Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 18869

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

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.

TABLE OF CONTENTS

Page

SUMMARY

I received a complaint about the nutritional care and treatment and fluid management provided to the complainant's mother while she was a patient of the Northern Health and Social Care Trust (the Trust). The patient was treated in the Antrim Area Hospital between 4 January 2018 and 10 January 2018.

I accepted the following issues of complaint for investigation:

- Was the patient's nutritional care and treatment and fluid management in the hospital, between 4 January 2018 and 10 January 2018, appropriate and reasonable?

The investigation identified failings in care and treatment in respect of the following matters:

i. Failure to complete a nutritional plan of care
ii. Failure to complete a MUST assessment
iii. Failure to commence food charts
iv. Failure to make an earlier referral to dietician
v. Failure to complete a fluid management plan of care
vi. Failure to adequately complete fluid balance charts
vii. Failure to ensure the patient received adequate fluids

I am satisfied the failures I have identified caused the patient to experience the injustice of upset, inadequate nourishment and hydration and frustration and uncertainty about her treatment and recovery. I also consider the failures in care and treatment I have identified have caused the complainant to experience the injustice of frustration and uncertainty.

I recommended that the NHSCT undertake the following action:

(i) In accordance with the Ombudsman's guidance on issuing an apology, provide a written apology to the patient and the complainant for the injustice identified in

this report. The NHSCT should provide the apology within one month of the date of my final report.

(ii) The Trust bring the failures identified in this report to the attention of the nurses who cared for the patient between 5 January 2018 and 10 January 2018 on Ward A1 and remind them of the importance of adhering to the NMC standards.

(iii) The Trust consider commencing food charts for patients who have been identified as requiring assistance, so as to establish the significance of the concern with dietetic referral, if required.

(iv) In acknowledging the steps already taken by the Trust to address the concerns raised by the complainant, I recommend that the Trust conduct an audit of MUST screening, dietetic referrals, nutritional care planning and fluid management documentation in Ward A1 of the AAH. The audit should be completed and report of audit prepared within three months from the date of my final report.

I am pleased to note the Northern Health and Social Care Trust accepted my findings and recommendations.

THE COMPLAINT

1. I received a complaint about the actions of the Northern Health and Social Care Trust. The complainant stated his mother was admitted to the Antrim Area Hospital (AAH) on 4 January 2018 suffering from a urinary tract infection and dehydration. He stated that on 9 January 2018, she fell and broke her right hip and was subsequently transferred to the Royal Victoria Hospital in the Belfast Health and Social Care Trust on 10 January 2018. The complainant said that between 4 January 2018 and 10 January 2018 his mother's nutritional care and treatment and fluid management in the Antrim Area Hospital were neither appropriate nor reasonable. He believed his mother was dehydrated upon her admission to the Royal Victoria Hospital on 10 January 2018 as a consequence of failings in her care and treatment at the Antrim Area Hospital.

Issue of complaint

2. The issue of complaint which I accepted for investigation was:

Was the patient's nutritional care and treatment, and fluid management in the Antrim Area Hospital between 4 January 2018 and 10 January 2018, appropriate and reasonable?

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. I also examined the patient's medical records from the Belfast Health and Social Care Trust (BHSCT). However, the actions of the BHSCT are not part of this complaint.

Independent Professional Advice

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

- A Consultant Geriatrician (CG IPA), MBChb, MSc, FRCP with 25 years as a Consultant Geriatrician and extensive experience in all aspects of geriatric and general medicine.
- A Consultant Nurse Specialist (N IPA) RGN, BA Hons, MSc, PGCert (HE) in healthcare for older people, practising across acute hospital, outpatients and community/care homes.

6. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPA has 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

7. 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.

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

- The Principles of Good Administration
- The Principles of Good Complaints Handling
- The Public Service Ombudsman Principles of Remedy
- The Public Service Ombudsman Human Rights Manual

9. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional judgement of the Trust staff whose actions are the subject of this complaint.

10. The specific standards relevant to this complaint are:

- General Medical Council (GMC) Guidelines Good Medical Practice (2013) (The GMC Guidelines)

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

- Nursing and Midwifery Council (NMC) The Code Professional Standards of Practice and Behaviour for Nurses, Midwifes and Nursing Associates (2015) (The NMC Standards)
- National Institute for Health and Care Excellence (NICE) Guidelines: Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition (February 2017) (Nutrition Guidelines)
- Northern Health and Social Care Trust's (NHSCT) Fluid Balance Record Keeping Policy (April 2014) (Fluid Balance Policy)
- Northern Health and Social Care Trust's (NHSCT) Regional Dietetic Acute Inpatient Access Criteria (February 2017) (Dietetic Criteria)
- Northern Health and Social Care Trust's (NHSCT) Protected Mealtimes Policy (July 2011) (Protected Mealtimes Policy)
- https://www.bda.uk.com/foodfacts/fluid.pdf (British Dietetic Association Guidelines)

11. 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.

12. As part of the NIPSO process, I shared a draft report with the Trust and The complainant for comments on factual accuracy and the reasonableness of the findings and recommendations. The Trust and The complainant have both made comments on the draft report and the report has been amended to reflect this.

INVESTIGATION

Detail of Complaint

13. The complainant said his mother did not receive appropriate care and treatment in relation to nutrition and fluid management between 4 January 2018 and 10 January 2018 in the Antrim Area Hospital. The complainant advised that when she was admitted on 4 January 2018, he informed her medical team she required assistance with eating and drinking. However, he complained the Trust did not monitor his mother's nutrition and fluid balance between 4 January 2018 and 10

January 2018. As a consequence, he believed she became dehydrated. This was evidenced following her admission to the Royal Victoria Hospital on 10 January 2018.

Evidence Considered

Guidance

14. I have considered the following relevant extracts of the Nutrition guidelines:
Section 1.2.2 *'All hospital inpatients on admission and all outpatients at their first clinic appointment should be screened. Screening should be repeated weekly for inpatients'.*

Section 1.2.6 *'Screening should assess body mass index (BMI)[2] and percentage unintentional weight loss and should also consider the time over which nutrient intake has been unintentionally reduced and/or the likelihood of future impaired nutrient intake. The Malnutrition Universal Screening Tool (MUST)[3], for example, may be used to do this'.*

15. I have considered the following relevant extracts of the Protected Mealtimes Policy:
Section 4.4 '*Supporting good nutritional care: It is important that mealtimes support the delivery of good nutritional care and that best practice is embedded into routines and practice. This includes:*

'Nursing staff will make food a priority during mealtimes, providing assistance and encouraging patients to eat, being aware of how much food is eaten and identifying patients nutritionally at risk'

'When required as part of plan of care, food and fluid intake will be accurately documented.'

Section 4.6 '*It is the responsibility of the nurse in charge of a shift to supervise*

[2] The **body mass index** (**BMI**) is a measure that uses your height and weight to work out if your weight is healthy.
[3] '**MUST**' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.

mealtimes and ensure nutritional needs are met'.

16. I have considered the following relevant extracts of the Dietetic Criteria:
'Routine referrals: Aim to be seen within 2 working days upon receipt of referral

- *High risk Malnutrition i.e. MUST score >2'.*

17. I have considered the following extracts of the Fluid Balance Policy:
Section 3.0 '*The registered nurse/midwife who has been assigned to provide care for patient's over the period of day, night or partial shift has the responsibility for ensuring that all fluid balance records are accurate and complete at the time of handover. The decision to commence, continue or discontinue recording of fluid balance charts will be taken by the Doctor or the registered nurse/midwife with responsibility for the patients care. This will be reviewed daily. The fluid balance chart will commence at 08.00 hours for a full 24 hour period'.*

The Trust's response to investigation enquiries

18. In response to investigation enquiries, the Trust stated '*Although [the patient] was noted and recorded as having variable and at times poor daily in-take of fluids, her renal function tests on admission were not suggestive of clinically significant dehydration. The patient was admitted on 4 January 2018 and commenced intravenous fluids following her fall due to the painful fracture and analgesics reducing her ability and desire to drink adequately and her renal function tests confirmed a sudden deterioration. [She] was assisted and encouraged to eat and drink. [She] was transferred to the RVH, BHSCT for surgical intervention by the orthopaedic surgeons following her fall and not due to her nutritional status. Given [her] clinical picture, the Trust does not accept that [she] would have died of dehydration and starvation had she remained in AAH'.*

19. The Trust further stated '*had [the patient] been clinically dehydrated, this would have been demonstrated in her bloods; poor nutrition is more likely to be reflected by a significant weight loss. I note [her] weight was recorded on 15 March 2017 as 45.3 kgs when she was referred for endoscopy by her GP. It is documented that on 15 January 2018 (five days after leaving the AAH and being transferred to the BHSCT) her weight was 50.02 kgs. This would indicate that the patient had a history of being*

underweight but had in fact gained approximately 5 kgs'.

20. The Trust clarified that *'a patient will require a referral to dietetics if the Malnutrition Universal Screening Tool (MUST) score is 2 or more'*. The Trust confirmed '*[The patient's] admission nursing documentation identified that assistance was required to eat and drink and a straw was required for drinking. The deputy sister when instigating the nursing assessment records that a MUST assessment and completed care plans were required. This was identified in the admission assessment tracking section of the nursing booklet which indicates uncompleted assessment which are outstanding at end of shift or transfer of patient. A MUST assessment should have been completed within 24 hours of admission; this was not completed which may have resulted in a food chart being instigated until/or dietetic review was required. On a retrospective review it is likely that the MUST score could have been 0 requiring no further intervention or referral'.*

21. The Investigating Officer made further enquiries of the Trust regarding its assertion that the patient '*could have had a MUST score of 0'*. The Trust confirmed '*The basis of the MUST score is based on the patient BMI score of 23, based on her height of 1.48m and weight of 50 kg giving a score of 0 on MUST (this was recorded while [she] was an inpatient in the RVH on 15 January 2018).* The Trust further stated *'whilst [the patient] presented to the ED with back pain and a urinary tract infection on 4 January 2018 and a National Early Warning Score[4] (NEWS) of 0, which indicated that [she] was not considered acutely ill at this time, this would reflect a score of 0 on MUST assessment if completed'.* The Trust stated '*The patient did not have MUST scoring completed on admission to ward A1 on 5 January 2018. A MUST score of 1 indicates the need to record food intake for 3 days on a food chart, this may not have been required. The patient fluid balance chart is completed by registered nurses and healthcare assistant staff for spans of duty whilst in ward A1'.* The Trust further stated '*The patient did not have a food chart completed between 5 January 2018 and 10 January 2018. However, [she] did have a fluid balance chart each day from 5 January 2018 to 10 January 2018'.*

[4] An early warning score is a guide used by medical services to quickly determine the degree of illness of a patient.

22. The Trust also confirmed '*The patient was transferred to RVH fracture clinic on 10 January 2018, arriving at the RVH at 19.30'.* The Trust also confirmed '*there were eight nursing staff cared for her* [between 5 January 2018 and 10 January 2018]'.

Clinical Records

23. I considered the following relevant extracts from the patient's clinical records;

NHSCT records document;

4 January 2018: a daily fluid balance and prescription chart was commenced…*'total fluid intake 1355mls'.*
4 January 2018: '*at approximately 12.20 assistance given at lunchtime and took small amount of soup and sips of milk, encouragement adhered to….at approximately 17.00 'appears settled, family concerned regarding oral intake'.*
5 January 2018: daily fluid balance and prescription chart documents '*total fluid intake 130 mls'.*
5 January 2018: person centred nursing assessment and plan of care was commenced….'*needs MUST assessment completed and careplans….Important to family that she* [the patient] *gets full assistance when eating/drinking as she won't on her own'.* I further note on the assessment, it documents '*requires assistance with eating and drinking and requires help with food (please ensure MUST is completed)…requires full assistance, would need a straw for drinking'.*

6 January 2018: daily fluid balance and prescription chart documents '*total fluid intake 1170 mls'.*

6 January 2018: *'oral intake not documented properly….plan, encourage oral intake'.*

7 January 2018: daily fluid balance and prescription chart documents '*total fluid intake 450 mls'.*

7 January 2018: '*observations stable, eating and drinking well'.*

8 January 2018: daily fluid balance and prescription chart documents '*total fluid intake 350 mls'.*

9 January 2018: daily fluid and balance and prescription chart documents '*total fluid intake 600 mls'.*

10 January 2018: '*500 mls saline administered'.*

BHSCT records document

15 January 2018: '*a MUST assessment was completed with a score of '0'.*

Independent Professional Advice

24. In relation to the patient's admission to the AAH, the CG IPA advised **'***The patient clerking* [in the Emergency Department] (ED) *states poor oral intake and reduced fluid intake as part of the presentation. There is no documentation on clinical examination of signs of dehydration for example a low BP, dry tongue or loss of skin turgor[5]. The diagnoses listed suggest dehydration and intra- venous (IV) fluids were prescribed. Her blood tests show a picture of mild dehydration with a urea[6] of 13.2 and creatinine[7] of 82. Following the IV fluids her urea was 7.5. In March 2017 blood tests show a urea of 6.2 and creatinine of 87 therefore the repeat blood tests on the 7 January suggest a return towards baseline results. It would appear from the fluid balance charts, [the patient] received IV fluids on 4 January 2018 in A&E, in total 1500mls of saline. It would appear she did not receive IV fluids again until 10 January 2018 when she was transferred to the RVH'.*

25. In relation to her nutritional management, the CG IPA advised '*there is no clear plan of care for the patient's food intake*'. The CG IPA further advised *'For the nutrition assessment on the admission document the boxes, "requires assistance eating and drinking "and "requires help with food "are ticked. It is also documented "needs a straw for drinking". The document also states "needs MUST completed and care plans" at 18.30 on the 5 January 2018 on ward A1……The daily evaluation of nursing care does not mention food and fluid intake until the 7 January 2018 at 19.30 when it is documented "eating and drinking well" and on the 9 January 2018 at 13.30 "small oral intake today" and at night it is stated "oral fluids encouraged". I have not found a specific care plan for food and fluid intake management and although there*

[5] **Skin turgor** is the skin's elasticity. It is the ability of skin to change shape and return to normal.
[6] a colourless crystalline compound which is the main nitrogenous breakdown product of protein metabolism in mammals and is excreted in urine
[7] The kidneys maintain the blood **creatinine** in a normal range. ... Elevated **creatinine** level signifies impaired kidney function or kidney disease

are daily fluid balance charts completed there are no food charts…her nutritional care appears to be sub-optimal'.

26. The Investigating Officer made additional enquiries of the CG IPA in relation to the impact the '*sub-optimal'* care had on the patient. The CG IPA advised '*It is impossible to state with any certainty what impact not having a food chart made to [the patient] but her family feel and stated her intake was poor and this may have been improved by an earlier dietician referral. There is insufficient information to say* any *more as no other parameters for example weight or nutrition screen are available. Furthermore, [her] initial fluid management on admission was appropriate but there is inadequate documentation after 6 January 2018 to state impact'.*

27. In relation to the MUST assessment, the CG IPA advised '*The MUST score which should have been completed on admission or within 24 hours according to Trust policy and NICE guidelines[8] was not completed and was only completed after transfer to the RVH'. A MUST score equal to or greater than 2 would trigger the use of a food chart and a dietetic referral.* The CG IPA advised *'the fluids charts do indicate some oral intake of food : on the 6 January 2018 the fluid chart shows an entry of soup 150 mls; the 7 January 2018 50 mls of custard; the 8 January 2018 and 10 January 2018 50 mls custard. Two supplements fortisip[9] were taken on the 9 January 2018, the same day as the referral to the dietician was made'.* The CG IPA further advised '*The patient did not have a MUST score documented but it was noted she had reduced oral intake on admission. From the limited information available it appears her food intake remained poor and even in the absence of a MUST score a referral to the dietician and blood test including a serum albumin[10] should have been taken. The medical and nursing staff should have been aware of the poor food intake…..A dietetic referral was made on the 9 January 2018 after her son raised concerns about her oral intake'.*

[8] NICE Guidance covers the use of screening 'Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition', Clinical Guidance (CG32) published date February 2006, last updated August 2017.

[9] **Fortisip** is a Food for Special Medical Purposes for use under medical supervision.

[10] Human **serum albumin** is the **serum albumin** found in human blood. It is the most abundant protein in human blood plasma; it constitutes about half of **serum** protein. It is produced in the liver.

28. The CG IPA also advised '*If a patient and family identify poor oral intake it would be appropriate to consider a food chart to establish the significance of the concern with dietetic referral if required. There should be clinical judgment used in addition to the MUST score which is just a screening assessment'.* Upon further enquiries with the CG IPA regarding the patient MUST assessment score, the CG IPA advised '*I agree* [with the Trust] *that the MUST score would probably have been 0 given that the score at Royal Victoria Hospital on the 15 January 2018 was 0 but the poor oral intake demonstrated should have triggered the use of a food chart and earlier referral to a dietician based on clinical observation'.*

29. In relation to fluid management, the CG IPA further advised that the patient was administered '*1500 mls of intravenous fluids, normal saline, were prescribed 500ml to be infused over 2 hours and 1000mls to be infused over 8 hours. The daily fluid balance chart on the 4 January 2018 shows a total infusion of 1125mls (summated as 1255 on the bottom of the chart) intravenous and 130 mls orally.* [However]…*the remainder of the 1000mls started at 13.55 on the 4 January 2018 is not documented [as given] on the patient chart….. On the 10 January 2018, 249 mls of intravenous fluid, normal saline, is documented on the chart prior to transfer to RVH, a further 1750mls was documented after transfer. A number of the totals on the chart do not match the documentation of fluids given at documented times*'.

30. *The remaining fluid amounts given until the 10 January 2018 are documented below*

Date	*Oral intake (mls)*	*Intravenous intake (mls)*
5/1/18	*130*	*0 documented*
6/1/18	*1170*	*0*
7/1/18	*450*	*0*
8/1/18	*350*	*0*
9/1/18	*700*	*0*
10/1/18	*270*	*249 and 1750*

31. In relation to the monitoring of [the patient's] fluid management, the CG IPA advised '*There is no real documentation of a fluid management plan after the 4 January 2018 when IV fluids were prescribed and given by the medical team. There are some entries relating to food and drink but they do not form a management plan. On the 5 January 2018 there is no mention of fluid and food intake, on the 6 January 2018 the notes state "oral intake not documented properly", on the 7 January 2018 the oral intake is stated to be 1170 mls, on the 8 January 2018 oral intake is documented as 450mls. There are no further entries on the 9 January 2018 and 10 January 2018 relating to fluid and food intake. A number of entries state "encourage oral intake" (6 January and 8 January 2018). The nursing care plan states that it is important to the family that the patient gets full assistance when eating and drinking as "she won't on her own".*

32. The CG IPA further advised '*[The patient's] initial fluid management was appropriate and it is difficult to predict what the outcome would have been if she had not fallen on the ward as the need to give strong analgesics made her drowsy and less able to take fluids and food at this point in the admission.* The CG IPA advised '*The patient was admitted to Antrim Area Hospital acutely unwell with dehydration which initially was managed appropriately but there was suboptimal review and management of ongoing fluid and food intake during the admission'.*

33. The Investigating Officer made further enquiries of the CG IPA in relation to the

patient being dehydrated. The CG IPA advised '*in this table I have shown the pertinent results available for the 4, 7 and 10 of January:*

Blood test	*4/1/18*	*7/1/18*	*10/1/18*	*Normal range*
Urea	*13.2*	*7.5*	*13.4*	*2.5-7.8*
Creatinine	*84*	*82*	*106*	*45-84*
Haemoglobin	*165*	*138*	*126*	*115-165*
White cell count	*6.8*	*6.6*	*24.8*	*4-11*
CRP	*6*	*4*	*197*	*0-5*

34. *The urea and electrolytes were otherwise normal. The urea was raised on admission, responded to IV fluids, and then rose again after the fall. Following the fall and fracture the rise in the urea may have been contributed to by bleeding into the fracture site. When a bleed occurs at a fracture site the blood is reabsorbed, broken down and metabolised by the body and can contribute to a rise in urea but at this time the creatinine has also risen, suggestive of hypovolaemia (lack of fluid in the vascular system due to lack of fluid).IV fluids were restarted after the fall. The haemoglobin on admission was raised [compared to levels in March 17 (122 and 117)] and also suggests the presence of dehydration. This was reduced to the normal range after the IV fluids and fell further after the fall this is most likely to relate to blood lost into the fracture site. The white cell count was normal on the 4 January 2018 and 7 January 2018 but raised on the 10 January 2018 which is likely to be multifactorial in origin.*

35. The CG IPA confirmed '*the raised urea and high haemoglobin on the 4 January 2018 suggest the patient was mildly dehydrated on admission. On the 10 January 2018 the results are abnormal suggesting dehydration but other factors may have contributed to the blood results after the fall. The patient's immediate treatment with IV fluids on admission was appropriate and her clinical condition and blood tests on the 7 January 2018 showed improvement. On the 8 January 2018 to 10 January 2018, there was insufficient attention given to her fluid intake'.*

36. In relation to nutritional care and treatment the N IPA advised '*I did not find a specific plan of care for food intake. There is a document titled 'person-centered nursing assessment and plan of care (acute and non-acute adult in-patients)' which has entries dated 5 January 2018 starting at 17:15, including a note at 18:30 that "needs MUST completed and care plans". The guidance for use on page 2 of the document specifies that MUST tool should be completed within 24 hours. A person-centered care plan should also be completed although a timescale is not specified for this. An entry on page 4 of the document states "important to family that she gets full assistance when eating / drinking as she won't on her own" and on page 6 under 'Nutrition & hydration' "requires full assistance. Would need a straw for drinking". This assessment information acknowledges needs in this area and indicates that full assistance is needed but does not go into detailed planning'.*

37. The N IPA advised '*the nursing team should have prepared a care plan that specified assistance to be provided with all meals, food and drink and for this to be recorded on a food management chart and evaluated. It is not possible to give an opinion on whether medical intervention would have been needed as there is insufficient information on her nutritional status. There is however evidence that she required assistance. If she was taking very little food during her hospital stay then she may have needed intervention, e.g. therapy assessment of ability to feed herself, cognitive assessment to determine whether she was alert enough or lucid enough (I note that she may have had a delirium), dietician advice, personalised meal planning and appetite stimulation, possibly dietary supplements. Because there was no effective monitoring or plan of care, these potential issues were not identified in the patient record. I conclude that whilst it is not possible to say whether medical intervention/ treatment was indicated, she did need nursing care and intervention for her nutritional needs'.*

38. The N IPA advised '*the 'daily evaluation of nursing care' document has entries from 5 January 2018 through to 10 January 2018…some of the entries are very faint and difficult to decipher. As far as I can see this records care activity but does not specifically evaluate diet or fluid intake until 10 January 2018 when the 02:00 entry records "tolerating oral fluids with assistance"….I conclude that the patient did not*

have an appropriate plan of care for fluid management and food intake'.

39.The N IPA further advised '*there is no record of the MUST tool being completed during [the patient's] stay at AAH….The patient should have had a MUST screening carried out in accordance to NICE clinical guidelines* (see below). *This is best practice. The MUST tool can be completed by any healthcare professional, but it is usually the responsibility of the registered nurse who is making the overall patient assessment and care planning. The Trust have stated in their response 14 December 2018 that it is the responsibility of the registered nurse during her span of care, and should be carried out within 24 hours. This is a reasonable approach and reflects good practice and interpretation of NICE guidance into practice:*

NICE Clinical Guideline 32 Nutrition Support for Adults:
Section 1.2.2 All hospital inpatients on admission and all outpatients at their first clinic appointment should be screened. Screening should be repeated weekly for inpatients and when there is clinical concern for outpatients

Section 1.2.6 Screening should assess body mass index[11] (BMI) and percentage unintentional weight loss and should also consider the time over which nutrient intake has been unintentionally reduced and/or the likelihood of future impaired nutrient intake. MUST, for example, may be used to do this'.

40. The N IPA advised 't*imescales for screening using MUST post – admission are not given either by the British Association of Enteral and Parenteral Nutrition (BAEPN) or NICE, therefore 24 hours post admission is a local policy. This means that at a minimum, inpatients MUST (or other nutrition screen) should be carried out weekly, but more frequently if there other concerns – the point being that initial screening is itself not sufficient to identify nutritional problems in acute care. If acute deterioration or other event occurs after screening…for example the patient becomes nil by mouth (NIL) the clinical team should reassess nutrition and hydration risk factors and take appropriate action'.*

[11] The **body mass index** (**BMI**) is a measure that uses your height and weight to work out if your weight is healthy.

41. The N IPA also advised '*I have noted in the* [Trust's] *protected mealtimes policy it is stated at section 4.4 "nursing staff will make food a priority during mealtimes, providing assistance and encouraging patients to eat, being aware of how much food is eaten and identifying patients nutritionally at risk.' It is further stated 'When required as part of plan of care, food and fluid intake will be accurately documented.*'

42. The N IPA highlighted '*on 4 January 2018 at 12:20 [The patient] "assistance given at lunchtime and took small amount of soup and sips of milk" and "Intentional rounding / SKIN bundle charts. These use a coding of 'A' for Assisted with food / assisted with drink".*

5 January 2018 'A' (Assisted with food / assisted with drink) is recorded as being offered: 21:00, 01:00, 05:00 and 07:00
6 January 2018 'A' (Assisted with food / assisted with drink) is recorded as being offered at 09:00 13:00 and 15:00

43. The N IPA advised '*the abbreviated coding is not clear on 7 January 2018 as the nutrition/ hydration line does not appear to relate to the coding key….there are occasional references to nutrition and hydration being offered:*

8 January 2018 'A' (Assisted with food / assisted with drink) is recorded as being offered at: 09:00
9 January 2018 'A' (Assisted with food / assisted with drink) is recorded as being offered once – it's not clear whether the time is 01:00 or 13:00'.

44. In response to enquiries made regarding the impact it had on the patient not having a food chart completed, the N IPA advised '*it would be difficult to know the full impact of not having a food chart completed as recording on clinical notes was poor. However, it is likely the patient would have had a slower rate of recovery from her illness and she would be more likely to suffer complications from immobility as she under nourished'.* The N IPA also advised '*she may be more susceptible to skin damage, muscle mass, inadequate protein and difficulty engaging in rehabilitation and a prolonged recovery period'.*

45. In regards to the record keeping of the patient's food intake, the N IPA advised '*overall the record keeping regarding food management is incomplete and she did not have an effective food management chart between 4 and 10 January 2018…in my opinion her food intake should have been recorded because the staff had already noted that assistance was needed: Person-centred care plan page 4 "important to family that she gets full assistance when eating / drinking as she won't on her own" and on page 6 under 'nutrition & hydration' "requires full assistance". Therefore, there are two failures: one was the MUST not being completed. The other was, irrespective of the MUST score, the staff failing to take action on information that this patient required assistance with eating and drinking'.*

46. In regards to fluid management, the N IPA advised ''*I did not find a specific plan of care for fluid management….In my opinion, her fluid balance records were monitored and reviewed daily, which is appropriate, but there is evidence that the oral intake was not properly documented (6 January entry and 7 January 2018) on all occasions'.* The N IPA concluded '*for an older person admitted with UTI and dehydration I would expect to see a comprehensive assessment by the multidisciplinary team, including detailed nursing assessment, with clear management plan for addressing her diet and fluids needs. In my opinion there were several failures in care for [the patient]: The nursing team did not pick up on information provided on admission regarding the need for assistance with food and drink; she did not have a MUST tool recorded; there was no plan of care for nutrition and hydration; recording of food and fluid intake was inadequate. None of these aspects of nursing care were carried out to a reasonable or appropriate standard…unfortunately The patient nursing care was not adequate with respect to her nutrition and fluid needs prior to her transfer to the RVH'.*

The Trust's response to Independent Professional Advice

47. The Investigating Officer provided the Trust with an opportunity to comment on the CG IPA and N IPA advice. The Trust stated '*the Trust has previously acknowledged the MUST score was not recorded in AAH. Retrospectively having reviewed the nursing assessment on admission, if MUST had been completed, it would have been a score of 0 which would not have triggered a food chart or referral to a dietician. However, the Trust accepts that a MUST assessment should be*

completed within 24 hours of admission and assessed weekly or if the patient's condition changes. Dietetic referral criteria for nutritional support requires MUST to be completed first and a risk score to be identified. If there is a clinical concern regarding intake, nursing staff should start food records, review MUST and commence a nutritional care plan regardless of the MUST score and we acknowledge this did not occur. We accept therefore that best practice procedures in relation to nutritional screening and support were not followed in [this] case'.

48. The Trust also stated '*it accepts the learning and conclusions identified by the IPAs and we recognize that we did not fully respond to the family's expressed concerns and this is an opportunity for reflection and learning for the team. I can give you full assurance that the Trust has implemented learning from [the patient's] experience through safety briefings, professional supervisions and professional fora. The learning will also be tabled at our next care of the elderly clinical governance multidisciplinary meeting to raise awareness with medical staff*'.

49. In regards to the patient not being given a serum albumin test, the Trust stated '*Our medical staff state that this laboratory test would not be regarded as routine in the workup or management of a patient admitted with urosepsis[12] and delirium[13]. Therefore the serum albumin was not requested between 5 and 10 January 2018 by the Consultant. The medical opinion is that serum albumin is felt to be a poor indicator of nutritional status especially when there is infection or other acute inflammatory processes. Medical staff feel that any subsequent change in serum albumin concentration following a fractured hip is likely to represent the loss of blood and rapid infusion of intravenous fluid replacement received as part of treatment for this condition'.*

50. The Trust stated '*We acknowledge there is learning in [this] experience for the ward team and in addition to steps already take we are currently targeting support to this clinical area and looking at record keeping including the completion of fluid balance charts. There will also be updates on nutrition for all ward staff and more*

[12] **Urosepsis** is a condition where a urinary tract infection spreads from the urinary tract to the bloodstream, causing a systemic infection that circulates through the body through the bloodstream.
[13] **Delirium** is a serious disturbance in mental abilities that results in confused thinking and reduced awareness of the environment. The start of **delirium** is usually rapid — within hours or a few days.

focus on nutrition at the multidisciplinary ward rounds. A specific emphasis has been placed on care planning and ensuring relatives concerns are taken into account when planning care. The nurse in charge daily on each shift will ensure all relevant risk assessments and documentation is updated and any concerns are escalated quickly for discussion or action'.

51. In response to the Trust's response to the CG IPA and N IPA, the Investigating Officer made further enquiries with the CG IPA and N IPA. The CG IPA further advised **'***while accepting serum albumen is not a routine test and can be affected by acute illness given the family's concern regarding food intake and the nursing documentation that suggests the patient needs assistance to eat, it would have been a reasonable test to undertake and it could have been monitored to assist in nutritional assessment'.*

52. In regards to the Trust failing to complete a MUST assessment and the impact of the patient not having a food chart completed, the N IPA stated '*As there were eight nurses who had been on duty between 4 January 2018 and 10 January 2018, then there was a collective failure by nurses post 24 hours after the patient was admitted to the ward, to complete a MUST assessment. There had been an assumption someone else had completed it…there had been a collective failure regarding the incompletion of [the patient's] MUST assessment'.*

53. The N IPA further advised '*it would be difficult to determine or know the full impact of not having a food chart completed as recording on clinical notes was poor and no further additional nutritional matrix was recorded so she could only speculate on the likely impact…The patient may have had a slower rate of recovery from her illness, she would have been more susceptible to complications from her illness, she would have been more likely to suffer complications from immobility if she was under nourished, inadequate nourishment and hydration, more susceptible to skin damage, muscle mass inadequate protein and difficulty engaging in rehabilitation'.*

The complainant's response to draft report

54. The complainant provided the following response to the draft report: '*The draft report has clearly established that AAH failed to provide the most basic of care to my mother i.e. failure to ensure that she was provided with adequate nourishment and hydration. This finding confirms my view of the events at that time and is particularly shocking given that the concerns with respect to her care were raised by family members with hospital staff in ward A1 on a daily basis. As indicated at the time of making the complaint I had and continue to have no interest in financial compensation'.*

55. '*My major concern at the time of my complaint was to ensure that no one else would be failed by AAH in the same manner as my mother. Given this I wish to state my full support for the audit of MUST screening, dietetic referrals, nutritional care planning and fluid management in ward A1. Disappointingly despite the weight of evidence, the report demonstrates that the Trust continues to dispute many of the facts of the case and has taken every avenue open to try to cover its neglect…it is stated by the Trust (paragraph 18) that 'the patient was assisted and encouraged to eat and drink' - this is simply not the case'.*

56. '*[Also]* a*t paragraph 21 that [the patient[did have a fluid balance chart yet it fails to note the inadequacy in the completion of the chart and the lack of a fluid management plan despite the recorded concerns of the family'.*

57. '*On arrival at the RVH at 19.30 on 10 January 2018, I was informed that my mother was dehydrated, this is evidenced by her intravenous intake of 1750ml saline on arrival. It is perhaps noteworthy that this was required in addition to the 500 ml given by the AAH earlier in the day. In the previous five days in ward A1, my mother had a combined total recorded intake (even assuming the intake volume figures were correct) of 2800 ml. At this point given the findings within the draft report, I see little value in responding to the claims of the Trust on a line by line basis however should the thrust of the report change significantly on receipt of further comments from the Trust I would request the right to do so'.*

58. *'Having now considered the report in detail I remain of the view that, should my*

mother not have had the good fortune to fall out of bed , break her leg and be moved to the Royal Victoria Hospital, she would have died of dehydration and starvation in AAH. As such I am firmly of the belief that publication of this report is entirely in the public interest i.e. the public must be made aware that they should not automatically assume that the care they are being provided with while in hospital is adequate, if they have concerns they should continue to highlight these until they are addressed. In addition, I suggest the outcome of the audit proposed within the recommendations of this report are made publicly available with a view to addressing concerns and convincing public opinion that lessons have truly been learned and acted upon by the Trust'.

The Trust's response to draft report

59. Upon receipt of the draft report the Trust stated *'I acknowledge your decision to uphold the … complaint and in respect of failings identified mainly in relation to [the patient's] nutritional care and fluid management. The Trust accepts the findings in the report and has no new comments to add and I will undertake to forward my unreserved apology to [the complainant] and his mother for the shortcomings identified. Finally I would like to assure you that we are actively considering your recommendations and are taking forward a number of actions. We will further consider these when we receive your final report'.*

Analysis and Findings

Nutritional care planning

60. I note that the patient's person-centred plan recorded '*important to family that she gets full assistance when eating /drinking as she won't on her own'*. I have considered and I accept the CG IPA advice that '*I have not found a specific care plan for food'*. I have considered and I accept the N IPA advice that '*if she was taking very little food during her hospital stay then she may have needed intervention'* and '*there was no plan of care for nutrition…nursing care was not* adequate'. It is of concern to me that information provided by the patient's family in regards to her requiring assistance when eating was not reflected upon by nursing staff or considered within the context of a nutrition care plan. I consider this information would have been invaluable in establishing a plan of care to meet her nutritional needs.

61. I consider the concerns raised by the CG IPA and N IPA that a plan regarding nutrition and fluids was not put in place and the wishes of the family were not adequately addressed due to the absence of a clear plan. In my consideration of the patient's right to an adequate standard of living which encompasses the right to adequate food and water, the FREDA[14] principle of dignity is particularly important. I consider as an older person, the patient was more at risk to be dehydrated and adequate steps were not taken by the Trust to ensure she received assistance with eating and drinking especially since her family had raised this as a concern from the onset of her admission on 4 January 2018. I consider that failing to adequately plan for the patient's nutritional care, the Trust did not have sufficient regards for her rights.

62. I consider the Trust did not put in place a plan of care for the patient's nutritional management. I refer to the protected meal-times policy section 4.6 *'it is the responsibility of the nurse in charge of a shift to supervise mealtimes and ensure nutritional needs are met'*. Furthermore, it would appear that a number of nurses did not follow NMC guidelines on prioritising people, paragraph 1.2 '*make sure you deliver the fundamentals of care effectively'* and paragraph 1.4 '*make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*'. I consider the Trust's lack of a nutritional plan of care to be a failure in the patient's nursing care and treatment and not in accordance with the Trust's protected meal-times policy. **Therefore, I uphold this element of the complaint.**

63. In relation to the completion of a MUST assessment, the Trust stated *'when instigating the nursing assessment records that a MUST assessment and completed care plans were required…..a MUST assessment should have been completed within 24 hours of admission, this was not completed which may have resulted in a food chart being instigated until/or dietetic review was required…*'a *MUST score of 1 indicates the need to record food intake for 3 days on a food chart'.*

[14] In essence, the human rights-based approach is the way in which human rights can be protected in clinical and organisational practice by adherence to the underlying core values of fairness, respect, equality, dignity and autonomy (**FREDA**).

64. I examined and I note the NICE nutrition guidelines, sections 1.2.2 and 1.2.6 state '*All hospital inpatients on admission and all outpatients at their first clinic appointment should be screened…screening should be repeated weekly for inpatients and when there is clinical concern of outpatients….the MUST tool for example may be used to do this'.*

65. I have considered the CG IPA advice and I accept that '*The patient did not have a MUST assessment score documented…from the limited information available it appears her food intake remained poor and even in the absence of a MUST score a referral to the dietician and blood test including serum albumin should have been taken'.* However, I would highlight the Trust stated in its response to this element of the CG IPA advice that '*medical staff state the [serum albumin] test is not regarded as routine in the workup or management of a patient admitted with urosepsis and delerium*'. The Investigating Officer made additional enquiries of the CG IPA regarding this matter. I have considered and I accept the additional advice of the CG IPA that '*while accepting serum albumen is not a routine test and can be affected by acute illness given the family's concern regarding food intake and the nursing documentation that suggests the patient needs assistance to eat it would have been a reasonable test and it could have been monitored to assist in nutritional assessment'.*

66. I have also considered the N IPA advice and I accept that '*there is no record of the MUST tool being completed…The patient should have had a MUST screening carried out in accordance with NICE Guidelines.* I note the nursing IPA highlights '*the MUST tool can be completed by any healthcare professional but it is usually the responsibility of the registered nurse who is making the overall patient assessment and care planning'.*

67. I would highlight the investigation also established '*there were eight nursing staff*' who had been on duty in Ward A1 and who cared for the patient between 5 January 2018 and 10 January 2018. I have considered and I accept the N IPA advice that '*as there were eight nurses who had been on duty between 4 January 2018 and 10 January 2018, there was a collective failure by nurses post 24 hours after the patient was admitted to the ward to complete the MUST assessment*'. I refer to NMC

standards on prioritising people, paragraph 1.2 '*make sure you deliver the fundamentals of care effectively'* and paragraph 1.4 '*make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*'. I consider the nurse in charge's failure to ensure the patient's MUST assessment was completed to be a failure in her nursing care and treatment. I also consider it to be a failure by those nurses who cared for her to fail to complete the MUST assessment in accordance with NICE nutritional guidance. I am concerned that there has been individual and collective failure to use a screening tool to assess the patient's nutritional needs.

68. However, I note the Trust stated if the patient had a MUST assessment completed '*it would have been a score of 0 - this is based on the patient BMI score 23, her height of 1.48m and weight of 50 kg' (this was recorded while [she] was an inpatient on the RVH on 15 January 2010)*. Following enquiries of the BHSCT, the Investigating Officer confirmed that the patient had a MUST assessment completed in the BHSCT on 15 January 2018 and a MUST assessment score of *'0'* was recorded. I further note and accept the advice of the CG IPA '*that the MUST score would probably have been 0'*. Therefore, I do not consider the patient to have suffered an injustice as a result of this failing.

69. I welcome the Trust's acceptance that '*best practice procedures in relation to nutritional screening and support were not followed in [this] case'.* However, I consider the completion of a MUST assessment could have led to a food chart being commenced for the patient, therefore highlighting the need for assistance with her nutritional care.

70. In response to enquiries made in relation to the patient having a food chart commenced, I note the Trust state '*The patient did not have a food chart completed between 5 January 2018 and 10 January 2018'*. However, I note the Trust stated '*a registered nurse is responsible for making an onward referral to a dietitian from a MUST assessment score of 2 or more…a dietetic referral was made for the patient on 9 January 2018.*

71. I have considered and I accept the CG IPA advice that *'there should be clinical judgement used in addition to the MUST score which is just a screening assessment…if a patient and family identify poor oral intake it would be appropriate to consider a food chart to establish the significance of the concern with dietetic referral if required…the poor oral intake demonstrated should have triggered the use of a food chart'.* I also accept the CG IPA advice that '*it is impossible to state with any certainty what impact not having a food chart made to the patient but her family feel and stated her intake was poor and this may have been improved by an earlier dietician referral'.* I have also considered and I accept the N IPA advice that '*overall the record keeping regarding food management is incomplete and she did not have an effective food management chart between 4 and 10 January 2018'.* I consider the Trust's failure to commence the patient's food chart to be a failure in her nursing care and treatment. **Therefore, I uphold this element of the complaint.**

72. Furthermore, I accept the CG IPA advice that '*an earlier referral to a dietician based on clinical observation*', should have been carried out. I consider there was a delay by the Trust in referring the patient to a dietician at the earliest point in her care, on 5 January 2019. I consider the failure by the Trust to make an earlier referral for the patient to a dietician was a failure in her care and treatment.

73. I consider the impact of the failures that I have identified, the patient would have had a slower rate of recovery from her illness, more likely to suffer complications from her immobility and a pro-longed period for her recovery as outlined by the N IPA. I am satisfied the failures that I have identified have caused the patient the injustice of upset, inadequate nourishment and uncertainty about her treatment and recovery. I also consider the complainant to have suffered the injustice of frustration and uncertainty for the failures I have identified.

Fluid Management

74. In relation to fluid management, I have also considered the advice of the CG IPA and accept that '*there is no real documentation of a fluid management plan after the 4 January 2018…there are some entries relating to drink but they do not form a management plan'*. I also accept the CG IPA advice that '*a number of entries state encourage oral intake…the nursing care plan states that it is important to the family*

that the patient gets full assistance when drinking as she won't on her own…I have not found a specific care plan for fluid intake management. Furthermore, I accept the advice of the CG IPA that '*The patient was initially managed appropriately but there was sub-optimal review and management of ongoing fluid intake…The patient's initial fluid management on admission was appropriate but there is inadequate documentation after 6 January 2018 to state impact…however she did have a fluid balance chart each day from 5 January 2018 to 10 January 2018..*

75. I have also considered and I accept the N IPA advice that '*for an older person admitted with UTI and dehydration I would expect to see a comprehensive assessment by the multidisciplinary team including detailed nursing assessment, with clear management plan for addressing her fluid needs.…the nursing team did not pick up on information provided on admission regarding the need for assistance with drink; there was no plan of care for hydration'.*

76. In accepting the CG IPA and N IPA advice, I consider the Trust did not put in place an adequate plan of care for the patient's fluid management. I consider the Trust's lack of plan of care for the patient's fluid management to be a failure in her nursing care and treatment. **Therefore, I uphold this element of the complaint.** I am satisfied the failure to have a fluid management plan of care for the patient to have caused her the injustice of upset, inadequate hydration and frustration about her treatment. I also consider the complainant to have suffered the injustice of frustration and uncertainty for the failure I have identified.

77. In relation to the record keeping of the patient's fluid records, I note the CG IPA advised '*the remainder of the 1000mls started at 13.55 on 4 January 2018 is not documented as given'*. I further note the N IPA highlighted discrepancies (paragraph 46 refers). I am concerned about poor record keeping in relation to fluid management given that the patient was mildly dehydrated upon admission to the BHSCT and required fluids on 10 January 2018. I further note and accept the N IPA advice that '*there is evidence that the oral intake was not properly documented on all occasion's… recording of fluid intake was inadequate'*.

78. I refer to the Trust's fluid balance policy section 3.0 states '*the registered nurse who has been assigned to provide care for patients over the period of day, night or partial shift has the responsibility for ensuring that all fluid balance records are accurate and complete at the time of handove*r'. I conclude the failure to adequately complete the patient fluid balance charts between 5 January 2018 and 10 January 2018 to be a failure in her nursing care and treatment and not in accordance with the Trust's fluid balance policy.

79. In my consideration of the complaint that the patient was dehydrated upon admission to the BHSCT on 10 January 2018, the investigation established that she fell on the ward on 9 January 2018. I have considered and accept the CG IPA advice that '*the urea was raised on admission* [4 January 2018]*, responded to IV fluids and then rose again after the fall…following the fall and fracture the rise in urea may have been contributed to by bleeding into the fracture site…on the 10 January 2018 the results were abnormal suggesting dehydration but other factors may have contributed to the blood results after the fall'.* Furthermore*,* I also accept the CG IPA advice that *'at this time* [the patient's] *creatinine*[15] *has also risen, suggestive of hypovolaemia….lack of fluid in the vascular system due to lack of fluids'.* I consider the patient's urea and creatinine levels on 10 January 2018 suggest that she was dehydrated. I accept that her blood test results showed indications of dehydration upon admission on the 4 January 2018. I further accept that upon being administered fluids she responded to the fluids and her blood results fell back into normal range (paragraph 33 refers) by 7 January 2018. I note that the patient was commenced with fluids on 10 January 2018, the day she was admitted to the BHSCT.

80. However, I have considered the advice of the CG IPA and N IPA alongside the patient's fluid balance chart and test results. While acknowledging other factors may have contributed to the abnormal blood results suggestive of dehydration, when considered alongside the low fluid intake recorded in the fluid balance charts I consider she was showing signs of dehydration on the 10 January 2018 when she was transferred to BHSCT as a result of inadequate focus on her fluid intake. I

[15] **Creatine** alters your body's stored water content, driving additional water into your muscle cells (10). This fact may be behind the theory that **creatine** causes **dehydration**

consider this was a failure in the patient care and treatment and therefore uphold this element of the complaint. I am satisfied this failure caused the patient the injustice of inadequate hydration and frustration about her treatment.

CONCLUSION

81. I received a complaint about the actions of the Trust.

82. I have investigated the complaint and have found failures in care and treatment in relation to the following matters:

i. Failure to complete a nutritional plan of care
ii. Failure to complete a MUST assessment
iii. Failure to commence food charts
iv. Failure to make an earlier referral to dietician
v. Failure to complete a fluid management plan of care
vi. Failure to adequately complete fluid balance charts
vii. Failure to ensure the patient received adequate fluids

I am satisfied the failures I have identified caused the patient to experience the injustice of upset, inadequate nourishment and hydration and frustration and uncertainty about her treatment and recovery. I also consider the failures in care and treatment I have identified have caused the complainant to experience the injustice of frustration and uncertainty.

Recommendations

I recommended that the Trust undertake the following action:

(i) In accordance with the Ombudsman's guidance on issuing an apology, provide a written apology to the patient and the complainant for the injustice identified in this report. The NHSCT should provide the apology to the patient and the complainant within one month of the date of my final report.

(ii) The Trust bring the failures identified in this report to the attention of the nurses who cared for the patient between 5 January 2018 and 10 January 2018 on Ward A1 and remind them of the importance of adhering to the NMC standards.
(iii) The Trust consider commencing food charts for patients who have been identified as requiring assistance, so as to establish the significance of the concern with dietetic referral if required.
(iv) In acknowledging the steps already taken by the Trust to address the concerns raised by the complainant, I recommend that the Trust conduct an audit of MUST screening, dietetic referrals, nutritional care planning and fluid management documentation in Ward A1 of the AAH. The audit should be completed and report of audit prepared within three months from the date of my final report.

83. The Northern Health and Social Care Trust accepted my findings and recommendations.

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.