appropriate speciality for ongoing care and the Mental Health Liaison Team reviewed her before discharge. Having said that and while the above represents appropriate medical and clinical care for the presenting condition, I also agree with the IPA advice that there were elements of the overall care received which could have been better and which, if received, could have improved the patient's experience.

24. The patient arrived at the ED at 00.30 on 8 September 2021, approximately 30 minutes after taking an overdose of quetiapine[4]. She was triaged as [5]Category 2 at 00.45, that is 15 minutes after arrival and in line with relevant standards. The patient then had bloods taken, an ECG[6] and a toxbase review[7]. At this time other clinical observations (respiratory rate, oxygen level, pulse, blood pressure and temperature) were checked and were all within normal limits. Following these observations, she was to wait in the waiting room pending a medical review. The patient had two routine reviews by nursing staff and further observations taken before a doctor reviewed her at approximately 08.30 that

[4] A medication to treat mental health conditions, brand name seroquel
[5] Triage is the process of sorting patients as they present to ED. Patients are generally sorted into one of 3 categories. 1. Those requiring immediate care 2. Those requiring some type of immediate care but who are able to wait a short time (e.g.minutes) 3. Those requiring standard care and who are able to wait considerable time (e.g. hours)
[6] Electrocardiogram, a check on the hearts rhythm and electrical activity
[7] This is an online poisons information database providing clinical toxicology advice to healthcare professionals

morning. The observations taken did not raise any serious concerns over the patient's immediate condition, nor did those taken on five subsequent occasions after she was initially seen by the doctor. I also note that the patient did not require any airway protection or intervention at any time. I accept the IPA's advice that there were no medical interventions which were not taken, and which should have been taken. I therefore conclude that the overall clinical treatment received by the patient was appropriate.

25. From the complainant's description of events, it is apparent that the patient became more agitated and aggressive as the night wore on and while she waited to be seen. This is noted in the nursing records. The IPA advised that this is a common side effect of a quetiapine overdose and advised that some consideration could have been given to administering a sedative which may have alleviated this behaviour. I note that the complainant has said that nurses watched on while she sought to cope with the patient on her own. I would have expected that not only should the nurses have assisted, a point I will return to, but they should have sought a medical review so that sedation could have been considered. I consider the lack of evidence regarding the consideration of medical review to consider a sedative being given to represent a failure in the care and treatment provided.

26. The IPA did advise that ideally every page of the medical record should include the patient's details, and should be dated, time stamped legible and signed by the person making the entry. This would accord with the guidance produced in the General Medical Council's Good Medical Practice and the Royal College of Physicians. The IPA advised that while this did not happen for every entry in this case, overall the medical record keeping was appropriate for the presenting conditions and that in general the documentation was clear, dated and signed. Nonetheless the IPA did reference a gap in the documentary record to evidence if the ECG was reviewed prior to the medical review at 09.05. He also advised that it would have represented best practice if a cursory review had been conducted to ensure that '*the patient wasn't developing more serious side effects of the Quetipine that wasn't immediately obvious due to her mental state'*. This would have been in addition to the observations which were taken,

that is the blood tests, ECG and toxicology review. The IPA further advised of the recording of inaccurate NEWS scores, one of nought, at 06.10, which should have been three and one at 12.25 (translated from the GCS), reading two, should have been five. Thankfully these issues, as advised by the IPA did not have a consequence, and the patient's level of alertness overall, throughout her time in the ED Department, although fluctuating, remained within acceptable limits and did not require active medical intervention. Nonetheless I consider the lack to evidence to show if the ECG was reviewed prior to the medical review at 9.05 and the recording of inaccurate NEWS scores to represent a failure on the part of the Trust causing a loss of opportunity in that more frequent observations may have been required. The lack of observation is a central element of the issues raised by the complainant and if the NEWS scores had been calculated properly it is likely more frequent observation would have been carried out.

27. I am also concerned to note that the patient was triaged as Category 2 at 00.45 after arrival at the ED. This category of triage requires a patient to receive immediate medical care within minutes, yet I note that she did not have a medical review by a doctor until approximately 8 hours after this. I am also conscious of the advice from the IPA that '*It would have also been best practice to have conducted a cursory medical review to ensure the patient wasn't developing more serious side effect of the Quetipine overdose that wasn't immediately obvious due to her mental state at the time*.'

28. It is the case that in this instance a patient categorised as needing and requiring immediate care did not receive a medical review for almost 8 hours. I accept that initial investigations and observations were carried out during this period by nursing staff. However, the fact that the patient had to wait for this length of time without a full review, or even a cursory review by a doctor, I consider to represent unacceptable delay and to constitute a failure on the part of the Trust and to have caused a loss of opportunity for a full assessment of her condition to be carried out for what was potentially a serious condition.

29. My impression from the content of the complaint received was that another main area of concern was the perceived lack of professionalism shown by the staff and of a lack of communication as to what was happening. This has evidently caused the complainant much distress as she describes in her initial letter of complaint the chaotic events which were occurring around her and I get the sense of a feeling of exasperation that she was being left alone and without assistance to cope with her daughter as she suffered with the anxiety and agitation of the distressing effects of an overdose. The complainants' feelings were heightened by a lack of privacy in that the patient was left to wait in an open seating area rather than in area with a curtained cubicle which would have provided a degree of privacy. While this may have resulted from an excess number of patients in the ED and a lack of available space, the lack of respect and dignity shown to the patient by the Trust is unacceptable. I consider that in this respect the Trust did not have appropriate regard for the patient's human rights.

30. I am conscious that the events the complainant described occurred during a period of time when the Health Service throughout Northern Ireland was experiencing pressures dealing with the consequences of the Covid-19 pandemic which had devastating effects all areas of health provision. At the time of this complaint Covid-19 was by no means abating with a surge in the omicron variant commencing shortly after, in November 2021. At that time the effects of Covid -19 were being very widely felt with no let-up in the number of cases attending overstretched ED services with record waiting times and number of attendances. The Trust's performance management statistics for this period, which I have examined, evidence this.

31. The Trust stated that the patient was allocated to a seating area which is unfortunately quite open, and which is used for patients whom it is unable to provide a monitored cubicle for, but which nonetheless remains visible to the nursing team. Unfortunately, the curtained cubicles which might have afforded some privacy were all in use with other patients and one did not become free until 13.50. I am not critical of staff and clinicians who often work in difficult conditions to maintain functionality in stretched ED Departments with limited

space and increased patient numbers. I am however critical that this type of situation has been allowed to develop to become a regular situation in our ED departments putting ever more pressure on staff, patients and their families. It is clear in this case the complainant and the patient may have had less negative experience during their stay in ED had there been an appropriate area for her to be managed and more engagement and communication from nursing or medical staff. I note that there is no record in the clinical documentation of any of the staff speaking to the complainant and explaining what the treatment plan was or to provide reassurance to her regarding the condition and outcome for her daughter. Such attitudes and actions are embedded in clinical guidelines and in particular the NMC Code which references communication and listening to people. I appreciate the difficulties during busy and sometimes chaotic periods in acute clinical settings of taking time to do this but it is well recognised that a more communicative approach to situations such as that experienced by the complainant has the potential to diffuse and improve what can be difficult situations.

32. I appreciate the distressing experience described by the complainant and the basis behind the complaint. I also acknowledge the Trusts acceptance that the care provided fell below appropriate standards. In responding to my enquiries, the Trust has expressed its regret and has added to the apologies given to the complainant in response to her initial complaint. The CEM informed me that the complainant had to wait an excessive time to be seen and that while it is unusual for a patient to have to wait for that length of time at Altnagelvin hospital, he feels that the complainant is due a significant apology for the delay in medical review. The ASMUC added that he recognised that the nursing behaviours and attitudes the complainant described were inexcusable and that staff involved have been spoken to regarding their attitudes and professionalism in the department. He apologised to both the complainant and the patient for their negative experiences and the fact that the complainant did not receive the assistance she felt necessary at that time. The Trust also stated that, subsequent to the complainant's attendance in September 2021, it now has a sensory room in its ED which can be used by those experiencing a mental health crisis.

CONCLUSION and RECOMMENDATIONS

33. I received a complaint about the care and treatment the Trust provided to the patient in September 2021 following an attendance at the ED of Altnagelvin Hospital. Overall, in relation to the care and treatment provided I accept the advice of the IPA and find that the care and treatment provided was generally clinically and appropriately reasonable for the presenting condition.

34. I did however find there to have been failures in the following areas
    i. A failure to evidence that consideration had been given regarding the potential of a sedative being given
    ii. A failure in the lack to evidence to show if the ECG was reviewed prior to the medical review at 9.05.
    iii. A failure to medically review the patient before 09.05.
    iv. A failure in the recording of NEWS scores

35. Irrespective of the apology previously given to the complainant and the subsequent apologies given in response to my enquiries, I recommend that the Trust provide a separate apology to the complainant to encompass the failings identified above, the CEM's recognition that the complainant was due a significant apology for the delay in medical review and the ASMUC's comments recognising that the nursing behaviours and attitudes the complainant described were inexcusable. The apology should update the complainant on actions taken and seek to, as far as possible, provide reassurance to the complainant that the distress caused by her experience has been recognised.

36. I recommend that the nursing staff who were spoken to regarding the lack of care and compassion provided to the patient personally reflect on how they could have improved the complainant's experience and raise and discuss this complaint as part of their next appraisal.

MARGARET KELLY
OMBUDSMAN **August 2023**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and 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.