Northern Ireland
Public Services
Ombudsman

Investigation Report

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

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NIPSO Reference: 17467

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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. She may also investigate and report 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.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

Reporting in the Public Interest

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

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

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Appendix 1 – The Principles of Good Administration
Appendix 2 – The Principles of Good Complaints Handling

SUMMARY

I received a complaint about the care and treatment given to the complainant's late wife whilst she was an inpatient in Ward 4A (Fracture Unit) of the Royal Victoria Hospital, Belfast.

Issues of Complaint

I accepted the following issues for investigation:

Issue 1: Was the care and treatment provided to the patient on Ward 4A appropriate and reasonable?

Issue 2: How the Trust handled the complaint

Findings and Conclusion

The investigation of the complaint identified the following failures in care and treatment:

- Failure to record and monitor the patient's fluid intake, output and balance during her admission
- Failure to make a record of the 'virtual' ward round
- Failure to have a review by senior doctors

The investigation did not identify a failure in care and treatment in respect of the following:

- The patient contracting Hospital Acquired Pneumonia
- The Trust's monitoring/escalation of swelling experienced by the patient
- The removal of oral Furosemide (also known as Frusemide) (fluid tablet)
- That the patient's diabetes was not taken into account during her care and treatment
- That the patient was not on a heart monitor

The investigation identified maladministration in respect of the following matters:

- Failure to make a formal record of the complaints meeting

- Failure to share a record of the complaints meeting with the complainant
- Delay in responding to the complaint

I am satisfied that the failures in care and treatment identified caused the patient to experience the injustice of lack of opportunity to have her fluid balance assessed. I am satisfied that these failures caused the complainant to experience the injustice of uncertainty regarding his late wife's care and treatment. I am satisfied that as a result of the maladministration I identified, the complainant also experienced the injustice of uncertainty, frustration and time and trouble in bringing his complaint to my Office.

Recommendations

I recommended:

- The Chief Executive of the Trust issues an apology to the patient for the failings I have identified, within one month of the date of my final report;
- The Trust make a payment of £750 by way of solatium for the injustice of uncertainty, frustration and time and trouble, within one month of the date of my final report;

I considered there were a number of lessons to be learned which provide the Trust with an opportunity to improve its service, and to this end I recommended that the Trust:

- Provide training to nursing staff on Ward 4A of Royal Victoria Hospital regarding the importance of the full and accurate recording of the fluid intake, output and balance on Fluid Balance Charts
- Provide training to complaints department staff regarding the importance of making a full and accurate record of complaints meetings and sharing these with complainants
- Draw to the attention of relevant staff the signposting guidance issued by my Office

I recommended that the Trust implement an action plan to incorporate these recommendations and 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).

I am pleased to note that the Trust accepted my findings and recommendations.

THE COMPLAINT

1. The patient was admitted through the Emergency Department of the Royal Victoria Hospital on 12 November 2014 having suffered a fracture to her left ankle. She had a number of underlying health conditions. She underwent surgery on her ankle and later developed hospital acquired pneumonia (HAP). The patient suffered two cardiac arrests on 7 December 2014. She was resuscitated and treated in the Intensive Care Unit (ICU) of the Royal Victoria Hospital but sadly passed away on 8 December 2014. Her husband complained about the actions of the Trust in relation to the care and treatment provided to his late wife. He complained that she contracted pneumonia due to the conditions in the hospital. He also complained that her fluid medication was changed and that there was poor management of her fluid. He further complained that a nurse made a comment to him that she was not aware that she suffered from diabetes and he feels her diabetes was not sufficiently taken into account by the medical staff who were treating her. Finally, he complained that she was not placed on a heart monitor, despite her having a heart condition.

Issues of complaint

2. The issues of complaint which I accepted for investigation were:

Issue 1: Was the care and treatment provided on Ward 4A appropriate and reasonable?

Having reviewed the evidence I determined that an additional issue warranted further investigation, namely:

Issue 2: Did the Trust adequately investigate the complaint?

INVESTIGATION METHODOLOGY

3. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised.

This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

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

- A Consultant Physician (PIPA)
- A Consultant Cardiologist (CIPA)
- A Registered General Nurse, (NIPA)

5. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs have provided me with 'advice'. However how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

6. 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.

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

- The Principles of Good Administration
- The Principles of Good Complaints Handling
- The Public Services Ombudsman's Principles for Remedy

7. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional

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

judgement of the Trust and clinicians whose actions are the subject of this complaint.

The specific standards relevant to this complaint are:

- The National Institute for Health and Care Excellence (NICE) guidelines entitled *'Intravenous [IV] fluid therapy in adults in hospital'* (December 2013)
- The Nursing and Midwifery Council (NMC) Code for Nurses and Midwives (1 May 2008)
- General Medical Council (GMC) 'Good Medical Practice' guidance (25 March 2013)

8. I have not included 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 has been taken into account in reaching my findings.

MY INVESTIGATION

Issue 1: Was the care and treatment provided on Ward 4A of the Royal Victoria Hospital, appropriate and reasonable?

9. The complaint related to the following aspects of the patient's care and treatment:
(i) That she contracted hospital-acquired pneumonia due to the conditions in the hospital ward;
(ii) That her fluids were mismanaged;
(iii) That there was a failure to adequately consider her diabetes, and
(iv) That there was a failure to monitor her heart.

10. In response to investigation enquiries relating to the issue of pneumonia, the Trust referred to its response to the initial complaint, whereby it advised the complainant that *'on investigation* [Ward Sister] *had indicated that there had been an on-going issue regarding heating throughout Ward 4A at that time. This had been reported*

appropriately to the Estates Department and the heating within the ward area had been turned up but there was an acknowledgement that there was an intermittent issue at that time…'

11. The Trust also referred to its correspondence to the complainant whereby it stated that the Consultant Physician had provided information and *'his advice [is] that [HAP] could have been acquired from a variety of sources. Those sources being as a result of a bacterial or viral infection precipitated by [the patient's] general medical conditions, bed rest and anaesthesia…'* The Trust also stated *'[Consultant Physician]'s original statement, which we would reiterate is that the development of hospital acquired pneumonia, is unlikely to have been related to a failure of the heating system.'*

12. The Trust was asked about what steps were taken to make the patient comfortable given the conditions in the hospital. The Trust stated *'it would be expected that the nursing staff would have offered additional blankets […] given the conditions in her room. However, the available documentation has been reviewed and it would appear that there is nothing documented relating to this. I am deeply sorry that [the patient] was not offered additional blankets to make her more comfortable and would apologise to [the complainant] for the undue upset and distress that caused his wife. This is not the standard of care that would be expected from Trust staff.'*

13. I note from the patient's clinical records an entry dated 7 December 2014 which states *'CXR* [Chest Xray] *noted…R* [right] *basal consolidation…'*[2]

14. The PIPA advised that this condition *'is pneumonia that develops in hospital in a patient 48-72 hours after hospitalisation. It is usually of bacterial origin…in the case of [the patient] the pneumonia developed on 7/12/14.'*

15. The PIPA also advised that HAP was diagnosed on 7/12/14 by the F1 doctor and *'by definition, this was HAP because it occurred 25 days after admission…'*

[2] Basal consolidation occurs when an area of the lung fills with liquid instead of air

16. The PIPA was asked if it was likely that the patient contracted HAP as a result of the lack of heating and broken window on the hospital ward. The PIPA stated *'HAP is caused by the germs in hospital in a person who is run down and lacks immunity. It is not per se caused merely by exposure to a cold environment. However exposure to cold does lower one's immunity and may thus contribute to the pneumonia. Yet it cannot be said for certain that* [the patient] *contacted HAP as a result of lack of heating and a broken window because it would only develop in the debilitated person who is already in hospital and had reduced immunity…to make it abundantly clear, sleeping in a room with the window open would not have caused pneumonia.'*

Analysis and Findings

17. I note that there was a broken window in the hospital ward in which the complainant's late wife was being treated, and that the heating was malfunctioning. I note from the Trust's response to investigation enquiries that the issues raised about the facilities in the hospital at the time are accepted by it.

18. I accept the advice of the PIPA who stated that the diagnosis of HAP was made on 7 December 2014. I note the diagnosis is also made in the medical notes on 7 December 2014 with the recorded reference to basal consolidation. I note it is also accepted by the Trust that the patient contracted this condition during her hospital stay.

19. I also accept the advice of PIPA in outlining the causes of this type of pneumonia and his view that the poor facilities would not have caused the patient to contract HAP. I therefore find no failure in care and treatment in respect of this element of the complaint. However, I note the Trust accept that there is no record that additional measures were put in place to ensure the patient's comfort during her hospital admission. I consider this was a missed opportunity and welcome the apology proffered by the Trust in relation to this issue.

20. The complainant also complained about his wife's fluid management and the Trust's management of swelling she experienced in her leg and stomach. The National Institute for Health and Care Excellence (NICE) guidelines entitled *'Intravenous [IV]*

fluid therapy in adults in hospital' (December 2013) (the NICE guidelines) states that patients undergoing IV fluid therapy *'should have an IV fluid management plan, which should include details of:*

- *the fluid and electrolyte prescription over the next 24 hours*
- *the assessment and monitoring plan…'*

21. I have also considered paragraph 42 of the Nursing and Midwifery Council (NMC) Code for Nurses and Midwives (the NMC Code) (1 May 2008) which states *'you must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been…'*

22. In response to investigation enquiries, the Trust stated *'the Trust's initial letter of response did indicate that [the patient's] input and output were monitored as clinically required. The clinical notes indicate that [she] was being seen and reviewed every day and on many occasions more than once a day by the medical team in orthopaedics and cardiology as required. There is a record of the medical team observing swelling in [her] left leg and this is recorded as being pitting oedema. This oedema was as a result of her heart failure and her reduced renal function. [She] was treated appropriately in relation to this with the administration of diuretic medication in the form of Frusemide[3].'*

23. I note reference throughout her clinical records to her diagnosis of CCF [congestive cardiac failure][4].

24. I also note the following from relevant dates in the clinical records:

17 November 2014 –	Ward round – *'swelling settled…ready orthopaedically'*
19 November 2014 –	Ortho-medicine review – *'no oedema…hold diuretics…daily review on ward round'*
20 November 2014 –	Review of chest x ray, *'start IV frusemide'*
22 November 2014 –	Ortho-medicine review – '*restarted frusemide yesterday…calves SNT* [soft, non - tender], *no peripheral oedema'*

[3] Also known as Furosemide – a medication used to treat fluid build up
[4] CCF occurs when the heart is unable to cope with its workload of pumping blood around the body

23 November 2014 –	Ortho-medicine review - *'no symptoms DVT/PE [deep vein thrombosis, pulmonary embolism][5], calves SNT'*
3 December 2014 –	Ward round – *'ankle oedema'* Review – *'referral made to cardiology with regards to best ongoing management'*
4 December 2014 –	Review - *'left leg ++ oedema...abdomen soft, pitting oedema left leg'* Cardiology review – '*suggest IV furosemide 48 hours. Measure I/O* [input/output]
7 December 2014 –	Review – *'calves SNT, pitting oedema left leg up to knee', 'start IV furosemide'*

25. I also note the following relevant extracts from the patient's nursing daily evaluation records:

1 December 2014 15:30	'*L [left] leg swollen + oedematous*[6] *++ ? fluid overload. FY1*[7] *informed. IV fluids to be discontinued and oral fluids encouraged'*
2 December 2014 20:50	*'Frusemide given 20 mg as per ward round. Leg swollen due to Frusemide…previously held'*
3 December 2014	*'? overload. IV Frusemide 40 mg administered'*
4 December 2014	*'Pt [patient] assisted to toilet, PU'd [passed urine] good amounts. Please monitor output closely – catheterise if needed'* *'48 hours IV Frusemide as per Cardiology ?? R/V [review]…'*
5 December 2014	*'IV Frusemide given this am'*

26. Finally, I note within the clinical records Daily Fluid Balance and Prescription Charts for each day of her hospital admission.

[5] Both these conditions are complications of blood clots
[6] Having symptoms of an excessive accumulation of serous fluid in the intercellular spaces of tissue
[7] Foundation level doctor, completing their first year following medical school

27. The PIPA stated that the patient's admission to hospital was following a fall and *'hence to that extent the presence of swelling in the left leg was secondary.'* The PIPA advised *'…monitoring of swelling was relevant to the management of her CCF'* and *'CCF is usually associated with swollen legs and abdomen due to accumulation of fluid in these parts of the body…'*

28. The PIPA further advised *'the assessment of swelling is firstly by clinical examination – looking for the presence of swelling. There is evidence in the notes that this was done…'*

29. The PIPA was asked if there was evidence within the medical records of staff assessing the patient for swelling. The PIPA advised that there was and *'on 19/11/14 it is specifically stated that there was no swelling. On 20/11/14 the notes say "no peripheral oedema"[8] and that line was again repeated on 23/11/14.'*

30. The PIPA was asked about leg swelling and stated *'following a fracture, swelling of the fractured leg is to be expected. On 17/11/14, the notes say "swelling settled…ready orthopaedically"…the first mention of swelling was on 3/12/14. On that day, there was a raised JVP[9] and crackles in the chest up to mid-zone. These findings point to CCF…it was the F2 doctor who reviewed [the patient] on 4/12/14 who noted that she had swelling ("pitting oedema") of her left leg.'*

31. The PIPA further advised that the patient *'was referred to cardiology the same day the swelling was observed. It was the cardiology Specialist Registrar (SpR)[10] who recommended IV furosemide for 48 hours. The said SpR saw her on 4/12/14 at 1520 hrs. And again on 5/12/14 at 1225 hrs…Of concern is the fact that the note on 4/12/14 mentioned swelling of the left leg. This isolated swelling of the left leg is not mentioned anywhere else in the medical notes…hence one cannot really comment on the degree of swelling observed on her left leg on that day and whether this was significant…'* The PIPA also stated that tests performed subsequently indicated that

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[8] The accumulation of fluid causing swelling in tissues supplied with blood by the peripheral vascular system usually in the lower limbs
[9] Jugular Venous Pressure – pressure in the vein located in the neck
[10] A doctor who is receiving advanced training in a specialist area of medicine

she did not have a pulmonary embolism (PE).

32. The PIPA was asked for advice on the swelling to the patient's stomach. The PIPA advised that *'swelling of the abdomen occurs in CCF due to fluid retention'* and *'escalation was not required because the consultant … had himself identified the CCF almost as soon as [she] was admitted to hospital.'*

33. The PIPA advised that in a patient with CCF *'the balance of fluid intake and output is important'.* The PIPA also advised that medical staff monitored the patient's fluid intake and output using fluid balance records and stated *'the fluid intake-output record was not being religiously maintained'* and stated *'…I do not see great evidence from the medical notes that [she] needed a very strict fluid balance to be maintained…'*

34. Finally, the PIPA was asked about the cessation of oral Furosemide. The PIPA advised that it was the SpR in the Cardiology team who suggested intravenous (IV) Furosemide on 4 December 2014. The PIPA was asked about the timing of the referral to cardiology and advised that it was appropriate and reasonable to have sought a cardiology opinion at that point. The PIPA clarified *'it was at that particular juncture that it was recorded in the notes that [the patient] had signs of heart failure…based on the findings recorded in the notes, the referral on 4/12/14 was the right thing to do…'*

35. As she was reviewed by the cardiology team on 4 and 5 December 2014, advice was sought from a CIPA. The CIPA confirmed that it was the cardiology SpR who *'suggested changing oral diuretics to intravenous diuretics'*. The CIPA advised that he agreed *'that oral diuretic administration would have been ineffective and that intravenous therapy was a more effective option'.*

36. The CIPA was asked if the care and treatment provided by the cardiology team was to a reasonable standard. The CIPA advised *'she was seen appropriately and managed in a reasonable fashion by the cardiology team…it seems that by the time she was referred to the cardiology team that she was already in advanced decompensated heart failure with superadded lung sepsis…'*

37. Further, due to the issues raised by the PIPA, the CIPA was asked what difference earlier recognition of the deterioration would have made to the patient's diagnosis. The CIPA advised *'it would seem reasonable to assume that when the cardiology team saw [her] on 04/12/2014, that they felt she was fluid overloaded as they suggested treatment with intravenous frusemide…it seems likely that the development of fluid overload and pulmonary oedema (fluid on the lungs) may have negatively impacted on her prognosis'.* The CIPA further clarified that *'theoretically if her heart failure had been identified early on and managed by an expert, then her clinical course may have been better. Diuretic cessation and administration of intravenous fluids may have contributed. It is important however to stress that [she] had multiple severe medical conditions and her prognosis once sustaining an injury requiring surgery was poor.'*

38. The CIPA finally stated *'the lack of any helpful notes entries documenting any clinical assessment for a 10 day period from 24/11/2014 to 03/12/2014 is a concern especially given my above concerns about her fluid balance.'*

39. The NIPA was also asked to provide advice in relation to the role of nursing staff in relation to fluid management. The NIPA advised that *'fluid intake and output was documented on the trusts Daily Fluid Balance and prescription Chart…the daily nursing evaluation of care was also used to document intake and output…'*

40. The NIPA also *advised 'the fluid balance charts were not completed to a reasonable standard. Although a fluid balance chart was used, all of the charts were not completed adequately and had inaccuracies. Three of the charts had inaccurate calculations on the input. Not one of the charts was calculated to give an overall fluid balance. The output section of the chart was completed very poorly. There were very few entries on all the charts and apart from one entry of 400mls, they did not specifically state a volume, just whether the patient had passed urine.'* In providing the advice, the NIPA referred to Clinical Nursing Procedures and the NICE guidelines and stated *'if fluid balance totals had been calculated correctly then nursing staff would be expected to raised concerns/escalate to medical staff any*

abnormalities i.e. excess/deficits in 24 hour fluid balance. I would expect nurses to escalate overall fluid balance as part of their ongoing assessment of a patient…'

41. The NIPA further advised *'there was no evidence of any escalation regarding fluid balance' and that 'there are entries on 1/12/14 and 3/12/14 which acknowledge that the patient was possible overloaded and the intra venous fluids had been stopped.'* The NIPA concluded *'the fluid balance chart should have been completed accurately and calculated over a 24 hour period. This final calculation would indicate whether the intake was sufficient or needed supplementing with intra venous fluids. The output would indicate whether there was adequate kidney function and whether any intravenous fluids were having an impact on kidney function and improving hydration.'*

42. The NIPA was also asked about the role of nursing staff in relation to swelling experienced by the patient. The NIPA advised *'there is evidence by nursing staff on 01/12/14 and 02/12/14 of recognition of leg swelling and this was escalated to a doctor. The medical notes have three entries on the 03/12/14, 04/12/14 and 07/12/14 of left leg swelling, ankle oedema and pitting oedema…nursing staff have observed a leg swelling and have escalated this to a doctor as documented in the nursing evaluation notes. This was appropriate and reasonable.'* The NIPA further advised *'…they also documented the possible causes of the swelling being possible fluid overload secondary to stopped of diuretics which demonstrates their understanding of the findings of the swelling.'*

43. The Trust was given an opportunity to comment on the IPA advice received. The Trust stated *'in the early part of her admission [the patient] was able to mobilise to the toilet with assistance and because her clinical condition did not require accurate measurement of her fluid input/output, a catheter was not considered to be essential as there is a risk of developing urosepsis with insertion of a urinary catheter.'* The Trust also stated *'the medical team tend to withhold diuretics in the immediate perioperative period as the patient is often made hypovolaemic[11] by fasting and surgery. This hypovolaemia can be exacerbated by diuretics leading to hypotension*

[11] Having decreased blood volume

and potential collapse. If signs develop suggestive of incipient heart failure then the diuretic is reintroduced. On 20 November 2014 the chest xray was suggestive of developing heart failure and the diuretic was reintroduced.'

44. The Trust further stated that during the period from 23 November 2014 until 3 December 2014, *'fluid balance records and clinical notes could have been better as at one point there appears to have been concerns about acute kidney injury and therefore intravenous fluids were used. Despite the relative paucity of documented clinical assessments by the medical team looking after [the patient] during this particular period, the observation charts show satisfactory respiratory rate and oxygen levels on room air. In relation to this point* [Clinican Director/Consultant Physician] *states that whilst [her] fluid and diuretic management could have been optimised better it is unlikely this would have changed her outcome…although it is difficult to know the exact cause of cardio-pulmonary arrest [Clinical Director/Consultant Physician] advised that this is very unlikely to have been due to sudden pulmonary oedema or acute fluid overload... [Consultant Physican] acknowledges that clinical documentation included fluid balance recording could have been improved in this case. Notwithstanding this, [Consultant Physician] considered that it is important to emphasise that [the patient] had significant and severe comorbidities which placed her at risk and therefore, at risk for rapid deterioration."*

45. The IPA advice was also reviewed by a Divisional Nurse within the Trust. In its response, the Trust stated *'having reviewed the notes,* [Divisional Nurse] *acknowledges that [the patient's] fluid balance was not measured or documented accurately on the occasions noted in the IPA report nor was it documented consistently in line with expected standards…'*

46. The Trust also stated *'when [the patient] deteriorated she was promptly reviewed by senior members of the Cardiology team on 4 and 5 December 2014. These doctors did not feel that [she] needed urgent transfer to the Cardiology unit for further management and monitoring although this option would have been available to them. Both reviews suggested that [she] could be followed up by outpatient cardiac review when [her] fracture admission was complete…[Clinical Director/Consultant*

Physician] stated further to his review of the case that [the patient's] congestive cardiac failure was managed appropriately. Periods of decompensation were noted and treatment instigated in a timely fashion.'

47. Finally, the Trust stated *'fluid balance recording is an area that the Trust realised could be improved and since 2014 this area has been prioritised in a number of audits focussed on improving fluid balance recording…'*

48. The PIPA was provided with the Trust's comments and asked to advise further on the issues raised by it. The PIPA stated in relation to the Trust's assertion that the patient was not catheterised because of the risk of infection, *'that is a weak argument because in order to monitor urine output in a patient it is NOT necessary to catheterise the urinary bladder. It would have sufficed if the urine was collected, and measured in a measuring jug and duly recorded on the output chart…it would not make sense to record only the intake without the urine output…'*

49. In response to the Trust's assertion regarding the weighing of the patient on admission, the PIPA stated *'she could have been easily weighed while seated on chair scales which are freely available in NHS hospitals…'*

50. Similarly, the CIPA was asked to provide further advice in relation to the response received by the Trust in relation to the IPA advice. The CIPA stated *'the reply still makes no explanation for the rationale behind concern for acute kidney injury and the necessity to give an elderly lady with severe heart failure who was eating and drinking acceptably, large volumes of intravenous fluid with no monitoring of her fluid balance either clinically or via nursing observations. I note the reintroduction of diuretics on 20th November when the X ray suggested heart failure, but IV fluid continued to be given. I agree with [Clinical Director/Consultant Physician]'s comment about the fact that her heart failure was appropriately managed. I would contend though that the development of heart failure might have been linked to the poor quality of fluid balance management beforehard [sic]. I agree that her death was in all likelihood multifactorial and due to the massive amount and severity of comorbid disease. I am also unclear in the reply what is meant by "senior member of*

the cardiology team"…I would argue that a specialist registrar does not count as a senior doctor under current terminology…'

51. In response to the draft Investigation Report, the complainant stated that nursing staff reported to the family that his wife was eating normally. However, she informed her family that she was unable to eat as she felt full. The complainant also stated that the family's undertaker made a comment to him about noticeable swelling. Finally, he stated that he and his family were not informed by the Trust as to his wife's poor prognosis.

Analysis and Findings

52. I note the complainant's allegations about how the clinicians treating his wife managed her fluid intake and output, how they responded to swelling which he stated she experienced in her leg and stomach areas, and that her 'fluid tablet' was withdrawn from her treatment.

53. I have carefully considered the timeline in the patient's notes and records, the Trust's response to investigation enquiries and the IPA advice. I accept the advice of the PIPA who stated that the monitoring of the patient's swelling was relevant to the management of her pre-existing heart condition, CCF, as it is associated with the accumulation of fluid around these parts of the body. I also accept the advice of the PIPA that there is evidence contained in her clinical records of staff assessing for swelling during their examinations. I also accept the advice of the NIPA that a finding of swelling on 3 December 2014 by nursing staff was escalated to a doctor, and that it was appropriate for nursing staff to have done this. The advice I have received is supported by my findings following an examination of the patient's medical notes and records.

54. I note that following a finding of swelling on 3 December 2014, input was sought from the cardiology team within the Trust. I accept the advice of the PIPA that this was an appropriate time to have sought cardiology advice, based on the information contained within the clinical records. However, I note the advice of the CIPA that the patient's cardiac failure had already progressed and other complications had

developed.

55. I have considered the evidence contained in the medical records carefully. There is no evidence in these records of swelling prior to 3 December 2014. I am therefore unable to make a finding of whether swelling prior to that went without detection or escalation, prior to that. However, I can conclude that there is evidence of clinicians assessing the patient for swelling and there is evidence of the finding being escalated appropriately. **I therefore do not uphold this element of the complaint.**

56. I have also considered the patient's clinical records carefully in the context of how the clinicians managed her fluid. I accept the advice of the PIPA that fluid balance was also an important consideration due to her diagnosis of CCF and I note references within the clinical records that her ongoing plan of treatment included the measurement of fluid input and output. However, I also note and accept the advice of the PIPA that he did not uncover evidence that she required a 'very strict' fluid balance.

57. I note the advice of both the PIPA and the NIPA that fluid balance charts were used by nursing staff in the management of the patient's fluid intake and output. I note that both these IPAs have highlighted that the fluid balance charts were not completed appropriately. I note the advice of the NIPA that the charts were not fully completed and that they contained inaccuracies and none of the charts were calculated to give an overall fluid balance. This finding is also reflected in my examination of the nursing records in relation to this period of the patient's care. I have considered the Trust's comments in relation to the patient's fluid output that she was not catherised due to the risk of urosepsis. I note and accept the advice of the PIPA in relation to this that the fluid output could have been measured in another way. I am therefore cannot be satisfied that this precluded the accurate measurement of fluid output.

58. I also consider it would have been good practice to have weighed the patient in the context of fluid management.

59. I acknowledge that the Trust accept the IPAs' findings. I have taken careful consideration of the NMC Code and the NICE guidelines which outline why a record

of fluid balance is appropriate. I consider that the failure to make an appropriate record of fluid input, output and balance is a failure in the care and treatment afforded to the patient by nursing staff. I am also critical of the clinicians for not identifying that this action was not being carried out by nursing staff, when they were assessing and reviewing the patient.

60. I accept the advice of the NIPA that as a result of the failure to adequately measure and record fluid input, output and balance, there was no assessment of how the patient was tolerating the fluid she was receiving. I note the advice of the CIPA that when she was reviewed by the cardiology team on 4 December 2014 that it is reasonable to assume they considered her fluid overloaded. I note the Trust stated in response to the sharing of the IPA advice that the cardiology team did not feel a transfer to a cardiology ward was necessary. The investigation did not uncover evidence that a transfer to a cardiology ward was considered.

61. I also note reference within the nursing records of possible fluid overload. I conclude that the patient sustained the injustice of lack of opportunity of an assessment of how her fluid was being managed by medical staff. I am unable to conclude that as a result of the failure to record fluid balance that the patient became fluid overloaded. However, I note the advice of the CIPA that the development of her heart failure *'might have been linked to the poor quality of fluid balance management'*.

62. The IPA has advised that to continue with oral Furosemide would have been 'ineffective' and the IV Furosemide was more effective. I have considered this advice carefully and accept same. I have however noted that there was a failure to monitor and adequately record fluid input and output by Trust staff in this case. There is no evidence that this failing caused the patient's condition to deteriorate. **In light of this failing however, I uphold this element of the complaint.**

63. I note and accept the advice of the CIPA that to continue with oral Furosemide would have been *'ineffective'* and that IV therapy was more effective. I consider the concerning failure to adequately record and monitor fluid input and output is exacerbated by the potential for fluid overload in this case. However I am not

satisfied to the relevant standard that the failures in management of the patient's fluid directly led to a deterioration in her condition. **I therefore do not uphold this element of the complaint.**

64. In response to investigation enquiries in relation to the Trust's consideration of the patient's diabetes, the Trust stated *'examination of medical and nursing documentation indicates that staff where (sic.) aware of [the patient's] diabetes and it is referred to on a regular basis in the daily records kept by the team. We do apologise if on any occasion staff appeared to be unaware.'*

65. I note when the patient was admitted to ward 4A on 12 November 2014, a record was made in her past medical history that she had Type 2 diabetes. There is also a record of her suffering from diabetes in the clinical record made by the Consultant Physician who examined her on 13 November 2014. From my examination of the clinical records during her admission on ward 4A, there are several references to her suffering from type 2 diabetes.

66. The daily nursing notes made in Intensive Care Unit (ICU) dated 8 December 2014 record that the patient's co-morbidities are *'COPD[12]; Type 2 Diabetes; AF[13]; heart bypass'*. I also note an entry on the records on the same date under the heading 'daily goals', *'20% Glucose commenced at 40ml/hr as per Dr. as BMs[14] have been very low at times despite treatment with 50% dextrose'*.

67. Finally, I note in a document entitled 'clinical summary' which was prepared after the patient passed away, *'Type 2 diabetes mellitus'* is listed under *'past medical history'*.

68. I have obtained independent advice in relation to this issue. The PIPA advised that it is recorded in the clinical records that the patient suffered from diabetes and that it was recorded *'on admission by the Trauma and Orthopaedics doctor on 12/11/14 and as Type 2 diabetes mellitus on 12/11/14 at 1720 hrs. When she was once again seen by the consultant he had noted her Type 2 diabetes.*

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[12] Cardio Pulmonary Obstructive Disease - a progressive lung disease
[13] Atrial fibrillation –A heart condition that causes an irregular and often abnormally fast heart rate
[14] Boehringer Mannheim - the name of the brand that manufactures blood sugar testing devices

69. The PIPA was asked if the patient's diabetes was taken into account in her care and treatment. The PIPA advised *'it is documented that she was normally on metformin [medication] 500 mg twice daily but the doctors decided to withhold it as her kidney function was impaired based on blood tests. And the blood glucose levels remained normal. Therefore she did not need any other medication like insulin for her diabetic control. All this is in order and in keeping with standard good medical practice…'*

70. Finally, the PIPA was asked for evidence of the Trust's monitoring the patient's blood glucose level. The PIPA advised *'I would not expect the consultant in charge to monitor the blood glucose himself. The NEWS[15] observation records the glucose level done on 18/11/14 was 6.2. Glucose was 8.2 on 7/12/14…as the two blood glucose levels done 19 days apart were normal one would not deem it necessary for her to have capillary glucose (fingertip) measurements on a daily [basis] or even intermittently…from the notes it would appear that doctors caring for her were aware of her diabetes. Metformin was prescribed but not given due to her renal function being impaired. That was the correct decision…'*

Analysis and Findings

71. I note the complainant complained that a member of the nursing staff treating his wife stated she was not aware that she suffered from Type 2 diabetes. He was unable to identify this staff member. He also complained that as a result, he considered that her diabetes was not taken into account when decisions were made about her care and treatment. I note that this issue of complaint originated from a comment made to him by a nurse.

72. An examination of the patient's medical records identified a number of records pointing to her suffering from type 2 diabetes. I accept the advice of the PIPA who stated that there was evidence of this condition being noted by clinical staff treating her. There is no record of the discussion with a member of nursing staff to which the complainant refers. I note the Trust has provided an apology to the complainant if this appeared to be the case in respect of any one particular member of staff.

[15]National Early Warning Score

73. I accept the advice of the PIPA who indicated that there is evidence that the patient's blood glucose levels were measured, which indicate that her diabetes was under control during her hospital admission. I accept the PIPA's advice that there is evidence that her diabetes was taken into account. Further that her treatment was appropriate and reasonable. **I therefore do not uphold this element of the complaint.**

74. In response to investigation enquiries about the alleged failure to monitor the patient's heart, the Trust stated that she *'had regular and appropriate observations carried out in the Fracture Unit. Continuous cardiac monitoring is not usually performed in the Fracture Unit and is only used in areas such as Cardiology. [She] was seen by the Cardiology Team and they did not advise either continuous monitoring, or transfer into their unit for monitoring. They did suggest that [she] have some cardiac monitoring as an outpatient using a Holter Monitor when she had been discharged from the Fracture Unit.'*

75. In relation to this issue of complaint the PIPA was asked whether the patient suffered from a pre-existing heart condition. The PIPA advised that she *'had ischaemic heart disease*[16] *and had triple coronary bypass surgery. She had CCF and established atrial AF for which she was on anticoagulation with warfarin.'*

76. The PIPA confirmed that there was no evidence that the patient was on a heart monitor during her admission at the Royal Victoria Hospital. He clarified that he considered this to be reasonable as *'a heart monitor is used when there is abnormal rhythm and the possibility of life threatening arrhythmias. NICE does not recommend this for patients with CCF…neither is it required in AF…'*

77. The PIPA advised that there would have been no benefit from her being on a heart monitor.

[16] When the coronary arteries become narrowed by a gradual build-up of fatty material within their walls. These arteries supply your heart muscle with oxygen-rich blood

Analysis and findings

78. I note the complaint that the patient's heart was not monitored during her period of admission to hospital, despite clinicians being aware that she had a pre-existing heart condition. I also note it is accepted by the Trust that she had pre-existing heart conditions including CCF and AF.

79. I note and accept the advice of the IPA that a heart monitor is recommended for use in a hospital setting, where a patient has an abnormal heart rhythm and the possibility of life threatening arrhythmias. I note therefore the advice of the PIPA that as the patient did not suffer from either of these pre-conditions and that the use of a heart monitor was not required. **I therefore find no failure in care and treatment in relation to this issue and I do not uphold this element of the complaint.**

80. As part of the investigation into the complaint, I received IPA advice from the PIPA and the CIPA which disclosed the issue of the potential failing in the lack of senior review of the patient's care and treatment.

81. I refer to the General Medical Council (GMC), 'Good Medical Practice' published on 25 March 2013 states in paragraph 19 '*documents you make (including clinical records) to formally record your work must be clear, accurate and legible…'*
Paragraph 21 states *'clinical records should include:*
a. relevant clinical findings
b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions
c. the information given to patients
d. any drugs prescribed or other investigation or treatment
e. who is making the record and when.'

82. I have examined the patient's clinical records and have prepared an outline of the grading of doctors who are recorded as having carried out the reviews an assessments.

83. The PIPA advised *'it is noteworthy that a lot of the ward rounds appear to have been*

done by F1 and F2 doctors. There seems to be a dearth of senior medical input into her day to day care. The Trust's letter to the complainant dated 11/3/15 refers to "the more senior medical F2 doctor". Both F1 and F2 doctors are under foundation training. The F2 doctor is just in the second year after leaving medical school. It is not clear from the medical notes as to how much senior supervision was given to these F1 and F2 doctors. There is no evidence however that the care of [the patient] was inadequate or below par.'

84. The CIPA advised *'there does not appear to be a clear strategy in her post-operative management about her fluid balance. There was administration of both IV fluid and diuretics after a period of diuretic cessation, with no recourse to senior review or expert cardiology opinion until late in her admission. It also seems that the totality of her problems and the severity of her medical problems was underestimated…the lack of any helpful notes entries documenting any clinical assessment for a 10 day period from 24/11/2014 until 03/12/2014 is a concern especially given my above concerns about her fluid balance.'*

85. The Trust was given an opportunity to comment on this IPA advice. The Trust responded as follows: *'having reviewed the records, the Trust understands the reasons why the independent advisers (sic.) have found it difficult to ascertain the seniority of the doctors who reviewed [the patient] on ward rounds as it is poorly documented…it is usual practice for the Consultant Physician to lead the ward round… [Consultant Physician] conducts a "virtual" ward round every morning. This occurs in the doctors' room in Ward 4A. The doctors who are on duty for the day, then attend any patient who were reported to be unwell, addressing their concerns and providing and arranging the necessary medical care. The daily weekday ward round usually begins at 10.30 a.m. A nurse, F1, F2 and specialty doctor would usually accompany [Consultant Physician] on the ward rounds…on Fridays…the Consultant Orthophysician from MPH*[17] *would normally conduct the ward round in the RVH.'*

86. The Trust also stated that the patient *'would have been seen and discussed by*

[17] Musgrave Park Hospital

senior doctors on the daily weekday ward round…[Consultant Physician] doesn't not accept that he and his team underestimated the severity of [her] condition. [She] had severe co-morbidities and this was recognized by the fact that she was reviewed in detail by [Consultant Physician] soon after admission – low risk surgical patients would not have had such a review.'

87. The Trust further confirmed that the '[Consultant Physician] *has advised he will now ask the junior medical team to document the names and grades of the doctors in attendance on the ward round.'*

88. The PIPA was provided with the Trust's comments and asked to advise further on these issues. The PIPA stated *'the Ombudsman's advisers rely on what is recorded in the clinical notes. When the notes say "Ward Round FY1 doctor" we reasonably conclude that the ward round was conducted by the FY1 doctor. If it was the ward round led by the consultant, we would have expected the notes to say so. It seems incomprehensible for the FY1 doctor to claim it was his or her WR [ward round] when it was actually being done by the consultant. One does accept the Trust's statement that "it is the usual practice for the Consultant Physician to lead the WR". But the records show that most of this (sic.) [The patient's] ward rounds were carried out by junior doctors.'*

89. As part of the investigation the CIPA was also provided with the Trust's comments and asked to advise further on the issues. The CIPA advised *'there is no evidence whatsoever that [the patient] was seen by senior doctors on daily ward round…whereas she might have been discussed on "virtual ward rounds" (for which there is no evidence in the notes), the documented evidence or regular senior clinical input is lacking…one would expect clinical consultant review, and documentation of such, more frequently.'*

90. In response to the draft Investigation Report, the Consultant Physician stated *'I would like provide reassurance that the Medical F1 and F2s work under close supervision and leadership as part of the Medical team…as part of the learning from this complaint, the junior members of the medical team have been asked to document the names and grades of doctors in attendance on ward rounds, so that*

there is clarity in this respect going forward.' The Consultant Physician also stated 'whilst the term "virtual ward round" has been used, this could equally be described as a meeting held with the Medical Team each morning to discuss any new, or ongoing medical problems of the patients…'

Analysis and Findings

91. I note that both the PIPA and the CIPA raised, independently of each other, an issue regarding the seniority of the medical reviews which were carried out in respect of the patient's care and treatment.

92. I note in my examination of the clinical records that it is recorded during her hospital admission on ward 4A, she was reviewed by the Consultant Physician on one occasion, 13 November 2014.

93. I note the Trust's detailed submissions in response to the IPA advice in relation to this issue, and in particular the resource constraints on the Consultant Physician. However, the investigation has found no evidence to support the assertion by the Trust that a 'virtual ward round' is carried out by the Consultant Physician each day. Similarly, the investigation has found no evidence to support the assertion that the patient was seen by senior doctors on the daily ward round. The clinical records clearly suggest that the reviews were carried out by junior doctors. I accept the advice of both the PIPA and the CIPA in this regard.

94. I take into consideration the GMC's 'Good Medical Practice' provisions in paragraph 19 in relation to the maintaining of clear and accurate records. I conclude on balance that there is a failure on the clinicians to accurately record the 'virtual ward round'. I find this failure is a failure in the care and treatment provided to the patient as it is so closely linked to the care she was receiving. In the absence of a contemporaneous record of discussion ('virtual ward round'), I am unable to reach a conclusion on decisions made by the Consultant Physician at that meeting regarding the patient's care and treatment. As a result of the failing in care and treatment, I am satisfied that the complainant suffered the injustice of uncertainty regarding the care and treatment being afforded to his late wife.

95. The investigation has been unable to establish GMC guidelines in relation to 'virtual ward rounds'. I accept the Consultant Physician's comment to my draft Investigation Report that this could also be referred to as a 'meeting'. I am however concerned that this practice does not afford the clinicians an opportunity to discuss with the patient, their conditions and concerns. Neither does this practice facilitate a physical assessment of the patient's mood and condition. I am concerned therefore that there is a potential gap in the clinician's ability to properly assess their patient.

96. I have considered all of the evidence available to me regarding this issue. The investigation has not uncovered evidence of a daily review by senior doctors. I find that there was no review by senior doctors during the patient's admission, other than on 13 November 2014. Having considered carefully the IPA advice I received, I consider the lack of review by senior doctors to be a failure in the care and treatment afforded to the patient. I do not consider that she sustained an injustice as a result of this failing, however, I consider that the failure caused the injustice of uncertainty to the complainant. I welcome, as a result of my findings, the Consultant Physician's commitment to improving record keeping in this respect.

Issue 2: How the Trust handled the complaint

97. The investigation into this complaint led to my consideration of a further issue - namely how the Trust handled the complainant's complaint.

98. I have considered the HSC Complaints Procedure published on 1 April 2009, in particular section 1.4 which states *'HSC organisations should work closely with service users to find an early resolution to complaints. Every opportunity should be taken to resolve complaints as close to the source as possible, through discussion and negotiation. Where possible, complaints should be dealt with immediately. Where this is not possible, local resolution should be completed within 20 working days of receipt of a complaint'.*

99. I also note section 3.38 which states *‘A response must be sent to the complainant within 20 working days of receipt of the complaint … where that is not possible, the complainant must be advised of the delay.’*

100. Further, I note section 3.43 which states ‘*The HSC organisation should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying “closure”. Complainants should contact the organisation within 3 months of the organisation’s response if they are dissatisfied with the response or require further clarity…’*

101. I refer to section 3.40 which states *‘where a meeting is scheduled it is more likely to be successful if the complainant knows what to expect and can offer some suggestions towards resolution. Complainants have a right to choose from whom they seek support and should be encouraged to bring a relative or friend to meetings. Where meetings do take place they should be recorded and that record shared with the complainant for comment.’*

102. I examined the complaints records provided by the Trust. A chronology of the actions taken by the Trust has been prepared.

103. I also note within the complaints records, a copy of a handwritten note entitled ‘Summary meeting [patient] 12/8/15’ which lists those present. The handwritten note comprises three pages. It can be ascertained that the note contains several apologies and action points in relation to issues raised by the complainant and his family at the meeting.

104. I further note a letter which was issued to the complainant on 26 January 2017 which states *‘the Trust would be of the position that local resolution is still available should you wish to engage with the Trust and the Trust would attempt to address any outstanding or unresolved issues. The position of the Trust does not preclude you from going the (sic.) NIPSO…’*

Analysis and Findings

105. I note the complainant submitted his complaint to the Trust on 16 January 2015 and the complaints file was closed on 2 February 2017, indicating a period of two years to deal with the complaint.

106. I note the initial response was issued at the conclusion of seven weeks. I have considered the HSC complaints procedure and note that this timeframe falls outside the HSC guidance. However, I acknowledge that that Trust informed the complainant there was a delay in a response being issued as the matter was under investigation.

107. I also note that following receipt of the written response, the complainant expressed continued dissatisfaction. It was thereafter agreed that a meeting would be arranged with treating clinicians in order to resolve the issues. This meeting took place on 12 August 2015. I note from the complaints records that this meeting took some time to organise. The complaints department made several contacts with the service area in an effort to arrange the meeting. I am critical of the service area for delaying the progress of the resolution of the complaint in this regard.

108. I note that during the meeting, a handwritten note was taken by the complaints manager. There is no typed record or minute of the meeting. I refer to section 3.43 of the HSC complaints procedure regarding the process that should be undertaken following a meeting. There is no evidence that the complainant was provided with a record of the meeting. He confirmed to the Investigating Officer that he did not receive a record of the meeting. The first Principle of Good Complaint Handling requires public bodies to act in accordance with published guidance. I find that the failure to make a formal record of the complaints meeting, and the failure to share a record with the complainant is contrary to this Principle and constitutes maladministration.

109. I also note that during the meeting, several apologies were made by Trust staff and action points which the Trust staff indicated were to be progressed. The investigation has found no evidence that following the meeting, the Trust followed this up with a written apology or confirmation of the action points. This is a failure in the

administrative process.

110. The complainant contacted the Trust six months later seeking an update as to the action which was to be taken following the meeting. There is no evidence of action taken by the Trust in the intervening period. This incurred significant delay in the resolution of the complaint, in addition to the delay identified in responding to his initial correspondence. The second Principle of Good Complaint handling requires public bodies to deal with complainants 'promptly and sensitively, bearing in mind their individual circumstances'. I consider that the Trust failed to meet this standard and the failure to act upon what was agreed at the meeting, constitutes maladministration. I acknowledge that the complaints manager communicated with the complainant on the telephone after this period and he was provided with an update in terms of the action points.

111. Finally, I note that the complainant contacted the Trust seeking correspondence indicating that its handling of his complaint was closed. This was to forward his complaint to my Office and this correspondence was issued to him on 26 January 2017. I have considered the contents of this letter carefully and in line with section 3.43 of the HSC complaints procedure. The letter has the effect of delaying the closure of the complaint on the part of the Trust as it does not provide a timescale within which the complainant is to raise further issues. I consider this correspondence may have caused confusion to him and indeed to any member of the public. I refer to my guidance on signposting.

112. I am satisfied that as a result of the maladministration I identified above, the complainant suffered the injustice of uncertainty, frustration and time and trouble in bringing his complaint to my Office.

113. After consideration of my draft Investigation Report, the complainant and his family feel that communication of his wife's prognosis was poor. I note the obligations on clinicians to communicate openly with patients and families. There is no contemporaneous records of the nature of discussions with the family. In the absence of such records, I accept the family's view and would remind the Trust of the importance of good communication in such circumstances.

114. The complainant also raised an issue following consideration of my draft Investigation Report, regarding a letter which was sent from the Trust to his wife's GP on 9 December 2014. He stated that the date noted in this letter that his wife suffered the cardiac arrest was incorrect. I note that the Trust have taken steps to rectify this error.

CONCLUSION

115. I have investigated the complaint and have found a failure in care and treatment in respect of the following matters:

- Failure to record and monitor the patient's fluid intake, output and balance during her admission
- Failure to make a record of the 'virtual' ward round
- Failure to have a review by senior doctors

116. I have not found a failure in care and treatment in respect of the following matters:

- The patient contracting Hospital Acquired Pneumonia
- The Trust's monitoring/escalation of swelling experienced by the patient
- The removal of oral Furosemide
- That the patient's diabetes was not taken into account during her care and treatment
- That the patient was provided with a heart monitor

117. I have identified maladministration in respect of the following matters:

- Failure to make a formal record of the complaints meeting
- Failure to share a record of the complaints meeting with the patient
- Delay in responding to the complaint

118. I am satisfied that the failures in care and treatment identified caused the patient to

experience the injustice of lack of opportunity to have her fluid balance assessed. I am satisfied that these failures caused the complainant to experience that injustice of uncertainty regarding his late wife's care and treatment. I am satisfied that as a result of the maladministration I identified, the complainant experienced the injustice of uncertainty, frustration and time and trouble in bringing his complaint to my Office.

Recommendations

119. I recommend that:
    - The Chief Executive of the Trust issues an apology to the complainant for the failings I have identified, within one month of the date of my final report;
    - The Trust make a payment of £750 to the complainant by way of solatium for the injustice of uncertainty, frustration and time and trouble, within one month of the date of my final report;

120. I consider there are a number of lessons to be learned which provide the Trust with an opportunity to improve its service, and to this end I recommend that the Trust:
    - Provide training to nursing staff on Ward 4A of RVH regarding the importance of the full and accurate recording of fluid intake, output and balance on Fluid Balance Charts
    - Provide training to complaints department staff regarding the importance of making a full and accurate record of complaints meetings and sharing these with complainants
    - Draw to the attention of relevant staff, the signposting guidance issued by my office

I recommend that the Trust implement 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).

121. I am pleased to note that the Trust accept my findings a recommendations in relation to this case.

Marie Anderson

MARIE ANDERSON
Ombudsman

February 2019

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.