Ombudsman investigation finds that hospital failed to properly monitor patient's eating and drinking

An investigation by the Public Services Ombudsman has found that the Northern Health and Social Care Trust failed to properly monitor a patient's food and drink intake during her stay in the Antrim Area Hospital.

While in hospital the patient fell and was admitted to the Royal Victoria Hospital, Belfast, for surgery. On admittance she was found to be suffering from dehydration.

The patient's son, who made the complaint, said that when his mother went to the Antrim Area Hospital to be treated for a urinary tract infection he told her medical team that she needed help with eating and drinking. However, he complained that during her stay there wasn't a proper plan in place to check how much food she was being given nor how her fluids were being managed.

The Ombudsman obtained the patient's clinical records, which were looked at by an independent consultant geriatrician. It was established that on arriving at Antrim Area Hospital the patient was given intravenous fluids, but that she did not receive intravenous fluids again until six days later when she was in the Royal Victoria Hospital.

The consultant said that a screening tool used to identify the patient's nutritional needs was not completed at the beginning of her stay at Antrim Area Hospital. This was contrary to Trust policy. He also said that overall the management of her fluid and food intake during her stay in hospital was 'sub-optimal'.

The Trust was asked for its response to the consultant's comments. It said that eight nurses cared for the patient during her stay, and that the initial screening, which could have highlighted the need for assistance, was not carried out because there was an assumption it had been done by somebody else.

It stated that the reason she was transferred to the Royal was to have surgery on her leg, not because of her nutritional status. However, it acknowledged that 'best practice procedures in relation to nutritional screening and support were not followed' in this case.

After examining the evidence the Ombudsman concluded that the Trust had failed to put in place a plan for the patient's nutritional care and fluid management, meaning that during her stay in hospital she did not get enough to eat and drink. As a result, she would have had a slower rate of recovery from her illness and was more likely to suffer complications from her immobility.

The Ombudsman's report recommended that the Trust apologised to both the patient and the complainant, and that it carry out an audit of similar cases on the hospital ward in question. The Trust accepted the recommendations.