Investigation Report

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

NIPSO Reference: 202000572

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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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Case Reference: 202000572

Listed Authority: Belfast Health & Social Care Trust

SUMMARY

I received a complaint about the actions of the Belfast Health & Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to his mother, the patient. In particular, the complainant was concerned the Trust failed to test the patient for COVID. He asked what the implications of this were for her care management and subsequent discharge.

The investigation examined the details of the complaint, the Trust's response and relevant local and national guidance. I also obtained independent professional advice from an experienced Registered General Nurse, a Consultant Radiologist, and a Consultant in Acute and Emergency Care.

The investigation established that the Trust's decision to base the patient's care on a diagnosis of a sepsis, linked to a urinary tract infect was reasonable and appropriate. It found that the patient was not exhibiting a number of the classic symptoms consistent with a COVID infection during her admission. It found that the Trust's decision to discharge the patient to her home address without testing her for COVID was in accordance with the guidance in place at the time. However, the investigation found the Trust failed to retest the complainant for COVID when it became apparent that the laboratory had not processed her swab taken in the Emergency Department. I concluded that the patient was denied the opportunity to have an effective COVID test. However, I was unable to conclude that the Trust's failure to retest the complainant caused her detriment.

I recommended that the Trust provide the complainant with a written apology for the injustice caused as a result of the failures in care and treatment I identified. I also made recommendations for service improvements in relation to record keeping.

THE COMPLAINT

1. The complainant raised concerns about the actions of the Belfast Health and Social Care Trust (the Trust) in relation to the care and treatment provided to his mother (the patient) at the Royal Victoria Hospital (RVH) between 9 and 11 December 2020.

Background

2. The patient attended the Emergency Department (ED) at RVH on 9 December 2020 with blood in her urine and raised inflammatory markers. ED staff reviewed the patient and diagnosed her with a possible urinary tract infection[1] (UTI)/ urosepsis[2]. Observations documented the patient had low oxygen saturations and she commenced on oxygen therapy.

3. The patient's medical records indicate a nurse took a swab from the patient upon her arrival in the ED to test for COVID 19 (COVID). However, the swab was not processed and clinicians never received confirmation of the patient's COVID status. Nursing staff did not take another swab during the patient's stay in RVH

4. The patient was transferred to Ward 7C on 10 December where a consultant reviewed her. The consultant confirmed that a UTI/urosepsis was the most likely cause of her symptoms. Following a further review on 11 December, ward staff found that the patient was fit for discharge. The hospital discharged her later that day.

5. The complainant attended hospital again on 19 December 2020 where she sadly passed away several hours after admission. At that time, the patient tested positive for COVID. Her death certificate recorded the cause of death as colorectal cancer with COVID recorded as other significant conditions.

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[1] An infection of any part of the urinary system, including kidneys, ureters, bladder, and urethra.
[2] a type of sepsis that is caused by an infection in the urinary tract. It is a complication that is often caused by urinary tract infections that have not been treated promptly or adequately.
Urosepsis is a serious complication which requires immediate medical care to prevent it from becoming potentially life-threatening

Issue(s) of complaint

6. The issue of complaint accepted for investigation was:

Issue 1: **Whether the care and treatment provided to the patient between between 9 December and 11 December 2020 was reasonable and in accordance with relevant standards?**

In particular this will examine:

- COVID testing;
- Decision making around the patient's care and treatment in RVH;
- Discharge from hospital

INVESTIGATION METHODOLOGY

7. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling the complaint.

Independent Professional Advice Sought

8. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor(s) (IPA):

- **Registered General Nurse (RGN)**: Diploma in Asthma, Diploma in Chronic Obstructive Pulmonary Disease, BSc (Hons) Nurse Practitioner, MA Health Service Management, V300 Non-medical prescriber Association for Respiratory Technology & Physiology. Spirometry. A senior nurse with twenty one years nursing and managerial experience across both primary and secondary care. Has continued to work through the COVID pandemic, and therefore aware of the issues raised within this complaint (N IPA);
- **Consultant Radiologist:** MBChB FRCR. A consultant radiologist for 23 years. Sessions as on call radiologist and colorectal MDT.

Reported X-rays and CT throughout COVID with multiple positive cases (R IPA); and

- **Consultant in Emergency and Acute internal Medicine**: BSc (Med Sci) MBChB MRCP(UK) MRCP(AIM) FCEM DipIMC PGCert(EM): A dual trained consultant working in emergency and acute internal medicine at a regional trauma centre for over 11 years. Daily practice includes managing poorly patients with complex medical needs. (G IPA).

The clinical advice received is enclosed at Appendix three to this report.

9. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'; however how this advice was weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

10. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[3]:

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

11. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

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

- COVID-19 Infection Prevention & Control Guidance April 2020 (COVID national guidance);
- Department of Health (DoH) COVID 19 Interim Protocol for Testing, Version 7, October 2020 (COVID testing protocol)
- The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
- The National Institute for Health and Care Excellence (NICE) Guidelines: NG51 Sepsis, recognition, diagnosis and early management September 2017 (NICE NG51);
- National Institute for Health and Care Excellence (NICE) Urinary tract infections in adults (QS90) June 2015 (NICE QS90);
- National Institute for Health and Care Excellence (NICE) COVID-19 rapid guideline: critical care in adults (NG159) March 2020 (NICE NG159);
- Nursing & Midwifery Council (NMC) The Code – Standards of Conduct, performance and ethics for nurses and midwives, March 2015 (NMC Code); and
- Royal College of Physicians 2017 'National Early Warning Score (NEWS) 2. Standardising the assessment of acute illness severity in the NHS.

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

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

13. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The complainant raised a number of issues in relation to the draft report. He highlighted that the complainant's oxygen saturations dropped 1% within 30 minutes after the Trust stopped oxygen therapy. He also noted

that her oxygen saturations continued to fall after the Trust discharged her and that she required oxygen after her return home. The complainant questioned if the Trust should have monitored the patient's oxygen saturations for a longer period before it discharged her, as patients with COVID have '*their oxygen levels…monitored once oxygen therapy is removed to ensure that no decline occurs again*.' The complainant also asked if the patient's symptoms on 19 December 2020 upon admission to the Mater hospital were attributable to complications from undiagnosed blood loss. I considered the complainant's response and obtained additional independent professional advice.

14. The Trust stated that it had no comments to make.

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the patient between between 9 December and 11 December 2020 was reasonable and in accordance with relevant standards?

COVID testing

Detail of Complaint

15. The complainant was concerned the Trust did not test the patient for COVID during her stay at RVH. He said the patient told him that staff did not take a swab when she arrived at the ED.

16. The complainant asked if the Trust actually took a swab, why the virology laboratory did not process it. He questioned why staff in Ward 7C did not take another swab when they were unable to get confirmation of a test result from the laboratory.

17. The complainant also questioned if it was appropriate to discharge the patient without a negative COVID test, especially as her husband was vulnerable and sheltering at home.

Evidence Considered

Legislation/Policies/Guidance

18. I considered the following guidance:
    - COVID testing protocol; and
    - The NMC guidance;

Relevant extracts are enclosed at Appendix four to this report

The Trust's response to investigation enquiries

19. The Trust stated the patient's records documented that a nurse took a COVID swab from her in the ED on 9 December; however, the laboratory did not process it. The Trust stated this might have been because staff incorrectly labelled the swab, or because the laboratory did not receive it. The Trust explained that once the nurse took a swab, they left it in a box for collection by porter staff, who took it to the laboratory for testing. The Trust was unable to provide any additional information.

20. In response to the complainant's question as to why staff on Ward 7C did not request an additional COVID test when they were unable to get confirmation of a result from the laboratory, the Trust explained, as '*it had been communicated to ward staff that a swab had been sent from the ED they assumed it was being processed and were awaiting the result'.* The Trust clarified the patient was admitted to RVH before the provision of rapid COVID testing. This meant test results could often take over 24 hours to process.

21. The Trust explained staff checked with the laboratory again on 11 December; however, '*no result was available*'. It stated as the patient '*was being discharged to her own home rather than another care facility, a COVID 19 swab result was not required as part of the discharge criteria'.* It clarified that had the patient remained on the ward, staff would have sent another swab for testing due to the '*exceptional delay*' in obtaining a result.

Clinical records

22. I considered the patient's clinical records. A summary of the relevant clinical records is enclosed at Appendix five to this report.

Relevant Independent Professional Advice

23. The N IPA advised the Trust took a COVID swab from the patient in the ED on 9 December. The N IPA advised the patient's first contact with nursing staff was at 14.20 and '*this would have been the earliest time that a swab could have been taken.'*

24. I asked the N IPA if nursing staff in Ward 7C should have taken another swab to test for COVID when the laboratory could not provide confirmation of the patient's status after 24 hours. The N IPA advised the COVID testing protocol required that '*all elective and non-elective patients admitted overnight into hospital should be tested for COVID 19'.* The N IPA also advised that during the period the patient was in RVH, the turnaround time from receipt of a swab to uploading the results was 24 to 30 hours.

25. The N IPA further advised that approximately 48 hours elapsed between ED staff swabbing the patient and her discharge home. The N IPA advised that after '*30 hours and no receipt of results, the laboratory should have been contacted and the patient retested*'.

26. The G IPA and N IPA both advised it was appropriate for the Trust to discharge the patient without retesting the patient for COVID. This was because the COVID testing protocol required hospitals to test only those patients transferring to other care facilities on discharge.

27. The G IPA further advised that even if staff had retested the patient during her stay in Ward 7C '*the result would not have been made available until after the patient had been discharged*'.

Analysis and Findings

28. The complainant said the patient told him hospital staff did not take a swab for COVID when she was in the ED. He said the patient was familiar with the process, having undergone it previously. However, both the G IPA and N IPA advised the clinical records document that the Trust took a swab from the patient in the ED. In addition, I note the patient's nursing plan of care upon her

admission to Ward 7 documented that the Trust placed her in a single room because she was '*awaiting Covid swab result*' In investigating a complaint of this nature, I am reliant on the information contained in the clinical records. While I acknowledge the complainant's concern, I am satisfied on the balance of probabilities that a nurse took a COVID swab from the patient in the ED.

29. However, the complainant said *'[a] Covid-19 test does not mean just taking a swab*'. I agree with the complainant. The Trust acknowledged it did not process the patient's swab, although it was unable to explain why. It explained that while staff on Ward 7C recognised there was an '*exceptional delay*' in obtaining the patient's result, they did not take another swab as a consultant had cleared the patient for discharge.

30. The N IPA advised the COVID testing protocol required '*all elective and non-elective patients admitted overnight into hospital should be tested for COVID 19'*. She advised that staff on Ward 7C should have retested the complainant for COVID when the laboratory had not provided a result after 30 hours, as results generally took 24-30 hours to process. I note the Trust stated it did not retest the patient on 11 December as ward staff decided she was fit for discharge. I examined the patient's records, which document that the consultant made the decision to discharge her at 10.30 on 11 December. This was approximately 44 hours after staff swabbed her in the ED.

31. I refer to the NMC code which requires nurses to '*make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*'. I accept the N IPA's advice that nursing staff should have contacted the laboratory after 30 hours and retested the patient when it became clear the laboratory had not processed the swab. I consider the failure to do so was a failure in the patient's care and treatment and contrary to the requirements of the COVID testing protocol. I am hopeful that following the introduction of rapid testing which was not available at the time, it is unlikely this situation would reoccur. However, I am satisfied that as a result of this failure; the patient suffered the injustice of the loss of opportunity to have an effective COVID test.

32. However, I note the G IPA's advice that even if the Trust had retested the patient '*the result would not have been made available until after the patient had been discharged'.* I accept the G IPA's advice and I am satisfied that the failure to retest the patient had no impact on her immediate care and treatment. on Ward 7C.

33. The patient attended hospital again eight days after her discharge from Ward 7C. She tested positive for COVID upon her arrival there. I acknowledge the complainant's concern that her outcome may have changed had staff tested her for COVID during her previous stay in RVH. While it is not possible to be certain whether retesting the patient for COVID during her previous stay would have changed the outcome, I also acknowledge the complainant's understandable concern. There will always be an element of doubt for the complainant, as he will always question whether things could have been different if the Trust had retested the patient on the ward.

Decision making around the patient's care and treatment in RVH

Detail of Complaint

34. The complainant questioned the Trust's statement to him '*that during her admission to the RVH from 9 December to 11 December your mother did not demonstrate any clinical signs of Covid-19*'. The complainant said the patient had low oxygen saturations, inflammation, high levels of lactate, haematuria and UTI/urosepsis. The complainant said COVID patients often displayed symptoms similar to those of a UTI and that a COVID infection could cause sepsis. He said low oxygen saturations and inflammation were issues commonly associated with COVID infections. He highlighted that staff gave the patient two litres of oxygen due to her low oxygen saturations. He also said that gross haematuria was a lesser-known symptom of COVID. He asked why clinicians ignored these symptoms.

35. The complainant asked if the radiologist who viewed and interpreted the patient's scans, based his conclusions on the assumption that because she was on a ward, she was therefore COVID negative. The complainant asked if

clinicians on Ward 7C made a similar assumption. He asked if staff who treated the patient failed to consider obvious signs of a COVID infection because of this assumption.

36. The complainant said the Trust's claim a positive COVID result would not have changed the patient's management plan in Ward 7C was '*outrageous*'. The complainant said a positive result would have '*have changed a lot of things and would have resulted in different and better care*'. He believed that in the event of a positive COVID test, RVH might have transferred the patient to the Mater Hospital[4] for assessment by '*covid-19 experts'.* He also believed staff would have continued with oxygen therapy and '*she may have been given steroids*'.

Evidence Considered

Legislation/Policies/Guidance

37. I considered the following guidance:
    - COVID testing protocol; and
    - NICE NG51;

The Trust's response to investigation enquiries

38. The Trust stated '*on discharge [the patient] was not showing any clinical signs of COVID 19*'. It explained her oxygen saturations were within '*normal limits*' on room air and her chest x-ray '*was not clinically indicative'* of COVID. It stated her inflammatory markers were raised on admission; however, '*this was attributed to the diagnosis of urinary sepsis*'. The Trust acknowledged a COVID infection could cause sepsis. However, it clarified when this happened, the patient '*almost always*' showed signs of severe respiratory failure, which it stated was not the case with the patient. The Trust also explained that COVID could cause '*microscopic haematuria (small traces of blood not visible to the naked eye)*', but it was unaware of any cases of '*frank (overt) haematuria*' caused by COVID.

39. In relation to the patient's management plan in the case of a positive COVID

[4] The designated COVID treatment hospital in the Belfast Trust.

test, the Trust stated that staff would not have continued to give the patient oxygen, or transfer her to the Mater, as her oxygen saturations were '*satisfactory*' on room air on 11 December.. It explained that it would not have administered steroids for the same reason. It stated that a positive COVID test '*would not have changed, or resulted in better care*' for the patient.

Relevant Independent Professional Advice

40. The R IPA examined the patient's chest x-ray taken on 9 December and the CT[5] scan of the patient's kidneys ureter and bladder (KUB CT scan) taken on 10 December. I asked the R IPA if the Trust radiologist's findings and conclusions were reasonable and appropriate. The R IPA advised both scans were '*appropriately reported with no suggestion of COVID infection'.*

41. The G IPA advised the ED doctor's list of differential diagnoses[6] included a UTI, urosepsis, or a possible dislodged uretic stent[7]. The G IPA advised that given the patient's presenting symptoms these were all appropriate considerations. The G IPA referred to the COVID testing protocol, which lists the '*classical*' symptoms of COVID including a high temperature, a new continuous cough, or loss of taste or smell. The G IPA advised the patient did not complain of any of these symptoms.

42. The N IPA advised the patient '*was not displaying any signs of Covid 19 at the time of her admission between 9-11 December 2020*'. She clarified that the patient did not have '*fever, cough, rigors (cold and shivery), or new onset shortness of breath*'. The N IPA added that the patient had shortness of breath on exertion, but this '*was documented as* "*long standing"*'. She further advised the patient's oxygen saturations '*resolved on low dose oxygen (2%)'* and were '*normal'* on room air when the hospital discharged her.

[5] A computerised tomography **(CT) scan** uses X-rays and a computer to create detailed images of the inside of the body.
[6] the process of differentiating between two or more conditions which share similar signs or symptoms.
[7] A thin plastic tube which is inserted into the ureter between the kidney and bladder which allows the urine produced by the kidney to pass easily into the bladder

43. The G IPA advised that the patient's nursing records documented she was '*awaiting covid test result*' upon her admission to Ward 7C. I asked him; in light of this would it have been reasonable for clinicians to consider COVID as a possible cause of her symptoms, or an aggravating factor? The G IPA advised it would not. He advised clinicians '*repeatedly questioned*' the patient about respiratory symptoms *'which she did not complain of*'. He advised the clinical records did not document if clinicians ever considered COVID as a potential diagnosis. However, he clarified, as the patient was not displaying the '*cardinal symptoms'* of COVID infection '*it would be difficult to expect to the clinicians to arrive at the diagnosis*' The G IPA concluded that the patient's clinical records do *'not support that a diagnosis of Covid-19 should have been considered'.*

44. In relation to the complainant's concern that the patient's haematuria may have indicated a COVID infection, the G IPA advised COVID could affect the kidneys, resulting in Acute Kidney Injury (AKI) and microscopic haematuria. However, he advised that from the medical evidence available on the issue, his conclusion was, frank haematuria *'is a very rare complication of covid and would almost never occur in isolation (ie without other symptoms suggestive of the condition*)'.

45. I asked the G IPA if a positive COVID test would have changed the patient's management plan. The G IPA advised if the patient had tested positive on admission, her low oxygen saturations meant she would have fulfilled the criteria for steroid administration. However, he also advised as the patient ceased to require oxygen while on the ward '*any steroids prescribed in hospital would have been discontinued on discharge*'.

46. In response to the complainant's concern that the patient's oxygen saturations dropped by 1% 30 minutes after the Trust stopped oxygen therapy, the G IPA advised this was within acceptable limits. He advised it was '*not uncommon for the saturations to swing 1-2% over time*' due to a variety of factors. He advised that as the patient's saturations were 95% on room air, there was no indication for the Trust to repeat the test.

47. The G IPA advised that he was unaware of any guidance regarding how long

clinicians should continue monitoring a patient with COVID after stopping oxygen therapy. He also advised that as the medical team did not consider that the patient had COVID, it '*could not be expected to manage*' her as if she had.

48. The GIPA further advised if nursing staff had retested the patient after realising that the laboratory had not processed the first swab, the result would not have been available until after the patient's discharge. The G IPA advised this would therefore '*not have had any bearing on the management plan of the patient while in hospital*'.

Analysis and Findings

Consideration of a COVID diagnosis

49. The complainant asked if clinicians failed to consider if the patient's symptoms were indicative of a COVID infection. He questioned if clinicians on Ward 7C assessed and treated the patient based on the assumption she was COVID negative.

50. I acknowledge the patient's concern that in the absence of a confirmatory test, clinicians at RVH presumed the patient was COVID negative. As a result, I note his concerns that they failed to consider that her symptoms might have been COVID related. However, I note that ED clinicians made their diagnosis in the knowledge that a COVID result would not be available for 24 to 30 hours; it is therefore difficult to conclude they made the diagnosis based on the assumption that the complainant was COVID negative.

51. In his response to the draft report the complainant said '*Just because there is a diagnosis made in ED, it does not mean that Ward clinicians cannot rediagnose*.' While I acknowledge the complainant's point, the issue remains that ED clinicians did not appear to make their diagnosis based on the assumption that the patient was COVID negative and the patient's symptoms did not change or deteriorate after her admission to Ward 7C.

52. I note further that the R IPA advised the patient's radiology scans gave no indication of a COVID infection. In addition, both the G IPA and N IPA advised that the patient was not displaying any of the symptoms suggestive of COVID

infection, either in the ED, or on Ward 7C. I accept the advice of each of the IPAs. On this basis, I am satisfied that the Trust's decision to base the patient's treatment on a diagnosis of UTI/urosepsis was reasonable and appropriate. I hope the complainant finds reassurance in the unanimous advice from the IPAs that the patient was not displaying any of the cardinal symptoms suggestive of COVID infection during her stay in RVH.

Management plan

53. The complainant questioned the Trust's statement that it would not have changed the patient's management plan in light of a positive COVID test. I note the G IPA advised it was possible clinicians may have commenced the patient on steroids if she had tested positive for COVID on admission. However, having considered the G IPA's advice, the Trust's response and the patient's clinical records, I am satisfied had the complainant tested positive on admission, the Trust would have continued to treat her for suspected UTI/urosepsis and would not have altered her management plan significantly.

54. The G IPA advised that even if nursing staff retested the patient for COVID while she was on the ward, '*the result would not have been made available until after the patient had been discharged'.* This is because at the time, a PCR[8] test took 24 to 30 hours to process. The G IPA advised that in light of this, clinicians would not have altered the patient's management plan while she remained in hospital. I accept the G IPA's advice.

55. The complainant said that six days after her discharge from RVH, the patient's oxygen levels had dropped to the point where she required oxygen again. I acknowledge the complainant's concern; however, the investigation is concerned with the Trust's management of the patient during her admission to RVH. I note the G IPA's advice that following the Trust's decision to stop oxygen therapy the patient's oxygen levels remained '*within acceptable limits*' on room air and that there was no indication to retest her, or available guidance on how long to monitor her. On this basis, I accept the G IPA's advice that the

[8] A polymerase chain reaction (PCR) test detects genetic material from a pathogen or abnormal cell sample.

Trust's management of the patient in this respect was appropriate.

Conclusion

56. I considered the Trust's decision-making around the patient's treatment in terms of consideration of COVID symptoms and the appropriateness of its management of her. I found the Trust's decision to treat the patient based on a diagnosis of a UTI/urosepsis was reasonable, given the absence of '*cardinal*' COVID symptoms. In relation to the management plan, I am satisfied that that a positive COVID test on admission, or retesting the patient in Ward 7C would not have caused the Trust to significantly change her management plan. In addition, there was no indication for clinicians to restart the patient on oxygen therapy, or continue to monitor her levels. Overall I am satisfied the Trust's decision-making around the complainant's treatment was reasonable and I do not uphold this element of the complaint.

Additional issue

57. I note the G IPA's advice that there is no record in the patient's notes that clinicians reviewed her radiology scans. The G IPA advised '*the consolidation picked up on the CT KUB could have been due to concurrent pneumonia*'. There is no evidence that this interpretation was considered in the treating clinicians' decision-making process.

58. In view of this I must record my concern that the patient's notes do not evidence that clinicians considered the patient's CT scan in their decision making process. Although the Trust's record keeping is not a matter the complainant raised in bringing his complaint to me, it is important that I highlight it in this report, particularly as the complainant had other concerns around the Trust's management of the patient. I note the GMC guidance requires that '*Clinical records should include: a relevant clinical findings b the decisions made and actions agreed, and who is making the decisions and agreeing the actions*'

59. It is my expectation that the Trust will give careful consideration to this matter

and to the need to remind relevant staff of the specific requirement of keeping accurate records of their decision making process.

Discharge from hospital

Detail of Complaint

60. The complainant questioned the Trust's decision to discharge the patient on 11 December in the absence of a negative COVID test. He said if the patient had tested positive, she '*would not be sent home…to lie in a bed with a clinically extremely vulnerable husband*'.

61. The complainant also questioned why the patient's discharge letter indicated that the patient '*had no recent haematuria*'. The complainant said the patient's urine was cola coloured when she arrived home from hospital and that it remained that way.

Evidence Considered

Legislation/Policies/Guidance

62. I considered the following guidance:
    - COVID national guidance; and
    - The GMC guidance;

The Trust's response to investigation enquiries

63. The Trust stated it considered the patient was medically fit for discharge because '*there were no ongoing aspects of her care that necessitated ongoing hospital admission*'. It also stated that as the patient returned to her own home, rather than another care facility, '*a COVID 19 swab result was not required as part of the discharge criteria*.'

64. In response to the complainant's concern about how the Trust did not consider the possible impact on the patient's husband when it discharged her without a test result, the Trust apologised. It acknowledged the communication with the patient '*could have been better*'. It also acknowledged it would have provided advice to the complainant and the patient, had she tested positive before

discharge.

65. In response to the complainant querying the patient's discharge letter, which indicated she had '*no recent haematuria*', the Trust apologised for the confusion. It stated the cola colour of the patient's urine indicated '*the haematuria was resolving with no new blood loss in her urine*'.

Relevant Independent Professional Advice

66. The N IPA referred to the COVID national guidance which states *'there is no restriction on discharge unless the patient/individual is entering a long-term care facility where testing may be required'.* The N IPA said that as the Trust discharged the patient to her home, there was '*no requirement*' to test her for COVID before discharge. The G IPA also advised the Trust's decision to discharge the patient without a COVID test was appropriate.

67. The G IPA advised the patient's clinical notes did not indicate how the consultant reached his conclusion that the patient had no recent haematuria. The G IPA advised that the consultant did not appear to have inspected the patient's urine to check the haematuria had abated prior to discharge. The G IPA advised that a potential consequence of not checking her urine was blood loss via the urinary tract. He advised this could lead to '*symptomatic anaemia*'[9], or '*hypovolaemic shock*'[10].

68. The IPA clarified that hypovolaemic shock was a potential consequence of '*severe and rapid loss of blood from the urinary tract*'. He said that there was no evidence in the patient's notes that this occurred during her presentation to the Mater Hospital on 18 December. He said that any hypovolaemia *'if it occurred*' was probably '*due to dehydration*' as patients who are ill do not often maintain sufficient fluid levels.

Analysis and Findings

69. The G IPA and N IPA both advised the Trust's decision to discharge the patient

[9] Anaemia is a deficiency of healthy red blood cells in blood. Fatigue, unexplained weaknesses are some of the common symptoms

[10] A life-threatening condition that results from the loss of more than 15 percent of the body's blood or fluid supply and the heart function is impaired

without a COVID test was appropriate and in accordance with the COVID testing protocol. This is because she was returning home and not transferring to another place of care. I accept both IPAs' advice.

70. I note the complainant's concern that the patient's discharge letter recorded she had '*no recent haematuria*' when her urine remained cola coloured after her discharge. The Trust explained to this office that the colour of the patient's urine indicated that her '*haematuria was resolving with no new blood loss'.* The G IPA advised there was no record in the patient's notes of how the consultant reached this conclusion. The G IPA further advised that the patient's notes do not record if the consultant checked the patient's urine prior to distance. The G IPA explained the potential consequences of not checking the patient.

71. There is no evidence in the patient's clinical records that she subsequently experienced symptomatic anaemia, or 'hypovolaemic shock' resulting from blood loss through her urinary tract. Therefore, I cannot conclude that the patient experienced an injustice as a result of the Trust's actions. However, I remain concerned the patient's notes do not record the consultant's observations and conclusions in relation to her haematuria.

72. I refer to the GMC Guidance which states *'Clinical records should include: the decisions made and actions agreed, and who is making the decisions and agreeing the actions'.* In my view, the clinical records should accurately record the details of any decisions made by clinicians in order to ensure clarity for those clinicians who will later rely on the information recorded in these records. I am satisfied that these actions in relation to record keeping fall below the required standard and constitute service failures. I therefore partially uphold this element of the complaint. However, I am satisfied that the patient did not suffer detriment as a result of these record keeping failures.

CONCLUSION

73. I received a complaint about the actions of the Trust. The complainant raised concerns about the care and treatment the hospital staff provided to his mother, the patient.

74. The investigation was unable to establish if the failure of clinicians to test the patient for COVID had an impact on her. The investigation established failures in the care and treatment in relation to the following matter.

- The failure to retest the patient for COVID when it became apparent that the laboratory had not processed her sample.

75. I am satisfied that the failure in care and treatment identified caused the patient to experience the injustice of the loss of opportunity to have an effective COVID test.

Recommendations

76. I recommend that within **one month** of the date of this report:

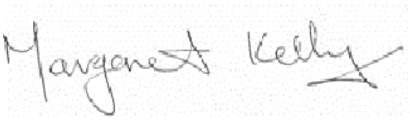
- The Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures identified

77. I also recommend for service improvement and to prevent future recurrence, the Trust:

- Carry out a random sampling audit of patients' records in Ward 7C to ensure that clinical records contain relevant information in accordance with GMC guidance;

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

79. I am pleased to note the Trust accepted my recommendations.



NAME Margaret Kelly
Title Ombudsman **February 2023**

Appendix 1

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.