Investigation Report

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

NIPSO Reference: 201915506

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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 Northern Health and Social Care Trust (the Trust) in relation to the care and treatment the staff of Antrim Area Hospital (AAH) provided to the complainant's sister (the patient).

The investigation established, given the information available to staff at the time, that the actions of Doctors were appropriate in relation to the patient's ED attendance on 14 May 2019; treatment provided to the patient between 14 and 20 May, including her discharge; and the treatment provided to the patient between 23 and 24 May 2019. The investigation also established that the patient's death certificate accurately reflected the cause of death. However, I asked the Trust to reflect on the learning identified by the General and Colorectal Surgeon independent professional advisor.

The investigation found there was a failure to accurately report on the CT scan of 13 May 2019 and as a result the care offered to the patient by the Trust was not appropriate. I concluded that this failure in care and treatment caused the patient to experience the injustice of loss opportunity to access more timely palliative/supportive care, better symptom control and to prepare for and discuss her end of life care. I am also satisfied the failure in care and treatment caused the complainant and her family to experience the injustice of loss of opportunity to prepare for and discuss for the patient's end of life, as well as distress. This impact on the quality of the family's remaining time with the patient deeply saddens me and I wish to convey my heartfelt condolences to the complainant and her family.

The investigation also identified that nursing staff incorrectly calculated the patient's total fluid balance during her second admission. I considered this a service failure but was satisfied that this failure did not cause the patient to experience an injustice or affect patient care.

I recommended that the Trust provides the complainant with a written apology for the injustice caused as a result of the failure in care and treatment I identified.

I also made recommendations for service improvements in relation to the reporting and reviewing of CT scans. I acknowledged and welcomed the Trust's ongoing examination into the peer review and discrepancy meeting process in relation to imaging. The Trust confirmed that it would be implementing changes following the examination. Whilst I cannot change what happened to the patient, I can provide the complainant and her family with reassurances that lessons have been learned and the Trust will take action to improve its service delivery to prevent this happening to another family.

THE COMPLAINT

1. I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust) in relation to the care and treatment the staff of Antrim Area Hospital (AAH) provided to the complainant's late sister (the patient) from 14 May 2019 to 24 May 2019.

Background

2. The patient, who was 59 years old, attended the Emergency Department (ED) of AAH on 14 May 2019 following her General Practitioner's (GP) referral. The patient had a history of breast cancer two years previously. A recent ultrasound[1] and CT scan[2] had indicated abnormalities within the abdomen and pelvis, in particular the liver. The patient presented to the ED with breathing difficulties, abdominal discomfort and was generally feeling unwell. She was admitted for assessment and management of her symptoms. During this time, pleural fluid[3] was drained and sent for cytology[4]. She underwent a talc pleurodesis[5] procedure and was discharged on 20 May 2019, for an oncology review the following day. On 23 May 2019 the patient re-presented at AAH ED with profuse faecal vomiting and abdominal pain. A small bowel obstruction[6] (SBO) was diagnosed. The patient was admitted, but sadly passed away the following day. A chronology detailing the events leading to the complaint is enclosed at Appendix six to this report.

Issue of complaint

3. The issue of complaint accepted for investigation was:

Issue 1: Was the care and treatment provided to the patient at Antrim Area Hospital between 14 May 2019 and 24 May 2019, appropriate, reasonable and in accordance with relevant guidelines/standards?

[1] A diagnostic technique used to image inside the body
[2] A medical imaging technique used in radiology to get detailed images of the body noninvasively for diagnostic purposes.
[3] Fluid that is found between the layers of the pleura, the membranes of which line the cavity and surround the lungs.
[4] A study of cells to detect diseases.
[5] A procedure in which sterile talc mixed with saline is inserted via a tube in order to cause an inflammatory reaction (irritation) in the lining of the lung. The aim is to prevent fluid building up in the lining of the lung.
[6] An obstruction of the small intestine that prevents the free passage of material.

INVESTIGATION METHODOLOGY

4. 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

5. I obtained independent professional advice from the following independent professional advisors (IPA):

- **Consultant in Emergency and Critical Care Medicine**, MD, MRCP, FRCSEd, FRCEM, FFICM, with over 20 years' experience in that role. Also held roles with responsibility for emergency and medical services in acute hospital as well as roles with responsibility for clinical quality and outcomes.(ED IPA)
- **Consultant Physician in General and Respiratory Medicine,** BMedSci, BM, BS, FRCP, with 25 years' experience including responsibility for acute admissions including many with pleural effusions in that time. (RM IPA)
- **General and Colorectal Surgeon,** MB.ChB, MSc, MD, FRCS, with over 20 yrs. of experience in emergency and elective general and colorectal surgery. (C IPA)
- **Consultant Radiologist, Dr Med, MRCP, FRCR,** with 16 years in a specialist cancer centre with a high workload of CT scans, including cases of bowel obstruction by cancer and pleural effusions, including talc pleurodesis.(R IPA)
- **Senior Nurse,** RGN, BA (Hons); MA, with nineteen years nursing and managerial experience across both primary and secondary care. (N IPA)

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

6. 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

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

The general standards are the Ombudsman's Principles[7]:

- The Principles of Good Administration

8. 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:

- The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
- The Nursing and Midwifery Council's (NMC) Code: Professional standards of practice and behaviour for nurses and midwives, March 2015 (the NMC Code);
- Royal College of Physicians (RCP) National Early Warning Score (NEWS)2[8]. Standardising the assessment of acute illness severity in the NHS, 2017(the RCP NEWS guidance); and
- Royal College of Radiologist (RCR) Standard for Interpretation and reporting of imaging services, second edition, March 2018 (the RCR reporting guidance).

[7] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[8] A guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs.

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

10. 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 INVESTIGATION

Issue 1: Was the care and treatment provided to the patient at Antrim Area Hospital between 14 May 2019 and 24 May 2019, appropriate, reasonable and in accordance with relevant guidelines/standards?

In particular, the following elements will be considered under this issue:

- **Emergency department attendance on 14 May 2019 (including consideration of blood test results)**
- **Bowel obstruction not diagnosed (including nursing care provided and the administration of pain relief)**
- **Discharge on 20 May 2019**
- **Actions of Trust staff on 23 May 2019 (including failure to administer oxygen therapy, nursing care and communication of prognosis)**

Detail of Complaint

11. Following the patient's attendance at the ED on 13 May 2019 the complainant said that doctors focused on the patient's metastatic breast cancer[9] and not on the acute abdominal pain she was experiencing. She also said that blood results were not taken into account and she believed there were inaccuracies in the CT scan report taken on 13 May 2019. The complainant said that Dr A,

[9] Known as stage IV or advanced breast cancer, is breast cancer that has metastasised, or spread, to other organs.

Consultant Respiratory Physician, ignored the patient's abdominal pain and treated the non-urgent respiratory problem which resulted in the patient's bowel obstruction being misdiagnosed/mismanaged. She raised concerns about the turnaround time of the chest cytology, the recording of the patient's dietary intake, fluid balance, including the monitoring of urine and faeces output. She also complained about the administration of pain relief, in particular that staff did not communicate, to the patient or family, about the administration of morphine. The complainant also said that the patient was discharged from hospital on 20 May 2019 despite being in pain.

12. In relation to the patient's second admission on 23 May 2019 the complainant raised concerns about the treatment Dr B, Consultant Colorectal Surgeon provided. She also had concerns about the length of time taken to complete and report on a CT scan and the lack of oxygen administered to the patient. She also said that the family were not informed the patient was at end of life prior to visiting the patient on 24 May 2019. She believed the patient received poor nursing care during the night before she died. The complainant also believed the patient's Medical Certificate of Cause of Death (MCCD) did not reflect the patient's true cause of death as it failed to record that she died of small bowel obstruction.

Evidence Considered

Legislation/Policies/Guidance

13. I considered the following policies/guidance:
    - The GMC Guidance;
    - The NMC Code;
    - The RCP NEWS guidance; and
    - The RCR reporting guidance.

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

Trust's response to investigation enquiries

14. I made written enquiries of the Trust about the issues the complainant raised. The Trust's responses to my enquiries are enclosed at Appendix three to this report.

Clinical records

15. The patient's clinical records were considered. Relevant extracts from the clinical records are enclosed at Appendix four to this report.

Relevant Independent Professional Advice

Emergency department attendance on 14 May 2019 (including consideration of blood test results)

16. The ED IPA advised that the patient's working diagnosis was *'...pleural effusion.'* He also advised *'There were a series of blood tests performed…A CT scan performed the previous day was referred to. There was a recognition of the need for admission. A discussion took place between clinicians that concluded the correct admission area was the DAU [Direct Assessment Unit].'* The ED IPA further advised that *'For the presentation of shortness of breath, the investigations were appropriate.'*

17. The ED IPA advised all the blood tests except the CRP (C-reactive Protein[10]) were *'..noted to be in the normal range..'* The CRP was noted *'…to be slightly outside the normal range…'* and *'…is a non-specific test that can be used to monitor and track infections.'* He went on to advise that none of the single blood tests, or combination of tests, *'…pointed towards a diagnosis of bowel obstruction'… 'None of the tests are specific to the investigation of abdominal pain. The normality of most results, and in particular the lactate of the blood gas, are reassuring that there was no acute abdominal issue ongoing.'*

18. The ED IPA was asked to comment on the interpretation and actioning of the blood results. He advised *'This patient's primary presenting complaint was shortness of breath. There was a secondary symptom of abdominal pain recorded that had been present for two months. The CT scan performed the*

[10] A protein made by the liver in response to inflammation.

*day before identified the likeliest cause for this presenting complaint: large effusions (fluid collections) into the chest and abdominal cavities…*He went on to advise *'The clinical urgency, as dictated by the triage assessment and observations, was low. The blood tests ruled out any other significant cause for the breathlessness. The blood tests also ruled out any significant abnormality associated with a bowel obstruction (although this was not the primary purpose of the investigations). The assessment identified a need for admission and after consultation identified an appropriate area further management.'*

19. In relation to the potential for hypothyroidism and associated blood results the ED IPA advised '*There was no reference made to any results from 17 April 2019. It is not clear whether these tests were available. Importantly, in the emergency assessment of a patient complaining of shortness of breath these tests would not be required...'*

20. The ED IPA was asked to comment on whether there was an emphasis on treating the patient's respiratory problem, over her abdominal pain. He advised *'Shortness of breath was the primary referral reason...There was no indication that the abdominal symptoms were urgent either by clinical examination signs or blood tests. On the basis of the information provided I believe that it was reasonable to focus on the respiratory symptoms over the abdominal symptoms.'* He went to advise *'The decision to admit the patient from the ED to the DAU on the 14th May 2019 was reasonable. The patient reported increasing symptoms of shortness of breath. CT imaging showed bilateral pleural effusions as a cause….These effusions were not going to resolve without treatment (drainage). Admission for treatment was appropriate.'*

21. The ED IPA identified the following learning *'…Given that the likeliest diagnosis for the shortness of breath was already known by the GP an ED attendance was unnecessary step in the patient journey. The patient should have been admitted directly to an assessment unit and not via the ED.'* He went on to conclude that *'…On the 14th May 2019 the clinical assessment and management by the ED was appropriate. There were no features of acute*

abdominal crisis that required management by them at that time. The abnormal thyroid function test was not relevant in the context of this presentation.'

Bowel obstruction not diagnosed (including nursing care provided and the administration of pain relief)

i. Reporting of CT scan dated 13 May 2019

22. In relation to the CT images of 13 May 2019 the R IPA advised *'A CT study of the chest, abdomen and pelvis was performed after the administration of oral contrast for the stomach and bowel and an intravenous injection of contrast into a vein. The study is of good quality…'* He goes on to advise on the abnormalities identified as detailed at Appendix five to this report.

23. In relation to the CT scan report the R IPA advised *'…The radiology report makes the following comments…*
a. "The examination was done without bowel preparation or oral contrast."
This is incorrect. Oral contrast medium has been administered, but not passed as far as the large bowel….In this case the oral contrast had not got very far and this was probably misinterpreted as none having been given at all.
The tumour would have been more conspicuous if the content of the bowel had been highlighted by oral contrast…'
…b. "Based on the pre-contrast examination of the bowel appears normal. There are areas where the bowel wall appears to be faintly thickened but is most probably due to the large amount of ascites fluid."
This is incorrect. There is clear dilatation of the second part of the ileum and abnormal appearances of the ileo-caecal junction and the caecum with features of small bowel obstruction by cancerous tissue.'

24. In relation to the comment on the report that the *''The examination was done without bowel preparation or oral contrast."* The R IPA advised
'…The minor concern about the comment is that the technical aspects of the scan were not correctly reported. It is an easy error to make and this did not have any immediate consequences for the quality of the report on this patient, but raises the question, why this was missed in a patient with a bowel problem.

The fact that it had not progressed through the bowel might have alerted to the presence of a transit problem, like obstruction.'

25. The R IPA went onto advise *'The salient findings…were under-recognised and thus under-reported. Reports do not automatically undergo peer-review. This depends on the stage of training of the reporting radiologist and staffing levels and workload pressures in the department. It is worth noting that this is a complex and difficult scan, however if interpretation was difficult, a second opinion should have been sought. Having said that, the report on the follow-up CT from 23/5/19… states that small bowel obstruction by tumour was seen on review of the initial scan, which subsequently deteriorated…'*

26. He further advised that *'the report on the interim CT KUB[11] from 16/5/19 (which was an examination only designed to demonstrate kidney stones and insufficient to examine the bowel) the comment was made: "Other intra-abdominal findings are unchanged in the interim." This suggests that the previous CT was not adequately reviewed. This may not be regarded as essential or may have been done superficially due to workload pressures, but here was a missed opportunity to identify the full extent of the problem, as the kidney stones were peripheral to this.'* The R IPA went to advise that *'…the patient was in a terminal stage of cancer with no option for cure or modifying the course of the disease…'* However clearer identification of the abnormalities on the earlier scan would have led to *'…a more appropriate management of the final stages of life, better symptom control and the opportunity for the family to prepare for [the patient's] death.'* The R IPA commented on the various chest x-rays taken during the patient's first admission and advised *'…What can be seen of the bowel on the series of chest x-rays is normal.'*

27. The R IPA commented on the experience of Dr E, Consultant Radiologist who reported on the CT scan of 13 May 2019. He advised Dr E's had *'…17 years of experience reporting CT scans in appointments of a general diagnostic nature, having a high workload of this type of examination. It can be assumed that the doctor had extensive experience in abdominal imaging with CT. However a*

[11] kidneys, ureters and bladder

migrant working pattern[12] *impacts negatively on follow-up, feedback and learning opportunities and the regular attendance at Radiology Events And Learning Meetings (REALM), formerly "discrepancy meetings", as recommended by the Royal College of Radiologists….With the experience according to the CV one would expect him to be able to work independently.'* The R IPA also advised on the actions taken by the Trust following the identification of the discrepancy and stated the process was *'..of a good and acceptable standard.'*

28. The R IPA concluded that '*The report on the admission CT scan from 13/5/2019 did not adequately identify the extent of tumour spread and the consequent small bowel obstruction*…' and potential causes included *'• Insufficient experience with complex cancer scans*
• Poor IT infrastructure and reporting conditions
• Time or workload pressures not allowing thorough review of difficult examinations.' In relation to learning/service improvement, the IPA advised *'…Adequate assessment and supervision of locum staff need to be provided…'* The R IPA also identified actions to minimise risks which would help prevent observation/interpretation errors at the time of reporting including, *'Any time and workload pressures on the radiologists need to be identified and addressed…'* and ensuring '*A suitable working environment…'*

ii. Treatment provided to patient

29. The RM IPA advised *'…the patient was seen in the Emergency Dept. (ED) following referral by her GP…for help with management of the patient's pleural effusion on the right stating that this was "the most pressing concern"…This was documented on the ED clinical record…as well as the patient's complaint of exhaustion. The background of a CT scan the day before showing probable liver metastases, ascites and pleural effusions was noted. After a discussion with an Oncology team member the plan was for care by Respiratory Medicine for a pleural tap…'* He went on to advise *'…The same history was noted on the post take ward round at 9am on the 15th and it was noted the patient was*

[12] Regularly working in different hospital settings

breathless but not at rest. The Consultant's plan was for Ultrasound scan of the chest to confirm the presence of fluid and if so to remove some for analysis. They explained to the patient the possibility of pleurodesis or a PleurX catheter together with their pros and cons. Shortly afterwards the patient was reviewed by a member of the Oncology team who also documented the predominant symptom of breathlessness. After this [Dr A]…also spoke to the patient's sister and again the focus was on management of the pleural fluid which would also probably confirm the suspected underlying diagnosis to assist in the planning of more definitive management.

30. In relation to Talc pleurodosis procedure completed the RM IPA advised *'…The patient had collections of fluid – effusions – on both sides so the intention to drain and secure one side at least in the first instance was appropriate particularly in the context of someone with likely disseminated cancer. …'* He went on to advise that *'…Because one is inciting "pleurisy" pain can be an issue though it is said that the more pain there is the better the effectiveness of the procedure. Extra analgesia…was prescribed to counter this and was documented as being effective…An alternative known as a PleurX drain was also discussed. This is a long term indwelling drain used to intermittently drain fluid. With it one has the continual inconvenience of a drain sticking out of one's chest which can act as a portal of entry for infection. Given the plan for potential further chemotherapy with its enhanced infection risk the better option as [sic] chosen.'*

31. In relation to the steps taken to treat any abdominal pain the RM IPA advised *'…On discussion with Urology a further CT KUB (Kidney Ureter Bladder) was requested to clarify the cause of the blockage to the ureter. This was reported as showing a stone at the bottom end of the ureter… Urology advised on therapy for the stone reported as the cause of ureteric obstruction on the KUB…*' He went on to advise '*Although nausea and or vomiting are not listed in the patient's complaints in the admission clerking Paracetamol and Ondansetron (an anti-emetic) were prescribed in DAU on 14th May at 13.03 Prior to coming to hospital the patient had been prescribed Buscopan and Mebeverine on 9th May and Metoclopramide (anti-emetic) on 14th May by her*

GP…At no further point in the medical notes are abdominal pain and or vomiting documented as being an active symptom. Nursing records on admission…state "patient reports feeling uncomfortable with intermittent pain and feeling of pressure on abdomen. Also feeling SOB" no mention is made of vomiting or bowel problems. The section on elimination asks "Have you any difficulties with your bowel?" No is ticked..."patient known to have a loose bowel, this is her norm". On admission on the 14th the patient was complaining of symptoms in keeping with abdominal distention from liver metastases and ascites not small bowel obstruction…Analgesia and anti-emetics given with effect…'

32. The RM IPA concluded that *'All steps were appropriate and in keeping with national guidance particularly the management of the effusions…'* with '*Appropriate involvement of other teams ie Urology and Oncology…'*

33. In relation to the CT scan report dated 13 May 2019 the RM IPA advised *'…No specific mention of bowel mass or obstruction was made in this initial report available to the clinicians…I have no doubt given how well the patient was managed by the team that if the amended report had been made available…that referral to the surgical team would have been made. However, it is very doubtful even at this stage that this would have made any difference to the patient's extremely poor prognosis. It is conjecture whether it would have lessened the impact of symptoms present at readmission.'* He went on advise that *'…there is no documentation of symptoms to suggest SBO in any of the documentation during IP [inpatient] stay from 14th May. Nor is it mentioned in the Oncology letter of 21st May. The GPs referral letter of 23rd says symptoms were "in last 24 hours profuse faeculant vomiting with no bowel movement for two days"…The clerking sy [sic] readmission on 23rd May describes symptoms of SBO from "last night". This strongly suggests the symptoms suggestive of SBO occurred AFTER discharge on 20th.'*

34. The RM IPA concluded following the patient's GP referral for her pleural effusions *'…This was undertaken in an efficient and timely manner with a lot of personal input by the Consultant. Suitable techniques were used and in terms*

of the fluid removal a good outcome was achieved. It is unfortunate the CT report performed prior to admission did not describe bowel pathology more accurately but the Respiratory team would have had no way of knowing this might be the case. There is no evidence that the patient had or reported symptoms of small bowel obstruction during this inpatient stay. Had they done so or the CT reported it, it is likely a surgical opinion would have been sought…This lady was well managed during this admission.'

iii. Pain Management

35. The RM IPA advised *'It is difficult from the record to ascertain the amount of pain the patient experienced. The admission clerking on examination of the abdomen writes "v. mild pain only" Abdominal discomfort is then mentioned on a number of occasions between 14th and 20th May in medical and nursing note entries….There is no documented evidence in medical or nursing notes that describes the patient as being in pain that was unmanageable or out of control at any time but comments as above including "no pain at present" are found… There is no indication …that pain was ever a major problem or that it was refractory to the therapies offered.'* He further advised as to when morphine was given to the patient *'Oramorph 2-4mg was prescribed on 14th. Two mg was administered on the 19th at 14.00 and 22.00 and again on the 10th [sic][13] at 10.10. This was for the pain from the talc pleurodesis…'* In relation to the level of communication with the patient about pain medication the RM IPA advised *'This was clearly reviewed at least daily by the nursing staff, often more frequently. It is also documented in medical notes entries.'*

iv. Turnaround for chest cytology

36. The RM IPA advised '*A…sample was sent…on 15th. The length of time for processing is partly dependent on how long it takes to get to the lab but usually this happens swiftly. At the oncology outpatient appointment (21st May) the results available were not conclusive but as is often the case further processing of the specimen was underway. This is a not unusual occurrence. Diagnostic results from a first pleural fluid sample in studies only occur in about 60% of*

[13] Prescription records confirm this date to be 20 May 2019 at 10.10

case….A formal report of "no malignant cells seen" was dated 26th May…This is 11 days after the sample was taken. Certainly not ideal but by no means an unduly lengthy delay in modern clinical practice.'

v. Nursing care – recording of fluid balance and diet

35. The N IPA advised on admission the patient was *'…independently mobile…and… she was independent with her toileting needs. The nursing evaluation …confirms that the patient was mobile independently on the ward and did not need help with her ADL's (activities of daily living). This changed from 17th and the moving and handling plan was updated to reflect this…*' The N IPA advised*'…The assistance [to the toilet] was in line with the patients moving and handling plan and was therefore person-centred and appropriate as per: NMC (2017) 'The Code. Professional standards of practice and behaviour for nurses, midwifes and nursing associates'…'* She further advised that *'…There was no other documented occasion when assistance was needed and not given.'*

37. In relation to the management of the patient's use of pads to prevent soiling of the bed the N IPA advised 'The *patient is documented as 'continent' on assessment (page 177) and using the toilet rather than pads. There is no reference to continence products, including pads. Whilst I have no reason to doubt the complainant's recollection of the events, I have been unable to find any reference to this. In summary, it is documented that the patient used the toilet to open her bowels and I could find no reference to pads being used during this admission.'*

38. The N IPA also advised '*Not all patients will require input and output monitoring… I note that the patient had left hydronephrosis[14]…but there is no indication that this affected her ability to pass urine….' If monitoring '…was required, a direct instruction from the medics should be documented (I could see no evidence of this).'* The RM IPA advised *'…the hydronephrosis was due*

[14] Excess urine accumulation in the kidney

to a compression or blockage of the ureter and monitoring of fluid would not have had an impact on this and therefore was not required in this regard.'

39. The N IPA went on to advise '*There was no monitoring of faeces or urine in this patient between 14th– 20th May 2019. There is no documented rationale for the monitoring of faeces or urine over this timeframe. The patient was independent to the toilet and there were no problems with constipation or loose stools documented which would support the use of monitoring via a stool chart*.'

40. In relation to the recording of the patient's dietary intake the N IPA advised *'The patient was recorded as having a poor appetite from admission…It is therefore expected that food intake would be monitored. This would be to ensure that dietary intake was sufficient to meet her nutritional needs. There was no monitoring; however, it is documented that she 'continues to try to eat' and it appears that nausea was causing the poor appetite. The patient was referred to a dietician on 18/05/2019…and anti-emetics (metoclopramide), to address the ongoing nausea, were administered three times a day…There was therefore no impact from the lack of dietary monitoring because the appropriate action needed to address the poor appetite had been taken.'*

41. The N IPA concluded that from 14 to 20 May 2019 *'…nursing care was appropriate…'*

Discharge on 20 May 2019

42. The RM IPA advised '*The task the GP had requested had been carried out – The fluid had been drained and sent for analysis, pleurodesis had been performed and the drain had been removed. Pain was reported as controlled so particularly with time at home probably being limited and therefore very precious given the likely poor prognosis, discharge was appropriate and in keeping with the patient's wishes. An outpatient appointment with Oncology was booked for the next day so discharge at that time did not interfere with important specialist input*.' He concluded that *'Discharge was appropriate'*

Actions of Trust staff on 23 May 2019 (including failure to administer oxygen therapy, nursing care and communication of prognosis)

i. Treatment provided to patient

42. The C IPA advised that the patient *'…was seen by the surgical team around 19:00 on 23rd May after recent discharge…Blood tests were performed…blood gas analysis and an abdominal and chest X-ray. A CT scan was arranged later in the evening...Her admission was with abdominal pain and distension with a background of breast cancer. The initial investigation of blood tests…and X-Rays were appropriate. The subsequent arranged CT scan was appropriate….'* In relation to the x-rays and the CT scan the C IPA advised *'…The chest and abdominal X-ray were requested and… the timing was acceptable in terms of urgency….' '…Following the X-ray, it was recorded that the chest x-ray appearances had improved compared to recently after the fluid on the chest was removed. The Abdominal X-ray was described as showing dilated loops of small bowel consistent with a small bowel obstruction. A CT scan was ordered later in the evening….'* Other treatment was advised as '…*A Tube was placed in the stomach to aspirate the fluid which sometimes helps in a bowel obstruction. Intravenous fluid was prescribed to help with hydration. The notes documents that [the patient] should have nothing by mouth…These steps were reasonable and appropriate…The timeframe was very reasonable with no untoward delay. The X-ray was reported on at 18:19 showing dilated small bowel loops. CT scan request 21:53 reported at 23:14.'*

43. In relation to overnight treatment from 23 to 24 May 2019 the C IPA advised Overnight treatment plan *'At 19:15…the plan was for intravenous fluids, Nasogastric tube drainage of the stomach. To be nothing by mouth and for CT scan…The proposed management plan was appropriate. The first approach to a bowel obstruction is to rehydrate with intravenous fluids and monitoring. Patients with obstruction need rehydration and drainage of fluid from the stomach helps decompress the bowel. This sometimes leads to resolution of the obstruction. Whilst there was no definitive plan on what to do after conservative management, this was an evolving situation with a background of serious underlying disease and would require discussion later with a senior*

clinician in terms of judging suitability for surgical management and whether it indicated. It was reasonable not to raise or discuss at this stage but to focus on stabilization…the plan was reasonably adhered to.'

44. The C IPA was asked to comment on what the advice of colorectal surgeons would have likely to have been, had the CT of 13 May 2019 referred to SBO or colonic tumor, and a referral to colorectal surgeons been made. He advised *'…If the scan fit with symptoms of a bowel obstruction the initial management plan would have been the same as that on the 23rd of May. The clinical diagnosis that this obstruction was likely due to metastatic disease was reasonable…[The patient] had liver, abdominal and chest metastases and obstruction of a kidney secondary to metastases. She had fluid in her abdomen and chest from the metastases….Managing a bowel obstruction against this background carries a poor prognosis and outcome from surgery. It would be regarded as reasonable not to offer surgery since most likely there will be deterioration after surgery and no significant change in life span. There is the very real likelihood that the symptoms can also recur. …The CT scan on the 13th May gives enough information for a diagnosis of metastatic disease. cytology of fluid returning no malignant cells is not uncommon. They are only useful if positive but negative does not mean no malignancy. The overall picture is however very consistent with metastasis…'*

ii. Administration of oxygen

45. The C IPA advised that on admission the patient's *'…oxygen saturation levels were 97%. This is acceptable and does not require additional oxygen…. The NEWS chart shows that the oxygen saturation levels on air was averaging 97% and recorded from 17:00. This would not indicate a need for oxygenation….Therefore, oxygen was not administered…'* and *'the management was appropriate.'*

iii. Nursing care

46. In relation to the nursing care provided to the patient on 23 and 24 May 2019, the N IPA advised the patient *'…was medically reviewed at 16:08. The management plan…includes IV access, IV medications as prescribed…and*

admit to surgical team. At 16:41 the plan was for NG tube (naso-gastric tube for drainage) NBM (nil by mouth) and IV fluids. There is no specific instruction for fluid balance monitoring, however, given the treatment included IV fluids, it was indicated as per national guidance…' She went onto advise *'…Fluid balance charts from this admission have not been fully completed…however, recording was sufficient on 24th given that the patient's care was palliative from 09:30 after a medical review. Fluid balance is not necessary under such circumstances as the focus is on comfort measures rather than addressing any deficits in fluid balance. Monitoring on 23rd sufficiently included fluid input and output however, total output was incorrectly calculated as 1280 when it should have been 1400 and total intake was not calculated but was 1875. Monitoring was therefore not in line with NICE CG174….'*

47. The N IPA further advised that *'…This is a failing in record keeping only and would not have impacted on patient care…' 'The patient was in positive fluid balance of 475mls (input higher than output). This should have been identified by nursing staff on totalling [sic] fluid balance on the morning of 24th at 0700 (which is when the chart finishes). There was no requirement for urgent escalation because nursing staff would have been aware that the patient would be reviewed during daily ward round. Sadly, when the patient was reviewed, she was identified as being at the end of life and the focus of care changed to palliative.'*

48. In relation to the nursing care provided to the patient on the night before she passed away the N IPA advised *'…NEWS was taken at 01:30 and 04:30 and was 1, the frequency of NEWS was in line with RCP standards (2017). The documentation indicates that she was comfortable overnight and there were no concerns when she went to the toilet/ commode at 03:00…'* The N IPA went on to comment on the assessment of the patient on the morning of 24 May 2019. She advised *'At 07:15…'* following assessment *'…the patient scored 1. She was not documented as being in any pain and she was documented as being alert. The clinical response to NEWS triggers…indicates a minimum monitoring frequency of between 4 -6 hours unless the observations are different to baseline observations, in which case the monitoring frequency is hourly. This*

was not the case with the patient, and her observations remained stable at this time….Assessment at 07:15 was appropriate because it was in line with RCP standards… Escalation was not indicated at this time based on NEWS and also the nursing evaluations (documented at 06:00 when patient was stable and 10:30 after patient had been reviewed by the doctor)'

49. The C IPA advised *'…it would appear that the fluid regime was not monitored as robustly as could be…However the level of management here was unlikely to contribute significantly to demise within 24 hrs of admission…'* The N IPA concluded that *'No failings were identified with the nursing management of the patient between 23rd and 24th May 2019.'*

iv. Communication of prognosis

50. The C IPA advised *'The official report of the X-ray was not avail [sic] until 18:19 23rd May and did not conclusively say small bowel obstruction although the clinical indications and interpretation was that of a small bowel obstruction. There were no records to indicate what discussion was had between the patient or family after diagnosis or treatment. There was no indication that the relatives were present at the hospital and unless urgent (not deemed to be so at time of admission) it would not be anticipated that the relatives would be called. There should have been a discussion with the patients [sic] regarding treatment. The admission to demise was short and I suspect that may have been an issue as to why the discussion did not take place. It would however be normal practice to document the discussion if it took place to ensure everyone is aware. There was a request for a Macmillan nurse input but did not occur until the following day. The Macmillan nurse did not come until late morning at which stage Mrs. A was moribund…'*

51. The N IPA commented on the complainant's statement that at 08:00 on 24 May 2019 the family were informed there were *'no concerns'* in relation to the patient's condition. She advised '*It is documented prior to this at 06:00 that 'the family' had been in contact through the night: "family in contact through the night, will visit tomorrow to update on any changes". The documentation was sufficient, as it is not expected that all calls will be documented when no*

changes and no risks or problems are reported. There would be no changes at 0800 from the calls and responses given to family overnight…the patient was very 'acutely' unwell from admission...It is documented that her family were with her on admission…She was stable (as per NEWS charts) and was described as comfortable at 06:00. Given these particular circumstances (family phoning through the night, family being aware of admission); it was not inaccurate to say that there were no concerns. This would more accurately be 'no new concerns'. She went on to advise that at this stage there was *'…nothing to suggest from a nursing perspective that she was in the last hours or even days of life. Her NEWS was stable overnight and she was 'settled'….There was no clear indication of deterioration until after 10:30 on 24th…'*

v. Medical Certificate of Cause of Death

52. The C IPA advised '*A cause of death written on a death certificate is often a clinical diagnosis based on the facts known at the time that can lead to death often with associated contributory factors…A certificate is often written based on reasonable clinical assumption…In [the patient's] case she was known to have advanced lobular breast carcinoma. The evidence from all investigation to date gives a reasonable diagnosis of metastatic carcinoma of the breast. This (lobular) cancer often can spread widely and is well known to produce spread seen in [the patient]. Fluid accumulation both in the chest and abdomen are known and metastases can also cause kidney blockage as seen here. The abdomen can have widespread disease from the cancer, and this can lead to bowel obstruction. These situations are difficult to manage surgically due to advance disease in the abdomen and the ascites further complicates the issue.*

53. He went on to advise *'The clinical diagnosis on the death certificate was metastatic carcinoma of the breast. This was the definitive diagnosis that was effectively the cause of death. Whilst the presence of a bowel obstruction can for completeness can be added, the assumption that the bowel obstruction was secondary to the tumour was reasonable. It is encouraged when writing Death certificates be more detailed in adding contributory causes with other possible underlying factors…This is encouraged but not mandated… In this case the most serious and contributing factor to death remains metastatic carcinoma of*

the breast. Whilst the family are understandably concerned regarding the absence of bowel obstruction on the death certificate, more importantly it would [sic] be an inappropriate action not to list the cancer as the main cause of death. The death certificate could have been written with cause of death being small bowel obstruction with the underlying factor of metastatic carcinoma of the Breast. However, it remains the significant cause leading to death was the cancer….' The C IPA further advised that for learning consideration should be given to *'…ensuring death certificates are as far as possible reflect the cause of death and related factors for completeness.'*

Complainant's response to draft report

54. The complainant and her family provided commentary on what they felt were the missed opportunities, which would have *'...avoided [the patient's] death…'*, all of which have been given further consideration. They further disagreed with the Trust's view that had early stage of bowel obstruction been detected and reported on 13 May 2019 no change would have been made to the patient's treatment. They believed this view was 'ethically wrong' and contradicted the strategy of Oncologists who try to extend fruitful lives of patients. They further believed that early invention for SBO even within cancer patients could be successful.

55. The complainant and her family also said that the patient as well as her family, up until 09.30 on 24 May 2019, was left with the *'…disillusion…the medical team would find a solution for [the patient]…'* They also held the view that *'…Lessons should be learned from the…investigation. Patients and family need all true information on their personal conditions if they are to make choices and deal with crises. Other cancer patients and in particular lobular breast cancer patients need to be aware that SBO is a likely complication. They should be informed of the symptoms and be encouraged to seek medical attention at the Belfast Cancer Unit as early as possible.'*

Medical Certificate of Cause of Death

56. Given the advice of the C IPA, the complainant and her family requested that the Ombudsman acknowledge the specific cause of death of patient was small bowel obstruction and that her death certificate be modified to reflect this.

Analysis and Findings

Emergency department attendance on 14 May 2019 (including consideration of blood test results)

57. The complainant was concerned about the treatment the patient received during her time in the ED on 13 May 2019. I note the GP referral letter, to AAH dated 13 May 2019, states *'…[the patient's] most pressing issues at the moment is her right pleural effusion….'* I also note the ED clinical record triage note dated 14 May 2019 at 10:52 documents the patient's complaint as *'…Exhaustion, Shortness of breath…'* I further note the ED clinical assessment , on the same day, documents the patient's history as increased SOB with some pain in the abdomen. The examination record documents *'…very mild pain generally, slightly tense…*' I also note the direct assessment records document the same history. A discussion was had with acute oncology and a respiratory doctor reviewed her.

58. I note the Trust comments that the patient *'…was seen initially by general physicians but referred to respiratory as it was felt that the most pressing issue was the pleural effusion that needed dealt with…Any relevant clinical decisions made were based on examination and investigation findings.'*

59. I note the ED IPA's advice that *'…The CT scan performed the day before identified the likeliest cause for this presenting complaint: large effusions (fluid collections) into the chest and abdominal cavities*. *'…On the basis of the information provided…it was reasonable to focus on the respiratory symptoms over the abdominal symptoms… the clinical assessment and management by the ED was appropriate… Admission for treatment was appropriate…'*

60. I also note the ED IPA's advice about the blood tests taken *'…None of the tests are specific to the investigation of abdominal pain. The normality of most results, and in particular the lactate of the blood gas, are reassuring that there*

was no acute abdominal issue ongoing.' I further note his comments that none of the tests *'…pointed towards a diagnosis of bowel obstruction'* I also note the ED IPA's advice about ED clinicians referring to previous a blood test from 17 April 2019. *'…It is not clear whether these tests were available. Importantly, in the emergency assessment of a patient complaining of shortness of breath these tests would not be required.'*

61. Given the available evidence, including information available to the ED clinicians at the time, I accept the ED IPA's advice that '…*the clinical assessment and management by the ED was appropriate…'* including the consideration of blood test results. It is my opinion the patient received appropriate treatment in the ED and therefore I do not uphold this element of complaint. However, I would ask the Trust to reflect on the learning the ED IPA identified that given the likeliest diagnosis the GP made *'…The patient should have been admitted directly to an assessment unit and not via the ED.'*

Bowel obstruction not diagnosed (including nursing care provided and the administration of pain relief)

i Reporting of CT scan dated 13 May 2019

60. The complainant raised concerns about inaccuracies within the report of the CT scan taken on 13 May 2019. I further note the complainant's concerns in relation to the Trust's view that even if SBO had been detected no change would have been made to the patient's treatment. I note the findings of the CT scan on 13 May 2019 and the subsequent scan of 23 May 2019 and the Trust's comments in this regard.

60. The R IPA's advised that *'…What can be seen of the bowel on the series of chest x-rays is normal.'* I also considered his advice about the report of CT scan of 13 May 2019 and the inaccuracies in that report as detailed in paragraph 23 above. I note the R IPA's advice that *'…if interpretation was difficult, a second opinion should have been sought. Having said that, the report on the follow-up CT from 23/5/19… states that small bowel obstruction by tumour was seen on review of the initial scan, which subsequently deteriorated…'* I further note his comments that the report on the interim CT

KUB, of 16 May 2019, although not regarded as essential, could have used by clinicians as an opportunity to go back and query the initial CT scan of 13 May 2019. I also considered the R IPA's comments about the peer review of scans, the experience of Dr E and, the actions taken by the Trust following identification of the discrepancy.

61. I further note the RM IPA's advice about the initial scan *'… if the amended report had been made available…that referral to the surgical team would have been made. However, it is very doubtful even at this stage that this would have made any difference to the patient's extremely poor prognosis. It is conjecture whether it would have lessened the impact of symptoms present at readmission…there is no documentation of symptoms to suggest SBO in any of the documentation during IP [inpatient] stay from 14th May…'*

62. I accept the R IPA's advice that the report on the CT scan of 13 May *'…did not adequately identify the extent of tumour spread and the consequent small bowel obstruction…'* I consider the failure to accurately report on the CT scan of 13 May 2019 a failure in the patient's care and treatment. I also acknowledge Dr A's comments that had he been '*…aware that the CT from 13 May 2019…revealed a colonic tumour, he would have asked for a surgical opinion prior to discharge*.' However I accept the advice of both the RM IPA and R IPA that earlier identification of the SBO is unlikely to have altered the prognosis of the patient. While the prognosis of the patient may not have been altered it would have helped the patient and her family to understand the symptoms that the patient subsequently experienced.

63. As a consequence of this failure I consider the patient suffered the injustice of loss of opportunity to access more timely palliative/supportive care, better symptom control and, to prepare for and discuss her end of life care. I consider the complainant and her family also experienced the injustice of loss of opportunity to prepare for and discuss the patient's end of life care. I also consider they sustained the injustice of distress. This is because of the unfortunate circumstances surrounding her death. Therefore, I uphold this element of complaint.

64. I acknowledge the actions taken by the Trust once the discrepancy was identified by Dr A. I note and welcome the Trust's comments that it is *'…currently reviewing the peer review and "discrepancy" meeting process and will soon be implementing changes in that regard.'* I will comment on this in my recommendations.

ii. Treatment provided to patient

65. I am considering the treatment provided to the patient on the basis that clinical staff did not know the CT scan report was not reported accurately. The complainant said that Dr A ignored the patient's abdominal pain and treated the non-urgent respiratory problem which resulted in the patient's bowel obstruction being misdiagnosed/mismanaged. I further note the complainants comments made in relation to D A's actions as a potential missed opportunity for the identification of the SBO.

66. Having reviewed the clinical records I consider they show that the respiratory registrar, Dr F, reviewed the patient in the DAU. A discussion was also had with acute oncology. The patient was admitted for further assessment and management and a Talc Pleurodosis procedure was carried out on 19 May 2019. I note the Trust comments that on the basis of the initial CT report *'… there was nothing to suggest that [the patient] had an imminent bowel obstruction or colonic tumour. [The patient's] most pressing symptom was shortness of breath and management was focused on treating that… She had mild abdominal distension secondary to ascites…'* I also note its comments that '*…If [Dr A] had not made the decision to do talc pleurodesis during that admission, it would have delayed her chances of getting active treatment such as further palliative chemotherapy. This was discussed with [the patient] and her oncologist. It was [Dr A's] opinion that these effusions would re occur within weeks and cause her breathlessness to return…'*

67. I note the RM IPA'S advice that *'…After a discussion with an Oncology team member the plan was for care by Respiratory Medicine for a pleural tap…'* I also note his advice that *'…The Consultant's plan was for Ultrasound scan of*

the chest to confirm the presence of fluid and if so to remove some for analysis. They explained to the patient the possibility of pleurodesis or a PleurX catheter together with their pros and cons…a chest drain was inserted…with samples sent for appropriate lab investigation.' I further note the RM IPA's advice about the Talc pleurodosis that *'… Given the plan for potential further chemotherapy with its enhanced infection risk the better option as [sic] chosen.'* I also note his advice about the treatment provided that *'All steps were appropriate and in keeping with national guidance particularly the management of the effusions…'*

68. Given the available evidence and the information that was available to Dr A, at the time of the patient's first admission, his treatment plan was reasonable. In reaching this conclusion I acknowledge that the decisions taken were on the basis of incomplete information due to the inaccurate reporting of the CT scan. So while the actions of Dr A were appropriate on the basis of the information available to him, the treatment of the patient by the Trust was not appropriate as the indications of SBO were not investigated and considered, due to the inaccurate reporting of the CT scan, as part of the future management of the patient. Therefore, while I do not uphold the element of complaint relating to the actions of Dr A, the care offered to the patient by the Trust was not appropriate as the possibility of SBO was not further investigated and not considered at that time as part of the patient's management plan, for example, discussions of treatment available and possible future symptoms. This issue is considered further at paragraphs 85 and 86.

iii. Pain management

69. The complainant raised concerns about the administration of pain relief, to the patient, in particular that the administration of morphine had not been communicated to the patient or family. I note from the clinical record on admission to the ward on 14 May 2019 the patient reported '…*feeling uncomfortable with intermittent pain and feeling pressure on abdomen...'* I further note the patient's comments about pain as documented in the nursing record. During the early hours of 19 May 2019 the patient had abdominal pain and was given Buscopan, after which I note the patient said she was *'..ok at present…'* I also note Oramorph given at 14:00 and at 22:00 on 19 May 2019

for pain due *'chest drain and urethral stone…'* and at 10:10 on 20 May 2019. The nursing records documents the patient had pain in *'…shoulder and drain site…'* for which Oramorph was given.

70. I also note the Trust comments that *'…[the patient] received only a small dose of morphine, oramorph 2mg…During this admission [the patient] had some mild pain which required paracetamol and intermittent diclofenac. She received only 2 doses of oramorph. She did not have severe abdominal pain…' It is unclear over what period the Trust are referring to however from my review of the record and the with the benefit of the IPA advice I am satisfied that the patient received 3 doses of 2mg Oramorph over 19 hours.*

71. I further note the RM IPA's advice that '*It is difficult from the record to ascertain the amount of pain the patient experienced….There is no documented evidence in medical or nursing notes that describes the patient as being in pain that was unmanageable or out of control at any time…There is no indication …that pain was ever a major problem or that it was refractory to the therapies offered.'* He also advised that Oramorph was prescribed '*…for the pain from the talc pleurodesis…'* I also note the RM IPA advised that communication about pain *'…was clearly reviewed at least daily by the nursing staff, often more frequently. It is also documented in medical notes entries.'*

72. Given the available evidence, I accept the patient had intermittent abdominal pain and the RM IPA's advice that Oramorph was given for the pain from the talc pleurodesis. I also acknowledge the complainant's concerns that the patient's abdominal pain had returned on the evening after discharge, and the distress this must have caused. However, I accept the RM IPA'S advice that the records do not indicate the patient's pain was '…*unmanageable or out of control at any time…'* Therefore I do not uphold this element of complaint.

73. I note the RM IPA's advice that pain medication was reviewed at least daily by the nursing staff although there is no evidence to indicate whether or not a specific discussion took place about the administration of Oramorph with the patient. I acknowledge the concerns of the complainant about the

communication of the administration of Oramorph with the patient or the patient's family. Although I have no reason to disbelieve the complainant I am unable to make a determination as to whether or not the patient was informed about the use of Oramproh.

iv. Turnaround for chest cytology results

74. The complainant raised concerns about the turnaround time of the chest cytology results. I note the Trust comments that *'…Laboratory received Pleural fluid 15/5/19. Report authorised 28/5/19…'* and that the turnaround times *for non-gynae specimens is '…95% samples reported within 14 days…Of note an extensive panel for immunocytochemistry undertaken which extended the reporting time to 13 days.'*

75. I also note the RM IPA's advice that '*A…sample was sent…on 15th… At the oncology outpatient appointment (21st May) the results available were not conclusive but as is often the case further processing of the specimen was underway. This is a not unusual occurrence. Diagnostic results from a first pleural fluid sample in studies only occur in about 60% of case….A formal report of "no malignant cells seen" was dated 26th May…This is 11 days after the sample was taken…'* I accept the RM IPA's advice that the time taken to report on cytology results was *'…by no means an unduly lengthy delay in modern clinical practice.'* Therefore I do not uphold this element of complaint. However, I do wish to acknowledge that any period of time waiting for such results can be distressing for patients and their families.

v. Nursing Care

76. The complainant believed the recording of the patient's dietary intake and fluid balance was not appropriate. I note from the nursing records that the patient, on admission to Ward A4, was continent, used the toilet independently and had no issues with her bowel. However, it was recorded that the '*patient known to have loose bowel this is her norm…'* I also note the patient was eating and drinking independently and had a poor appetite. I further note the Trust comments that *'…The decision to commence, continue or discontinue recording of fluid balance charts will be taken by the doctor or the registered*

nurse/midwife with responsibility for the patient's care….Fluid balance charts are not required for each patient 24/7…With regards to food charts – these are not required for each patient…During the admission 14-20 May [the patient] was noted to have a poor appetite – eating small amounts but drinking fairly well. MUST score was 0 – this would be reviewed weekly but she was discharged before this could be done.'

77. I note the N IPA's advice that in relation to assistance provided to the patient for toileting *'…The assistance was in line with the patients moving and handling plan...'* and *'….There was no other documented occasion when assistance was needed and not given.'* I also note the N IPA's advice that '*The patient is documented as 'continent' on assessment…and using the toilet rather than pads….'* and she was unable to find any *'…reference to pads being used during this admission.'* I further note the N IPA's that '*There was no monitoring of faeces or urine in this patient between 14th– 20th May 2019. There is no documented rationale for the monitoring of faeces or urine over this timeframe….'* I further note the RM IPA's advice in relation to the hydronephrosis *the '…monitoring of fluid would not have had an impact on this and therefore was not required in this regard.'*

78. I also note the N IPA's advice that *'…The patient was recorded as having a poor appetite from admission…It is therefore expected that food intake would be monitored…'* However, I also note her advice that '…*The patient was referred to a dietician on 18/05/2019…and anti-emetics (metoclopramide), to address the ongoing nausea,…were administered three times a day…There was therefore no impact from the lack of dietary monitoring because the appropriate action needed to address the poor appetite had been taken.'* I further note the N IPA's that *'…nursing care was appropriate…'* from 14 to 20 May 2019.

79. I wish to acknowledge the complainant's comments that one of the patient's major concerns was she had to wear a pad to avoid soiling the bed. However, given the available evidence I have been unable to establish that pads were used regularly. The N IPA's advice from her review of the records indicated that

the patient was using the toilet rather than pads and that assistance with toileting was given when required. Maintaining dignity and autonomy of patients are an essential element of good nursing practice and encouraging independence where appropriate is to be commended. However where patients require pads it is essential that these are checked regularly and a patient's dignity is maintained. I accept in this case there was no requirement to monitor frequency or volume of urine or faecal output. I acknowledge the patient had a poor appetite and I have identified a difference in the view of the N IPA and that of the Trust in relation to the monitoring of food intake. I am concerned given what is recorded in the notes that the Trust did not consider that the patient's food intake required to be monitored. While the IPA has provided assurance that no harm to the patient arose from this, I would ask the Trust to reflect on its approach to monitoring food intake in patients recorded as having a poor appetite. I also accept the N IPA's advice that the patient's nursing care was appropriate from 14 to 20 May 2019. Therefore I do not hold this element of complaint.

Discharge on 20 May 2019

80. The complainant believed the patient was discharged from hospital on 20 May 2019 despite being in pain. I note from clinical records that at 12:40 on 20 May 2019 the clinical record documents *'…Drain removal…Pt well…wants to go home..'* I also note the patient was discharged later that afternoon. I further note the Trust's comments that *'…based on the information which was available to him [Dr A] at that time; he considered [the patient] was fit for discharge on 20 May 2019…She was subsequently able to attend an outpatient appointment in the Belfast City Hospital the following day…'* I also note the Trust's comments *'…Had [Dr A] been aware that the CT from 13 May 2019…in reality revealed a colonic tumour, he would have asked for a surgical opinion prior to discharge….'* I also note the RM IPA's advice that '*The task the GP had requested had been carried out…Pain was reported as controlled…discharge was appropriate and in keeping with the patient's wishes….'*

81. Given the available evidence which, includes the information that was available to Dr A at the time, I accept the RM IPA'S advice that the discharge of the

patient on 20 May 2019 was appropriate. Therefore, I do not uphold this element of complaint. As noted at paragraph 68 this decision was taken on the basis of an incorrect CT report and therefore without the benefit of a surgical opinion as to whether the Trust should have discharged the patient or whether further inpatient management was necessary.

Actions of Trust staff on 23 May 2019

i. Treatment provided to patient

82. The complainant raised concerns about the treatment provided by Dr B, including the length of time to complete and report on a CT scan. I have also considered the complainants comments made in relation to D B's actions. The clinical records indicate that the patient attended the ED via a GP referral on 23 May 2019 and was triaged at 15:36. The ED clinician requested an abdominal x-ray and the patient was to be admitted under the care of the surgical team. I have reviewed and considered the contents of the x-ray report, the initial management plan of the surgical clinicians and the subsequent CT scan completed at 21:59 and reported on at 23:14. I have also considered the management plan following the ward round on the morning of 24 May 2019.

83. I note the Trust's comments that on 23 May 2019 *'…[The patient]… was seen by the surgical doctor at 19:15…Abdominal x-ray showed evidence of a small bowel obstruction and the surgical concern was that of disease progression causing bowel obstruction. The CT scan was undertaken later that day and reported at 23:14. The CT findings were compared with those on the CT 10 days previously… There was evidence of progressive dilatation of the small bowel consistent with obstruction…'* I further note its comments that Dr B *'…met [the patient] on the morning of the 24th May 2019…. Her history was reviewed….Her clinical condition at the time and the evidence available to [Dr B] suggested that surgical intervention was not in her best interest…There was evidence of rapid deterioration in her condition around that time. [Dr B] discussed the likely diagnosis and prognosis with [the patient's] family. He made an urgent referral to the palliative care team and a DNACPR form was completed with the family.'*

84. I note the C IPA's advice that *'…The initial investigation of blood tests…and X-Rays were appropriate. The subsequent arranged CT scan was appropriate….The timing was acceptable in terms of urgency…The timeframe was very reasonable with no untoward delay. The X-ray was reported on at 18:19 showing dilated small bowel loops. CT scan request 21:53 reported at 23:14.'*

85. The C IPA advised that overnight the patient *'At 19:15…The proposed management plan was appropriate…'* and *'…the plan was reasonably adhered to.'* I also note his advice that had the CT scan of 13 May 2019 '…*fit with symptoms of a bowel obstruction the initial management plan would have been the same as that on the 23rd of May. The clinical diagnosis that this obstruction was likely due to metastatic disease was reasonable…It would be regarded as reasonable not to offer surgery since most likely there will be deterioration after surgery and no significant change in life span..'*

86. Given the available evidence I accept the C IPA's advice that following the abdominal x-ray the timescale for the CT scan was reasonable with no delay. I also accept that the overnight management plan was appropriate and would not likely have been different had a referral been made to the surgical team during the previous patient's previous admission. It is my opinion the actions of the clinicians' were appropriate during this second admission. Therefore I do not uphold this element of complaint. Nevertheless I do acknowledge how quickly the patient deteriorated and passed way following admission and the clear distress this caused the family. I refer to paragraph 63 that highlights the loss of opportunity to both the patient and her family to prepare for her death and receive more appropriate palliative care in the final stages of her life. I consider the patient was denied the opportunity of spending what little time she had left with her family.

ii. Administration of oxygen

87. The complainant was concerned about the lack of oxygen administered to the patient. I note the ED clinical review on 23 May 2019 at 16:08 states the patient's oxygen levels were '…94% on room air…' and there was a working

diagnosis of *'1. Abdominal pain 2. Vomiting faecal matter 3. Abdomen distended.'* I also note the surgical clinician record at 19:15 the patient's oxygen levels were at *'97%'* I further note the C IPA's advice that *'…The NEWS chart shows that the oxygen saturation levels on air was averaging 97% and recorded from 17:00. This would not indicate a need for oxygenation….Therefore, oxygen was not administered…'* I accept the C IPA's advice that *'The management [of oxygen] was appropriate.'* and consider the treatment the patient received in relation to the administration of oxygen appropriate, Therefore I do not uphold this element of complaint.

iii. Nursing care

88. The complainant believed that the patient received poor nursing care during the night before she passed away. I note from the patient's NEWS score chart that observations were taken at on 23 and 24 May 2019 at 21:50, 01:20, 04:30, 05:45 and 07:15. All record a total score of one. I also note the nursing records document that the patient was assisted to the toilet overnight and was comfortable at 03:30 I further note the Nursing records at 10:30 document that the *'…[patient] stated she was comfortable and in no pain..'*

89. I note the N IPA's advice that *'…Fluid balance charts from this admission have not been fully completed…however, recording was sufficient on 24th given that the patient's care was palliative from 09:30 after a medical review…Monitoring on 23rd sufficiently included fluid input and output however, total output was incorrectly calculated…'* I further note her advice that *'…This is a failing in record keeping only and would not have impacted on patient care…'* I also note the C IPA's advice that the level of fluid management *'…was unlikely to contribute significantly to demise within 24 hrs of admission…'*

90. I also note the N IPA advice about the care provided to the patient on the night before she passed away. I note the monitoring of observations, overnight and in the morning was in line with the RCP NEWS guidance and that *'…The documentation indicates that she was comfortable overnight and there were no concerns when she went to the toilet/ commode at 03:00…'* I further note the N IPA's advice that at 07:15 on 24 May 2019 the patient *'…was not documented*

as being in any pain and she was documented as being alert…' I further note the N IPA's advice that *'No failings were identified with the nursing management of the patient between 23rd and 24th May 2019.'*

91. I note the N IPA's advice about the calculating of total fluid output although I hope the family are reassured that this did not have an impact on the patient's care. However, I refer to the NMC Code, Standard 10, which requires nurses to *'keep clear and accurate* records..' '… so that colleagues who use the records have all the information they need'. I consider a failure in maintaining accurate records impedes the thorough, independent assessment of care provided to patients. I also consider that maintaining accurate and appropriate records affords protection to staff involved in providing patient care by providing a clear record of their actions and the treatment provided. I consider incorrect calculation of fluid output a service failure. I would ask the Trust to remind nursing staff about the importance of accurately recording fluid input and output.

92. Overall, given the available evidence, I accept that the nursing care provided to the patient between 23 and 24 May 2019 was appropriate. Therefore I do not uphold this element of complaint. However I wish to emphasise that this in no way diminishes the clear distress the patient's family experienced as a result of how quickly the patient's condition deteriorated and later passed way.

iv. Communication of prognosis

93. The complainant said the family were not informed the patient was at end of life prior to their visit to the patient on 24 May 2019.I further note the complainant's comments that they and the patient should have been made aware of any diagnosis and prognosis earlier.

94. I note the nursing records dated 24 May 2019 at 03:00 state *'…[patient] uncomfortable on arrival, more settled at time of writing. Family in contact throughout the night,.will visit tomorrow. To update on any changes…*' I also note the Trust comments that that Dr B *'…met [the patient] on the morning of the 24th May 2019…There was evidence of rapid deterioration in her condition*

around that time. [Dr B] discussed the likely diagnosis and prognosis with [the patient's] family. He made an urgent referral to the palliative care team and a DNACPR form was completed with the family.'

95. I note the C IPA's advice that *'The official report of the X-ray [requested in the ED] at was not avail [sic] until 18:19 23rd May and did not conclusively say small bowel obstruction although the clinical indications and interpretation was that of a small bowel obstruction. There were no records to indicate what discussion was had between the patient or family after diagnosis or treatment….There should have been a discussion with the patients [sic] regarding treatment. The admission to demise was short and I suspect that may have been an issue as to why the discussion did not take place. It would however be normal practice to document the discussion if it took place to ensure everyone is aware…..'*

96. I note the N IPA's advice that '*… the patient was very 'acutely' unwell from admission. ..It is documented that her family were with her on admission…She was stable (as per NEWS charts) and was described as comfortable at 06:00. Given these particular circumstances (family phoning through the night, family being aware of admission); it was not inaccurate to say that there were no concerns. This would more accurately be 'no new concern's'…there is nothing to suggest from a nursing perspective that [the patient] was in the last hours or even days of life. Her NEWS was stable overnight and she was 'settled'….There was no clear indication of deterioration until after 10:30 on 24th…'*

97. Given the available evidence I accept the N IPA's advice that when the family were in contact overnight, with the ward, the patient was stable and there was nothing to suggest that the patient was nearing end of life. It appears that the patient deteriorated so quickly there was not an opportunity to discuss the patient being at end of life until the ward round on 24 May 2019 when a referral was made to the palliative care team and the DNACPR was completed. Although I do not consider there to be a failing in relation to the family not being informed the patient was at end of life prior to visiting the patient on 24 May

2019, I wish to emphasise that this in no way diminishes the feelings and hurt experienced by the family. I again refer to paragraph 63 which highlights the injustice the patient and the family sustained as a result of the inaccurate CT report, in particularly the loss of opportunity to prepare for and discuss end of life care.

98. I am unable to determine whether clinicians discussed with the patient the results of her X-ray prior to undertaking the CT scan as well as her likely diagnosis and prognosis. Although I note the Trust have stated this was discussed on the morning of the 24 May 2019 the clinical record lack details to that regard. I accept the C IPA's advice that *the x-ray '…did not conclusively say small bowel obstruction although the clinical indications and interpretation was that of a small bowel obstruction…'* but that a discussion should have taken place with the patient, *after diagnosis or treatment…about treatment and* this should have been recorded. I would ask the Trust to reflect on when information about a patient's prognosis is conveyed to them and how this is recorded.

v. Medical Certificate of Cause of Death

110. The complainant believed the patient's MCCD did not reflect the patient's true cause of death failing to indicate that she died of small bowel obstruction. I further note the complainant's requests to have the MCCD modified given the advice of the C IPA. I note that the MCCD documents metastatic breast cancer as the condition/disease directly leading to the cause of death and osteoporosis as another significant condition. I also note the C IPA's advice that *'The clinical diagnosis on the death certificate was metastatic carcinoma of the breast. This was the definitive diagnosis that was effectively the cause of death. Whilst the presence of a bowel obstruction can for completeness can be added, the assumption that the bowel obstruction was secondary to the tumour was reasonable…'* I further note the C IPA's advice that *'…It is encouraged…but not mandated… when writing, Death certificates be more detailed in adding contributory causes with other possible underlying factors…The death certificate could have been written with cause of death being small bowel obstruction with the underlying factor of metastatic carcinoma of the Breast.*

However, it remains the significant cause leading to death was the cancer….'

111. The clinicians treating the patient made a judgement on the contribution of the various disease processes affecting the patient and included this on the MCCD. I acknowledge that the C IPA advised the MCCD could have been written '… *with cause of death being small bowel obstruction with the underlying factor of metastatic carcinoma of the Breast*...' but that also *metastatic carcinoma of the breast '…was the definitive diagnosis that was effectively the cause of death*...' From the available evidence I am satisfied the MCCD could not be considered inaccurate and reflects the cause of death. I do not uphold this element of complaint but do recognise the inclusion of SBO on the MCCD would have been reasonable and may have reduced the upset caused to the patient's family as a result of the SBO not being included in the MCCD. I would ask the Trust to reflect on the C IPA's comments in relation to learning that consideration should be given to *'…ensuring death certificates are as far as possible reflect the cause of death and related factors for completeness.'*

CONCLUSION

112. I received a complaint about the actions of the Trust in relation to the care and treatment the staff of AAH provided to the patient between 14 May 2019 to 24 May 2019.

113. The investigation established a failure in the care and treatment in relation to the following matter:

    i. The reporting of the CT scan dated 13 May 2019 and as a result the care offered to the patient by the Trust was not appropriate.

114. I am satisfied that the failure in care and treatment identified caused the patient to experience the injustice of loss opportunity to access more timely palliative/supportive care, better symptom control and, to prepare for and discuss her end of life care. I am also satisfied the failure in care and treatment

caused the complainant and her family to experience the injustice of loss of opportunity to prepare for and discuss for the patient's end of life as well as distress.

115. The investigation also identified that nursing staff incorrectly calculated the patient's total fluid balance during her second admission. I consider this a failure although I note this failure did not cause the patient to experience an injustice or affect patient care.

116. The investigation of this complaint did not find a failure in the relation to the remaining elements of this complaint. However, for some of these elements I wish to emphasise that although I did not identify failures, this is based on the information available to clinicians at the time of the events. I consider had the failure in the CT scan not occurred, the patient and her family might not have experienced the injustice detailed above.

117. The investigation also did not find failures in relation to the; treatment clinicians provided during patient's second admission; administration of oxygen therapy during the patient's second admission; nursing care provided to the patient during the second admission; communication of prognosis and; MCCD reflecting cause of death.

Recommendations

118. I acknowledge the Trust is currently reviewing the peer review and discrepancy meeting process in relation to imaging and will '*soon be implementing changes with that regard.'*

119. I recommend:

    i. 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 (within **one month** of the date of this report); and

    ii. The Trust discusses the findings of this report with the clinicians involved in the patient's care.

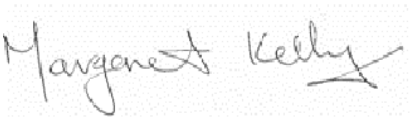
120. I further recommend for service improvement and to prevent future recurrence the Trust:

    i. Provide evidence that Dr E, reporting Radiologist for the CT scan dated 13 May 2019, as well as the Responsible Officer in the locum agency, has been informed of the identified discrepancy;
    ii. Review the current arrangements for the evaluating of work by locum radiologists, including locum consultant radiologists, and advise this office on the outcome of this review including any recommendations or improvements in practice;
    iii. Provide evidence of the examination into the peer review and discrepancy meeting process including and any recommendation made as a result of the review; and
    iv. Carryout out a random sampling audit of Dr E's CT scan reports and advise this office on the outcome of this audit including any recommendations or improvements in practices.

121. I recommend that the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **six** 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).

122. I wish to acknowledge the complainant's and her family's clear care and devotion to the patient when in AAH and I hope this report provides them with some reassurance in relation to the care and treatment provided to the patient.

123. The Trust accepted my findings and state they were committed to implementing my recommendations in full.



MARGARET KELLY
OMBUDSMAN **26 September 2022**

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.