Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 19595

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust) regarding the care and treatment provided to the complainant's late mother (the patient) in the Royal Victoria Hospital. The complainant raised particular concerns about the nutritional care, fluid management and nursing care and treatment of her mother.

The investigation of the complaint identified that in general the patient's care and treatment was appropriate. In respect of fluid management, administration of medication (haloperidol and antibiotics), management of bedsores and mobility the investigation did not find a failure in the care and treatment provided to the patient. It was also established it was not a failure by the Trust to prevent the patient's discharge as remaining in hospital was in her best interests.

The investigation did establish while the general fluid and nutritional management was appropriate, fluid balance and food charts were not completed appropriately. The patient's charts in relation to the management of her risk of her developing bed sores was also not completed appropriately for six days during her admission.

The investigation also identified maladministration in respect of how the Trust handled the complaint.

I made a number of recommendations including an apology to the complainant.

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

THE COMPLAINT

1. The complainant's mother was admitted to the Royal Victoria Hospital (RVH) on 5 August 2014 with a chest infection. She complained that her mother's nutritional care and treatment was neither appropriate nor reasonable between 5 August 2014 and 7 September 2014. The complainant also said her nursing care was poor as she had developed bed sores[1] and was immobile. The complainant also said that her mother was unnecessarily prescribed and administered a sedative drug haloperidol on 10 August 2014. She also advised her mother had been prescribed antibiotics between 5 August 2014 and 7 September 2014. However, the medical team changed the antibiotic and she believes this left her mother upset and confused. The complainant also said that she had wanted to take her mother home however medical staff refused to allow her to be discharged. She also said that the Trust's complaints handling was inadequate.

Issues of complaint

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

Issue one: Was the care and treatment provided by the Trust appropriate and reasonable. In particular

- **Nutritional care and treatment and fluid management**
- **Nursing care and treatment**
- **Administering of haloperidol**
- **Change in antibiotics**

Issue two: Was it appropriate and reasonable the Trust did not allow the patient to be discharged?

Issue three: Was the Trust's complaints handling adequate?

[1] Bedsores — also called **pressure ulcers** are injuries to skin and underlying tissue resulting from prolonged **pressure** on the skin. Bedsores most often develop on skin that covers bony areas of the body, such as the heels, ankles, hips and tailbone.

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 by the complainant. 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 in Respiratory Medicine (CRM IPA) MB ChB MD FRCP AFOM, with 20 years experience as a consultant physician in respiratory and general medicine;
- An Advanced Nurse Practitioner (N IPA) RGN BA (HONS) MSc PhD, with 16 years experience in renal medicine and two and a half years in older peoples care within an acute medical unit setting;
- A Senior Dietician (D IPA) Masters of Nutrition, HCPC, with nine years experience managing patients requiring nutritional support through oral, enteral and parenteral routes; and
- A Speech and Language Therapist (SALT IPA) BA Hons, Post Graduate Diploma in clinical communication studies, MSc in speech/swallowing, PhD in the lived experienced of dysphagia[2], consultant speech and language therapist in dysphagia in people with a learning disability and professional advisor in dysphagia.

5. 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.

[2] difficulty or discomfort in swallowing, as a symptom of disease

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[3]:

- The Principles of Good Administration
- The Principles of Good Complaints Handling
- The 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 judgement of the Trust staff whose actions are the subject of this complaint.

8. The specific standards relevant to this complaint are:

- Department of Health, Social Services and Public Safety (DHSSPS) Good Practice in Consent, Reference Guide for Consent for Examination Treatment and Care (2003) (The Consent Guide)
- National Institute for Health and Care Excellence (NICE) Guidelines: Nutrition support in adults (2006) (NICE Nutrition Guidelines)
- General Medical Council (GMC) Guidelines Patients and Doctors Making Decision Together (The GMC Guidelines)
- The Belfast Health and Social Care Trust (BHSCT) Dietetics Access Criteria (2009) (Dietetics Access Criteria)
- DHSSPS Complaints in Health and Social Care, Standards and Guidelines for resolution and Learning (2009) (Complaints in Health and Social Care)
- BHSCT Food, Fluid and Nutrition Policy – Adult In-Patient Setting (2011) (Nutrition Policy)

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

- NICE Quality Standards: Nutrition support in adults (2012) (NICE Quality Standards)
- BHSCT Policy for Recording Fluid Prescription and Balance Charts (2013) (Recording Fluid Prescription and Balance Charts)
- BHSCT Policy and Procedure for the Management of Complaints and Compliments (2013) (Complaints Policy 2013)
- BHSCT Adult Pressure Ulcer Risk/Skin Assessment Chart (2014) (Adult Pressure Chart)
- Nursing and Midwifery Council (NMC) The Code for Professional Standards of Practice and Behavior for Nurses Midwifes and Nursing Associates (The NMC Code)

9. 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.

10. In accordance with the NIPSO process, a draft copy of this report was shared with the Trust and the complainant for comment on factual accuracy and the reasonableness of the findings and recommendations.

INVESTIGATION

Issue one Was the care and treatment provided by the Trust appropriate and reasonable?

Detail of Complaint

11. The complainant said that her mother was not being given adequate food and fluids during her admission to the RVH between 5 August 2014 and 7 September 2014. She also complained that the nursing care and treatment her mother received was poor as she developed bed sores during this period. The complainant states that upon admission to the RVH her mother had been alert and mobile and was able to walk. However, she complained that her mother's mobility deteriorated during her admission to the RVH. She believes this was because her mother's medical team did not allow her to be active, go to the toilet or be mobile on the ward. The complainant also said that her mother had been wrongly administered a sedation drug haloperidol on 10 August 2014. In addition, she advised her mother had been prescribed antibiotics on 5 August 2014; however the medical team changed her antibiotic which she believes made her mother very confused. The complainant believes the medical team should never have adjusted her mother's antibiotic.

Evidence Considered

Guidance

12. I have considered the following relevant extracts of the NICE 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 and when there is clinical concern for outpatients'*.

(Screening for nutrition) Section 1.2.6 '*Screening should assess body mass index (BMI)*[4] *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[4] (MUST), for example, may be used to do this'.

13. I have considered the following relevant extracts of the NICE quality standards: Quality Statement 2: Treatment states '*people who are malnourished or at risk of malnourishment have a management care plan that aims to meet their complete nutritional requirements'.*

It is important that nutrition support goes beyond just providing sufficient calories and looks to provide all the relevant nutrients that should be contained in a nutritionally complete diet. A management care plan aims to provide this and identified condition specific circumstances and associated needs linked to nutrition support requirements. A nutritionally complete diet can improve speed of recovery and contribute to reducing admissions to hospital and length of hospital stays'.

Quality Statement 5: Review states '*people receiving nutrition support are offered a review of the indications, route, risks, benefits and goals of nutrition support at planned approach. People's nutritional status is affected by a number of different factors and can therefore change rapidly. Regular review of the nutrition support care plan by a care professional enables the plan to be adapted to best meet the current needs of the person'.*

14. I have considered the following extracts of the Trust's nutrition policy:
Section 8.1 '*All patients will be screened on admission or at an opportunity within 24 hours to assess their nutritional status using MUST'.*

Section 8.2 '*Robust plans of care will be developed for those deemed at nutritional risk. These will include advice and support by appropriate members of multi disciplinary team'.*

Section 8.3 *'All patients remaining in hospital for more than one week will be re-screened as per MUST'.*

[4] '**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.

Section 8.8 '*Appropriately modified or fortified diet or oral nutritional supplements will be available for patients who require these, following assessment by speech and language therapist and dietician'.*

Section 8.21 '*Standardised food and fluid charts will be utilized to document fluid and nutritional intake in those patients deemed at hydration or nutritional risk'*.

Appendix 1: '*Patients who require nutritional intervention will have a nursing care plan devised, implemented, evaluated and renewed to reflect the patients nutritional and physical care needs and which documents both the dietetic plan and the nursing care assessment…Patients who require food and/or fluid intake to be monitored will have that activity carried out in a way that is informative, accurate and up to date'.*

15. I have considered the following extracts of the Trust's recording fluid, prescription and balance charts policy:
Section 4.10 '*oral intake will be recorded contemporaneously. Cumulative totals will be maintained when indicated by the clinical condition of the patient or, as prescribed'.*

Section 4.11 '*All patients receiving intravenous fluid must have their input measured and recorded on the fluid prescription and balance chart'.*

16. I have considered the following relevant extracts of the Dietetics access criteria:
'*Referral sources for adults and children can come from:*

- *Medical staff*
- *Specialist teams*
- *GP's*
- *Practice Nurses*
- *Other health and social care professionals*
- *Dentists*
- *Dieticians from acute sector to community and vice versa*
- *Health visitors*
- *District nurses*
- *Community children's nurses*

Referral criteria – adults

1. Obesity

2. Nutritional Support (b) BMI<18.5 or (c) Unintentional weight loss of 10% or more over the previous 3-6 months

3. Diabetes

4. Cardiovascular disease risk prevention

5. Gastro-intestinal disorders

6. Renal disease

7. Malabsorption syndromes/food intolerances

8. Dietary assessment related to vitamin and mineral deficiencies

9. Dietary assessments to assist in the diagnosis of a food intolerance'

17. I have considered the Trust's Adult Pressure Ulcer Risk/Skin Assessment Chart which states: '*Braden Score – if the patient scores 18 or below OR they already have a pressure ulcer, a pressure ulcer prevention/management care plan must be completed. Reassess if the patient's condition deteriorates, otherwise reassess at least weekly in acute care, monthly in continuing care and 6-8 monthly in community'.*

The Trust's response to investigation enquiries

18. In response to investigation enquiries about the patient's nutritional care and treatment, the Trust state '*[the patient's] appetite was poor but she was offered food and fluids at all mealtimes when she was alert to eat and drink safely. Nursing staff were concerned [the patient] was not eating enough and commenced a food record chart on 10 August 2014 to monitor intake. Intravenous[5] (IV) fluids were prescribed and administered to maintain fluid balance. Daily blood tests were analysed and electrolytes were replaced as indicated. Potassium was replaced both intravenously and by oral medication. Vitamin supplements were also prescribed'*.

19. The Trust state '*A MUST assessment was completed on the patient's admission on 5 August 2014. The patient's MUST score was 0 (low risk). On the*

[5] existing or taking place within, or administered into, a vein or veins.

MUST chart the recommendation for this score is a well-balanced diet and weekly screening. The patient's nursing documentation care plan on 6 August 2014 at 01:20 states she should be assisted with diet and encouragement of oral fluids. The patient's oral and intravenous (IV) fluid intake and urinary output were monitored and recorded on her daily fluid balance chart as per her nursing care plan. IV fluids were prescribed and administered. The patient was offered food and fluids at all mealtimes when she was alert enough to eat and drink safely with encouragement and assistance given as required.

20. The Trust also state *'there were initially no concerns regarding food intake as the patient's MUST assessment on 5 August had identified and scored her as low risk 0. On 6 August 2014, it is documented on [the patient's] fluid balance chart that she took 200mls of soup. The care plan daily evaluation sheet records on 8 August 2014 at 17:35 states [the patient] was "tolerating good diet and fluids needs prompted and arms a bit shakey and minimal required and given". It is recorded on 9 August 2014 that [the patient's] appetite was poor and she was encouraged to take fluids. Food charts were commenced on 10 August 2014 and [the patient] was referred to the dietitian on 12 August 2014. [The patient] was commenced on a food record chart on 10 August 2014'.*

21. '[*The patient] was referred to the dietitian on 12 August 2014. The dietitian assessed the patient's oral intake, requirements calculated and deficit highlighted. The dietitian put a plan in place that reflected poor oral dietary intake and attempt to meet the deficit. Nutritional supplements were prescribed and commenced with a number of different high calorie and protein supplements being tried to improve oral intake. On 22 August 2014 once it was established that oral intake was optimised within the acute setting and still insufficient, discussions began and continued with the medical team with regard to more aggressive nutritional support, i.e. the appropriateness of enteral (NG) tube feeding[6]. A feeding tube was placed on 1 September 2014. Unfortunately, the patient pulled out the tube at this time. The patient continued to be nil by mouth (NBM). The tube was then reinserted 3 September 2014 and again NG tube feeding was commenced*

[6] [6] A **nasogastric tube** (**NG tube**) is a special **tube** that carries food and medicine to the stomach through the nose. It can be used for all feedings or for giving a person extra calories.

slowly'. The Trust further stated '[*The patient] was referred to nutrition and dietetic team on 12 August 2014 and was assessed on 13 August 2014. The dietician advised prescribing nutritional supplement forticreme*[7] *and consider IV pabrinex*[8] *which was prescribed and administered from 26 August 2014. [The complainant] was present during the assessment and was informed she could bring in food her mother preferred if it was not possible for this to be obtained from the hospital kitchens.* The Trust further confirmed '*the dietician reviewed [the patient] on 22 August 2014 and documented in the medical notes that oral intake was poor secondary to drowsiness. [The patient] was identified as being a potential risk from re-feeding syndrome*[9]*. Additional food supplement of fortisip compact*[10] *was recommended and provided'*.

22. In response to investigation enquiries regarding [the patient's] SALT referral and assessment, the Trust state '*It is documented in the nursing notes that [the complainant] was observed trying to give her mother food when drowsy and a referral for speech and language team (SALT) was made on the 27 August 2014 as the nursing and medical staff were concerned that [the patient] was aspirating. A blood test showed her inflammatory markers were increasing and a chest x-ray showed deterioration in [the patient's] lung fields. [Respiratory Consultant] advised to keep [the patient] nil by mouth until her swallow was assessed by the speech and language team. The SALT documented in the notes that nursing staff reported they were concerned that [the patient] was aspirating*[11] *and had been eating and drinking minimal amounts. It is also documented that [the patient] was drowsy when examined but opened her eyes to voice but became drowsy quickly. There was an attempt to use tactile stimulation to rouse her but she remained very sleepy. A half teaspoon of fluid*

[7] **Forticreme** Complete is a Food for Special Medical Purposes for use under medical supervision. **Forticreme** Complete is a nutritionally complete, high energy, high protein, dessert style nutritional supplement. It contains 200kcals and 12g protein per 125g serving and contains added vitamins, minerals and trace elements.
[8] **Pabrinex**® is an injection that contains vitamins B and C (thiamine, riboflavin, pyridoxine, nicotinamide and ascorbic acid). It is used to treat symptoms that can be caused by a lack of these vitamins.
[9] **Refeeding syndrome** is a **syndrome** consisting of metabolic disturbances that occur as a result of reinstitution of nutrition to patients who are starved, severely malnourished or metabolically stressed due to severe illness. ... Cardiac, pulmonary and neurological symptoms can be signs of **refeeding syndrome**.
[10] **Fortisip Compact** is a Food for Special Medical Purposes for use under medical supervision. **Fortisip Compact** is a nutritionally complete.
[11] Aspiration means you're breathing foreign objects into your airways. Usually, it's food, saliva, or stomach contents when you swallow, vomit, or experience heartburn. This is common in older adults, infants, and people who have trouble swallowing or controlling their tongue.

was placed on [the patient's] lips to determine if increased stimulation would rouse her but this was unsuccessful. SALT recommended nil by mouth due to [the patient's] level of alertness with the plan to repeat assessment the next day'.

23. The Trust further state '*Respiratory consultant met with [the complainant] on 28 August 2014 to update her on her mother's condition and to answer any concerns she had. The [respiratory consultant] documented in the medical notes on 1 September 2014 that she had spoken with the complainant and following a SALT review, their advice was that her mother was to be NBM, then NG would have to be considered. The following day on 29 August 2014 at 12:50 the SALT was bleeped to come to the ward as [the patient] appeared more alert. [The patient] was assessed with her granddaughter present. When examined by the SALT there were variable levels of alertness and [the patient] required regular prompting throughout. Speech intelligibility was also variable. [The patient] was trialled with four sips of water and two teaspoons of yoghurt. She declined further trials.*

24. *[The patient's] ability to manage food in her mouth was assessed but she was unable to control the food or fluids and there was evidence of drooling and the food or fluids remaining in her mouth. When she tried to swallow, it was generally very slow, weak and in-coordinated. She did not cough when swallowing which would indicate that food or fluids were going down the wrong way but the SALT was concerned regarding possible silent aspiration due to presentation. She was also swallowing air and burping. SALT were unable to make definitive recommendations based on these limited trials and suggested consideration of nasogastric tube to allow for stable nutrition whilst swallowing assessment completed with a plan to review on the following Monday'.*

25. The Trust also advised '*on 1 September 2014 at 11.25am, [the patient] was reviewed again by SALT but was too drowsy. She responded with attempted vocalisation but then went back to sleep unfortunately the SALT assessment was incomplete. Their recommendations was that [the patient] continued to be NBM with regular mouth care and consider a NG tube. The assessment and recommendations were discussed with the medical and nursing team with the*

plan to review and if [the patient] became more alert they were to be contacted again. A further SALT assessment on 2 September 2014 at 9.20 which documents further attempts to rouse/ assess [the patient] at different times of day but was unsuccessful. Advice again was given to nursing staff to contact the SALT if more alert and the plan was again to review. A NG tube was inserted and feeding was commenced on 3 September 2014. On 5 September 2014 at 09.15 it is documented that [the patient] continues to be drowsy and her prognosis poor. SALT discussed with medical staff and advised that patient would be reviewed on request of the ward'.

26. In response to investigation enquiries regarding [the patient's] bed sores, the Trust state '[*The patient] had a braden pressure damage risk assessment*[12] *completed. On admission 5 August 2014 it is scored at 15 so [the patient] was nursed on atmosair pressure relieving mattress*[13]*. [The patient's] skin assessment on admission has documented a bruise to right hip and that both groins were excoriated. Unfortunately, [the patient] lay at home on the floor for approximately 10 hours. [The patient] was commenced on a repositioning chart and skin bundle on 5 August 2018. Her skin bundle chart records that despite advice, [the patient] was reluctant to lie on her side to relieve pressure on her sacrum. A grade two pressure damage to left buttock is recorded on 8 August 2018 which improved following application of duoderm*[14] *dressing. [The patient] was further assessed and her care plan updated on 20 and 27 August 2014. Her initial risk braden score of 15 had not changed but as her nutritional intake was still poor she was transferred to an autologic mattress*[15] *to provide additional pressure relief.* The Trust confirmed a braden score of 15 means *'a pressure ulcer prevention/management care plan must be completed and reassessed if a patient's condition deteriorates, otherwise assess weekly'.*

[12] The **Braden** Scale for Predicting **Pressure Ulcer Risk**. The purpose of the scale is to help health professionals, especially nurses, **assess** a patient's **risk** of developing a **pressure ulcer**
[13] **AtmosAir Mattress** Replacement System is a self-adjusting **pressure** redistribution system that offers advanced features and benefits to provide clinically non-powered **pressure** redistribution. **AtmosAir Mattress** Replacement System is indicated for the prevention or treatment of **pressure** ulcers
[14] Duoderm dressing hydrocolloid dressing is an opaque or transparent dressing for wounds.
[15] The **Auto Logic** pump uses Self Set Technology (SST) to regularly assess the resident's/patient's body mass distribution and readjusts cell air pressures to meet their specific needs ensuring optimum pressure area management.

27. The Trust confirmed *'this is the only area of pressure damage [the patient] had between 5 August 2014 and 7 September 2014. Duoderm was applied at 05:00 on 8 August 2014 once. According to [the patient's] skin bundles, she was repositioned two to four hourly. However, on occasions it is documented she refused to lie on her side and was non-compliant with pressure relief advice.* The Trust also confirmed *[the patient] was not referred to a Tissue Viability Nurse (TVN) between 5 August 2014 and 7 September 2014 as TVN input was not required at this time. Nursing staff receive training in the management and prevention of pressure damage and have the autonomy to manage pressure damage grade 3 or less. Staff would only refer grade 2 pressure damage to TVN if they were concerned'.*

28. The Investigating Officer made enquiries of the Trust in regards to [the patient's] mobility between 5 August 2014 and 7 September 2014. The Trust state *'[the patient] was very ill on admission and was not medically well enough to get out of bed. She required noninvasive ventilation[16] (NIV) with continuous oxygen therapy and cardiac monitoring. [the patient] showed signs of delirium and was non-compliant with wearing her Airvo[17] and oxygen masks. Unfortunately, this caused her blood oxygen levels to fall to unsafe levels and increased her drowsiness. [The patient] was referred to a physiotherapist who made an initial assessment on the 7 August 2014 and documented that [the patient] would be mobilised when she was fit to do so. [The patient] had a urinary catheter in place to monitor her urinary output. Unfortunately, her condition meant that she required to use a bedpan but on occasions when [the patient] was well enough to sit out of bed, a commode was available'.*

29. In response to investigation enquiries regarding the patient being administered haloperidol on 10 August 2014, the Trust state '*At times [the patient] would be non-compliant with wearing her airvo mask. Alternatives such as nasal cannula were trialled but this method of oxygen delivery was not sufficient in giving her an adequate oxygen supply. The oxygen levels parameters for [the patient] set by the*

[16] **Noninvasive ventilation** (NIV) refers to the administration of ventilatory support without using an invasive artificial airway (endotracheal tube or tracheostomy tube)
[17] The **AIRVO** is a humidifier with integrated flow generator that delivers warmed and humidified respiratory gases to spontaneously breathing patients.

medical staff was to be kept above 92%. [The patient's] levels, desaturated to 76% at times due to her non-compliance with the oxygen masks. To decrease [the patient's] anxiety and to ensure she kept the mask in place, the medical staff prescribed haloperidol 1.5mg. This was administered on 10 August 2014 at 02:35, as she was agitated showing signs of hypoxia[18]. [The complainant] was informed the following day that her mother had received a sedative halperidol and she then requested her mother did not receive any further sedation. Taking into consideration [the complainant's] request, additional staff were sourced to provide 1 to 1 supervision for [the patient'].

30. In response to investigation enquiries regarding the patient's antibiotics being changed, the Trust clarified '*[the patient] initially responded well to the first antibiotic but unfortunately her inflammatory markers (CRP)[19] continued to rise. A portable chest x-ray was carried out on 10 August 2014 and while there was some improvement to the right chest, there was worsening left midzone consolidation. Respiratory consultant prescribed intravenous meropenum[20] on 10 August 2014. Specialist input was requested from the microbiology team if this was appropriate and if intravenous antibiotic therapy should continue. Microbiologist advice was to continue with intravenous meropenum for a further 48 hours from 11 August 2014 and monitor patient closely'.* The Trust further stated *'Respiratory consultant and the ward Sister spoke with [the complainant] on 11 August 2014 to explain that a new antibiotic had been started'.*

Clinical Records

31. I considered the following relevant extracts from the patient's clinical records:1

5 August 2014: A MUST screening exercise completed…. *'score 0':* A daily fluid balance and prescription chart was commenced and completed daily: The nursing assessment and plan of care was completed. The record states '*nutrition and hydration, appetite poor, does not require assistance with eating and drinking,*

[18] **Hypoxia** is a condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level

[19] **C-reactive protein** (**CRP**) is a blood test **marker** for **inflammation** in the body. **CRP** is produced in the liver and its level is measured by testing the blood. **CRP** is classified as an acute phase reactant, which means that its levels will rise in response to **inflammation**

[20] **Meropenem** is used to treat a wide variety of bacterial infections. This medication is known as a carbapenem-type antibiotic. It works by stopping the growth of bacteria

condition of mouth dry, patient usually able to feed herself' no fluid restriction, no difficulty swallowing, no SALT referral, no vomiting, no nausea, according to family patient able to walk but mobility has been deteriorating…..condition of skin on admission 'intact, sacrum slightly red, both legs slightly swollen': An adult pressure ulcer risk/skin assessment chart was carried out…*'braden score 15'.* A 24 hour skin bundle chart was commenced and completed every 2-4 hours. Falls risk assessment completed. Moving and handling assessment completed.

6 August 2014: '*Administer IV fluids as prescribed correct rate and type of fluid, administer IV antibiotics correct dose, time and route to [the patient], monitor cannula site ensure infection free, re-site 72 hourly, record fluid balance chart and report any issues with positive negative balance, monitor urine output hourly, monitor for signs of infection and report to medical team i.e. temp…promote oral intake to prevent dry mouth, measure [the patient's] urine output hourly at this time…assist [the patient] with personal care daily, providing a bed bath when unwell at this time, monitor skin areas and encourage pressure areas, re-position 4-6 hourly while bed bound, encourage back to baseline when improving and encouraging independence, assist [the patient] with diet and push oral fluids'.*

7 August 2014: Physiotherapist carries out mobility assessment.

8 August 2014: 24 hour skin bundle care plan completed '*Duoderm applied to grade 2 left buttock'.*

10 August 2014 – 27 September 2014: A food chart was commenced and completed daily: '*very aggressive, violent and abusive to staff, cardiac monitor removed as per patient wrapping it around hand and neck…IV paracetamol given and halepordol given to try and settle patient but unsuccessful….daughter would prefer to be called if patient aggressive rather than injections given….patient says she feels much better this morning…daughter feels her mother is much better this morning…some agitation last night, haloperidol given….patient pulled out cannula…only half IV replacement received…refusing oral supplementation…daughter on way…explained to patient how critically low her potassium is and she could become critically unwell, refusing any further bloods/IV access…will reattempt further oral supplementation and to gain further access when daughter present':* 24 hour skin bundle care plan completed.

11 August 2014: '*CRP slow to settle, changed to meropenum….discussed with microbiology today':* '*advised that Tazocin*[21] *would have been the ideal option but to continue with meropenum for 48+ hours and monitor patient closely, if failure to improve clinically re-contact again'*: Physiotherapist mobility assessment carried out. 24 hour skin bundle care plan completed.

12 August 2014: 24 hour skin bundle care plan completed.

13 August 2014: A MUST screening exercise completed, recommended full MUST assessment repeated weekly: '*Nutrition and dietetics referral received, thanks re poor oral intake…estimate nutritional requirements – 1700kcal*[22]*, 84grams protein…very poor oral reported since admission, 200 kcal, 2grams protein, patient confused during dietetic assessment…spoke to patient's daughter who reports good oral intake at home…nurses report patient refusing some medication including electrolyte replacement…patient may be at risk of re-feeding syndrome…aim minimize losses in lean body mass, meet nutritional requirements…nurses have trialled patient with nutritional supplements and she refused all drinks…trialled forticreme this morning and tolerating some…plan, if not tolerating oral medication suggest IV pabrinex for ten days prior to supplements, complete food charts, forticreme x3 (600kcal, 36 grams protein), new weight please, encourage oral intake, daughter to bring in snacks, monitor bowels, fluid':* 24 hour skin bundle care plan completed '*bed sore shaped grade 1 pressure ulcer access buttocks'.*

14 August 2014: 24 hour skin bundle care plan completed: '*discussed with microbiology, they advised stopping antibiotics'.*

15 August 2014: *'stable stopped antibiotics yesterday, no further spikes, comfortable less agitated': 'unable to complete functional assessment at this time as patient sleeping and not currently medically fit….will complete care management form and functional assessment as able…Unable to complete physiotherapy mobility assessment for care as patient sleeping':* 24 hour skin bundle care plan completed.

16 August 2014: *'patient 80mls today, catheter flushed….input 525 mls orally…push oral fluids':* 24 hour skin bundle care plan completed.

17 August 2014: '*feels thirsty this morning (16 August 2014 975 mls in and 250 mls*

[21] **Tazocin** is an IV antibiotic that is given via drip to treat serious bacterial infections such as pneumonia
[22] **kcal** to Cal - small kilocalories to large calories. One large food calorie is equal to 1 small **kcal**: 1 Cal = 1 **kcal**.

out), catheter concentrated urine…generally reports feeling well this morning….encourage oral fluids': 24 hour skin bundle care plan completed.

18 August 2014: '*600-800 mls orally/daily'.*

19 August 2014: '*patient generally weak, not fit to mobilise further today….pleasantly confused throughout assessment': 'aim for 600-800 mls orally….out sitting in chair…denies any pain, eating and drinking'.*

20 August 2014: An adult pressure ulcer risk/skin assessment chart was carried out…*'braden score 15':* '*push oral fluids, aim for at least 600-800 mls daily':* '*indicated for cardiac disease with heart failure confusion and agitation…oral intake 350 mls'.*

22 August 2014: *'patient increasingly confused today, lying in bed….doctor feels she is dehydrated…fluids 500 mls over 2 hours then 500 mls over 4 hours': patient very drowsy today….food charts indicated very poor oral intake…nurses report managing only spoonful's of meals and forticreme….patient may be at risk of re-feeding syndrome….suggested the patient trial nutritional supplements and drinks…although they were refused previously by the patient, they may help with fluid intake if tolerated…aim to minimize losses in lean body mass, prevent re-feeding risk': ''vulnerable adult situation…dehydration…poor oral intake…fluctuating confusion….patient lacks capacity…patient quite drowsy and disorientated'.*

23 August 2014: 24 hour skin bundle care plan completed.

24 August 2014: 24 hour skin bundle care plan completed

25 August 2014: *'70 mls oral input so far, refusing drinks…confused in bed, alert responds to voice': 'patient was commenced on IV fluids yesterday due to poor oral intake. Patient remains agitated and confused during review':* 24 hour skin bundle care plan completed.

26 August 2014: *'oral intake remains poor…nurses report patient has been very drowsy, has been refusing meals and forticremes':* '*currently [the patient] is not medically fit to transfer out of bed with physiotherapy or nursing staff. [The patient] was repositioned upright in bed with assistance of three'*: 24 hour skin bundle care plan completed.

27 August 2014: '*patient medically unfit to mobilise with physio or sit out of bed':* An

adult pressure ulcer risk/skin assessment chart was carried out…*'braden score 15'.* 24 hour skin bundle care plan completed. Falls risk assessment carried out. Moving and handling assessment carried out….A MUST screening exercise completed…. '*score 2':* '*patient's daughter [the complainant] was present during review. I provided daughter with an update on patient's clinical condition. I explained that she was nil by mouth at present until SALT review…daughter happy with above'.*

28 August 2014: '*The patient's daughter [the complainant] who is concerned regarding patients care and condition requested to see me alone and did not want other medical staff/nursing staff present. Updated on patients medical condition and admitted with chest infection/fast heart rate, heart failure. Treated with IV antibiotics, diuretics but condition has not improved…patient is weak, frail, concern regarding swallowing, awaiting SALT, recent chest x-ray shows shadowing …fluid….infection…poor urine output, getting IV fluids….explained [the patient] remains very ill and would not be fit for discharge, prognosis guarded under daily review by medical team*….': '*SALT referral received with thanks…concerns regarding aspirating yesterday and until then had been eating minimal amounts….drowsy today…attempted to rouse with stimulation, unresponsive, given half teaspoon of fluid on lips to see if stimulation could raise patient – unsuccessful, fluid ran of lips, patient unaware, not appropriate for assessment today…continue nil by mouth':* 24 hour skin bundle care plan completed.

29 August 2014: *'bleeped to review patient by ward as alert…variable level of alertness…required regular prompting throughout…incoherent speech…occasional intelligible speech when declining further trials…SALT unable to make definitive recommendations based on such limited trials. SALT would support possible NG tube consideration to allow for stable nutrition whilst further swallow assessments are conducted…recommend NGT feeding to allow for stable nutrition': 'Several attempts to rouse patient for assessment…continues to drowsy for swallow assessment…nil by mouth…decisions regarding NG feeding':* 24 hour skin bundle care plan completed.

30 August 2014: 24 hour skin bundle care plan completed.

31 August 2014: 24 hour skin bundle care plan completed.

1 September 2014: *'Respiratory consultant updated patients daughter [the*

complainant] of the plan from today's ward round. Respiratory consultant explained the importance of nutrition considering patients poor clinical state. If SALT advise nil by mouth we need to consider NG feeding. Respiratory consultant explained to The complainant that her mother remains very unwell. [The complainant] happy with current assessment plan': 'patient remains drowsy, opening eyes but non compliant…not fit to sit out at present': 'estimated weight 65kg, BMI[23] 24.5kg, estimated nutritional 1595 kcal, 81 grams protein…patient has been NBM for five days and had very little nutrition for at least 7 days prior to this…..I therefore suggest to commence on slow rate of feed (ie 5kcal 1kg)…with NG placement….aim minimize losses in lean body…plan once safe to NG feed, suggest nutrition protein plus @15ml ltr x 20 hrs….increase rate daily as per NG feed regime depending on tolerance…aim for full rate of NG feed of 64 ml x 20 hrs nutrition protein plus…..flush NG tube': 24 hour skin bundle care plan completed.

2 September 2014: '*[The patient] pulled NG tube out before feeding regime could commence…patient not fit to sit out at present': 'patient continues to be too drowsy for SALT swallow assessment. Attempts today to raise unsuccessful…note NG tube placed but pulled out prior to any feeding….patient pulled out NG tube, not tolerated….also pulling out cannulas repeatedly':* 24 hour skin bundle care plan completed.

3 September 2014: '*trial of further NG tube…four attempts at IV cannula….unsuccessful….refer palliative care team….repass NG tube':* 24 hour skin bundle care plan completed.

4 September 2014: '*NG tube inserted last night and patient tolerated six hours feed…nurses report no IV access at present': 'Respiratory consultant updated patient's daughter (The complainant) this morning after the ward round. Respiratory consultant informed [the complainant] that her mother's prognosis is poor. Respiratory consultant advised that we would continue with NG feeding and NG antibiotics while NG tube is in. However, if NG tube dislodges, we would be focusing on [the patient's] comfort. Respiratory consultant explained that despite review with antibiotics and nutrition that [the patient] may not survive. [The complainant] appeared content with current assessment plan':* 24 hour skin bundle care plan

[23] an approximate measure of whether someone is over- or underweight, calculated by dividing their weight in kilograms by the square of their height in metres.

completed.

5 September 2014: 24 hour skin bundle care plan completed.

6 September 2014: *'Met daughter [the complainant] explained oxygen requirements have increased this morning and patient is working very hard to breathe….whilst stats have improved this is the maximum amount of O_2 we can give her mother…[the complainant] was hopeful that NG feeding and antibiotics via NG tube would "revive" her…I explained that she hasn't responded as well as team had hoped and her current status is more towards end of life and comfort care. [The complainant] admits and agrees that she doesn't want her mother to suffer however she is still hopeful she may recover…however priest in attendance and has given last rights'.*

32. I examined correspondence from the Trust to the complainant on 4 April 2016 which states '*meals were always offered to your mother but she did not always feel like eating and would not always accept assistance. Patients who are very unwell would often have little or no appetite for food. A food intake chart was commenced on 10 August 2014 and fluid intake recorded on fluid chart. A referral was made to the dietician and your mother was seen on 22 August 2014. As the dietician discussed with you the initial selection of supplements were not to your mother's taste and these were replaced with drinks which she would take occasionally. Your mother was very drowsy at time due to her illness. There were times when it was unsafe to give her solids or fluids as she was at risk of not being able to swallow. Intravenous fluids were keeping your mother hydrated until her swallow was assessed. A referral was made to SALT on 27 August 2014 and she was seen on 28 August 2014 and again on 29 August 2014'.*

33. I examined correspondence from the Trust to the complainant on 2 July 2018 which states '*It is also documented in the notes on 6 August 2014 that you spoke with a specialist doctor[24] and specialist registrar[25] regarding the concerns you had about your mother's condition. The Specialist Doctor explained to you that your mother was confused because of hypoxia (low oxygen levels) and sepsis (infection). Unfortunately, you mother did not tolerate the oxygen mask and kept pulling it off.*

[24] A **specialist** is a **doctor** who is certified to practice independently in a specific area of medicine
[25] A specialist registrar is a doctor in the United Kingdom who is receiving advanced training in a specialist field of medicine in order to eventually become a consultant.

Your mother needed the oxygen as her levels were very low so the nursing staff had to ensure that your mother kept it on as her local levels of oxygen were making her confused and agitated. The service manager has also advised you that the specialist doctor telephoned you on 6 August 2014 at 14.00 although he had spoken to you earlier in the day, he was concerned that you did not realise how ill your mother was. He discussed with you how your mother was before coming into hospital, she lived in a bungalow with carers coming in to attend to her personal needs as she could not manage this herself and that she could only walk with her zimmer frame about 20-50 yards….your mother continued to become increasingly unwell and developed fluid on her lungs and was given medication to help relieve this: her antibiotics were also changed on several occasions'.

Independent Professional Advice

34. In relation to the patient's plan of care upon admission to the RVH on 5 August 2014, the CRM IPA advised '[*The patient] was admitted with a diagnosis of probably pneumonia and additional possible heart failure (retention of fluid). The plan of care was to treat her medical conditions. In terms of fluid management, [the patient] was noted to have a raised urea on admission indicating possible dehydration, she was treated with some intravenous fluids and this corrected very quickly'*. The CRM IPA confirmed '*The patient was drowsy on occasion and refusing a significant proportion of food when offered. There is a referral to the dietician service and [the patient] is seen on 13 August 2014, encouragement for oral intake is recommended. During the remainder of the hospital admission she has relatively poor oral intake, there is a brief period where she is documented to be eating and drinking, but there is an episode of probable dehydration at one point. Towards the end of her life an NG tube is placed for fluid, but prior to this she is maintained on intravenous fluid intermittently. It should be noted that [the patient] appears to be significantly unwell with raised national early warning score (NEWS)[26] throughout almost the whole of her admission'.*

35. In response to the Dietician and SALT referrals for the patient, the CRM IPA

[26] The National Early Warning **Score** (**NEWS**) determines the degree of illness of a patient using six physiological findings and one observation.

advised '[*The patient] is significantly unwell with her medical conditions throughout the hospital admission. I do not think that there was any particular delay with respect to referral to dietician. Ill patients do not usually eat much, there is no role for forced feeding and it is usual to allow improvement due to treatment of medical conditions and then observe if the feeding returns after this. If it does not then further intervention is usually required – calorie drinks, NG feeding etc'*. Furthermore, the CRM IPA advised '*there was no SALT delay identified, this was carried out when there were suspicions that swallowing might have been a problem, SALT review identified possible but not definite silent aspiration'.*

36. In response to the patient being placed on NG feeding, the CRM IPA advised it was appropriate and reasonable to commence the patient on NG tube feeding stating '*The commencement of NG tube feeding is a collective decision of the ward multi disciplinary team. Inevitably the consultant in charge of the patient (with their name attached to the patient's case record) carries the ultimate responsibility for this. In this case there is input from relevant professionals including dietician, medical doctors, nurses on the ward and the SALT team. This was first inserted on the 1 September 2014. There had been discussion of the NG tube with Respiratory consultant and the patient's family….she had been in hospital for some time, her oral intake was poor and there was concern about both venous access and aspiration'.*

37. In relation to whether the patient's nutritional care and treatment and fluid management was appropriate and reasonable, the CRM IPA advised *'from a medical perspective yes, on admission she was very unwell – she had heart failure and therefore care over her fluid balance was essential. She never became significantly dehydrated (as assessed by her blood tests (urea and creatinine)'.*

38. In relation to the patient's nutritional and fluid management care plan, the N IPA advised '*a MUST assessment was completed on 5 August 2014 and 13 August 2014. Fluid management charts were commenced on 5 August 2014 until 5 September 2014. These charts were not always completed in full, the main missing records were the totals of input and output for each 24 hour period. Food charts were commenced on the 10 August 2014 until the 2 September 2014 according to the records submitted. Some data was missing but they were mainly fully completed'.*

39. In response to enquiries made in regards to the adequacy of the patient's nutritional and fluid management care, the N IPA advised '*from the records reviewed adequate care was taken with fluid and food management. It appears, according to the records very challenging as [the patient] was unwell and often did not want to take fluid or food orally. Intravenous fluid was prescribed and dietician input is clearly documented with supplements prescribed. An NG tube was also placed on the 1 September 2014 to supplement her diet but also because of inability to swallow adequately due to drowsiness'.*

40. The Investigating Officer made enquiries of a dietitian IPA in regards to the patient's nutritional and fluid management care plan. The D IPA advised '[*The patient] was referred to the dietetic department on 13 August 2014. This referral was made by nursing staff. It is documented in the dietetic notes that the referral was made following [the patient's] daughter expressing concerns regarding her mother's poor oral intake. Evidence of referral is documented in nursing notes on 13 August 2014'.* The D IPA also advised '[*The patient] was seen for initial dietetic assessment on 15 August 2014. She also had subsequent dietetic reviews and updated dietetic notes on 21 August 2014, 22 August 2014, 26 August 2014, 27 August 204, 28 August 2014, 29 August 2014, 1 September 2014, 2 September 2014, 3 September 2014, 4 September 2014 and 5 September 2014'*.

41. The D IPA advised '*All dietetic care was reasonable and in-line with national guidance. The dietitian correctly identified that [the patient's] nutritional intake was inadequate and made appropriate suggestions to improve her nutritional intake initially though the use of oral nutritional supplements, and later NG feeding. The dietitian's suggestions were limited by [the patient's] deteriorating ability to swallow, and her later deteriorating clinical condition. However all actions suggested by the dietitian were clinically appropriate in trying to support [the patient's] nutritional intake during this time'*. The D IPA concluded *'all dietetic interventions and recommendations clinically appropriate and in-line with national guidance. Dietetic documentation is to an excellent standard'.*

42. The Investigating Officer made enquiries of a speech and language therapist IPA in regards to the patient's SALT care and treatment. The SALT IPA advised '*SALT*

documents that they receive the referral on 28 August 2014 at 11:45….the first mention of SALT referral is on 27 August 2014 and [the patient] was first seen by SALT on 28 August 2014, so this would suggest a good standard of service'. The SALT IPA confirmed '*attempts were made to assess/review [the patient] on 28 August 2014, 29 August 2014, 1 September 2014, 2 September 2014 and 5 September 2014. On 5 August 2014 the SALT documents that she will place her on review by request only as [the patient] had been too drowsy for assessment on prior attempts on 1 September 2014 and 2 September 2014'*. The SALT IPA confirmed '*SALT attempted to assess [the patient] on at least five occasions within the time frame identified. It may be that there are more occasions because on 2 September 2014, the SALT documents that "further attempts to rouse/see patient at different times of the day continue to be unsuccessful". It is not clear whether these are attempts by the ward staff to rouse the patient or whether the SALT has visited the ward on several unsuccessful occasions'.*

43. The SALT IPA confirmed '*on 29 August 2014 the SALT specifically documents that "SALT unable to make definitive recommendations based on such limited trials. SALT would support possible NG tube consideration to allow for stable nutrition whilst further swallow assessments are conducted"*. The SALT IPA advised '*on 1 September 2014 the SALT is not able to provide a full SALT care plan she advises care staff continue with nil by mouth, await decision regarding NG placement and provide regular mouthcare. In the context of being unable to complete adequate assessment of eating and drinking, in my opinion these are appropriate recommendations….given the evidence provided in the SALT records the SALT input/approach appears appropriate and reasonable'*. The SALT IPA further advised '*regardless of process, the NG tube was placed on 3 September 2014. The SALT engaged in discussion with the medical and nursing team, and this is specifically documented on 28 August 2014, 1 September 2014 and 5 September 2014. It is my opinion that the care provided by SALT to [the patient] was appropriate and reasonable and any further detail in the case notes with respect to this point would not have altered her care and treatment, it would just have provided further clarity when reviewing this case. It is my conclusion that the SALT provided care that was within in the boundaries of appropriate and reasonable, and she made multiple attempts to assess [the patient] from the point of referral to her death'.*

44. The Investigating Officer made enquiries regarding the patient's bed sores. The N IPA advised '*There is documentation of one pressure sore in the time specified this is documented on the 8 August 2014 and the 13 August 2014. Charts of the 24 hour skin bundle care plan were commenced on the 8 August 2014…the charts are not completed for each day from the 8 August 2014 but on those provided there were no changes from the pressure ulcers (PU) on the 8 August 2014 until the 13 August 2014 after this time it appears her pressure areas were intact.* The N IPA advised '*the care plan specifies repositioning and changes for 2-4 hour periods to 4-6 hour periods….not all records were completed'.* In response to enquiries made regarding a referral to a TVN, the N IPA advised '*there was no referral made to TVN but this would not occur as usually grade 3 or below is managed by staff unless there are specific concerns that TVN input is required….so it was appropriate and reasonable not to refer to TVN'.* The N IPA concluded '*It seems the care and management was appropriate and reasonable….documentation is poor on some aspects, not all care bundles were completed and not all days'.*

45. In response to enquiries made regarding the patient's mobility, the N IPA advised '*Nurses can assess patient's ability to mobilise….all patients should be encouraged to mobilise but it is based on clinical judgement and a patient's ability. In the case of [the patient] she was very unwell drowsy and had a delirium which likely made her ability to mobilise very difficult. She had a falls risk assessment completed on the 5 August 2014 and a moving and handling assessment on the 5 August 2014 and the 27 August 2014.* The N IPA further advised '*[the patient] had assessments by physiotherapist and occupational therapist regularly and there is clear documentation of mobility assessments. Firstly on the 11 August 2014 then the 15 August 2014 each time she was not fit to mobilise and too unwell. On the 19 August 2014 she was assisted out of bed but was not able to mobilise and was too unwell risks were documented. On the 26 August 2014 she was assessed again and was not fir for transfers in and out of bed'*. The N IPA also advised '*it is not clear exactly how much [the patient] mobilised it seems very little according to the records, she was sat in the chair on some occasions. As above she was regularly assessed for her mobility assessments…from the records [the patient] was not prevented from mobilising'.*

46. The N IPA advised '*It is good practice to ensure patients are mobile providing risks and assessments have been conducted on their needs to mobilise. On occasions when a patient is trying to mobilise but is at risk of falls one to one supervision can be provided. In the case of [the patient] it appears she was too unwell and agitated to mobilise safely'*. The N IPA confirmed '*a catheter was inserted on the 5 August 2014 on arrival in the emergency department…this was replaced on the 11 August 2014…having a catheter does not prevent mobilisation of patients but I don't think that was the issue in this case'.* The N IPA advised *'the care and treatment of her mobility was reasonable and appropriate'.* The N IPA concluded '*[the patient] was very unwell when admitted to hospital and did not respond to treatment. It is clear from the documentation she was dying from her illness. There are documented conversations with her daughter but with reading through records it is difficult to ascertain how much was understood'.*

47. The Investigating Officer made enquiries about the patient being administered haloperidol. The CRM IPA advised '*the only dose of haloperidol given which I can see is on the 10 August 2014 (day 5 of admission). It is a sedative drug given for agitation in this situation. As she (The patient) was agitated and this is an indication for this drug, this appears appropriate'.*

48. In relation to the patient's antibiotics being adjusted between 5 August 2014 and 7 September 2014, the CRM IPA confirmed the patient had entries for the following antibiotics '*Co-amoxiclav[27], Tazocin, Clarithromycin[28], Amoxycillin[29] and Meropenem and Gentamicin[30]'.* The CRM IPA advised '*the changes (in antibiotics) as described were appropriate in my view, they responded to changes in clinical condition and there were discussions with microbiology at times in addition'*. The CRM IPA further advised the care and treatment in relation to the changes made to the patient's antibiotics '*was appropriate and reasonable and in line with good medical practice'.*

49. The CRM IPA concluded '*this lady was significantly unwell, and despite*

[27] **Co-amoxiclav** is an antibiotic and works by killing bacteria that cause infections.
[28] **Clarithromycin** film-coated tablets are indicated for the treatment of the following bacterial infections,
[29] **Amoxycillin** belongs to a group of medicines called penicillins. **Amoxycillin** is used to treat a range of infections caused by bacteria.
[30] Gentamicin is an antibiotic used to treat several types of bacterial infections.

treatment she never really improved during the month of her stay in hospital. She was treated with antibiotics and fluid balance for her heart failure, this latter aspect was managed well with no significant fluid depletion (dehydration) or overload. There were clearly differences of opinion between the medical team and the relatives of the patient'.

The Trust's response to Independent Professional Advice

50. The Investigating Officer provided the Trust with an opportunity to comment on the CRM IPA. N IPA, Dietician IPA and SALT IPA advice. The Trust stated '*all relevant staff have reviewed the IPA reports. The Trust accepts all IPA reports and would provide comment concerning the N IPA recommendations. The Trust fully accepts the [N IPA] recommendations concerning improved documentation for pressure area care and fluid balance charts and this is an area for improvement. The Trust does not agree with the recommendation concerning "decisions and communication about prognosis early on as there is evidence of numerous conversations with the daughter throughout her mother's inpatient admission concerning how ill her mother was. The Trust does appreciate that there may have been a lack of understanding/acceptance by [the complainant] concerning how ill her mother was. Primarily it is the role of medical staff to diagnose and to provide a prognosis and the CRM IPA in particular has noted "multiple discussions" with family". These are noted in the clinical records'.*

Responses to the Draft Report

51. The complainant provided a very detailed and extensive commentary on the draft report in which she indicated she does not accept the evidence provided by the Trust and the advice of the IPA's. I have considered the complainant's comments and where appropriate I have included these within the analysis and findings section of the report.

52. In response to the draft report, the Trust stated '*they fully accept the Ombudsman's report and recommendations. We await your final report before any action is taken'.*

Analysis and Findings

Nutritional care and treatment and fluid management

53. The patient complained that her mother did not receive adequate food and fluids during her admission to the RVH. I established the patient had a MUST assessment completed on 5 August 2014 and her score was 0 (low risk) which indicates the need for a well balanced diet and weekly screening. I note the patient's nursing person centred care plan recorded *'she should be assisted with her diet and encouragement of oral fluids'*. The Trust state there had initially been no concerns about the patient's food or fluid intake as her MUST assessment had scored '0' and confirmed that from 9 August 2014 the patient's appetite began to become poor and she was encouraged to take fluids and food charts commenced on 10 August 2014. I note the patient had a further MUST assessment completed on 13 August 2014 in accordance with section 8.3 of the Trust's nutrition policy. 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 inpatient'.*

54. The investigation established the patient was referred to a dietician on 13 August 2014 and subsequently assessed on 15 August 2014. I note the dietician put in place a plan of care for the patient to address the poor food and fluid intake and this included a number of nutritional supplements with high calorie and protein supplements. Upon examination of the clinical records, I note the patient was

assessed and reviewed by a dietician on approximately 12 occasions between 15 August 2014 and 7 September 2014. I also established the patient's dietician had concerns regarding her food and fluid intake which was considered to be '*poor secondary to drowsiness'.* This view was also supported by the patient's nursing team who had witnessed her being drowsy while the complainant had been attempting to feed her. In light of the nursing and medical teams concerns that the patient might be aspirating, a referral was made to SALT so her swallow could be assessed.

55. The investigation established that SALT assessed the patient on 28 August 2014 where attempts were made to stimulate her lips with food but this was unsuccessful. I note SALT put in place a plan of care that recommended and included nil by mouth until her level of alertness improved, daily reviews and possible NG tube feeding. Upon examination of the SALT records, I note SALT recorded '*when she tried to swallow it was very slow, weak and in-coordinated…she did not cough when swallowing which indicate food or fluids going down the wrong way…concerns regarding possible silent aspiration…cannot make a definitive recommendations based on limited trials'.*

56. I have considered the advice of the CRM IPA that '*plan of care was to treat her medical conditions….in terms of fluid management, she had a raised urea indicating possible dehydration, treated with intravenous fluids'* and '[*The patient] was very drowsy and was refusing a significant proportion of food when offered'.* I note and I accept the CRM IPA advice that '*[the patient] was significantly unwell.…I do not think there was any particular delay with respect to referral to dietician…there was no SALT delay identified'.* I note and accept the CRM IPA advice that care and treatment was appropriate and reasonable, particularly '*from a medical perspective yes, on admission she was very unwell, she had heart failure and care over her fluid balance was essential'.* I also note the CRM IPA highlighted that Respiratory consultant's decision to insert an NG tube had been discussed with her medical team and the complainant and that '*it was appropriate and reasonable to commence NG feeding'.*

57. I have also considered and I accept the N IPA advice that '*from the records reviewed adequate care was taken with fluid and food management. It appears,*

according to the records very challenging as [the patient] was unwell and often did not want to take fluid or food orally'. I note the N IPA highlighted '*fluid management charts were not always completed in full….. food charts commenced on the 10 August 2014…some data missing but they were mainly completed in full.*

58. In regards to this element of complaint, I have considered and I accept the D IPA advice that '*all dietetic care was reasonable and in line with national guidance. The dietician correctly identified that the patient's nutritional intake was inadequate and made appropriate suggestions to improve nutritional intake…all actions suggested by the dietician were clinically appropriate in trying to support the patient's nutrition intake during this time'.* I welcome the D IPA observation that '*dietetic documentation is to an excellent standard'* and wish to draw this to the attention of the Trust.

59. Furthermore I note the SALT IPA advice, I note the SALT IPA highlighted the records document on 2 September 2014 '*further attempts to rouse/see patient at different times of the day continue to be unsuccessful…it is not clear whether these are attempts by the ward staff to rouse the patient or whether the SALT has visited on several unsuccessful occasions*'. That said, SALT reviewed and assessed the patient on approximately five occasions between 28 August 2014 and 5 September 2014. I have considered and accept the SALT IPA advice that '*given the evidence provided in the SALT records.…it is my conclusion that the SALT provided care was within the boundaries of appropriate and reasonable and she made multiple attempts to assess The patient from the point of referral to her death'.*

60. I note in the complainant's response to the draft report, she disputes that her mother was given fluids by nursing staff or that her mother was unable to eat or drink due to swallowing problems. In particular, the complainant stated '*the nurses neglected her care in regards to her food and drink'* and the nurses are '*lying in their attempts to get her to eat and drink and the nurses repeatedly lied on the clinical notes on her mother's records'.* The complainant also strongly denies her mother was reviewed and assessed by a dietician and SALT and stated '*they [dietician and SALT] are lying in their clinical notes'*. Upon a detailed examination of the clinical records I have been presented with no evidence that support's the complainant assertion's that her mother was neglected by nurses in providing the patient with

food and drink. Furthermore, the clinical records confirm the patient was assessed and reviewed on multiple occasions by Dieticians and Speech and Language Therapist's. I have not identified any evidence that the assessments were untruthful.

61. Having considered all the evidence I am satisfied the patient was re-screened as per MUST and I consider this was carried out in accordance with NICE guidelines and section 8.1 of the Trust's nutrition policy. I also consider the Trust put in place a robust plan of care for the patient by referring her to a dietician and SALT. I am satisfied that following the assessment by the dietician and SALT, the Trust put in place an appropriately modified diet for the patient, in accordance with its nutrition policy. I consider the patient's nutritional care and treatment and fluid management was adequate. **Therefore, I do not uphold this element of the complaint.**

62. I recognise that the patient was very ill upon admission to the RVH on 5 August 2014. I accept the Trust's assertion that as fluid and food charts were initiated, she was offered food and fluids while she was alert enough to eat and drink safely and she was offered assistance as and when she required it. Unfortunately, the patient was extremely unwell and I am of the view that as her condition deteriorated so did her ability to safely consume appropriate food and fluids. I note the Trust's recording fluid prescription and balance charts policy states '*oral intake will be recorded contemporaneously….cumulative totals will be maintained'.* I have considered and I accept the N IPA advice that '*fluid management charts were not always completed in full….. food charts commenced on the 10 August 2014…some data missing but they were mainly completed in full.* In relation to record keeping, the NMC Code states '*keep clear and accurate records relevant to your practice, complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event'.*

63. I consider the failure of nursing staff to adequately complete the patient's fluid and food management charts to be a failure in her care and treatment and not in accordance with Trust policy. However, I do not consider the patient to have experienced an injustice as a result of this failure. I would highlight the Trust's acceptance of the N IPA's recommendation concerning '*improving documentation for*

fluid balance charts'. With that in mind, I would remind the Trust of the importance of ensuring that all fluid and food records are completed appropriately.

The patient's bed sores

64. The complainant said that her mother had developed bed sores while she was a patient in the RVH between 5 August 2014 and 7 September 2014. The investigation established that the patient had an adult pressure ulcer risk assessment carried out on 5 August 2014, 20 August 2014 and 27 August 2014. I note the patient had a braden score of 15 at each assessment and therefore in accordance with the Trust's adult pressure ulcer skin assessment chart, required a pressure ulcer management care plan.

65. The investigation established the patient had 24 hour skin bundle charts commenced and completed from 6 to 17 August 2014, 23 to 31 August 2014 and 1 to 6 September 2014 (all inclusive). Upon examination of the 24 hour skin bundle charts, I established the patient required treatment for a pressure ulcer on 8 August 2014 and 13 August 2014 and she was regularly assessed and re-positioned every 2-4 hourly and where applicable 4-6 hourly.

66. I note the complainant's response to the draft report stated her mother's *'nursing care had been appalling….she never knew about her mothers' bed sores and her mother was being treated inhumanely'.* However, upon examination of the Trust's complaint's file and the complaints form to this office on 11 October 2018, the complainant did complain about her mother having bed sores. Therefore, I can see no evidence that would support the complainant's assertions that she knew nothing about her mother having bed sores.

67. I have considered and I accept the N IPA advice that '*there is documentation of one pressure ulcer on the 8 August 2014 and 13 August 2014…there were no changes from the pressure ulcer on the 8 August 2013 until the 13 August 2014 and after this time it appears her pressure areas were intact'.* I also accept the advice of the N IPA that the care and management for the patient's pressure ulcers was appropriate and reasonable. I therefore consider the care and treatment in relation to the patient's bed sores to have been appropriate and reasonable and in

accordance with Trust guidance on adult pressure ulcer risk/skin assessments.

68. However, I have been presented with no evidence that 24 hour skin bundle charts were completed between 18 August 2014 and 22 August 2014. I have considered and I accept the N IPA advice that '*not all records were completed and documentation is poor on some aspects',* a view the Trust has accepted. I would also highlight the Trust accepts the N IPA recommendation concerning '*improving documentation for pressure area care'.* I consider the failure of nursing staff to complete 24 hour skin bundle charts for the patient between 18 August 2014 and 22 August 2014 to be a failure in her care and treatment and not in accordance with the NMC code in relation to record keeping '*keep clear and accurate records relevant to your practice, complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event'.* However, I do not consider the patient to have suffered an injustice as a result of this failure as the patient did not develop any bed sores during this time.

The patient's mobility

69. I note the patient had a falls risk assessment and a moving and handling assessment carried out by her nursing team on 5 August 2014 and 27 August 2014. I note the patient had a physiotherapist assessment performed on 7 August 2014 who advised that the patient should be mobilized when she was fit to do so. Upon examination of the clinical records, I established the patient was reviewed by a physiotherapist approximately 23 times between 7 August 2014 and 5 September 2014. I note the patient had mobility assessments performed on 11 August 2014 and 15 August 2014 where she was deemed not fit to mobilise. I also established that during this time the physiotherapist recorded on two occasions that the patient was feeling well and able to sit out of bed on the 18 August 2014 and 19 August 2014, however she was not fit to mobilise. The patient was further assessed on 26 August 2014 and assessed as not being fit to transfer out of bed and be mobile.

70. The Trust state the patient was very unwell when she had been admitted and considered to be medically unfit to get out of bed. I accept the Trust's explanation

that the patient was non-compliant with wearing her aviro and oxygen masks and had showed signs of delirium. I note the Trust state the patient had a catheter inserted and was required at times to use the bedpan.

71. The complainant has highlighted in her response to the draft report that her mother had been '*prevented from walking to the toilet and being mobile'* and that the nurses are '*lieing [sic] in the clinical notes'* regarding her mother's ability to be mobile. However, upon reviewing the clinical records, I can see no evidence that would support the complainant's claims that her mother was prevented from walking to the toilet or that she was not allowed by nursing staff to be mobile when she was fit and able to do so.

72. I have considered and I accept the N IPA advice that '[*the patient] was not prevented from mobilising'.* I am of the view that the patient was very unwell and incapable of being mobile given her condition and her resistance to wearing her aviro mask may have affected her ability to safely mobilse. I further accept the advice of the N IPA that '*the care and treatment of her (the patient's) mobility was reasonable and appropriate'*. Therefore, I do not find any failings in the care and treatment in relation to the patient's mobility. **I do not uphold this element of the complaint.**

73. I would highlight the N IPA identified the Trust's decision and communications about prognosis early on as a learning/service improvement. However, I established the Trust does not agree and considers after multiple discussion's with the complainant *'she had unfortunately failed to grasp and accept just how ill her mother was'*. I would highlight that the complainant did not raise communications with the Trust regarding prognosis as part of her complaint to this office.

Administering of haloperidol

74. The complainant said that her mother was wrongly administered haloperidol on 10 August 2014. The Trust state that at times the patient had not been compliant with her aviro mask and therefore was not receiving sufficient oxygen. The Trust further stated that due to the lack of oxygen she had become agitated and was showing signs of hypoxia.

75. I have considered and I accept the advice of the CRM IPA that haloperidol is a sedative drug and '*as she (the patient) was agitated, this is an indication for this drug….this appears appropriate'*. I note the Trust confirmed that the complainant requested her mother was not to be administered any further sedatives and thereby the Trust ensured the patient had one on one supervision from thereon in. I note the CRM IPA confirmed the patient was only administered haloperidol once during her admission to the RVH. I consider the decision taken by the patient's medical team to administer haloperidol on 10 August 2014 to have been appropriate and reasonable. **Therefore, I do not uphold this element of the complaint.**

Change in antibiotics

76. I note the complainant said that her mother's medical team changed her antibiotic which she believes left her upset and confused. The investigation established that from 5 August 2014 to 7 September 2014, the patient had been prescribed approximately six different antibiotics. In particular, the patient was prescribed amoxicillin on 5 August 2014, clarithromycin on 5 August 2014, tazocin on 8 August 2014, meropenum on 11 August 2014, gentamicin on 11 August 2014 and co-amoxiclav on 3 September 2014.

77. The Trust state that the patient's inflammatory markers, CRP continued to keep rising while she was on tazocin. The Trust also confirmed that Respiratory consultant considered it necessary to change the patient's antibiotic to meropenum in order to try and address her rising inflammatory markers. Upon examination of the patient's medical records, I established Respiratory consultant recorded on 11 August 2014 '*CRP slow to settle, changed to meropenum'*. I further note the patient's medical team liaised with the microbiology team who agreed that the change to the patient's antibiotic was appropriate.

78. In response to the draft report the complainant stated that she had not complained about her mother's antibiotics being changed but rather she believed she was *'tricked by the doctors into allowing them to change her mother's antibiotic'*. I note the complainant stated all she wanted to do '*was take her mother home'* and

'*why did they have to change her antibiotic'*. Upon reviewing the complaints form to this office on 11 October 2018, I note the complainant did complain about her mother's antibiotics being changed by her medical team. I therefore consider she did complain about her mother's antibiotic being changed.

79. I have considered and I accept the advice of the CRM IPA that the changes made to the patient's antibiotics were appropriate and her medical team had responded to changes in her clinical condition. I note the CRM IPA also supports the Trust's view that discussions with the microbiology team had occurred. I further accept the advice of the CRM IPA that the changes made to the patient's antibiotics during her admission to the RVH '*was appropriate and reasonable and in line with good medical practice'.* **Therefore, I do not uphold this element of the complaint.**

Issue 2: Was it appropriate and reasonable the Trust did not allow the patient to be discharged?

Detail of Complaint

80. The complainant believes her mother had become upset during her stay in the RVH and she had requested if she could take her home. However, her mother's medical team did not allow her to be discharged. The complainant has complained that as her daughter she should have been allowed to take her mother home.

Evidence Considered

Guidance

81. I examined the following relevant extracts of the Reference Guide for Consent for Examination Treatment and Care:

Section 2.1 '*For a person to have capacity he or she must be able to comprehend and retain the information relevant to the decision. This applies particularly as to the consequences of having or not having the intervention in question. He or she must be able to use and weigh this information in the decision making process'*

Section 2.2 '*Thus, people may have capacity to consent to some interventions but not to others. Adults are presumed to have capacity but where doubt exists the health or social care professional should assess the capacity of the individual to take the decision in question. This assessment and the conclusions drawn from it should be recorded in the individual's notes'.*

Section 2.3 '*An individual's capacity to understand may be temporarily affected by factor's such as confusion, panic, shock, fatigue, pain, medication. However the existence of such factors should not be assumed automatically to render the individual incapable of consenting'.*

Chapter 2, section 1.4 '*A key principal concerning the provision of treatment or care to the incapable adult is that of the person's best interests. "Best Interests" are not confined to bed medical interests, other factors which may need to be taken into account include the individual's values and preferences when competent, their psychological health, well-being, quality of life, relationships with family or other carer's, spiritual and religious welfare and their own financial interests. It is good practice for the health and social care team to involve those close to the individual in order to find out about the individual's values and preferences before loss of capacity unless the individual has previously made clear that particular individuals should not be involved'.*

82. I examined the following relevant extracts of the GMC Guidelines:
Part 3 capacity issues, paragraph 62 '*In Northern Ireland there is currently no relevant primary legislation and decision making for patients without capacity is governed by the common law, which requires that decisions must be made in patients best interests'.*

Paragraph 64 '*You must work on the presumption that every adult patient has the capacity to make decisions about their care and to decide whether to agree to or refuse an examination, investigation or treatment. You must only regard a patient lacking capacity once it is clear that having been given all appropriate help and support they cannot understand, retain, use or weigh up the information needed to make that decisions or communicate their wishes'.*

Paragraph 71 '*You must assess a patients' capacity to make a particular decision at the time it needs to be made. You must not assume that because a patient lacks capacity to make a decision on a particular occasion, they lack capacity to make any decisions at all, or will not be able to make similar decisions in the future'.*

Paragraph 75 '*In making decisions about the treatment and care of patients who lack capacity, you must*
(a) make the care of your patient your first concern
(b) treat patients as individuals and respect their dignity
(c) support and encourage patients to be involved as far as they want to and are able to in decisions about their treatment and care
(d) treat patients with respect and not discriminate'.

The Trust's response to investigation enquiries

83. The Investigating Officer made enquiries about the complainant's request to have her mother discharged. The Trust state '*[the complainant] was informed her mother was critically ill, prognosis was guarded and that her mother was not medically fit for discharge'.* The Trust also state '*a patient who has capacity and can process why they should remain in hospital and the consequences if they discharge before the medical team deem them medically fit, can sign a contrary to medical advice form (CTMA) and leave hospital. If there is any doubt a patient may not be able to make an informed decision, process information and balance the risks to their health, then a capacity assessment is required to ensure the patients' best interests are met. Relatives or friends cannot give consent on behalf of others'*.

84. The Trust state '*the consultant psychiatrist's assessment was to determine if [the patient] understood the consequences of discharging herself from hospital against medical advice. [The patient] was critically ill and still receiving active medical treatment which could only be provided in the hospital setting. [The patient] needs to be deemed medically fit by the consultant in charge of their care. This is dependent upon an individual patient's condition or needs. Assessments by other multidisciplinary team members may be required after a patient is deemed medically fit.* The Trust confirmed '*they did not have a policy on the assessment of capacity*

and stated assessment of capacity is varied from individual to individual and the equally wide variety of decisions medical staff ask patients to make would make it very difficult to capture one individual approach in a policy or protocol'. However, the Trust confirmed '*there are a number of sources for guidance regarding this issue'.*

Clinical Records

85. I considered the following relevant extracts from the patient's clinical records:

6 August 2014*: 'patient agitated, confused but alert…imp: sepsis[31] 2 to CAP (community acquired* ***pneumonia) –*** *delirium…confused and aggressive at times…. daughter has concerns regarding her mother, overnight confusion issues…explained confusion can result from hypoxemia[32] and sepsis, explained necessity for O2':* '*Phone call to patient's daughter (The complainant) I had spoken with her earlier on the ward round and at that time she was worried about her mother's condition. Also appeared not to be aware how sick her mother was'.*

11 August 2014: '*daughter reports patient keen to go home, reinforced that patient is not well enough and hypoxic at present….daughter wanted to take mother home, explained that she remains critically ill and not fit for discharge'.*

13 August 2014*: 'remains agitated, denies any pain'.*

19 August 2014: '*pleasantly confused throughout assessment…patient remains agitated and confused'.*

20 August 2014: '*patient's mother expressed interest in caring for her mother at home and discharging her from hospital…explained need to treat [the patient] in hospital and the decision for best interest of the patient is in the hands of the doctors'.*

86. I considered the following relevant extracts from the patient's psychiatric assessment:

20 August 2014: '*delerious throughout inpatient stay and previous same when*

[31] **Sepsis** is a life-threatening reaction to an infection. It happens when your immune system overreacts to an infection and starts to damage your body's own tissues and organs.
[32] **Hypoxemia** is an abnormally low level of oxygen in the blood. More specifically, it is oxygen deficiency in arterial blood. **Hypoxemia** has many causes, often respiratory disorders, and can cause tissue hypoxia as the blood is not supplying enough oxygen to the body.

admitted in June 2014….lives alone, no documentation regarding cognitive impairment…confused and agitated this morning, presumed delirium…daughter wanting to take home…social services now involved re vulnerable adult issues…own team feel patient lacks capacity to decide about discharge (against advice) and believe patient needs to remain as inpatient for ongoing care…2nd opinion on capacity sought…difficult to commence assessment as daughter resistant to psych review but eventually persuaded to leave bedside to perform review'

87. '*Fluctuating level of consciousness apparent throughout review and misinterpretation evident…explained reasons why patient needs to stay in hospital and risks associated with premature discharge…patient unable to talk and retain, believe or weigh up the risks of discharge in order to make a decision due to delirium impairing her cognitive affecting recall, attention and belief…. In summary, [the patient] currently lacks capacity to decide about leaving early on the basis of a delirium second to community acquired pneumonia…throughout should be treated in her best interests by her responsible team. I explained this to her daughter who was irritable during our conversation and failed to take on board the findings of my assessment…...'*

88. I examined correspondence from the Trust to the complainant on 4 April 2016 which states '*it is understandable that you wished to take your mother home to look after her but your mother was clinically assessed and not fit to go home as she was confused and agitated and required medical and nursing care'.*

Independent Professional Advice

89. In relation to the complainant's request to take her mother home, the CRM IPA advised '*[the complainant] has stated that her mother seemed to be getting better and she had wanted to take her home. However, [the patient's] medical team did not permit [the complainant] to take her home. After some discussion on the matter, [the patient's] medical team arranged for a Consultant Psychiatrist to undertake an evaluation of [the patient's] capacity. She very clearly was very unwell from a physical perspective, was agitated and at times confused. She was diagnosed with delirium from the point of admission onwards. She clearly lacked capacity throughout her admission'.*

90. In response to enquiries made regarding the complainant's involvement in the decision making process about taking her mother home, the CRM IPA advised '*she was evidently present throughout the patient's inpatient stay, this is documented by the psychiatrist when he reviews the patient. So yes it would appear that there were multiple discussions about this*'. The CRM IPA confirmed the impact of not being discharged was '*she is likely to have been better managed from a medical and nursing perspective because she stayed in hospital – she will have been more comfortable and her symptoms will have been lessened'.*

91. In response to enquiries made regarding the decision taken by the patient's medical team to seek a psychiatric assessment and prevent the patient from being discharged, the CRM IPA advised '*it was appropriate and reasonable to seek a psychiatric assessment and to not allow [the patient] to be discharged'.*
The CRM IPA advised '*there is very clear evidence at all levels that she had no capacity for decision making about her own discharge…it was essential the psychiatric service (was consulted) should be seen (rightly) as the experts in this area'.* The CRM IPA also advised '*the medical management appears to be entirely appropriate, and the assessment of capacity appears entirely appropriate. The medical team appears to have acted throughout in the best interests of the patient'*. I also note the CRM IPA advised '*if she had been discharged, her suffering would have been greater and her death hastened'.*

The Trust's response to Independent Professional Advice
92. The Investigating Officer provided the Trust with an opportunity to comment on the IPA advice. The Trust state '*all relevant staff have reviewed the IPA reports…the Trust accepts all IPA reports'.*

Analysis and Findings
93. The investigation established that had the patient discharged herself from hospital, then it would have been against the wishes of her medical team. I note the consent guide states '*for a person to have capacity he or she must be able to comprehend and retain information relevant to the decision'*. Having examined the patient's clinical records, I established that it is recorded on approximately ten

occasions between 5 August 2014 and 5 September 2014, that the patient was either '*confused, agitated or experiencing delirium',* a view the CRM IPA supported *'she (the patient) was diagnosed with delirium from the point of admission onwards'.*

94. I consider the decision take by the patient's medical team to request a capacity test was reasonable under the circumstances. It is my view that in order for the patient's medical team to have allowed her to be discharged, it was fundamental that the Trust establish if she understood the consequences of being discharged, particularly in regard to the fact that she continued to require medical treatment which was not accessible to her at home.

95. I have considered and I accept the CRM IPA advice that '*[the patient] clearly lacked capacity throughout her admission… it was appropriate and reasonable to seek a psychiatric assessment and to not allow [the patient] to be discharged'.*
I accept the CRM IPA's view that '*there is very clear evidence at all levels that she had no capacity for decision making about her own discharge…it was essential the psychiatric service (was consulted) should be seen (rightly) as the experts in this area'.*

96. I note the complainant in response to the draft report stated '*her mother's psychiatric assessment should not have been allowed to happen…this assessment was based on lies and the Trust tricked her mother into allowing it to occur'.* I further note that the complainant strenuously denies that her mother did not have capacity and that she '*was aware of everything going on around her and she should have been allowed to go home'*. However, upon examination of the clinical records I have not been presented with any evidence that would support the complainant's belief that her mother had capacity or that the psychiatric assessment should not have been performed.

97. The investigation established that decisions made about patients who are without capacity must be made in the patients best interests. I note chapter one of the consent guide states '*for a person to have capacity he or she must be able to comprehend and retain the information relevant to the decision* 'and chapter two

states '*a key principal concerning the provision of treatment or care to the incapable adult is that of the person's best interests*. I refer to the GMC guidelines which state that '*you must only regard a patient lacking capacity once it is clear that having been given all appropriate help and support they cannot understand, retain, use or weigh up the information needed to make that decisions or communicate their wishes'.* I have considered and I accept the CRM IPA's advice that '*the medical management appears entirely appropriate and the assessment of capacity appears entirely appropriate…the medical team acted throughout in the best interests of the patient…if she had been discharged then her suffering would have been greater and death hastened'*. I consider the patient's capacity assessment informed her medical team and supported their initial concerns that the patient was unable to understand the consequences of discharging herself. I, therefore consider the decision taken by the patient's medical team to not allow her to be discharged was in her best interests and in line with good medical practice. **I do not uphold this issue of the complaint.**

Issue 3: **Was the Trust's complaints handling adequate?**

Detail of the complaint

98. The complainant stated that she submitted a complaint to the Trust on 26 August 2014 regarding the care and treatment her mother had received while a patient in the RVH. However, the complainant states the Trust failed to investigate her complaint and instead closed her complaint without her informing her. The complainant said there were significant delays by the Trust in its investigation into her complaint.

The Trust's response to investigation enquiries

101. In response to investigation enquiries on the Trust's handling of the complaint, the Trust state '*the issues raised by [the complainant] were discussed at ward level at every opportunity with Respiratory consultant and nursing staff while [the patient] was an inpatient in ward 4D in an effort to resolve [the complainant's] complaints. The clinical co-ordinator had also made herself available to discuss the complaints and seek to resolve these while her mother was an inpatient, however [the*

complainant] was unwilling to engage in such discussions at that time. Several efforts were made to invite [the complainant] to meet with medical and nursing staff to address her concerns but these were also declined'.

102. The Trust further state '*I apologise for the delay in responding to this formal complaint correspondence and for the frustration this will have caused. Upon review of [the complainant's] case file, it was discovered that the details of the complaint were investigated by the service area at the time and a response letter was drafted in relation to the complaints issues raised. In view of the sad death of [the patient], it was felt that a face to face meeting would be a better way to discuss [the complainant's] concerns and our investigation outcomes rather than issuing a formal letter containing this information.*

103. *Regrettably there were initially delays in offering such a meeting to [the complainant] and when meetings were subsequently proposed, [the complainant] advised she felt very strongly that she did not wish to proceed in this way but would prefer a written response instead (the last discussion in this regard taking place on 23 February 2016. Due to staffing and resource issues the response letter to [the complainant] was not issued until 4 April 2016. We subsequently received a letter from [the complainant] on 17 November 2016 advising she was unhappy with the Trust response. The Trust attempted to telephone [the complainant] at this time to discuss her complaint further, however these efforts were unsuccessful. Unfortunately the complaints manager responsible for [the complainant's] complaint subsequently closed the case in error when he retired from the Trust and as such no further action was taken to address [the complainant's] concerns. It was not until [the complainant] contacted the Trust on 25 April 2018 and her complaint file was retrieved from storage that this error was identified. A subsequent response letter, including an explanation and apology for the delay was issued by the Trust on 2 July 2018'.*

104. The Trust also state '*significant learning has been taken from these errors and a number of measures are now in place to improve complaints handling processes both within the central complaints department and across the wider Trust service areas. These measures include robust handover processes when a complaints*

manager leaves the service; implementation of key performance indicators focusing on the timeliness of complaint responses, additional information and reports being provided to service areas that identify any complaints where responses are long overdue and allow targets actions to take place to progress these; and data validation work being undertaken on the complaints central database as a checking mechanisms for any longstanding complaints'.

Analysis and Findings

106. The investigation has established that the complainant submitted her complaint to the Trust on 26 August 2014. I note the Trust failed to respond to the complaint until 4 April 2016. I note this was almost 20 months after the complainant submitted her complaint. I note the Respiratory consultant met with the complainant on 28 August 2014 in the RVH to discuss her issues of complaint.

107. Upon examination of the complaints files, I note the Trust made several attempts to engage with the complainant between 26 August 2014 and 4 April 2016. I established the Trust wrote and telephoned the complainant approximately ten times requesting a meeting to discuss her issues of complaint. I note the Trust state it had difficulty in engaging with the complainant as often the phone number provided did not connect. I further established the complainant informed the Trust on at least three occasions between 26 August 2014 and 4 April 2016 that she did not wish to meet with the Trust to discuss her complaint and her preferred option was to receive a formal written response from the Trust

108. I note after the Trust's formal response to the complainant on 4 April 2016, the Trust closed its complaints file on 15 April 2016. However the investigation established the complainant contacted the Trust on 17 November 2016 requesting a review of the Trust's investigation into her complaint which she submitted on 26 August 2014. This was approximately seven months after the Trust had issued its formal response to her complaint. I note the Trust re-opened the complainant's complaint, however it failed to respond to the complainant until 2 July 2018. This was almost 20 months after the complainant requested a review of her complaint on 17 November 2016.

109. The investigating officer made enquiries of the Trust about this issue of complaint. I note the Trust state it considered the complaint had been closed in April 2016. However, it did confirm the complaint was subsequently re-opened on 17 November 2016 after receiving the complainant's request to do so. The Trust state it made numerous attempts to engage with the complainant in order to discuss her issues of complaint from 24 August 2014 until 4 April 2016. The Trust also state the delay in responding to the complaint of 26 August 2014 was due to '*staffing and resources issues*'. Furthermore, the Trust state the additional delay in responding to the complainant's request from 17 November 2016 to re-open her complaint was due to a complaints manager closing the case in error. Unfortunately the Trust was unaware of this error until the complainant contacted it on 25 April 2018.

110. I have reviewed the complaints in health and social care guidance which outlines that *'a complaint should be acknowledged in writing within 2 working days of receipt and that it is good practice for the acknowledgement to be conciliatory, and indicate that a full response will be provided within 20 working days'*. The guidance also highlights '*that where timescales cannot be met and are not possible, then an explanation must be provided to the complainant……the Trust must offer opportunities to discuss the issues of complaint with the complainant'*. Furthermore, the Trust's complaints policy states that '*a complainant will be issued with a written response…. within 20 working days where possible. If for any reason this is not possible the complainant will be advised of the delay, the reason for it and when they are likely to receive a full reply'.*

111. I have established that the Trust did attempt to engage and offer the complainant on approximately ten occasions, an opportunity to discuss her issues of complaint and whilst this was refused by the complainant, I consider the Trust's actions to address the complaint were in accordance with the complaints in health and social care guidance to '*offer opportunities to discuss issues either with a member of the complaints staff or if appropriate a senior member of staff'.* However, I have not been presented with any evidence that indicates the complaint was acknowledged within two days and a full response provided with 20 days in accordance with the complaints in health and social care policy or complaints policy.

The investigation established it took the Trust approximately 20 months to respond to the complainant's original complaint from 26 August 2014. The response time did not meet the target of 20 working days. I also consider the complainant's concerns were also compounded as it took the Trust an additional 20 months to respond to her request for a further review of her complaint submitted on 17 November 2016. I consider this delay of over three years to adequately deal with the complainant complaint from 26 August 2014 to be wholly unacceptable.

112. It is also of concern that the Trust failed to consider the complainant's request on three occasions that she did not wish to discuss the complaint with the Trust and her preference was to receive a formal written response. I consider the complainant's wishes were not considered in this matter as the Trust continued to offer the complainant a meeting after her expressed wishes that she did not want to meet. I would remind the Trust of the importance of listening to and where applicable fulfilling the requests of complainants.

113. I note that in response to the draft report, the complainant reiterated her concerns in regards to the Trust's complaints handling. The complainant accepts the failings highlighted in the Trust's complaints handling.

114. I consider the significant delays in responding to the complaint to constitute maladministration. I have tested this failure against the Principles of Good Administration. The first principle requires a public body to 'Get it Right' by acting in accordance with its own policy and guidance. The second principle requires a public body to be 'Customer Focused' by dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances. The third principle 'Being open and accountable, principle four 'acting fairly and proportionately' requires a public body to treat people with respect and courtesy and principle five 'Putting things right' requires a public body to operate an effective complaints procedure'.

115. It is my view that this failing is also contrary to the first principle of good complaints handling getting it right, which requires public bodies to ensure staff are equipped and empowered to act decisively to resolve complaints and the second principle of good complaints handling, being customer focused, which requires public

bodies to deal with complainants promptly and sensitively, bearing in mind their individual circumstance and listening to complainants to understand the complaint and the outcome they are seeking.

116. Therefore, it is impossible to understand why the Trust did not adequately deal with the complaint at the time. I am satisfied that the significant delays to adequately respond to the complaint failed to meet the first, second, third, fourth and fifth Principles of Good Administration and the first and second Principles of Good Complaints Handling. I consider that a failing such as this can lead to a lack of confidence on the part of relatives about the quality of the Trust's ability to investigate complaints and respond accordingly. As a consequence of the failing identified I consider the complainant suffered the injustice of upset, frustration and time and trouble in bringing this complaint to our office. **I uphold this issue of the complaint.**

117. I established the Trust apologised to the complainant on 19 November 2014, 4 April 2016 and 2 July 2018 for the significant delays in handling and responding to her complaint. I welcome the Trust's confirmation that '*significant learning has been taken from these errors and a number of measures are now in place to improve complaints handling processes'.*

CONCLUSION

118. The complainant submitted a complaint to me about the actions of Belfast Health and Social Care Trust (the Trust).

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

i. Failure to adequately complete fluid balance and food charts
ii. Failure to complete 24 hour skin bundle charts between 18 August 2014 and 22 August 2014.

I have investigated the complaint and have found maladministration in:
iii. The Trust's complaints handling

I have not found any failures in care and treatment in the following matters:

iv. Nutritional Care and Treatment and Fluid Management
v. The patient's bed sores
vi. The patient's mobility
vii. Administration of haloperidol
viii. Changes in antibiotics
ix. Refusal to discharge the patient

I am satisfied that the maladministration and failures in care and treatment I identified caused the complainant to experience the injustice of upset, frustration and time and trouble.

Recommendations

I recommend:

i. In accordance with NIPSO guidance on issuing an apology, provide a written

apology to the complainant for the injustice identified in this report. The Trust should provide the apology to the complainant within one month of the date of my final report.

ii. The Trust's Chief Executive reminds staff charged with the responsibility of investigating complaints of the need to provide a response within a reasonable timeframe to enable it to meet the targeted timeframe set out in relevant guidance within three months of the date of my final report.

iii. The Trust share the outcomes of this investigation with relevant nursing staff highlighting the importance of comprehensive record keeping regarding food and fluid charts and 24 hours skin bundle charts within three months of the date of my final report.

iv. The Trust bring the failures in complaints handling to the attention of the complaints handling team reminding them of the Principles of Complaints Handling within three months of the date of my final report.

119. It is clear from the records and all of the evidence that the complainant cared dearly for her mother and she was devoted to attending to her care needs until her sad death. It is my sincere hope that by having carefully and fully investigated her issues of concern, the complainant will be reassured that I am satisfied the Trust's care and treatment of her mother was in general appropriate and reasonable.

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

PAUL MCFADDEN **12 March 2020**

Acting Ombudsman

Appendices

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.