Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Belfast Health & Social Care Trust

NIPSO Reference: 22364

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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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Listed Authority: Belfast Health and Social Care Trust

SUMMARY

The complaint concerned the care and treatment provided by the Belfast Health and Social Care Trust (the Trust) to the complainant's late father (the patient). The patient underwent surgery for lung cancer, following which he remained in the Trust hospital for more than three months, including time in the intensive care unit.

The complainant cited a number of issues in the complaint, including that the patient's initial surgery was not performed correctly and was performed by a physician who was not the nominated surgeon; the patient was given a tracheostomy for which consent was not given; the patient's drain was not appropriately managed; nursing care was not appropriate; and sepsis was not identified prior to the complainant raising a concern. The complainant said that these issues led to an overall deterioration in the patient's health, prolonged hospitalisation and the patient being peg-fed and bed-bound for the remainder of his life.

There were elements of the complaint that the investigation did not uphold. The investigation, however, established that there were failings in some aspects of the Trust's care and treatment. The investigation found that the Trust failed to comply with a number of standards, including in relation to management of the patient's chest drain and skin and hygiene care of the patient.

The investigation established that, as a result of the failings identified, the patient, the complainant and her family sustained injustice. This included that the complainant and her family suffered the injustice of anxiety, upset and uncertainty; and the patient suffered the injustice of distress.

I made a number of recommendations, including an apology to the complainant for the failings identified. I also recommended that the Trust ensures that relevant staff are made aware of relevant standards, guidance and policies to be demonstrated by the conduct of a sample audit of records.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complaint related to the care and treatment provided by the Trust to the complainant's late father (the patient).

2. The patient received right lower lobectomy[1] and wedge resection surgery for lung cancer. After the operation, the patient was very ill and was treated in intensive care for over one week. He subsequently underwent a second operation and remained in hospital for a further three months, during which time he experienced emphysema and a prolonged recovery.

Issues of complaint

3. The issue of complaint accepted for investigation was:

Whether the care and treatment, provided to the patient during the period 20 May to 5 September 2018, was appropriate, reasonable and in accordance with relevant standards, guidance and practice.

INVESTIGATION METHODOLOGY

4. 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.

5. Records were also sourced from a hospital in another Health Trust (Hospital A) where the patient received treatment in the Emergency department (ED) sometime after his discharge from the Trust but which treatment the

[1] Each lung is made up of sections called lobes. The right lung has three lobes, and the left lung has two. A lobectomy is a type of lung cancer surgery in which one lobe of a lung is removed because it contains malignant tumours. In this case the lower lobe in the right lung.

complainant believed was required as a result of the surgery undertaken by the Trust.

Independent Professional Advice Sought

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

- Consultant Thoracic Surgeon IPA; M.D., PhD, FRCS; a consultant in Thoracic Surgery, encompassing Thoracic Oncology with a focus on patients with lung cancer.
- Nurse IPA; BSc (Hons) Nurse Practitioner; MA Health Service Management; Diplomas in Adult Nursing, Chronic Obstructive Pulmonary Disease and Asthma; a senior nurse with twenty years nursing and managerial experience across both primary and secondary care.
- Consultant Physiotherapist IPA; DProf, MSc, BSc (Hons), MCSP, MMACP; a consultant Physiotherapist and Registered Osteopath with in excess of 30 years' experience in the NHS and a consultant for 17 years; clinical lead for audit, education, and research.

The professional advice received is enclosed at Appendix four to this report.

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 this advice was weighed, 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 which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[2]:

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

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.

The specific standards and guidance relevant to this complaint are:

- Belfast Health and Social Care Trust Policy for obtaining consent for examination, treatment or care in adults and children, 2015 (BHSCT Consent Policy);
- Belfast Health and Social Care Trust Policy for Tracheostomy tube in situ - Care of patients in the acute hospital setting, 2011 (BHSCT Trach Policy) ;
- Belfast Health and Social Care Trust Policy for the safe insertion and management of chest drains, 2010 (BHSCT Chest Drain Policy);
- Nursing and Midwifery Council Code: Professional standards of practice and behaviour for nurses, midwifes and nursing associates, 2017 (NMC Code);
- Royal Marsden Manual of Clinical Nursing Procedures (Royal Marsden);
- National Institute for Health and Care Excellence, Pressure ulcers: prevention and management, 2014 (NICE Pressure ulcers);
- Royal College of Physicians National Early Warning Score Guidance, 2017 (NEWS 2 Guidance);
- Health and Care Professions Council Standards of conduct, performance and ethics; and
- Health and Care Professions Council Standards of Proficiency Physiotherapists.

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

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

10. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

THE INVESTIGATION

Whether the care and treatment, provided to the patient during the period 20 May to 5 September 2018, was appropriate, reasonable and in accordance with relevant standards, guidance and practice.

Detail of Complaint

11. The patient was given a tracheostomy but the complainant said that consent was not given for this. The complainant also said that, following the surgery, the patient could not swallow.

12. The complainant said that the surgery was not performed by the person for whom consent for the surgery was given. The complainant also said that the surgery was not performed correctly and that this resulted in further surgery and a protracted period of recovery in hospital. The complainant said that, as a result, the patient became bed-bound and required peg-feeding for the remainder of his life. The complainant said that the patient attended ED in another Trust (Hospital A) because he '*coughed up surgical matter'* which the complainant believed was related to failures in the patient's original surgery on 21 May 2018.

13. The complainant also said that, on one occasion, a physiotherapist failed to reconnect the patient's chest drain following treatment and which the complainant believed led to the patient developing serious emphysema. The

complainant said that this was exacerbated by a failure by nursing staff to identify that the chest drain was twisted.

14. The complainant said that the patient developed sepsis but that this was not identified by the Trust until she raised concerns.

15. The complainant also said that the patient was left to lie in his own faeces.

Evidence Considered

Legislation/Policies/Guidance

16. I considered the BHSCT Trach Policy, the BHSCT Chest Drain Policy, the NMC Code, NICE Pressure Ulcers and the HCPC Standards. Relevant extracts are enclosed at Appendix three.

Trust response to investigation enquiries

17. Relevant extracts from the Trust's responses to enquiries made during the investigation of the complaint are at Appendix 5.

Relevant records

18. A significant volume of records were considered and referenced by the three IPAs in the provision of their advice.

19. I considered the consent form related to the surgery. I also considered the letter issued to the patient's General Practitioner (GP) following the patient's attendance at the Trust's clinic on 11 April 2018.

20. I also considered the records related to when the patient presented at ED in Hospital A because following a '*bad bout of coughing'* he coughed up matter.

Relevant Independent Professional Advice

Consent

Consultant Thoracic Surgeon IPA

21. The Consultant Thoracic Surgeon IPA advised that, in obtaining consent for the treatment, the '*procedure has to be discussed with patient and consent has to be signed by relevant health care professional and patient and both have to sign and date the consent.'* The Consultant Thoracic Surgeon IPA advised that the Trust did obtain consent, '*the patient did … sign the consent form'* but also that *'the patient did not date the consent form and did not print his name'*. The Consultant Thoracic Surgeon IPA recommended that the Trust '*implement an improved consent form process to make sure that the patient correctly dates it and writes his name under the signature.'*

Competence of the surgeon on 21 May 2018

Consultant Thoracic Surgeon IPA

22. The Consultant Thoracic Surgeon IPA advised that although *'a managing consultant is usually allocated to a patient … in a teaching hospital surgery can be performed by a Senior National Trainee according to the level of experience and the consultant evaluation. Senior trainees can perform unsupervised major lung resection if considered suitable by the managing consultant.*' The Consultant Thoracic Surgeon IPA advised that in the patient's case, '*there was a managing consultant and a senior trainee'*. The Consultant Thoracic Surgeon IPA also advised that '*based on documents provided … the trainee showed an appropriate level of training and experience to perform the … operation.'*

The patient's surgery on 21 May 2018

Consultant Thoracic Surgeon IPA

23. The Consultant Thoracic Surgeon IPA advised that the patient underwent '*a lung cancer operation which requires an anatomical lung resection: removal of right lower lobe and lymph node removal.'* The Consultant Thoracic Surgeon IPA advised that '*the operation was performed correctly. There were no intraoperative complications. All standard manoeuvres were performed to assure a good quality cancer operation*.' The Consultant Thoracic Surgeon IPA further advised that there were no issues during the course of the surgery. He advised that *'the bronchial stump was correctly tested with no evidence of air leak. An air leak from the lung surface is common in patients with COPD and the surgeon correctly repaired the source of the air leak.'* The Consultant Thoracic Surgeon IPA concluded that there was no '*evidence of impact of the surgical performance in the deterioration of patient.'*

The patient's surgery on 7 June 2018

Consultant Thoracic Surgeon IPA

24. The Consultant Thoracic Surgeon IPA advised that due to '*the presence of a bronchopleural fistula*[3]*'*, the surgery on 7 June 2018 was '*correctly performed by a senior consultant',* who was an appropriate and competent person to perform the procedure. The Consultant Thoracic Surgeon IPA further advised that this operation was '*to repair the bronchopleural fistula (communication between the airways and the pleural space) to prevent ongoing chest infection and stop the air leak.'* He also advised that the surgery was performed correctly*, 'according to national and international standards'.* The Consultant Thoracic Surgeon IPA advised that this surgery '*was appropriate and performed timely after conservative management*.' He also advised *that 'the pleural space was properly drained and surgery is required only if there is*

[3] A bronchopleural fistula (BPF) is a communication between the pleural space and the bronchial tree. BPFs are associated with high morbidity and mortality. The most common cause is postoperative complication of pulmonary resection but other causes include lung necrosis complicating infection, persistent spontaneous pneumothorax, chemotherapy or radiotherapy (for lung cancer), and tuberculosis. Treatment for BPF includes various surgical and medical procedures.

evidence of deterioration despite the drain and the antibiotics. Considering the risks related to redo surgery, a conservative approach was attempted first.'

25. The Consultant Thoracic Surgeon IPA advised that the surgery did not impact on the deterioration in the patient. He advised that '*bronchopleural fistula carries a high risk of respiratory failure despite optimal medical management and surgery. The deterioration was related to the fistula and not the surgery performed on 07/06/2018.*' He concluded that *'the patient experienced a well-known complication of thoracic surgery. Bronchopleural fistula is a life threatening complication which was correctly identified and managed by the surgical and medical team.'*

Impact of surgeries on the patient's condition

Consultant Thoracic Surgeon IPA

26. The Consultant Thoracic Surgeon IPA advised that *'bronchopleural fistula is a known complication in thoracic surgery. COPD, active smoking and lymph node disease are all risk factors to develop a postoperative bronchopleural fistula.'* The Consultant Thoracic Surgeon IPA advised that the patient was a *'current smoker with history of COPD'.* He further advised that *'unfortunately bronchopleural fistula carries an extremely high risk of respiratory complications and mortality even if appropriately treated.'* The Consultant Thoracic Surgeon IPA also advised that in relation to the patient *'all intraoperative measures to prevent it were adopted.'* The Consultant Thoracic Surgeon IPA further advised that the *'ongoing chest infection due to the aspiration of the pleural fluid through the bronchopleural fistula may have contributed to [the patient's] poor performance status and difficulties in swallowing.'*

The patient's attendance at ED in Hospital A in June 2019

Consultant Thoracic Surgeon IPA

27. The Consultant Thoracic Surgeon IPA advised that the patient presented to ED in Hospital A *'because he coughed up tissue and suture material.'* The

Consultant Thoracic Surgeon IPA further advised that *'when you attempt to repair a bronchopleural fistula but there is still ongoing communication between airways and the pleural space, a patient can cough up pleural debris or sutures used to repair the stump.'* The Consultant Thoracic Surgeon IPA advised that *'the surgery was performed correctly, direct repair of the fistula has a very high risk of failure, and when that happens it is common to cough the material used to repair the fistula at the time of surgery.'* He also advised that he could not identify *'any issue that may have aggravated an already life threatening complication such as a bronchopleural fistula.'*

The patient's swallow

Consultant Thoracic Surgeon IPA

28. The Consultant Thoracic Surgeon IPA advised that '*a persistent bronchopleural fistula increases the risk of aspiration to the other lung and persistent cough which can also have an impact on swallow.'* He advised that the Trust provided appropriate and timely care and treatment for the patient's issues with swallowing, the *'patient was regularly reviewed by the speech and swallow team and the dietician'* and that the '*patient was reviewed according to national standards.'*

Nurse IPA

29. The Nurse IPA advised that '*the patient did have swallowing issues and they were raised by the family on 3rd June'* and that *'the patient was referred to SALT the day after the swallowing difficulties were identified by family. There is no specific timeframe for referral to SALT after potential swallowing difficulties have been raised but the patient should be [*Nil by Mouth*] (NBM) until he has been reviewed, which did happen.* The Nurse IPA concluded that *'concerns were raised by family on 3rd June and he was observed by a Consultant that same day. He continued to cough after oral intake and was therefore referred to SALT on 4th. This is timely.'*

Emphysema

Consultant Thoracic Surgeon IPA

30. The Consultant Thoracic Surgeon IPA advised that '*according to the clinical notes, patient developed surgical emphysema on 26/05'.* He further advised that '*the surgical emphysema was related to the bronchopleural fistula which causes a significant air leak.'* The Consultant Thoracic Surgeon IPA advised that the care and treatment provided by the Trust for the emphysema was appropriate and was in line with relevant standards and practices. He advised that the patient '*was transferred to ITU for medical support. Appropriate antibiotics treatment started and no invasive breathing support commenced.'*

Physiotherapist's reconnection of the patient's drain

Physiotherapist IPA

31. The Physiotherapist IPA advised that *'there is no indication in the records that on 23 May, or at any other time, the physiotherapists failed to reconnect the patient's drain.'*

32. The Physiotherapist IPA also advised that *'documentation is not complete in many areas. For example, each entry should be dated and timed (24-hour clock) and the physiotherapist making the entry should provide a signature, job title and professional registration number. In addition, it is often considered more appropriate to document dates as, for example, 03/06/18 rather than 3/06/18 (since 3/06/18 could be changed later to 13/06/18).*' She also advised that '*it is generally considered good practice to check the drain before, during and after treatment … and documenting these pre- and post-treatment checks in the notes is important for safety and audit purposes.'* The Physiotherapist IPA referred to the BHSCT Chest Drain Policy and advised that *'chest drain insertion and the care/management of drains will be audited … It also states that the policy applies 'throughout the BHSCT and to all BHSCT medical staff involved in insertion of chest drains … Physiotherapists would presumably be*

covered by the 'throughout the BHSCT' statement''. She advised that there was *'insufficient documentation relating to the management of drains whilst providing physiotherapy treatment'*. The Physiotherapist IPA also advised, however, that '*this issue was acknowledged by the Trust in the complaint responses and is being addressed by the physiotherapy department.'*

33. The Physiotherapist IPA advised that '*whilst there is no evidence in the records that the physiotherapists mismanaged the patient's drain/s during treatment, the absence of a clear audit trail (i.e., detailed and regular documentation pre-treatment, during and post-treatment in relation to the care and management of drains during physiotherapy treatment) does raise concerns about the possibility that the drain could have been managed incorrectly, but this is not enough evidence to conclude that the drain was managed incorrectly*.' She advised that the BHSCT Chest Drain Policy '*should be reviewed by the physiotherapy lead, and part of the learning from this review may be to ensure that the wording of the policy specifically mentions physiotherapists (and other professional healthcare staff) so that they are included in training and audits led by the authors of the policy document.'*

Management of the patient's drain

Consultant Thoracic Surgeon IPA

34. The Consultant Thoracic Surgeon IPA advised that '*according to the clinical notes [the patient's] drain was kinked during patient mobilization*.' He also advised that '*this may happen … Kinked drain can cause worsening surgical emphysema and increasing oxygen requirement.'* The Consultant Thoracic Surgeon IPA advised that the kink in the drain *'was recognised and unkinked. As soon as this was recognised and the drain unblocked, the symptoms resolved pretty quickly'.* He further explained that the resolution was that *'increased breathlessness and discomfort caused by the increased need for oxygen ceased.'* The Consultant Thoracic Surgeon IPA further advised that

‘the *cause of the surgical emphysema was however the bronchopleural fistula.’*

Nurse IPA

35. The Nurse IPA advised that there is *‘evidence’* of the patient’s drain being twisted/kinked *‘on 25/05/2018 (tabbed in multi-professional notes) which says “o/e [on examination] drain tubing twist/ kinked”.* She advised that *‘the kink was rectified and air was released.’* The Nurse IPA advised *‘the chest drain was last reviewed on the chest drain chart at 05:00 with no documented concerns (the drain was ‘swinging’ which is not observed when a tube is twisted or kinked). The patient was also seen by a Physio at 10:20 and the drain was documented as “on suction” both during and after the intervention, making kinking of the tube unlikely at this time.’* She further advised, however, that *‘there was a failure to monitor the chest drain by nursing staff four hourly’* and that therefore although *‘it is not clear how and when the drain became kinked …any defects to the chest drain would be noted in a timely manner if monitoring was four hourly.’* The Nurse IPA advised that *‘this was therefore directly linked to his nursing care.’* She advised that *‘the patient’s chest drain was not checked and documented on the chest drain charts regularly as per national guidance, which is four hourly. The drain was monitored at 05:00 on 25th and then there is no further documented monitoring until 09:00 on 27th.’*

36. The Nurse IPA advised that *‘it is noted that the patient was already suffering from a surgical emphysema which is a well-recognised complication of chest drains. During the Registrar’s review it is documented that the emphysema had worsened and that the patient had ‘difficulty breathing”.* The Nurse IPA advised that ‘*nurses are taught … that kinking of the chest drain tube should be resolved quickly as it can cause a raise in intrathoracic pressure (pressure within the pleural cavity) and exacerbate breathlessness.’* The Nurse IPA referred to the Royal Marsden and advised that ‘*whilst there is no national ‘standard’ on the monitoring of chest drains, there is guidance which states that the status of the chest drain should be checked at least four hourly as per*

Woodrow (2013) 'Intrapleural chest drainage … Royal Marsden is an evidence based resource for clinical nursing procedures and is endorsed by the NHS'. She further advised that*, 'on reviewing the chest drain charts, monitoring was inconsistent and was not four hourly … there are a number of other occasions over the patient's admission when his chest drain was not checked for over 24 hours (for example: 23/06 09:00 – 24/06 09:00, 24/06 09:00 – 25/06 16:00, 25/06 16:00 – 01/07 20:50).*

37. The Nurse IPA also advised that, *'the actions taken at the time of the events were appropriate – medical review and medical decision making. However, the Trust has not commented on the failure of nursing staff to monitor the patient's drain four hourly in line with national guidance. Action should be taken to ensure that this is addressed within this ward area.'* The Nurse IPA concluded that '*the kinking of the chest drain tube was not noticed by nursing staff on 25th May because their checks were infrequent and not in line with national guidance … the Trust should ensure that staff are competent in the management and regular monitoring of chest drains. Chest drain documentation should reflect that four hourly checks are being made.'*

Sepsis

The Consultant Thoracic Surgeon IPA

38. The Consultant Thoracic Surgeon IPA advised that the patient *'started to develop sepsis with the bronchopleural fistula.'* He further advised that the sepsis *'developed around 26/05 because in the presence of bronchopleural fistula there is a communication between the pleural space and the airways with contamination and risk of multiple on-going chest infections.'* The Consultant Thoracic Surgeon IPA advised that *'the sepsis was identified by the medical team on 26/05 and treatment was started accordingly.'* He further advised that the care and treatment for the sepsis was appropriate.

Nurse IPA

39. The Nurse IPA referred to NEWS 2 Guidance and advised that *'nurses completed NEWS in line with [NEWS 2] standards and when the patient scored 5 or more (indicating possible serious illness, including sepsis), he was escalated for medical review. The continued monitoring of the patient's condition using NEWS was also in line with [News 2 Guidance].'*

Nursing care

Nurse IPA

40. The Nurse IPA advised that *'the nursing assessments show that the patient needed support in all aspects of nursing care, including hygiene provision, nutrition, hydration, and skin care. He was at risk of pressure area breakdown and therefore SKIN bundles were in place … There are however some gaps in the daily and nightly SKIN records and some of the charts are not dated, making it impossible to give all the dates when the gaps in care provision occurred.'* She referenced NICE Pressure Ulcers and further advised that *'skin checks should occur at least four hourly, which is in line with national skin care standards'.* The Nurse IPA advised that *'there is one occasion when checks did not occur from 22:00 to 08:00. There is no date, making it impossible to know when this was. On 19th July checks did not occur from 10:00 until 20:00. On 11th July he was not checked all day (08:00 to 20:00).'*

41. The Nurse IPA advised that the patient *'did develop a break to his sacrum (19th July) which would necessitate a minimum of four hourly checks (NICE 2014, referenced above). Poor documentation means that it is not known if this was a moisture lesion or a pressure sore. The description and position make a pressure sore more likely. This is because pressure sores form over bony prominences (sacrum in this instance)'.* She further advised that *'an 'Unavoidable' pressure sore means that the individual developed a pressure ulcer despite skin care that was in line with national standards … There were lapses in the patient's SKIN bundle, indicating infrequent skin and comfort*

checks, which indicates that the development of a pressure sore on 19th July was avoidable.'

42. The Nurse IPA advised that *'there is evidence of some 'good' nutritional and hydration care within the records, that is in line with the above guidance– referrals to SALT, dietician, food and fluid charts, NG tube and latterly PEG feeding (17th August). However, on a daily basis there are gaps in care provision, with incomplete documentation to 'prove' that daily support was given, specifically with skincare and hygiene. These gaps in care provision can be linked to the development of a pressure sore to the patient's sacrum, but it is not clear if he was left without hygiene care when it was needed.'* The Nurse IPA concluded that *'some areas of nursing care … failed to meet national standards. This resulted in the development of a pressure sore to the patient's sacrum on 19th July. The Trust should ensure that skin/ pressure area care meet the patient's needs. SKIN bundles should be completed four hourly in at risk patients and when a 'break' to the skin is noted there should be clear records to show the cause (moisture or pressure?).'*

Physiotherapy care and treatment

Physiotherapist IPA

43. The Physiotherapist IPA advised that *'the patient was appropriately assessed for treatment during the period 20 May to 05 Sept 2018.'* The Physiotherapist IPA advised that the '*treatment was delivered with consent and shared decision-making is evident'.* She further advised that *'the care and treatment was appropriate'.*

Responses to the Draft Investigation Report

44. The complainant and the Trust were given an opportunity to provide comments on the Draft Investigation Report. The Trust did not provide any comments beyond acceptance of the findings and recommendations in the draft report. The complainant's comments are outlined below in paragraph 45

below.

45. The complainant said that she recognised that a fistula is a life threatening complication but that she believed that this was not diagnosed by the Trust in a timely manner and that this delay impacted on the patient's recovery. The complainant said that Trust Surgeon who performed the first operation on the patient had '*no idea what was wrong'* with the patient and wanted to confer with the Trust Consultant. The complainant said that, due to the unavailability of the Trust Consultant, there was no intervention for two weeks after the 'post-operative complications' emerged. The complainant said that by this point, *'the bronchus had solidified open'* and had the operation been undertaken earlier, the outcome would have been very different. The complainant said that the solidified bronchus was not related to the patient's COPD, Cancer or smoking as advised by the Consultant Thoracic Surgeon IPA but was because the Trust Surgeon did not have the necessary knowledge to identify the cause of the post-operative issues and therefore the Trust did not act in a timely manner to rectify the issue. The complainant said this impacted on the patient's quality of life, prognosis and damage to his lung.

Analysis and Findings

46. I investigated the complaint by carefully examining the care and treatment the Trust provided to the patient.

Consent

47. I note that the Trust stated that the patient '*signed the consent for treatment form'* and that '*Minitrach (mini tracheostomy) is noted twice on this consent form both in hand written form by [the Trust Consultant Thoracic Surgeon] and typed as part of overall listed complications.'* In reviewing the records, I note that this form was signed by the Trust Consultant on 11 April 2018 and was also signed by the patient, although this signature is not dated. I note that the risks associated with the procedure, including infection, chest infections and

the need for a chest drain were stated on this consent form, together with the statement that a mini-tracheostomy might be inserted. I note that, in line with the required process, the consent form was signed again by a Trust doctor on 20 May 2018, following the patient's admission for the procedure. I also note that the letter to the patient's GP from the patient's attendance at the Trust clinic on 11 April 2018 stated that the Trust Consultant discussed the procedure with the patient, his wife and his daughter. I note this discussion incorporated risks to the patient including those related to his current smoking, infection, chest infection, persistent air leak and intensive care admission. The Consultant's letter also stated it was explained to the patient, and those of his family who were in attendance, that sometimes a mini-tracheostomy may be required.

48. I note the Consultant Thoracic Surgeon IPA advised that the records demonstrated that the patient and his family were informed of the possibility of the need for a mini-tracheostomy and the patient gave consent for the procedure, including a potential mini-tracheostomy. I accept the Consultant Thoracic Surgeon IPA's advice that the Trust did obtain consent. I therefore do not uphold this element of the complaint. However I note that the Consultant Thoracic Surgeon IPA's advised that *'the patient did not date the consent form and did not print his name'*. I commend the Consultant Thoracic Surgeon IPA's advice to the Trust to implement '*an improved consent form process to make sure that the patient correctly dates it and writes his name under the signature.'*

Consent and competence of the surgeon on 7 June 2018

49. I note that the consent form, which was signed by the patient on 20 May 2018, includes the statement that, in giving consent, the patient '*understand[s] that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have the appropriate experience.*' I note that the Trust stated *that 'at the time of [the patient's] operation, [the Trust Surgeon] had 12 years post-graduate training in surgery with 6 of those years*

in specialist thoracic surgery training. He had carried out a substantial number of similar operations as principle operator … [the Trust Surgeon] was assessed formally and signed off by a committee and the Regional Training Programme Director … as performing at the level of a Day 1 Consultant in August 2016 … At the time of [the patient's] surgery, [the Trust Surgeon] had completed approximately 200 anatomical lung resections as first operator, many of these performed independently'.

50. I note that the Consultant Thoracic Surgeon IPA advised that '*in a teaching hospital surgery can be performed by a Senior National Trainee according to the level of experience and the consultant evaluation. Senior trainees can perform unsupervised major lung resection if considered suitable by the managing consultant … there was a managing consultant and a senior trainee'* and that *'based on documents provided … the trainee showed an appropriate level of training and experience to perform the … operation.*' I consider that the record of the patient's consent evidences that the Trust informed the patient that the procedure might be performed by someone other than the Trust Consultant. I accept the Consultant Thoracic Surgeon IPA's advice that the Trust Surgeon was an appropriate and competent person to perform the surgery and that this was in line with the consent process. I therefore do not uphold this element of the complaint.

The patient's surgery on 21 May 2018

51. I note that the Trust stated that the patient's operation note of 21 May 2018 was reviewed by the [then] Clinical Director and [the Trust Consultant Thoracic Surgeon] and both were *'satisfied the technical aspects of the operation were conducted in line with accepted practice in the UK and no mistakes were made during surgery.'* I note that the Consultant Thoracic Surgeon IPA advised that on 21 May *2018 'the operation was performed correctly. There were no intraoperative complications. All standard manoeuvres were performed to assure a good quality cancer operation.'* I note that the Consultant Thoracic Surgeon IPA concluded that there was no

'*evidence of impact of the surgical performance in the deterioration of patient.'* I accept the Consultant Thoracic Surgeon IPA's advice and therefore do not uphold this element of the complaint.

The patient's surgery on 7 June 2018

52. I note that the Consultant Thoracic Surgeon IPA advised the operation on 7 June 2018 was '*to repair the bronchopleural fistula (communication between the airways and the pleural space) to prevent ongoing chest infection and stop the air leak'* and that he also advised that the surgery was performed correctly, '*according to national and international standards'.* I also note that the Consultant Thoracic Surgeon IPA advised that this surgery '*was appropriate and performed timely after conservative management … Considering the risks related to redo surgery, a conservative approach was attempted first.'*

53. I note that the Consultant Thoracic Surgeon IPA advised that the surgery did not impact on the deterioration in the patient as '*bronchopleural fistula carries a high risk of respiratory failure despite optimal medical management and surgery. The deterioration was related to the fistula and not the surgery performed on 07/06/2018.'* I note that the Consultant Thoracic Surgeon IPA concluded that '*the patient experienced a well-known complication of thoracic surgery. Bronchopleural fistula is a life threatening complication which was correctly identified and managed by the surgical and medical team.'* I accept the Consultant Thoracic Surgeon IPA's advice. Therefore, I do not uphold this element of the complaint.

Impact of surgeries on the patient's condition

54. I note the complainant's comments on the draft report that she believed that the delay of two weeks in undertaking the second operation had a negative impact on the patient's prognosis, quality of life and lung. I refer to the Consultant Thoracic Surgeon IPA's advice detailed in paragraphs 23 to 26 in which he confirmed that the patient's post-operative difficulties were managed

in line with appropriate standards, including an initial '*conservative*' approach because of the risks associated with further surgery and that the bronchopleural fistula is a risk associated with thoracic surgery, COPD and active smoking and that the patient was a '*recent smoker with history of COPD'*. I also note that the Consultant Thoracic Surgeon IPA advised that '*unfortunately bronchopleural fistula carries an extremely high risk of respiratory complications and mortality even if appropriately treated*'. I note that the Consultant Thoracic Surgeon IPA advised that in relation to the patient '*all intraoperative measures to prevent [bronchopleural fistula] were adopted.*'

55. I note that the Consultant Thoracic Surgeon IPA advised that the patient presented to ED in Hospital A '*because he coughed up tissue and suture material*.' I note that the Consultant Thoracic Surgeon IPA also advised that '*when you attempt to repair a bronchopleural fistula but there is still ongoing communication between airways and the pleural space, a patient can cough up pleural debris or sutures used to repair the stump.'* I note that the Consultant Thoracic Surgeon IPA advised that '*the surgery was performed correctly'.* I note that the Consultant Thoracic Surgeon IPA advised that he could not identify '*any issue that may have aggravated an already life threatening complication such as a bronchopleural fistula.'*

56. I accept the Consultant Thoracic Surgeon IPA's advice and therefore do not uphold this element of the complaint.

The patient's swallow

57. I note that the Trust stated that the concerns about the patient's swallow *were 'first raised by his family on 03 June 2018'* and that following a review by a Trust Thoracic Consultant Surgeon, the patient was advised to remain '*nil by mouth'* until he was assessed by a Speech and Language Therapist (SALT). I note that the Trust stated that the patient was referred to SALT on 4 June 2018 and initially assessed on 5 June 2018. I note that the timescales for this accorded with the Royal College of Speech and Language Therapists

standards. I note that the Trust stated that the patient was reviewed by SALT on 11 June 2018 and, following re-referral on 12 July 2018, was assessed again on 13 July 2018 and was subject to monitoring by SALT on 19, 20, 23, 25 and 30 July and on 1, 22 and 30 August. I note that the Trust stated that at each assessment and review, prior to 30 August 2018, there was '*no clinical evidence of laryngeal penetration or aspiration on consistencies'.* I note that the Trust stated that on 30 August 2018, the SALT review identified '*evidence of deterioration in swallow function. Based on this clinical examination, it was recommended [the patient] remain nil by mouth until an instrumental assessment could be carried out'*.

58. I note that the Trust stated that a Video Fluoroscopic Assessment (VFS) is one instrumental swallowing assessment that can be performed if a SALT assessment recommends this as a pathway of investigation. I note that the Trust stated that the assessment of the patient on 30 August 2018 by SALT led to the patient being offered a Fibre Optic Endoscopic Evaluation of Swallowing but that the patient declined this assessment as the patient felt it would be too invasive. I note that a VFS was then offered to and accepted by the patient and a referral made. I note that the Trust stated that VFS assessments are available onsite once each week with two appointments available and that referrals are placed on a waiting list. I note that a VFS was carried out on 4 September 2018 and that the Trust stated that this assessment led to the recommendation that the patient '*remain nil by mouth … as there was evidence of silent aspiration with all consistencies assessed. The assessment results were discussed with [the patient's] wife.'* I note that the VFS was performed three working days after the referral.

59. I note that the Consultant Thoracic Surgeon IPA advised that '*a persistent bronchopleural fistula increases the risk of aspiration to the other lung and persistent cough which can also have an impact on swallow.'* I note that the Consultant Thoracic Surgeon IPA advised that the Trust provided appropriate and timely care and treatment for the patient's issues with swallowing,

'according to national standards.' I note that the Nurse IPA advised that '*concerns were raised by family on 3rd June and he was observed by a Consultant that same day. He continued to cough after oral intake and was therefore referred to SALT on 4th. This is timely.'* I also note that the Nurse IPA advised that *'the patient should be [*Nil by Mouth*] (NBM) until he has been reviewed, which did happen.'* I accept the Consultant Thoracic Surgeon IPA's advice that a bronchopleural fistula can have an impact on swallow and that a bronchopleural fistula is '*a well-known complication of thoracic surgery'.* I also accept the Consultant Thoracic Surgeon and the Nurse IPAs' advice that the care and treatment for the patient's swallowing was timely and appropriate. I therefore do not uphold this element of the complaint.

Emphysema

60. I note that the Consultant Thoracic Surgeon IPA advised that '*according to the clinical notes, patient developed surgical emphysema on 26/05'* and that '*the cause of the surgical emphysema was … the bronchopleural fistula … which causes a significant air leak.'* I note that the Consultant Thoracic Surgeon IPA advised that the care and treatment provided by the Trust for the emphysema was appropriate and was in line with relevant standards and practices. I accept the Consultant Thoracic Surgeon IPA's advice and therefore I do not uphold this element of the complaint.

Physiotherapist's reconnection of the patient's drain

61. I note that the Trust stated that the '*clinical notes show the Physiotherapist did not mobilise [the patient] on 23 May 2018 and would not have needed to disconnect or reconnect the suction … Throughout the Physiotherapy notes, it has been documented [the patient] had evidence of emphysema prior to any Physiotherapy intervention.'* I note, however, that the Trust further stated, that *'on reviewing the Physiotherapy notes it has highlighted there is no consistent record of the Physiotherapist documenting if the drains were returned to suction when they did mobilise [the patient] on all other dates.*

62. I note that the Physiotherapist IPA advised that *'there is no indication in the records that on 23 May, or at any other time, the physiotherapists failed to reconnect the patient's drain.'* I also note, however, that the Physiotherapist IPA further advised that *'documentation is not complete in many areas'* and she also advised that there was '*insufficient documentation relating to the management of drains whilst providing physiotherapy treatment'.* I note that the Physiotherapist IPA also advised*, 'it is generally considered good practice to check the drain before, during and after treatment … and documenting these pre- and post-treatment checks in the notes is important for safety and audit purposes.'*

63. I note that the Physiotherapist IPA advised *t*hat *'whilst there is no evidence in the records that the physiotherapists mismanaged the patient's drain/s during treatment, the absence of a clear audit trail (i.e., detailed and regular documentation pre-treatment, during and post-treatment in relation to the care and management of drains during physiotherapy treatment) does raise concerns about the possibility that the drain could have been managed incorrectly, but this is not enough evidence to conclude that the drain was managed incorrectly.'* I accept the Physiotherapist's IPA's advice. I consider that it cannot be concluded whether, at any time, the physiotherapist failed to reconnect the patient's drain.

64. I note, however, that the HCPC Standards state that 'y*ou must keep full, clear, and accurate records for everyone you care for, treat, or provide other services to; you must complete all records promptly and as soon as possible after providing care, treatment or other services;* and that the HCPC Physio Standards state that Physiotherapists should '*be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines; and recognise the need to manage records and all other information in accordance with applicable legislation, protocols and guidelines.'* I accept the Physiotherapist IPA's advice that it is '*good practice to check the drain before, during and after treatment'* and to document these checks in the patient's notes. I also accept the Physiotherapist

IPA's advice that a clear audit trail of these checks was absent from the patient's records. In my view, clinical notes should precisely record the dates on which examinations referred to are performed in order to ensure clarity for those staff who will later rely on the information that is recorded in the patient's medical record. I consider that the absence of documented checks within the patient's records represents a failure in care and treatment.

65. I note that, in acknowledging the failure to document the connection of the patient's drain, the Trust stated that *'the Physiotherapists do follow a visual check guide to remind staff to re-attach all attachments and have now instigated an approach to document in the medical notes when drains are re-attached to suction post mobilising. The Physiotherapy service strives for quality care and sincerely apologise if this was not [the patient's] experience on the 23 May 2018 or at any time during [his] hospital stay.'*
66. I also accept the Consultant Thoracic Surgeon IPA's advice that '*the cause of the surgical emphysema was … the bronchopleural fistula'* and that the origin of the patient's surgical emphysema was not connected with the patient's drain. I do not, therefore, uphold the element of the complaint that the patient developed emphysema as a result of management of the patient's chest drain.

Injustice

67. I find that, as a result of the failure to document the chest drain checks, the complainant and her family suffered the injustice of uncertainty about the patient's condition as they could not be assured that the actions of the physiotherapist did not affect the patient's condition. I hope, however, that the Consultant Thoracic Surgeon IPA's advice detailed in paragraphs 34 above and 67 below, may provide reassurance to the complainant that the failing did not have a continuing impact on the patient's condition.

Management of the patient's drain

68. I note that the Nurse IPA advised that on 25 May 2018, there is '*evidence'* of the patient's drain being twisted/kinked. I note that the Nurse IPA advised that *'the kink was rectified and air was released'* and that the actions taken by the Trust when the kink/twist was identified *'were appropriate'.*

69. I note that the Nurse IPA referenced the Royal Marsden and advised that '*the patient's chest drain was not checked and documented on the chest drain charts regularly as per national guidance, which is four hourly'* and that '*any defects to the chest drain would be noted in a timely manner if monitoring was four hourly.*' I note that the Nurse IPA also advised that '*it is noted that the patient was already suffering from a surgical emphysema which is a well-recognised complication of chest drains.'* I note that the Nurse IPA advised that *'kinking of the chest drain tube should be resolved quickly as it can cause a raise in intrathoracic pressure (pressure within the pleural cavity) and exacerbate breathlessness.'* I note that the Nurse IPA advised that '*during the Registrar's review it is documented that the emphysema had worsened and that the patient had 'difficulty breathing''.* I note that the Nurse IPA further advised that, *'monitoring [of the patient's chest drain] was inconsistent and was not four hourly … there are a number of other occasions over the patient's admission when his chest drain was not checked for over 24 hours (for example: 23/06 09:00 – 24/06 09:00, 24/06 09:00 – 25/06 16:00, 25/06 16:00 – 01/07 20:50).'*

70. I note that the Consultant Thoracic Surgeon IPA advised that a '*kinked drain can cause worsening surgical emphysema and increasing oxygen requirement.'* I note that the Consultant Thoracic Surgeon IPA further advised that the kink in the drain '*was recognised and unkinked. As soon as this was recognised and the drain unblocked, the symptoms resolved pretty quickly.*' I also note, however, that the Consultant Thoracic Surgeon IPA advised that '*the cause of the surgical emphysema was however the bronchopleural fistula.'*

71. I note that the BHSCT Chest Drain Policy states that '*chest drain monitoring charts'* should be in place and that these should be audited. I note that the BHSCT Chest Drain Policy also states that '*the frequency of observations depends on clinical presentation, patient progress and medical staff request but should happen at least 4 hourly. Inspection of all aspects of the patient and the drainage system should take place regularly'.*

72. I accept the Nurse and Consultant Thoracic IPA's advice that the patient's drain was twisted/kinked. I accept the Nurse IPA's advice that the records indicate that on a number of occasions, including during a period when the drain became twisted/kinked, the patient's drain was not monitored at least four-hourly, in line with national guidance. I consider that the failure to monitor the chest drain at least four-hourly was also not in accordance with the BHSCT Chest Drain Policy. I also accept the Consultant Thoracic Surgeon and Nurse IPAs' advice that a kink/twist in the chest drain can exacerbate breathlessness and surgical emphysema. I consider that the Trust failed to comply with both its own Chest Drain Policy and national guidance. I also consider that, in accordance with the advice provided by both the Consultant Thoracic Surgeon and Nurse IPAs, this failure would have aggravated the patient's surgical emphysema and symptom of breathlessness. I consider this a failure in the patient's care and treatment. I therefore uphold the element of the complaint that the patient's emphysema was exacerbated by the nurses' failure to identify that the chest drain was twisted and which stemmed from the nurses' failure to monitor the patient's drain.

Injustice

73. I am satisfied that as a result of this failure, the patient suffered the injustice of distress because of the additional discomfort. I consider the complainant and her family suffered the injustice of anxiety and uncertainty about the patient's condition. As noted at the previous paragraph (64) about injustice, I hope that the Consultant Thoracic Surgeon IPA's advice detailed in paragraphs 34 and

67 above, may provide reassurance to the complainant that the failing did not have an ongoing effect on the patient's condition.

74. I also accept, however, the Consultant Thoracic Surgeon and Nurse IPAs' advice that once the twist/kink was recognised, the actions taken by the Trust were appropriate. I also accept the Consultant Thoracic Surgeon IPA's advice that, as soon as this was remedied, the patient's aggravated symptoms '*resolved pretty quickly*.' I accept both the Consultant Thoracic Surgeon and Nurse IPAs' advice that the patient was already suffering from surgical emphysema as a *'well-recognised complication of chest drains'* and the Consultant Thoracic Surgeon IPA's advice that the original '*cause of the surgical emphysema was however the bronchopleural fistula.'* Therefore, I consider that the deterioration in the patient's condition was of a temporary nature.

Sepsis

75. I note that the Consultant Thoracic Surgeon IPA advised that the patient *'started to develop sepsis with the bronchopleural fistula … around 26/05 because in the presence of bronchopleural fistula there is a communication between the pleural space and the airways with contamination and risk of multiple on-going chest infections.*' I note that the Consultant Thoracic Surgeon IPA advised that '*the sepsis was identified by the medical team on 26/05 and treatment was started accordingly*.' I note that he advised that the care and treatment for the sepsis provided by the Trust was appropriate.

76. I note that the Nurse IPA advised that the '*nurses completed NEWS in line with [NEWS 2] standards and when the patient scored 5 or more (indicating possible serious illness, including sepsis), he was escalated for medical review. The continued monitoring of the patient's condition using NEWS was also in line with [News 2 Guidance].*'

77. I accept the Nurse IPA's advice that the patient's condition was monitored in accordance with NEWS standards, including for sepsis and that the patient was referred for medical review when his NEWS scores indicated possible sepsis. I also accept the Consultant Thoracic Surgeon IPA's advice that the care and treatment for the patient's sepsis was appropriate. I therefore do not uphold this element of the complaint.

Nursing care

78. I note that the Trust stated that *'whilst the Trust has no evidence of* [the patient being left to lie in his own faeces] *and would be very saddened if it occurred, the Trust sincerely apologises if such a situation occurred. The Nursing teams strive to preserve dignity and ensure respect for all patients and ensuring personal hygiene is a key element of this aspect of care.'*

79. I note that the Nurse IPA advised that *'the nursing assessments show that the patient needed support in all aspects of nursing care'* and that the patient *'was*

at risk of pressure area breakdown and therefore SKIN bundles were in place'. I note that the Nurse IPA further advised that there were *'some gaps in the daily and nightly SKIN records.'* I note that the Nurse IPA referred to NICE Pressure Ulcers and advised that *'skin checks should occur at least four hourly, which is in line with national skin care standards'.* I note that the Nurse IPA further advised that *'there is one occasion when checks did not occur from 22:00 to 08:00'* and that *'on 19th July checks did not occur from 10:00 until 20:00. On 11th July he was not checked all day (08:00 to 20:00).'* I note that the Nurse IPA advised that the patient developed *'a break to his sacrum (19th July) which would necessitate a minimum of four hourly checks … Poor documentation means that it is not known if this was a moisture lesion or a pressure sore. The description and position make a pressure sore more likely. This is because pressure sores form over bony prominences (sacrum in this instance)'.* I note that she further advised that *'an 'Unavoidable' pressure sore means that the individual developed a pressure ulcer despite skin care that was in line with national standards … There were lapses in the patient's SKIN bundle, indicating infrequent skin and comfort checks, which indicates that the development of a pressure sore on 19th July was avoidable.'*

80. I note that the NICE Pressure Ulcers states that adults assessed as high risk of developing a pressure ulcer should be encouraged to *'change their position frequently and at least every 4 hours. If they are unable to reposition themselves, offer help to do so, using appropriate equipment if needed. Document the frequency of repositioning required'*. I note that the Nurse IPA concluded that *'some areas of nursing care … failed to meet national standards. This resulted in the development of a pressure sore to the patient's sacrum on 19th July'.* I note that the Nurse IPA also advised that *'on a daily basis there are gaps in care provision, with incomplete documentation to 'prove' that daily support was given, specifically with skincare and hygiene … but it is not clear if he was left without hygiene care when it was needed.'* I note that the NMC Code states that *nurses should 'complete all records at the time or as soon as possible after an event, recording if the notes are written*

some time after the event'.

81. I accept the Nurse IPA's advice that in relation to skincare, the Trust failed to monitor the patient in accordance with NICE Pressure Ulcers. I also accept the Nurse IPA's advice that, in relation to both skincare and hygiene, there were gaps in care provision. Whilst the Nurse IPA could not definitively conclude that the specific incident referenced by the complainant took place, I am satisfied that the Nurse IPA's advice confirmed that there were gaps in monitoring and in the provision of care, including in relation to the patient's hygiene. I consider this to be a failure in care and treatment and I uphold this element of the complaint.

Injustice

82. I find that, as a result of the failures, the patient suffered the injustice of distress arising from the increased discomfort because he was not monitored appropriately. I also find that the complainant and her family suffered the injustice of upset about the care being provided to the patient.

Physiotherapy care and treatment

83. I note that the Physiotherapist IPA advised that *'the care and treatment was appropriate'.* I do not, therefore, uphold the element of the complaint related to care and treatment provided by the physiotherapists.

CONCLUSION

84. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant said that the patient's surgery was performed by someone other than the person for whom consent was given; that a tracheostomy was performed on the patient for which consent was not given; the surgery was not performed correctly which resulted in the patient having to undergo further surgery and which permanently affected the patient's swallow and quality of life; that the patient's chest drain was not managed correctly which led to a protracted period of hospitalisation; the

patient developed sepsis which was not identified by the Trust but rather was indicated by the complainant; and the patient did not receive appropriate nursing care, including care related to personal hygiene.

85. I investigated the complaint and found failures in care and treatment in relation to the actions taken by the Trust.

    i. The Trust failed to document physiotherapist checks of the patient's chest drain.
    ii. The Trust failed to monitor the patient's drain in line with national guidance (Royal Marsden) and the BHSCT Chest Drain Policy.
    iii. The Trust failed to monitor the patient in accordance with national skincare and pressure ulcer standards.

86. I am satisfied that the failures identified caused the patient to suffer the injustice of distress arising from additional discomfort and pain. I am also satisfied that the failures identified caused the complainant and her family to suffer the injustice of anxiety, uncertainty and upset.

87. I note that the Trust acknowledged that there were gaps in its physiotherapy records and processes in relation to the management of chest drains and has instigated corrective action to address this. I welcome the learning and commitment to service improvement already identified by the Trust following the complaint and commend the Trust for its efforts to learn from this complaint.

88. The concerns raised by the patient's family about his care and treatment clearly reflect their commitment to the patient's wellbeing and comfort and demonstrate their determination to ensure that he received the best care possible through a long period of recovery.

Recommendations

1. 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 injustices caused as a result of the failures identified (within **one month** of the date of this report).

2. I refer the Trust to the HCPC Standards and the complete advice provided by the Physiotherapist IPA in relation to records to be maintained and the role of physiotherapists in the BHSCT Chest Drain policy. I recommend that the Trust ensures that relevant staff are made aware of the BHSCT Chest Drain Policy and the HCPC Standards and are given the opportunity to reflect on the Physiotherapist IPA's advice. This should be evidenced by a record of the information-sharing and the conduct of a sample audit of records.

   3.I refer the Trust to the Royal Marsden, the BHSCT Chest Drain Policy and the Nurse IPA's advice. I recommend that the Trust ensures that relevant staff are made aware of these guidance documents and are given the opportunity to reflect on the Nurse IPA's advice. This should be evidenced by a record of the information-sharing and the conduct of a sample audit of records.

4. I refer the Trust to the NICE Pressure Ulcers. I recommend that the Trust ensures that relevant staff are made aware of this guidance and are given the opportunity to reflect on the Nurse IPA's advice in relation to the identified gaps in care provision and monitoring. This should be evidenced by a record of the information-sharing and the conduct of a sample audit of records.

5. I recommend that the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

Margaret Kelly

Ombudsman **24 September 2021**

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.