Investigation of a complaint against Belfast Health and Social Care Trust

Report Reference: 202002717

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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: 202002717

Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the Belfast Health and Social Care Trust's (the Trust) care and treatment of the complainant's late mother (the patient) during her time as an in-patient in the Mater Hospital (MH) from 17 to 28 June 2021.

The complainant believed the Trust over-sedated the patient on one occasion and, on another, nursing staff failed to provide care and assistance when the patient was *'shaking violently'.* The complainant also raised concerns about nursing care, including the assessment and care of the patient's continence; administration of medication; support for the patient's nutrition and hydration; and the patient's access to the call-bell. The complainant said the patient's medical notes were not always available and medical staff communicated inaccurate information to the patient.

- The investigation established there were failings in the patient's care and treatment related to two of the seven elements of the complaint. These were:
- The Trust did not act in accordance with national guidance and standards because it did not make the patient a priority and provide care without delay when she was in a distressed and agitated state.
- The Trust also did not: ensure appropriate and timely multidisciplinary referral and review of the patient when her nutritional intake remained poor; discuss the patient's poor nutritional intake with her family; and fully facilitate the provision of food brought by the patient's family.
- The Trust failed to record a reason for not administering one dose of one of the patient's prescribed medications.

I recommended the Trust provide the complainant with a written apology for the injustice caused by the failures in care and treatment. I made further recommendations for the Trust to address under an evidence-supported action plan to instigate service improvement and to prevent further reoccurrence of the failings identified.

THE COMPLAINT

1. This complaint was about care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the patient during the period 17 to 28 June 2021. The complainant is the late patient's daughter. From the complainant's correspondence and the Investigating Officer's conversations with her, it is clear how deeply these events affected the patient's family.

Background

2. The complainant said the patient, who was 96 years old at the time, lived independently until a previous admission to the Mater Hospital (MH) in March 2021. The complainant said, after this, the patient continued to become less independent. The patient was re-admitted to the Trust hospital on 18 June 2021, after experiencing shortness of breath. The patient was discharged from the MH on 28 June 2021. Sadly, the patient died the following month.

Issue of complaint

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

   Whether the care and treatment provided to the patient by the Belfast Health and Social Care Trust at the Mater Hospital between 17 and 28 June 2021 was reasonable and in accordance with relevant standards.

INVESTIGATION METHODOLOGY

4. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

5. Following identification of those staff who worked on the relevant ward during the patient's admission in June 2021, eight nursing staff were interviewed. These staff were still in the Trust's employment at the time of the investigation.

Independent Professional Advice Sought

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

    - A Consultant Geriatrician for 11 years, MBChB, FRCP Edin, Dip Pall Med, Dip IBLM/BSLM (CG IPA);
    - A senior nurse with 21 years' experience across primary and secondary care; RGN, MSc Advanced Clinical Practice, BSc (Hons) Nurse Practitioner, MA Health Service Management, Diploma in Adult Nursing, Diploma in Asthma, Diploma in Chronic Obstructive Pulmonary Disease, V300 Non-medical prescriber (Nurse IPA); and
    - A Speech and Language Therapist with 20 years' experience, BA (Speech Therapy & Audiology) Hons (SLT IPA).

7. 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 complaint, is a matter for my discretion.

Relevant Standards and Guidance

8. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

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

    - The Principles of Good Administration.

9. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

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

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's Good Medical Practice, April 2019 (GMC Guidance);
- The General Medical Council's Guidance for Doctors: Decision-making and Consent, November 2020 (GMC Decision Guidance);
- International Dysphagia Diet Standardisation Initiative Complete IDDSI Framework July 2019 (IDDSI Guidance);
- Royal College of Speech and Language Therapists Dysphagia Guidance, 2015 (RCSLT Dysphagia Guidance);
- Royal College of Speech and Language Therapists Guidance on the Management of Dysphagia in Care Homes, 1 June 2021 (RCSLT Dysphagia Care Homes Guidance);
- The National Institute for Health and Care Excellence British National Formulary (NICE BNF Guidance);
- The Nursing and Midwifery Council's Standards for Nurses, 2018 (NMC Standards);
- The Nursing and Midwifery Council's Code, 2018 (NMC Code);
- The Royal Pharmaceutical Society Professional guidance on the administration of medicines in healthcare settings, 2019 (RPS Guidance); and
- The National Institute for Health and Care Excellence, Pressure ulcers: prevention and management, April 2014 (NICE Pressure Ulcer Guidance).

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

11. I shared a draft copy of this report with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Detail of Complaint

12. **Whether the care and treatment provided to the patient by the Belfast Health and Social Care Trust at the Mater Hospital between 17 and 28 June 2021 was reasonable and in accordance with relevant standards.**

    In particular this considered:

    i. Sedation of the patient and medication administered by nursing staff;
    ii. Toileting;
    iii. Missing medical notes;
    iv. Access to the patient's call-bell and fluids, including staff availability on the ward;
    v. Patient being informed they 'lived with cancer' during a conversation with staff;
    vi. Incident of patient shaking when family arrived for a visit; and
    vii. Consumption of food.

13. There were seven main elements included within the complaint, as noted above. Each of these elements are addressed separately in the report.

i. Sedation of the patient and medication administered by nursing staff

14. The complainant said, on 25 June 2021, the Trust informed the family by telephone, that it had difficulty rousing the patient from sleep. The Trust told the complainant doctors '*were concerned*'; therefore, it arranged a Computerised Tomography CT[2] scan of the patient's brain. The scan did not identify any concerns. The complainant believed the difficulty arose because the Trust '*over-sedated*' the patient the previous night. The complainant said, when she visited the patient on one occasion (date not provided), the patient told her she did not receive her medication.

[2] A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body.

Evidence Considered

Trust's response to investigation enquiries

15. As part of investigation enquiries, the Trust had an opportunity to respond to the complaint. The Trust's response to the enquiries related to all elements of the complaint was considered when drawing up this report.

Legislation/Policies/Guidance

16. I considered the RPS Guidance, the NICE BNF Guidance and the NMC Code.

Relevant records

17. I considered the patient's medical records for the period 17 to 28 June 2021.

Relevant Independent Professional Advice

18. The CG and Nurse IPAs provided advice on the medication prescribed and administered to the patient during her admission from 17 to 28 June 2021. The CG IPA provided advice about the medication prescribed and any associated sedative effect. The Nurse IPA advised on the medication administered and its impact on the patient.

19. The CG and Nurse IPAs' advice are enclosed at Appendices three and four to this report, respectively.

Analysis and Findings

Sedation of the patient

20. The complainant believed the Trust *'over-sedated'* the patient on the evening of 24 June 2021.

21. I refer to the CG IPA's advice. She listed the medication prescribed for the patient and advised, of these, the Butec patch[3], Midazolam[4] and Diamorphine[5] can have a sedative effect. The CG IPA advised the Butec patch was prescribed for the patient prior to her admission to hospital in June 2021. She

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[3] Butec patches are prescribed for the relief of moderate, long-lasting pain that requires the use of a strong painkiller.
[4] Midazolam is used for anaesthesia and procedural sedation, and to treat severe agitation. It causes sleepiness and decreases anxiety.
[5] Diamorphine is a strong opioid with many uses, including managing moderate and severe pain.

further advised the Trust's decision to continue to prescribe it during the patient's admission was appropriate.

22. I note the CG IPA's advice that Midazolam and Diamorphine are prescribed for distress and breathlessness, which she advised '*was the case for this patient'*. The CG IPA advised the prescriptions for these medications were *'low*' and '*appropriate*'. The CG IPA opined there was no evidence the patient was over-sedated but rather, the doses of sedative medication were '*small and infrequent'.* The Nurse IPA advised all the medication administered, which would have been sedative, was given in line with the prescription. I accept the CG and Nurse IPAs' advice. I also refer to the NICE BNF Guidance the Nurse IPA cited in her advice. Based on the IPAs' advice and, in consideration of the NICE BNF Guidance, I am satisfied all the medication with sedative effects was appropriately prescribed and administered. Therefore, I do not uphold this element of the complaint.

Medication administered by nursing staff

23. I refer to the NMC Code, section 10 which states nurses must *'keep clear and accurate records'.* The Nurse IPA outlined the medication nursing staff administered to the patient. She referenced the RPS Guidance in detailing records for each administration. Specifically, the RPS Guidance states, '*records are kept of all medications administered or withheld, as well as those declined … Such records are completed at the time of the administration/ refusal or as soon as possible thereafter and are clear, legible and auditable'.* She opined, of the medication administered, only Apixaban[6] was not administered in line with the prescription on one occasion without a record of the reason for this; however, the Nurse IPA advised *'the omission of one dose … would not have impacted on the patient.'*

24. I consider the failure to record a reason for the omission of the medication does not accord with the NMC Code. Further, I accept the Nurse IPA's advice the absence of a recorded reason for the omission of the medication does not

[6] Apixaban is an anticoagulant. It makes blood flow through the veins more easily, which means it is less likely to lead to blood clots.

accord with the RPS Guidance. I note the Nurse IPA's advice the omission of the administration of Apixaban on this one occasion did not negatively impact the patient. Therefore, I am satisfied this omission does not amount to a failure in the patient's care and treatment. I consider, however, the absence of this record a service failure, as it did not accord with either the RPS Guidance or the NMC Code.

Detail of Complaint

ii. Toileting

25. The complainant said, when the patient was admitted to hospital, she was *'encouraged to toilet in a 'nappy' rather than ask to attend the toilet'*. The complainant said, prior to this admission, the patient attended the toilet independently. The complainant believed it was more convenient for staff to encourage the patient to use a nappy rather than promote and respect her independence and dignity.

Evidence Considered

Legislation/Policies/Guidance

26. I considered the NICE Pressure Ulcer Guidance.

Relevant Records

27. I considered the patient's records from 17 to 28 June 2021.

Relevant Independent Professional Advice

28. The CG IPA provided advice about the assessment of the patient's continence during her time as an in-patient. The Nurse IPA provided advice about personal and skin care given to the patient during this period. The CG and Nurse IPAs' advice are enclosed at Appendices three and four to this report, respectively.

Analysis and Findings

29. I refer to the Trust's response to investigation enquiries. The Trust stated the patient wore the pads because the patient was incontinent on admission with a

moisture lesion[7] on her sacrum[8] of a level within the “at risk” category for skin breakdown. I refer to the patient’s records which were reviewed. I note these records evidence the patient was incontinent on admission, with fluctuating incontinence throughout her time in hospital.

30. I refer to the CG IPA’s advice that when the patient was in the Emergency Department (ED), *‘there was a full loss of bowel and bladder control’.* The CG IPA also advised the patient’s skincare records indicate the patient was incontinent during the early stages of her time as an in-patient, with the patient’s catheterisation also an indication the patient was incontinent during her hospitalisation. I note the CG IPA also opined, *‘the patient’s levels of continence … fluctuated’* across the period of hospitalisation which is *‘not uncommon in elderly and very unwell patients’.*

31. I refer to the Nurse IPA’s advice. She advised the patient had ‘*existing pressure ulceration*’ to her sacrum. The Nurse IPA explained the skincare and hygiene checks were in line with national standards and guidance and ‘*the use of pads at times, particularly in the early period of admission was appropriate’.*

32. I consider the records indicate the patient experienced ongoing and variable incontinence during her period as an in-patient and had skin damage, arising from moisture, when she was admitted to the hospital. Therefore, I accept the CG and Nurse IPAs’ advice. Based on the evidence of the records and the CG and IPA’s advice, I am satisfied both that the patient was incontinent during her time as an in-patient, and her continence and toileting needs fluctuated during her hospitalisation. Further, based on the evidence of the records and the Nurse IPA’s advice, I am satisfied the patient had existing ulceration at her admission. I consider this was the reason for Trust staff using pads for the patient during her admission. Therefore, I consider the use of pads appropriate. I do not uphold this element of the complaint.

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[7] A moisture lesion is soreness and blistering where the skin has been exposed to wetness over a long period of time. This wetness can be urine, faeces, sweat or wound fluid. Moisture lesions can vary in size, colour and shape. They often appear as patches of sore skin.

[8] The sacral region (sacrum) is located at the bottom of the spine between the fifth segment of the lumbar spine and the coccyx (tailbone). It is a triangular-shaped bone and consists of five segments fused together.

Detail of Complaint

iii. Missing medical notes

33. The complainant said, during a medical examination, the doctor in attendance asked the family to provide him with information about the patient's medical history as her notes were misplaced. The complainant expressed concern about the patient's notes not being available and said this indicated poor governance of personal records.

Evidence Considered

Legislation/Policies/Guidance

34. I considered the GMC Guidance, the NMC Standards and the NMC Code.

Relevant records

35. I considered the patient's medical records from 17 to 28 June 2021.

Relevant Independent Professional Advice

36. Both the CG and Nurse IPAs provided advice about evidence of missing patient records.

Analysis and Findings

37. I refer to the patient's records reviewed. I was unable to identify any gaps in the patient's clinical records or any other documentary evidence which would indicate a period when the patient's records were missing.

38. I also shared the patient's records with the CG and Nurse IPAs. I note their advice that they also could not identify any evidence to suggest records were ever misplaced or missing.

39. I do not doubt the doctor who attended the patient informed the complainant the patient's records were misplaced. However, I have not identified any gaps in the patient's records that would lead me to find the records were ever missing or misplaced. I have not identified any maladministration or failure in

the patient’s care and treatment. Therefore, I do not uphold this element of the complaint. I hope this brings the complainant an element of reassurance.

Detail of Complaint

iv. Access to the patient’s call-bell and fluids, including staff availability on the ward

40. The complainant said the patient ‘*was never able to access her buzzer as it was constantly left on her locker which she could not reach’*. She also said the patient’s water bottle was out of her reach. The complainant said, at each visit, the patient’s family asked staff to make sure the call-bell was on the patient’s bed. The complainant said, even when the patient returned home, she kept asking the family *‘not to leave her as ‘she could not reach her water or the button”*. The complainant believed the patient was *‘neglected within the hospital setting and was traumatised by her time as a patient. A fact that now traumatises us as a family.’*

Evidence Considered

Legislation/Policies/Guidance

41. I considered the NMC Standards and the NMC Code.

Relevant records

42. I considered the patient’s records from 17 to 28 June 2021.

Relevant Independent Professional Advice

43. The Nurse IPA provided advice about nursing care and attendance, including ensuring the patient’s access to hydration.

Interviews

44. Interviews took place with eight nursing staff who worked on the patient’s ward during the period of 17 to 28 June 2021 and who remained in the Trust’s employment.

Responses to the Draft Investigation Report

45. Both the complainant and the Trust were given an opportunity to provide comments on the Draft Investigation Report. Where appropriate, comments have been either reflected in changes to the report or are outlined in paragraphs 46 and 47 below.

The complainant's response

46. The complainant reiterated concerns related to the patient's access to, and use of, the call-bell. Although she disputed the IPAs' advice and records related to the patient's fluctuating confusion, she expressed concerns about whether, in these circumstances, Trust nursing staff took appropriate steps to ensure the patient understood both the purpose of the call bell and how to use it. She also queried whether Trust nursing staff took account of the patient's hearing difficulties in managing the call-bell. Further, she queried whether information about both issues was shared across Trust nursing staff.

47. The complainant also disputed several of the Trust nursing staff's comments, staff were always available in the bay. The complainant cited one incident as an example when *'there was at least 20 minutes where there were no staff available on that ward'* and there was no reason to assume this *'was a one-off situation'.*

Further Independent Professional Advice Following Receipt of Draft Investigation Report Responses

48. In consideration of the complainant's comments in response to the Draft Investigation Report, the Nurse IPA provided further independent professional advice. This advice focused on Trust nursing staff's actions in relation to the call-bell, in the context of the patient's confusion and hearing difficulties and staff availability on the ward.

Analysis and Findings

Access to the patient's call-bell

49. I refer to the patient's records reviewed. On 19 and 23 to 26 June 2021, checks of the call-bell, including whether it was within the patient's reach, are

documented. On 19 and 23 June 2021, there are two records referring to the call-bell reflective of different nursing shifts. On 24 to 26 June 2021 there is one record for each day. There are no records referring to the call-bell on 18, 20 to 21, or 27 June 2021. I note, on 23 June 2021 at 01:00, the record states, *'buzzer beside [patient] in reach. Explained to use buzzer when necessary but [patient] confused.'* Further there are several records in which Trust nursing staff documented the patient's intermittent confusion and her hearing difficulties. These relate to different days and staff across the period. These also include several records in which Trust nursing staff recorded consciousness of how the confusion might affect the patient's ability to use the call-bell.

50. I note the Nurse IPA advised *'it is clearly documented that [the patient] could reach [the call-bell] and that the purpose of it was to call for nurses'*.

51. I refer to the interviews conducted with eight Trust nursing staff. Each Trust nurse explained the process of regular checks of the call-bell, including ensuring the patient can reach it, the bell is working and the patient understands how to use it. Several of the Trust nurses interviewed explained they conduct regular rounds throughout the shifts, including when issuing medication. During these rounds, they check the call-bell is in reach. Several Trust nurses also referenced staff were always available in the bay for assistance. Several of those interviewed explained, because nursing staff are responsible for the safety and welfare of patients, they give particular care to ensuring the call-bell is within reach for patients who are elderly or vulnerable, and at risk of falls.

52. I consider several of the Trust nurses' statements about the risks of an elderly patient falling indicate it is reasonable to accept the associated checks of call-bell access was normal practice. However, there is no consistent pattern of records of these checks upon which I can rely as evidence that these checks took place. Nevertheless, I did not identify any requirement for these checks to be recorded or any documented procedure associated with this. I recognise the integrity of the complainant's experience in relation to the patient's access

to the call-bell; equally however, there was no evidence to suggest the call-bell was left out of the patient's reach and, therefore, I make no determination on this element of the complaint.

53. I refer to the further Nurse IPA's advice, following the complainant's comments on the Draft Investigation Report. The Nurse IPA cited examples from the patient's records and advised these '*indicate Trust nursing staff were aware of the patient's fluctuating confusion … and her communication difficulties'*. The records included those related to its potential to impact on the patient's ability to use the call-bell.

54. The Nurse IPA provided advice about the mitigation required to ensure Trust nursing staff met the patient's needs. The Nurse IPA referred to the NMC Standards and advised, when there are any issues with a patient's *'capacity for independence and self-care'*, for example, when there is confusion, *'closer observations should be in place'.* Further, *'this is generally through a structured process of 'intentional rounding' or 'skin bundles', whereby the nurse will check on the patient at regular intervals without them needing to call for help'.* I note the Nurse IPA advised *'it is evident [Trust] nurses carried out this process'.* The patient '*was on four hourly skin bundles whereby any nursing needs were met'.* Further, '*the records show that [the patient] was also seen more frequently than this when physiological observations were taken (NEWS) and medications were given. This would also be an opportunity for nurses to provide additional care if indicated. There is no evidence that the patient's needs were not met'.* The Nurse IPA concluded, *'to mitigate the risk that the patient was too confused or too unwell to use the call bell, four hourly intentional rounding/skin bundle was in place and there was also reference to 'close monitoring' within the nursing evaluations'.*

55. In relation to Trust nursing staff's awareness of, and actions in response to, the patient's hearing difficulties, I note the Nurse IPA referred to specific records. She advised that Trust nursing staff were aware of the patient's hearing issues and were able to communicate with the patient '*despite the hearing difficulty'.*

56. I consider the records clearly evidence Trust nursing staff were aware of both the patient's confusion and her hearing difficulties and considered these in relation to the patient's use of the call-bell. I also accept the Nurse IPA's further advice and am satisfied Trust nursing staff took appropriate actions to mitigate the patient's confusion and hearing difficulties. Therefore, I do not uphold this element of the complaint.

Staff availability on the ward

57. The Nurse IPA provided advice about Trust nursing staff's availability on the ward. '*There is no indication from the clinical records that the patient had any unmet nursing needs; rather the patient's records, including NEWS and medication also indicate regular attention and consistent availability. These all evidence the availability of staff was appropriate*'. Further, it '*is in keeping with standard practice'* for staff to maintain presence on the ward. The Nurse IPA was unable to advise on the specific circumstances the complainant described; however, '*would be surprised if the absence of staff presence on the ward was anything other than unusual'.* I note the Nurse IPA's advice, it was '*noteworthy that at this time, there continued to be significant pressures on hospitals because of Covid-19'.* Whilst again I recognise the integrity of the complainant's experience in relation to staff availability on the occasion described, I accept the Nurse IPA's further advice the patient received regular attention and staff were consistently and appropriately available. Therefore, I do not uphold this element of the complaint.

Access to fluids

58. The patient's daily fluid and prescription chart for the period of hospitalisation indicates, except for 25 June 2021, the patient's fluid input was between 875 and 1250 millilitres each day. I note this chart documents fluid balance, incorporating both fluid input and output; therefore, this indicates monitoring of fluid balance.

59. I note the patient's food and drink records also indicate the patient took several drinks and/or supplements on each day from 18 to 27 June 2021, except for 20 and 25 June 2021. For each of these two dates, one occasion is documented.

On 19, 23, 24 and 27 June 2021, there are also records of staff helping or encouraging the patient to eat and drink. In relation to 20 June 2021, the records indicate, and the IPAs confirmed, the patient received IV fluids until 21 June 2021. Further, as the records indicate, and the CG and Nurse IPAs advised, 25 June 2021 was the day on which the patient was difficult to rouse.

60. The patient also received intravenous (IV) fluids up to 21 June 2021.

61. I refer to the email from Deputy Ward Sister A to Deputy Ward Sister B, which details the outcome of the meeting staff had with the patient's family on 26 June 2021 about their concerns. I note there is no reference to a discussion about the patient's water being out of her reach or access to fluids.

62. I refer to the Nurse IPA's advice. She advised the SKIN charts document the patient was offered drinks regularly. I note the Nurse IPA also advised, initially, the patient was in receipt of intravenous fluids; however, these ceased because of fluid overload. Subsequently, from 21 June 2021, the Trust restricted the patient's fluid intake to 1.2 litres. The Nurse IPA referenced the patient's fluid balance chart and opined, this indicates the patient had access to oral fluids; specifically, '*the chart 'show[s] frequent drinks and a reasonable intake*'. The Nurse IPA explained, whilst there is no '*definition on 'reasonable''*, the patient took approximately one litre of fluid most days.

63. I refer to the interviews conducted with eight Trust nursing staff. The Trust nurses described the process of ensuring water was available and was on a table within reach. As described in paragraph 51 above, several of the Trust nurses interviewed explained they conducted regular rounds throughout the shifts. They stated, during these rounds, they checked water was available and reachable. They also stated staff were always available in the bay for assistance. Several Trust nurses also explained they ensure water is on the patient's table over the bed for those at risk of falls, such as this patient.

64. I consider the records indicate, except for 20 and 25 June 2021, the patient's oral fluid intake was consistently within the stipulated medical parameters of 1.2

litres. The records also document that, other than on these two days, the patient took various fluids on several occasions each day. I consider the records indicate the patient received IV fluids on 20 June 2021. On 25 June 2021, staff had difficulty rousing the patient. Therefore, I would expect the latter would have impacted the patient's fluid intake on that day, whilst the IV fluids provided the patient a supplement on 20 June 2021. I consider the records evidence staff also appropriately monitored the patient's fluid input and output. I consider the notes further document staff assisted and encouraged the patient to drink.

65. As with paragraph 52 above, I consider each of the eight staff interviewed consistently described a process of checking patient's access to water, but they did not specify a requirement to record these checks. I consider the Trust nurses' statements about the risks of an elderly patient falling indicate it would be reasonable to accept the associated checks of access to water was normal practice. However, there is no consistent pattern of records of these checks which provide evidence that these checks took place. Neither did I identify any requirement that such checks be recorded or any documented procedure for this.

66. I also accept the Nurse IPA's advice the patient was able to access oral fluids and she had '*frequent drinks and a reasonable intake*'. There is no reference to the patient's water being out of reach in the email record of the meeting between the Deputy Ward Sister A and the patient's family on 26 June 2021. Again, whilst I recognise the integrity of the complainant's experience in relation to the patient's access to water, there was no evidence to suggest the patient's water was left out of her reach. Further, based on the evidence of the records and the Nurse IPA's advice, I am satisfied the patient's access to, and intake of fluid, was reasonable. Therefore, I do not uphold this element of the complaint.

Detail of Complaint

vi. Patient being informed they 'lived with cancer' during a conversation with staff

67. The complainant said on one of the occasions when the patient attended ED, a doctor informed the patient her medical notes indicated she *'lived with cancer*'.

The complainant said the patient did not have a cancer diagnosis. The complainant said, when she queried this with another doctor, the second doctor suggested the previous doctor '*was probably reading the wrong notes'*. The complainant said this indicated *'this casual approach to patient confidentiality is common'.*

Evidence Considered

Legislation/Policies/Guidance

68. I considered the GMC Guidance and the GMC Decision Guidance.

Relevant records

69. I considered the patient's medical records from 3 to 21 June 2021.

Relevant Independent Professional Advice

70. The CG IPA provided advice on the Trust's actions in relation to the information given to the patient.

Analysis and Findings

71. I refer to the Trust's response to investigation enquiries. The Trust stated the patient's CT scan in March 2021 identified a "*suspicious lung nodule"*. It further stated the ED record of 29 May 2021 indicated the patient did not want "*to be made aware of any possible diagnosis of cancer".* Therefore, it was *'very unfortunate that this terminology was used'* on 17 June 2021 when the patient attended ED. The Trust explained it encourages doctors to review previous ED records when a patient presents a short time after their previous attendance; however, it did not happen in this case.

72. I note the Trust stated it previously '*apologised wholeheartedly to the family'* for this. It said, on 17 June 2021, the doctor did not reference another patient's notes when he spoke with the patient. Rather he referred to the record of the suspicious lung nodule and surmised there was a possible diagnosis of cancer. The Trust stated it implemented learning from this, for which it provided evidence. I welcome this learning.

73. I refer to the GMC Guidance which states, *'you must … make reasonable checks to make sure any information you give is accurate'.*

74. I also refer to the GMC Decision Guidance. In particular, it states, '*doctors must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements*'; and '*you should not withhold information a patient needs to make a decision for any other reason, including if someone close to the patient asks you to … you should seek legal advice if you are considering withholding information from a patient.'*

75. I refer to the records reviewed. They include a discharge letter to the patient's General Practitioner, dated 3 June 2021, prepared following the patient's hospital admission from 31 May to 3 June 2021. The letter documents, '*suspicious lung nodule'* and *'[the patient] is for CT chest in 3/12 for follow-up of a known lung nodule'.* Under *'Medical History'* documented in the clinical records from the patient's attendance at ED on 17 June 2021 is '*lung nodule*' and '*under investigation for suspicious lung nodule'*. On 18 June 2021, it is recorded another doctor discussed this with the patient's family and informed them, as the patient had capacity, she should be informed of the CT scan findings. The doctor arranged to inform the patient on 21 June 2021; however, it is recorded the patient was '*too weak'* and '*short of breath'* for this discussion at that time.

76. I refer to the CG IPA's advice. She advised the Trust's conclusion that the ED doctor referred to cancer because of the documented suspicious lung nodule was a '*reasonable conclusion and the most likely scenario given the records associated with the CT scan rather than the Dr was looking at incorrect notes.'* I note the CG IPA referenced the Trust previously acknowledged the doctor should not have referred to *'cancer*' and apologised to the patient's family for him doing so. The CG IPA opined, however, the doctor should have reviewed the previous ED records with more care.

77. I consider the records indicate the CT scan findings of suspicious lung nodule were clearly documented on the patient's notes and medical history at the time of the patient's attendance at ED on 17 June 2021. I accept the CG IPA's advice. Whilst I consider the doctor's reference to a cancer diagnosis does not accord with the GMC Guidance referenced in paragraph 73 above, I note the Trust previously acknowledged this error, apologised to the complainant for it and implemented learning to address it. Further, whilst the specific information conveyed to the patient was not accurate, I consider the GMC Decision Guidance referenced in paragraph 74 above indicates sharing of the CT scan findings with the patient, as explained to the complainant on 18 June 2021, would be appropriate. Based on the evidence of the records and the CG IPA's advice, I am satisfied that, on the balance of probability, the ED doctor's reference to cancer was based on the patient's documented clinical history and was not because the doctor reviewed incorrect notes. Therefore, I consider there was no breach of confidentiality, and do not uphold this element of the complaint.

Detail of Complaint

vi. Incident of patient shaking when family arrived for a visit

78. The complainant said on one visit to the patient, on either 22 or 23 June 2021, she found her *'shaking violently and clinging to the bed rails'*. The complainant said, although there were several staff nearby '*discussing non-work-related matters [and] took the time to comment on my co-ordinated outfit'*, no-one assisted the patient in her agitated state. She explained a Trust nurse was '*unable to advise if shaking violently was normal behaviour'* for the patient or provide an explanation for the shaking. The complainant said the Trust nurse '*did not appear to be surprised'* by the patient's state. The complainant queried *'what caused [the patient] to be in that state'* and why did staff not do anything at the time.

Evidence Considered

Legislation/Policies/Guidance

79. I considered the NMC Code and the NMC Standards.

Relevant records

80. I considered the patient's medical records from 17 to 28 June 2021 with particular reference to 22 and 23 June 2021.

Relevant Independent Professional Advice

81. The CG and Nurse IPAs provided advice about 22 and 23 June 2021 in relation to the patient shaking violently from a medical and nursing perspective respectively.

Analysis and Findings

82. I note the review of the records did not identify documentation of any incident which may attribute to the circumstances the complainant described.

83. The CG IPA referenced the patient's records and advised she could not identify any reference to the incident. I note she advised, however, there were several records of the patient being confused on 22 and 23 June 2021, with a record of the patient being "*unsettled*". The CG IPA suggested, in consideration of this, the incident described could relate to a delirium associated with the patient's underlying acute medical problems. The CG IPA opined the Trust should have explained the situation about the patient's delirium to the patient's family as it can be distressing to witness.

84. The Nurse IPA also referenced the patient's records and advised although there were no records of a '*shaking episode',* on 22 June 2021, the patient was agitated and confused. I note the Nurse IPA advised, in response Trust nurses administered Midazolam at 04:20, which was appropriate for the patient's agitation. Further, on 22 June 2021, the patient also experienced "*coughing fits".*

85. Whilst an incident such as the complainant described is not specifically documented, I accept the CG and Nurse IPAs' advice that, during the suggested dates of the incident, 22 and 23 June 2021, the patient was confused and unsettled. Further, I accept the CG IPA's advice that, in this context, the incident may have related to a delirium and the Trust should have explained the patient's condition to her family. I consider, therefore, on the balance of probability, this incident occurred. I refer to the NMC Code and the NMC Standards. The NMC Code states, '*you put the interests of people using or needing nursing … services first. You make their care and safety your main concern and make sure … their needs are recognised, assessed and responded to … make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay … recognise when people are anxious or in distress and respond compassionately and politely'.* I note the NMC Standards state, '*observe and assess the need for intervention and respond to restlessness, agitation and breathlessness using appropriate interventions.'* I consider, in this instance, the Trust nurses did not respond to the patient's state in accordance with the NMC Code or the NMC Standards. I consider this constitutes a failure in care and treatment and therefore uphold this element of the complaint.

Injustice

86. I considered carefully whether the failing caused an injustice to the patient and her family. I consider the patient sustained the injustice of unresolved distress and agitation. I also consider the complainant sustained the injustice of upset in witnessing the patient's distress.

Detail of Complaint

vii. Consumption of food

87. The complainant said, during her hospitalisation, the patient was put on a pureed diet. She said, whilst the patient's swallow was not good at home, given time, she was able to eat solids. The pureed food given to the patient was unpalatable, yet the patient was not provided with other options. The patient would have taken soup, but this was not often given. When it was agreed the

patient's family could bring food in for the patient, the stipulation was that it be '*shop bought food which had not already been heated'*. However, staff did not at any point state the food must not require heating. Further, on one occasion, Trust staff heated a carton of soup without query. The family should not have had to provide food to ensure the patient received nourishment and sustenance while in the care of the Trust.

88. The complainant said the patient told her staff did not have patience to feed her, and they fed her *"too fast*". The patient's family believed the patient was *'constantly overlooked and simply not fed'*.

89. The complainant said, although the family brought in several food items, Trust staff only used a few. A note about the food was attached to the patient's locker. Subsequently, the family met with Deputy Ward Sister A to discuss concerns. At the meeting, the Sister *'confirmed that communication was poor on the ward'* and a member of the family could come to the hospital at lunchtime to encourage the patient to eat. The Sister emphasised at that time, *'there was no difficulty getting [the patient] to eat'* but rather staff were '*not taking the time necessary to do it'.*

Evidence Considered

Legislation/Policies/Guidance

90. I considered the GMC Guidance, the NMC Code, the NMC Standards, the IDDSI Guidance, the RCSLT Dysphagia Guidance and the RCSLT Dysphagia Care Homes Guidance.

Relevant records

91. I considered the patient's records from 17 to 28 June 2021. I also considered the interviews with the eight Trust nurses and an email of 27 June 2021 sent by Deputy Ward Sister A to Deputy Ward Sister B following her meeting with the patient's family on 26 June 2021. I also viewed photographs of food the patient's family provided.

Relevant Independent Professional Advice

92. The CG IPA provided advice about the Trust doctors' involvement in the patient's nutritional care, including timely referral to and application of SLT advice and intervention and follow-up by doctors when the patient's nutritional intake was poor.

93. The Nurse IPA provided initial advice about the Trust nursing staff's involvement in the patient's nutritional care. Following receipt of the CG and SLT IPAs' advice, in which there were references to the patient's nutritional care which required further clarification, the Nurse IPA provided further advice about the Trust nursing staff's actions in response to the patient's poor food intake.

94. The SLT IPA provided advice on the Trust SLT's assessment and review of the patient.

Analysis and Findings

95. I refer to the patient's records cited in paragraph 91. On 17 June 2021 when the patient presented to ED, the clinical records indicate the patient had '*poor appetite and reduced oral intake'*. On 18 June 2021 at 09:45, it is recorded the patient had a poor appetite. This is also recorded in the nursing notes for this day. In the nursing plan of care and evaluation, full assistance required with eating and drinking and an assessment of Grade two nutrition, which is defined as '*probably inadequate*', are documented. There are records of nursing staff either assisting the patient with eating and/or encouraging the patient to eat on 19 June 2021, 23 to 25 June 2021 and on 27 June 2021. I note there are no records of this nature on 18, 20 to 22 or 26 June 2021. The records indicate, after 18 June 2021, the patient refused or ate little of the meals the Trust provided. On most of these days, the records indicate the patient did take some of the Ensure[9] supplement, along with foods such as ice-cream, custard, mousse, fromage-frais or jelly. The patient also took soup on a few occasions. The patient's family provided a range of foods, including 'children's' meals which required heating, jellies and custard.

[9] Ensure is an easy-to-drink product that provides complete, balanced nutrition to supplement an individual's diet.

96. The records also indicate SLT assessed the patient on 18 June 2021 and recommended a pureed diet. SLT then reviewed the patient again on 21 and 23 June 2021 and on 28 June 2021, prior to her discharge. I note at the review on 21 June 2021, records document ward staff discussed concerns about the patient's intake with SLT. However, SLT recommended to continue the existing plan. A dietician then assessed the patient on 21 June 2021 and prescribed the Ensure supplement.

97. I refer to the email from Deputy Ward Sister A to Deputy Ward Sister B about the meeting with the patient's family on 26 June 2021. The email describes the family's concerns about the patient's nutritional intake, including the family's provision of food, which they stated was not used. The outcome of the meeting was agreement that a member of the family would visit at lunchtime each day to feed the patient with a second visit permitted later in the day. I note the Trust facilitated these arrangements during restrictions on hospital visits due to the Covid-19 pandemic.

98. I refer to the Investigating Officer's interviews with eight Trust nurses. I note two of the Trust nurses specifically said there was no microwave in the ward. Therefore, it was not possible to heat food brought in by a patient's family. One nurse also referenced health and safety reasons for not heating food. All the nurses interviewed emphasised that food brought in by families was kept in the fridge rather than in a patient's locker. They also said they can only give food in accordance with SLT recommendations. Further, all the Trust nurses interviewed said, if a patient continued to refuse food and there were concerns about her nutritional intake, they would refer the patient to another professional within two to three days. Most of those interviewed said the referral would be to a doctor, for consideration of further tests or use of an IV; some also mentioned referral to SLT or a dietician.

99. The CG IPA advised the referral to SLT on 18 June 2021 was '*very prompt'*. She referenced the patient's records and advised SLT's recommendations for a pureed diet were followed, including nutritional supplements. The CG IPA

provided advice on the Trust doctors' role in the patient's nutritional intake. She opined, beyond identifying the need for SLT involvement at the beginning of the patient's hospital admission, *'the medical team did not appear to review the patient's nutrition'.* The CG IPA advised the records indicated the patient was *'frequently declining'* her food and *'her intake was poor'*. Therefore, the clinical team should have *'highlighted this as a concern, and considered whether anything different could be done to help the patient'.* I note the CG IPA further advised, staff should also have assessed the patient's mouth to identify any other underlying causes for the poor intake. She opined, in consideration of the patient's poor intake, staff should have discussed the patient's food preferences with her family. They also should have considered arranging for her family to come in to encourage her eating at an earlier stage.

100. The CG IPA also opined, however, when patients are very unwell, as this patient was at the time, food intake and appetite can be poor even if the patient is encouraged and assisted. She advised there are no records to indicate this was explained to the patient's family, which would have been helpful. The CG IPA concluded *'care and communication regarding nutrition were not reasonable'.*

101. The Nurse IPA advised Trust nursing staff implemented SLT recommendations throughout. She referenced the patient's records and advised a dietician assessed the patient on 21 June 2021, who prescribed a nutritional supplement to support the patient's poor oral intake. The Nurse IPA advised this was administered every day. The Nurse IPA explained Lansoprazole[10], a proton-pump inhibitor, was prescribed to the patient and administered daily. This medication is used for acid reflux, which can impact oral intake. The Nurse IPA referenced the NMC Standards and opined Trust staff completed the malnutrition universal screening tool, scoring the patient at medium risk as a minimum. She explained this level of risk requires staff to monitor food intake for at least three days. The Nurse IPA advised staff monitored the patient's intake from 18 to 21 June 2021, at which point Trust nurses referred her to a

[10] Lansoprazole is a proton-pump inhibitor and is used to reduce stomach acid. It is used for indigestion, heartburn, acid reflux and gastroesophageal-reflux-disease.

dietitian. I note the Nurse IPA advised this timing was in line with the relevant guidance.

102. The Nurse IPA referenced the records and opined Trust staff encouraged intake in accordance with SLT recommendations and the patient also received nutritional supplements. The Nurse IPA opined, whilst Trust nurses encouraged intake from the beginning, it was difficult to conclude from the records whether they rushed their assistance of the patient with eating. The Nurse IPA referred to the records documenting the patient's family brought in food for the patient and advised there was no structured approach. I note the Nurse IPA advised it would have been beneficial if the Trust prepared a nutritional care plan which detailed the patient's food preferences, her pace and position of eating, and which included input from her family. The Nurse IPA concluded there was no evidence of nutritional care planning which '*was clearly indicated for this patient.*' The Nurse IPA opined the patient was '*clearly not meeting her nutritional requirements*'. She also advised the patient was very unwell; therefore, if the Trust had put an appropriate nutritional care plan in place, it is not certain this would have remedied the situation.

103. The SLT IPA opined the patient's referral to SLT was both appropriate and timely, as was SLT's assessment and review. The SLT IPA referenced the IDDSI Guidance and the RCSLT Dysphagia Guidance. She advised the patient had oral dysphagia[11] and the SLT's assessment and decision to recommend a pureed diet was appropriate. The SLT IPA advised that ward staff implemented the SLT recommendations. The SLT IPA opined, the patient *'often did not get adequate nutrition'.*

104. I consider the records indicate the patient was at risk of inadequate nutrition from the beginning of her period of hospitalisation. Therefore, it is reasonable to expect the Trust to have closely monitored her intake and take appropriate and timely actions when required. Based on the interviews with the Trust nursing staff, and the Nurse IPA's advice, I consider it was appropriate for staff to refer

[11] Dysphagia is when there are problems with swallowing.

a patient to a doctor after three days of poor oral intake. However, there is no evidence this happened. I consider there is evidence ward staff spoke with the SLT on 21 June 2021 about concerns, after which nursing staff referred the patient to a dietician who prescribed a food supplement. There is no evidence, however, the SLT took steps to further discuss this with other professionals as part of an MDT. I consider the evidence indicates, even after the dietician's intervention, the patient's nutritional intake did not improve. However, staff took no further action, including referral to a doctor. I consider the SLT IPA's advice, and the evidence of one of the nurses interviewed, indicate an MDT approach to patient care was expected. However, there is no evidence staff employed such an approach.

105. I consider there is conflicting evidence from the complainant and the nurses interviewed about whether food, brought in by the patient's family which required heating, was permitted. I consider the records indicate, of the food the patient's family provided, the patient mainly consumed sweet foods. This food did not require heating but had little nutritional value. There is no evidence the patient was offered or ate any of the meals her family provided which required heating.

106. I accept the CG IPA's advice the ward staff should have taken further action to improve the patient's nutritional intake and the failure to do so was not reasonable. I refer to the GMC Guidance which states, '*you must: a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological …where necessary, examine the patient; b promptly provide or arrange suitable advice, investigations or treatment where necessary … In providing clinical care you must: … b provide effective treatments based on the best available evidence'.* I am satisfied the medical team's actions did not accord with the GMC Guidance. This is because the doctors did not take account of the patient's presenting symptoms and recent history in relation to nutritional food intake and did not undertake further examinations or investigations. I also accept the CG IPA's advice staff should have explained and discussed the potential context for the patient's reduced intake with her family. I consider this lack of communication unreasonable.

107. I refer to the NMC Code which states, '*make sure you deliver the fundamentals of care effectively … The fundamentals of care include, but are not limited to, nutrition … It includes making sure that those receiving care have adequate access to nutrition … and making sure that you provide help to those who are not able to feed themselves'.* The NMC Code also states, *'Listen to people and respond to their preferences … encourage and empower people to share in decisions about their … care … You assess need and deliver or advise on treatment, or give help … without too much delay, to the best of your abilities, on the basis of best available evidence … make a timely referral to another practitioner when any action, care or treatment is required'*. I also refer to the NMC Standards. In section three, it requires nurses to work with and develop care planning in partnership with patients and families. Further, it states, nurses will *'demonstrate the knowledge, skills and ability to act as a role model for others in providing evidence-based nursing care to meet people's needs related to nutrition … Use evidence-based, best practice approaches for meeting needs for care and support with nutrition … accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions … observe, assess and optimise nutrition … status and determine the need for intervention and support … assist with feeding … and use appropriate feeding … aids'.*

108. I accept the Nurse IPA's advice that Trust nursing staff should have put in place a structured nutritional care plan. However, in consideration of the evidence contained in the records, the process described by the nurses interviewed and the CG and SLT IPAs' advice, I am satisfied the Trust nurses did not act in line with either the NMC Code or the NMC Standards. This is because Trust nursing staff failed to make a timely referral to a doctor about the patient's intake and provide the fundamentals of care and optimise nutrition for the patient.

109. I refer to the RSCLT Guidance which states, SLTs should *'work with other healthcare staff, particularly dietitians, to optimise nutrition and hydration'.* One of the eight nursing staff interviewed specifically explained there was daily input

from a multidisciplinary team (MDT) on the ward, including doctors and SLT, and the MDT would review patients. I also refer to the SLT IPA's advice. She advised there was no evidence there was an MDT approach by those involved in the patient's daily care, which was required to support and manage the patient's nutritional needs. The SLT IPA referenced the RCSLT Dysphagia Guidance and opined, although a dietician was involved and prescribed supplements for the patient, an MDT approach involving doctors, nurses, the dietician, SLT, the patient and the patient's family was optimal to resolve the concerns to achieve the best outcome for the patient. I note the SLT IPA opined this was '*not a failing by the SALT, but a failure in the overall care of the patient which had an impact on the role of the SALT'.* Based on the SLT's advice and the process described by some of the nurses interviewed, I also consider the medical and nursing staff on the ward, and the SLT, failed to employ an appropriate MDT approach to the patient's care. I consider, therefore, the SLT failed to act in line with the RSCLT Guidance.

110. It is clear from my analysis of this issue that the family were keen to make every effort to ensure the patient received adequate nutrition and was provided with food she enjoyed. Based on the interviews with the eight nursing staff, there is evidence staff were not able to heat food provided by patients' families. I consider there is no evidence staff communicated this to the patient's family. I consider the evidence indicates there were meals which required heating included within the range of food the patient's family provided. I also accept the Nurse IPA's advice there was no structured approach in relation to the food the patient's family provided. I consider, whilst there is evidence the patient consumed some of the sweet foods her family provided, there is no evidence the patient was offered or ate any of the meals they provided, all of which required heating. Therefore, whilst there is conflicting evidence both about how the food the patient's family provided was used and communication around what food was appropriate, I am satisfied the staff did not provide the patient's family with appropriate information about this and did not utilise much of the food provided.

111. I consider the findings referenced in paragraphs 106 and 108 to 110 failures in care and treatment. Therefore, I uphold this element of the complaint.

Injustice

112. I considered carefully whether the failings caused injustice to the patient and her family. I refer to the CG IPA's advice, the patient was very unwell, and her poor oral intake may not have improved with additional action. However, I consider the patient lost the opportunity for improved well-being through enhanced nutrition. I also consider she sustained the injustice of frustration as she was offered foods which were unpalatable, without consideration of her preferences. I also consider the patient's family experienced worry about the patient's poor nutritional intake and frustration that Trust staff did not fully effect the family's efforts to remedy this.

CONCLUSION

113. I received a complaint about care and treatment the Trust provided to the complainant's late mother during her time as an in-patient from 17 to 28 June 2021. I upheld two elements of the complaint.

114. I also identified a further service failure because the Trust failed to record the reason for the omission of a single dose of Apixaban on 22 June 2021; however, this did not impact the patient's care and treatment.

115. The investigation found the Trust failed to act in accordance with national standards and guidance because it did not provide appropriate care and intervention for the patient's agitation on 22/23 June 2021 without delay.
    - I recognise this failing caused the patient to sustain the injustice of unresolved distress and agitation. I also recognise this caused the patient's family to sustain the injustice of upset in witnessing the patient's distress.

116. The investigation established the Trust failed to act in accordance with national standards and guidance because it did not make appropriate and timely referrals and interventions when the patient continued to have poor nutritional

intake. The Trust also failed to both explain reasons for the patient's reduced appetite to the patient's family and fully facilitate the provision of food brought in by the family.

- I recognise this failing caused the patient to sustain the injustice of a loss of opportunity for improved well-being by increased food intake and frustration because staff offered her foods which were unpalatable and did not discuss her preferences. I also recognise the patient's family sustained the injustice of worry about the patient's poor nutritional intake and frustration as Trust staff did not fully effect the family's efforts to remedy this.

117. The investigation found there were no failings in the Trust's care and treatment of the patient in relation to the following: - sedation of the patient; toileting; missing medical notes; informing the patient she 'lived with cancer'; staff availability on the ward; the patient's access to fluids; and actions taken to mitigate the patient's fluctuating confusion and hearing difficulties in relation to use of the call-bell.

118. The investigation was unable to conclude if the patient's call-bell was inaccessible.

119. I welcome the Trust's acceptance of, and commitment to implementing the report's recommendations.

Recommendations

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

121. I recommend the Trust should remind relevant staff of the importance of the RPS Guidance paragraph 17; the GMC Guidance, paragraphs 15 and 16; the NMC Code 1.2, 2.6 and 13.2; the NMC Standards 5, 5.1, 5.3 and 8.1; and the RCSLT Guidance related to working collaboratively with other health

professionals. These should be evidenced by records of information sharing and/or training.

122. I further recommend the Trust should ensure relevant staff are given the opportunity to reflect on the findings of this report and the full CG, Nurse and SLT IPAs' advice in consideration of their own practice and which should be noted in appraisal documentation. This should also be evidenced by records of information sharing.

123. I also recommend the Trust reviews the processes on the ward relating to policies on the provision of food by patients' families, and associated communication with families, to ensure clarity and consistency. This review should be documented with a copy of any outcomes or changes provided to this office.

124. I recommend the Trust also reviews the ward processes related to an MDT approach to patient care. In particular, the communication of concerns about patients across health professionals and the documentation of these. This should include the timeliness of any referrals to doctors when there are concerns. This should be evidenced by a sample audit with the outcomes and any associated improvements provided to this office.

125. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **six** months of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

MARGARET KELLY
Ombudsman **10 November 2023**

Appendix One

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being customer focused

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

Being open and accountable

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

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

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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