Investigation Report

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

NIPSO Reference: 201916394

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

I received a complaint about the care and treatment provided to the patient by the nurse attached to a Treatment room operated by the Northern Health and Social Care Trust (the Trust).

I obtained all relevant information, including the Trust's record of the patient's appointment and an explanation from the treating nurse. I also obtained Independent Professional advice from a nursing advisor who provided an opinion on the quality of care delivered at that appointment.

My investigation found that the one page record documented only the patient's blood pressure, which was elevated. There was no reason recorded for the request by the patient for a blood pressure check or details of her history or recent symptoms. I considered that the records failed to meet the relevant standards of record keeping.

I also concluded that the patient ought to have had her blood pressure rechecked in the treatment room. In addition, the nurse failed to consider whether a referral to the patient's GP was necessary; therefore, the care and treatment did not meet the NMC standards.

I considered that these failings led to uncertainty for the complainant that the outcome for her sister may have been different had the treatment and record keeping met the relevant standards. The patient also suffered a loss of opportunity to have further investigation into the cause of her elevated blood pressure.

I recommended that the Trust shares the outcome of its proposed meeting between the GP Practice and the Trust Treatment Room Manager to review the incident and consider the shared learning.

I also recommended that the Trust implements measures suggested by the Nursing advisor to ensure that the learning is embedded, namely:

- *'Audit record keeping within the Treatment room to ensure that it is in line with the NMC Code.*

- *Provide training to relevant treatment room nurses with particular reference to the updated NICE guidelines for hypertension. NICE NG136*

Finally, I recommended that the Chief Executive of the Trust apologises to the complainant within one month for the injustice arising from the failings I identified.

The Trust accepted the findings and recommendations and provided a plan of how these will be actioned. The Trust will aim to revisit the action plan within three months. I welcome the Trust's proactive approach to the investigation report.

The complainant also accepted the outcome of the investigation.

THE COMPLAINT

1. I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust). The complainant is acting on behalf of her niece, in relation to the care and treatment of her niece's late mother (the patient). The complainant is the sister of the patient.

Background

2. The complainant said that the patient experienced chest pain, faintness, weakness and nausea on 19 June 2018 and the following day attended to have her blood pressure taken in a treatment room attached to a GP practice. The Trust staffed and managed the treatment room. The nurse recorded the patient's blood pressure as 150/85. The complainant stated that the nurse provided no treatment or advice and failed to make a referral in accordance with NICE guidelines. The patient became unwell on holiday, suffered a cardiac arrest and died suddenly on 6 July 2018.

3. She complained to the Trust on 3 October 2018 and received the final response on 17 February 2020. She was not satisfied with the response and complained to this Office.

Issue of complaint

4. The issue of complaint accepted for investigation was:
   Issue 1: Whether the care and treatment provided by the nurse in the treatment room on 20 June 2018 and the records made of the attendance met the relevant standards of care and treatment?

INVESTIGATION METHODOLOGY

5. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint. The Trust obtained an account of the consultation from the treatment room nurse.

Independent Professional Advice Sought

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

    - BSc (Hons) Nurse Practitioner, a Senior nurse with nineteen years nursing and managerial experience across both primary and secondary care

    I enclose the clinical advice received at appendix three to this report.

7. I included the information and advice that informed the findings and conclusions within the body of this report. The IPA 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

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

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

    - The Principles of Good Administration
    - The Principles of Good Complaints Handling

9. I refer to the specific standards and guidance that 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:

- Nursing and Midwifery Council (NMC) Professional Standards of Practice and Behaviour; 31 march 2015. (The NMC Code).
- National Institute for Health and Care Excellence (NICE) guidelines Hypertension in Adults: Guidance and Management CG127 (24 August 2011). (NICE CG127)

10. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that I took into account everything I consider to be 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

Whether the care and treatment provided by the nurse in the treatment room on 20 June 2018 and the records made of the attendance met the relevant standards of care and treatment?

Detail of Complaint

12. The complainant said that the patient was due to take a long haul flight to a holiday destination. On 19 June 2018, she experienced chest pain, weakness and nausea. She experienced further chest pain the following day, an episode that was witnessed by a colleague at work.

13. The patient attended the treatment room on 20 June 2018 and the nurse took her blood pressure, which she recorded as 150/85. The complainant believed that the patient informed the nurse that she had experienced symptoms of severe chest pain and weakness but the nurse did not record this. The complainant said that the nurse did not follow guidelines in relation to the presenting symptoms and blood pressure reading on 20 June 2018. She did

not take into account a family cardiac history or that the patient was a smoker and overweight.

14. The complainant said that the nurse informed the patient she was likely stressed, and to go and enjoy her planned holiday. She complained that the nurse did not refer the patient to her GP and that no Electrocardiogram (ECG) was carried out. Sadly, the patient became unwell on holiday, suffered a cardiac arrest and died suddenly on 6 July 2018, aged 46.

15. The complainant also said that the nurse disclosed her own personal details, including bereavement and medical problems she had experienced, to the patient. The complainant said that she knows this because the patient relayed details of the conversation she had with the nurse to her. She said her sister also referred to it in emails to work colleagues.

Evidence Considered

16. I considered the following guidance which the IPA references in her advice:
    - The NMC Code (extracts are attached at appendix four).
    - NICE CG127 (see appendix five for hyperlink)

The Trust's response to investigation enquiries

17. The Trust informed the Investigating Officer that the treatment room nurse stated she had no recollection of the patient or her visit to the treatment room. In response to NIPSO enquiries the Trust stated:
    'During interview on 29 August 2019, as part of the reinvestigation, the Nurse confirmed that, had she been fully informed of any serious concerns, she would have made contact with the GP Practice for further medical assessment. She advised that she would have "insisted" that [the patient] was seen by the GP before leaving the Practice that day.
    The Trust would conclude that in both investigations there is no first-hand evidence to definitively support that [the patient] reported all her symptoms or concerns to the Nurse.
    It is acknowledged that the blood pressure, at the time of assessment, was

inaccurately determined to be within 'normal' parameters. The Trust accepts that while the blood pressure gave no cause for immediate concern, the NICE guidelines were not followed.'

18. The Trust accepted that, had the nurse followed the guidelines, she would have re-checked the patient's blood pressure during the consultation. The Trust stated, in the absence of any additional 'reported symptoms' being shared, there was nothing to prompt the nurse to escalate the consultation for immediate intervention by the Practice Nurse or GP.

19. The Trust identified the following action points based on the learning from this complaint.

'a. *Any referrals without a reason for attendance must be explored with the GP Practice. A communication to reflect this change in process was issued to NHSCT Treatment rooms in January 2019.*
This document states at point 4 '*Reminder; Do not accept any self referred blood pressure requests. All tasks coming to the treatment room must be referred by another professional. Remember to refer to NICE guidelines on the ranges or the Practice protocol on when to seek advice.*'

b. The NICE guidelines will be re-issued to all Nursing staff within the Community Care Division.

c. Record keeping within Treatment Rooms requires an update on the professional standards of record keeping.

d. To introduce a chest pain written protocol for all Treatment Rooms, in consultation with GP Practices.

e. A meeting to be convened with the GP Practice and the Trust Treatment Room Manager to review the incident and consider the shared learning.

Relevant Independent Professional Advice

20. The investigating Officer asked the IPA if it was appropriate for a nurse to see a patient in the treatment room for a blood pressure test without a referral from a GP. She advised:
'There should be a documented rationale for a blood pressure check to be taken. It should not simply be a 'task'. If the rationale is because the patient is

acutely unwell, a Treatment room appointment is not appropriate, and the patient should be given an emergency GP appointment'.

21. The Investigating Officer asked the IPA to explain the significance of a blood pressure (BP) measurement of 150/85. The IPA advised:
'In accordance with national guidance applicable at the time of these events a 'normal' blood pressure reading taken in a clinic setting should be 140/90 or less; NICE CG127 2011 'Hypertension in adults. Diagnosis and management' (replaced in 2019 by NICE CG136). Therefore, a blood pressure measurement of 150/85 potentially indicates stage 1 hypertension (defined as clinic readings of between 140/90 – 159/99). It should be noted however that this cannot be concluded on the basis of one reading (NICE CG127 2011)... The nurse should have taken another blood pressure reading (two consecutive seated measurements at least 1 minute apart as part 2011 NICE guidelines).'
She added *'It should have been documented that the patient was advised to make an appointment with her GP or the nurse should have referred her back to her GP.'*

22. The complainant said that the nurse disclosed her own personal details to the patient. The nurse admitted she did this as a 'coping mechanism' The Investigating Officer asked the IPA how appropriate this was. She advised:
'The patient's needs should come first [in accordance with the NMC code] If the sharing of personal information is to demonstrate empathy and understanding with your patient, this could be reasonable, however to do this as a 'coping mechanism' is not appropriate as you are not putting the patient first.'

23. The Investigating officer asked the IPA to identify any learning / service improvements. She acknowledged the actions already identified by the Trust and advised the learning points:
'…*should include the action to be taken when a blood pressure reading is raised (in line with the updated 2019 NICE hypertension guidelines NG136). The learning points should also include that two blood pressure readings should be taken.*
...This complaint has highlighted the importance of record keeping. If the nurse

had followed national standards, it would be clear why the patient had attended for a blood pressure check. This would have revealed if she had any symptoms at the time of the appointment or leading up to the appointment.'

24. The IPA suggested the following measures :
    - *'Audit record keeping within the Treatment room to ensure that it is in line with national standards: NMC 2017 'The Code. Professional standards of practice and behaviour for nurses, midwifes and nursing associates' section 10.*
    - *Ensure that Treatment room nurses are working within the updated NICE guidelines for hypertension: NICE NG136 (August 2019) 'Hypertension in adults: diagnosis and management'.'*

Analysis and Findings

25. The complainant believed that her sister presented to the treatment room because she had experienced severe chest pain and weakness the previous day and that she informed the nurse of these symptoms. The patient's work colleague provided evidence to the complainant that she had witnessed these symptoms.

26. The IPA noted that the nurse did not document the reason why the patient attended for a blood pressure check. She advised that '*this would have revealed if she had any symptoms at the time of the appointment or leading up to the appointment'*. In the record of the consultation, there is no entry reporting symptoms of severe chest pain and weakness. There is no record of family history, weight or that the patient was a smoker.

27. The NMC Code requires a nurse to *'assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay and to the best of your abilities, on the basis of the best evidence available and best practice.'* As part of its investigation, the Trust interviewed the nurse involved, who did not recall the consultation with the patient. As the patient is deceased, it is not possible for me to determine whether she voluntarily provided full disclosure to the nurse. As there is no record, I do not

know whether the nurse asked the appropriate questions about history and symptoms and acted upon the responses. I therefore cannot determine whether the nurse acted on the best available evidence.

28. Section 10 of the NMC code is *'Keep clear and accurate records relevant to your practice'.* In my view, clinical notes should precisely record information obtained as part of a consultation in order to ensure clarity for those clinicians who will later rely on the information recorded in the patient's medical record. This includes information that may rebut any suggestion of relevant history or symptomology. As there is no record, I cannot be satisfied that the nurse adopted the best nursing practice in this case and I therefore make a finding of failure in care and treatment in that regard.

29. I also consider that the practice of this nurse of talking to patients about her own health and personal challenges as *'part of her coping mechanism'* does not meet the NMC guidance to put '*the interests of people using or needing nursing …services first'.* In my view, in a very brief consultation in a treatment room, the focus of attention should be on the patient.

30. The IPA advised, and the Trust agrees that a BP of 150/85 is elevated and that the nurse should have taken further action; as a minimum, she should have taken a second BP reading. I note that the Trust accepts that the history and recent symptoms, if discussed and considered, would have prompted a referral to the GP. I accept the IPA advice that the nurse failed to follow the NICE CG127 guidelines in relation to the BP reading. This is a failing in care and treatment.

CONCLUSION

31. I received a complaint about the care and treatment provided to the patient by the nurse in the treatment room on 20 June 2018 and the lack of records made of the attendance

32. I found that the nurse failed to obtain a second BP reading or consider whether a referral to the patient's GP was necessary; therefore the care and treatment did not meet the NMC standards.

33. I also found that record keeping did not meet the standards expected by the NMC code and that this amounted to a failure in care and treatment.

34. I considered that these failings caused the complainant to experience the injustice of uncertainty that the outcome for her sister may have been different had the treatment and record keeping met the relevant standards. The patient also suffered a loss of opportunity to have further investigation into the cause of her elevated BP.

Recommendations

35. I welcome the learning and the action points identified by the Trust that I recorded at paragraph 19.

36. I recommend that the Trust implements the measures suggested by the IPA to ensure that the learning is embedded, namely

- *'Audit record keeping within the Treatment room to ensure that it is in line with the NMC Code. Carry out a random sampling audit of the treatment room records to ensure they are in line with the NMC code, and take action to address any identified trends or shortcomings.*
- *Provide training to relevant treatment room nurses with particular reference to the updated NICE guidelines for hypertension; NICE NG136*

37. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures identified within **one month** of the date of this report.

38. I further recommend, for service improvement and to prevent future recurrence, that the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **three months** of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms that indicate that staff have read and understood any related policies. This should include the outcome of the *'meeting to be convened with the GP Practice and the Trust Treatment Room Manager to review the incident and consider the shared learning.'*

39. The Trust and the complainant accepted my findings and recommendations.

Margaret Kelly **1 November 2021**
Ombudsman

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

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

2. Being customer focused

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

3. **Being open and accountable**

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

4. **Acting fairly and proportionately**

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

5. **Putting things right**

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

6. **Seeking continuous improvement**

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.