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

Report Reference: 202002121

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Case Reference: 202002121
Listed Authority: Western Health and Social Care Trust

SUMMARY

I received a complaint about the Western Health and Social Care Trust's (the Trust) care and treatment of the complainant's late wife (the patient) during her time as an in-patient in Altnagelvin Hospital (AH) from 16 October 2020 until 21 October 2020.

The patient was admitted to AH on 16 October 2020 on the advice of her GP. On 17 October 2020, the Trust carried out a CT scan which identified a mass in the patient's liver. Subsequently, the Trust undertook an endoscopy on 20 October 2020. Sadly, the patient died on 21 October 2020.

The complainant said, given the CT scan findings, the endoscopy was unnecessary, and which process would have '*terrified'* the patient. The complainant said the Trust did not carry out an appropriate consent process for the endoscopy. The complainant also said the Trust did not conduct the endoscopy correctly. The complainant also said the Trust gave the patient inappropriate medication, given her age and health. The complainant raised concerns about the Trust's management of the 'do not attempt cardiopulmonary resuscitation' process, as well as concerns about the Trust's management of the patient's pain and end-of life care.

The investigation established there were significant failings in the patient's care and treatment. These related to how the Trust managed consent for the endoscopy and also established the Trust undertook two endoscopies which were outwith the consent the patient had provided. The endoscopy further contributed to aspiration in the patient. I found further failings with managing the patient's pain and ensuring she did not suffer un-necessary pain as well as the information provided to the patient about her prognosis.

In relation to facilitating contact between the patient and her family, the investigation found the Trust did not act fully in accordance with the Department of Health Covid-19: Regional Principles for Visiting in Care Settings in Northern Ireland. Sadly, this

meant the patient and her family lost the opportunity to have more time together, through virtual visiting, before the end of her life.

I recommended the Trust provides the complainant with a written apology for the injustice caused by the failures in care and treatment. I made further recommendations for the Trust to address under an evidence-supported action plan to focus on service improvement and preventing a re-occurrence of the failings.

The patient was in hospital during the COVID-19 pandemic. These were difficult and uncertain times with stretched National Health Service resources. Despite this, the patient's care should have been of an acceptable standard. The impact on the quality of the family's remaining time with the patient related to the failings identified, deeply saddens me and I wish to convey my sincere condolences to the complainant and his family on the sad loss of their loved one.

THE COMPLAINT

1. This complaint is about care and treatment the Western Health and Social Care Trust (the Trust) provided to the patient while she was in hospital from 16 to 21 October 2020. The complainant was the late patient's husband. From the complainant's correspondence and the Investigating Officer's conversations with him it is clear how deeply these events have affected him and his family. I also recognise the complainant and his family will find much of the detail in this report distressing.

Background

2. The patient attended Altnagelvin Hospital Emergency Department (ED) on 16 October 2020 where a Computerised Tomography[1] (CT) scan was undertaken. The CT scan results indicated a high possibility of advanced metastatic cancer and an endoscopy was planned to confirm the findings of the CT scan to identify the most appropriate treatment options. An endoscopy was undertaken on 20 October 2020. The patient's condition deteriorated thereafter, and she sadly died on 21 October 2020.

Issue(s) of complaint

3. I accepted the following issue of complaint for investigation:

Issue 1: Whether the care and treatment the Trust provided to the patient between 16 and 21 October 2020 was appropriate and reasonable in accordance with relevant standards and guidance.

In particular this considered:

i. The consent process for the endoscopy procedure;
ii. The conduct of the endoscopy procedure;
iii. Medication prescribed and administered to the patient;
iv. Facilitation and restriction of contact between the patient and her family;
v. Management of the 'do not resuscitate' process;

[1] A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body. They can be used to diagnose conditions – including cancer and guide further tests or treatments; for example, they can help determine the location, size and shape of a tumour before having treatment.

vi. Management of the patient's pain and discomfort on 20-21 October 2020;
vii. Communication with the patient and her family about her cancer diagnosis; and
viii. End-of-life care.

INVESTIGATION METHODOLOGY

4. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

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

- A Consultant Geriatrician/Physician for more than 11 years, with additional expertise and qualifications relating to palliative care; MBChB MRCP (UK), Dip Pall Med (CP IPA);
- A Consultant Gastroenterologist for 33 years; MB BCh BAO, MRCPI MRCP FRCP; an interventional endoscopist with a wide experience, including vast experience in ERCP and enteral stenting; a member of the British Society of Gastroenterology (CG IPA); and
- A Nurse with 21 years' experience across primary and secondary care; RGN, MSc Advanced Clinical Practice, BSc (Hons) Nurse Practitioner, MA Health Service Management, Diploma in Adult Nursing (Nurse IPA).

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 I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

7. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

   The general standards are the Ombudsman's Principles[2]:

   - 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 Ethical Guidance: Decision Making and Consent, September 2020 (GMC Consent Guidance);
   - The British National Formulary, September 2020 (BNF Guidance);
   - The Department of Health Covid-19: Regional Principles for Visiting in Care Settings in Northern Ireland, 23 September 2020 (DoH Covid Visiting Guidance);
   - The General Medical Council's Ethical Guidance: Treatment and Care towards the end of life: Good Practice in Decision Making, July 2010 (GMC DNR Guidance);
   - The British Society of Gastroenterology (BSG) and the Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (AUGIS) Quality Standards in Upper Gastrointestinal Endoscopy, September 2017 (BSG/AUGIS Endoscopy Standards);
   - The Nursing and Midwifery Council's Standards for Nurses, 2018 (NMC Standards); and
   - The General Medical Council's Good Medical Practice, April 2019 (GMC Guidance).

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

9. I did not include all information obtained during the investigation in this report. However, I am satisfied I considered everything I considered 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

Detail of Complaint

11. There were eight elements included within the issue of complaint. Each of these are addressed individually below. I further separated the first element related to the consent process for the endoscopy procedure into the following:
    - Information provided to and support for the patient in the consent process;
    - The timing of the endoscopy; and
    - The parameters of the procedure to be undertaken within the consent process.

i. The consent process for the endoscopy procedure: Information provided to and support for the patient in the consent process

12. The complainant said he spoke with the patient who told him the Trust Consultant Gastroenterologist explained the endoscopy procedure and told her if she did not proceed with the endoscopy, they would not *'be able to do it again'*. The complainant said '*guidance'* states '*someone particularly next of kin, should be with the patient to explain the medical facts to the patient'* but this did not happen.

13. The complainant said the Trust Consultant Gastroenterologist told the patient there would be six students present at the procedure and the patient was *'supposed to have given consent to the 'procedure' and to the attendance of six students'*. The complainant explained the patient '*was terrified of an endoscope*

and said she would rather die, as she' gagged' once they tried it. She was totally terrified … completely and utterly distressed'.

i. The consent process for the endoscopy procedure: The timing of the endoscopy

14. The complainant also questioned the need for the endoscopy; he said, *'what was there to gain'* from the procedure. The complainant also said the Trust tried to '*prove there was Cancer'* but it was '*just a polyp. There was no proof of a Malignant Cancer from at least 14 biopsies'.*

i. The consent process for the endoscopy procedure: The parameters of the procedure to be undertaken within the consent process

15. The complainant said, *'Fourteen times an endoscope was shoved down her throat … no pity'.*

Evidence Considered

Trust's response to investigation enquiries

16. As part of investigation enquiries, the Trust had an opportunity to respond to the complaint. The Trust's response to the enquiries was considered when drawing up this report.

Legislation/Policies/Guidance

17. I considered the GMC Consent Guidance.

Relevant records

18. I considered the patient's medical records for the period 16 to 21 October 2020.

Relevant Independent Professional Advice

19. The CP and CG IPAs both provided advice on different aspects of the process related to proceeding with the endoscopy, including in the context of the CT findings.

20. The CP IPA provided advice about the patient's overall pathway of care following the CT findings. This incorporated discussions with the patient about the plan of care, including the endoscopy and the consent process both in terms of timing and involvement of the patient's family.

21. The CG IPA provided advice on the CT findings; the decision to perform the endoscopy, including the timing of the procedure; and the endoscopy consent process.

22. The CG IPA's original advice, prior to issue of the Draft Investigation Report and responses to this, along with the CG IPA's further advice, were considered fully.

Responses to the Draft Investigation Report

23. Both the complainant and the Trust were given an opportunity to provide comments on the Draft Investigation Report. Where appropriate, comments have been either reflected in changes to the report or are outlined in paragraphs 24 to 27 and 52 below.

The Trust Response

24. The Trust stated the ward round records of 19 October 2020 documented the Trust Consultant Surgeon informed the patient of the '*possibility*' she had cancer, with further investigations discussed. Further, the patient's nursing records indicated the patient was told of the CT findings. The Trust stated, *'at this stage, there was a suspicion of metastatic malignancy but no definitive proof hence the wording 'possibility'.* The Trust acknowledged it had *'poor'* communication with the family.

25. The Trust referred to the complainant's comments related to its decision to perform an endoscopy when there was no proof of cancer and what purpose did it have in the context of the CT findings. The Trust explained it made the decision to perform the endoscopy on 19 October 2020 because the CT scan *'was highly suggestive*' of a malignant cancer but '*the cell line of the cancer could not be determined'.* The Trust stated the purpose of the endoscopy was

to determine the type of cancer to *'better predict'* the optimum treatment '*to extend [the patient's] life expectancy'.* The Trust stated it opted for an endoscopy because it considered this to be a safer option than a liver biopsy. The Trust also acknowledged '*in retrospect'* from *'prior to the time of [the patient's] admission',* the patient '*was deteriorating and irrespective of the [type of cancer], this was almost certainly going to be [the patient's] final admission'.* The Trust also stated it should have considered palliative care '*at an earlier stage'*.

26. The Trust stated the Trust Consultant Gastroenterologist said, when he discussed the procedure *'in advance with [the patient]'*, he '*was sure that [he] discussed the indication for the procedure, proposed benefits and potential risks including common or significant potential complications, how she may experience the procedure, the availability of local anaesthetic spray and the role of [intravenous] sedation'.* The Trust Consultant Gastroenterologist also said he *'would have advised [the patient] that the decision to proceed would be hers … [and] the possibility of performing an [O*esophago-Gastro-Duodenoscopy[3]] (*OGD) with a standard gastroscope[4] initially, with a view to passing a duodenoscope[5] thereafter if this was indicated to assess any abnormality at the ampulla[6]'.* The Trust Consultant Gastroenterologist acknowledged '*omitting to document that on the consent form, along with details of the discussion was a significant failure … and falls well below expected standards'.*

Further Independent Professional Advice Following Receipt of Draft Investigation Report Responses

27. In consideration of the Trust's comments in response to the Draft Investigation Report, the CG IPA provided further independent professional advice. The additional advice relates to the Trust's communication to the patient about her diagnosis and prognosis.

[3]An *O*esophago-Gastro-Duodencopy, also known as a gastroscopy, is an examination of the oesophagus (gullet / food pipe), stomach, and duodenum (the first and second part of your small bowel). It involves inserting a long, thin, flexible tube called an endoscope into the mouth which is passed down into the stomach. The endoscope is about the thickness of a little finger with a mini video camera built into its tip. This sends pictures to a video screen.
[4] A standard gastroscope is a tube used to access the oesophagus, stomach and duodenum during endoscopy.
[5] A duodenoscope is like a gastroscope but has a hinge which enables the Gastroenterologist to angle a small tube into the pancreatic or bile duct to see these so is used to investigate concerns about these areas.
[6] The ampulla (of Vater) is located where the bile and pancreatic ducts join the small intestine.

Analysis and Findings

i. The consent process for the endoscopy procedure: Information provided to, and support for, the patient in the consent process

28. I note the records of the procedure clearly evidence the only people present at the procedure were the Trust Consultant Gastroenterologist and three nurses.

29. The GMC Consent Guidance states, '*you must give patients the information they want or need to make a decision. This will usually include diagnosis and prognosis'.* I note it also states, '*accommodate a patient's wishes if they would like anyone else – a relative, partner, friend, carer or advocate – to be involved in discussions and/or help them make decisions … give them time and opportunity to consider it before and after making a decision'*.

30. I refer to the patient's medical records. On 21 October 2020 00:00, it is recorded a Trust doctor explained to the patient's husband the patient was 'v*ery unwell … a scan showed lesions in her liver and duodenum … [patient's husband] was not aware of*' this. The endoscopy consent form is dated 20 October 2020. Within the form, the points below are pre-printed but there is no indication these were specifically discussed with the patient either by notation of ticks, initials or signatures or through any additional notes, including any detail of the leaflet/tape referenced. There are no other notes relevant to the consent in the patient's other clinical records.

'Allergic reactions to the equipment, materials or sedative.
Breathing/ heart problems as result of reaction to the sedation.
Bleeding increases if biopsies or polypectomy is performed.
Perforation-risk approx. 1:3,000 and is increased during therapeutic intervention.
Incomplete procedure/ missed pathology/damage to teeth.

Possible additional procedures which may become necessary during the procedure.

I have also discussed what the procedure is likely to Involve, the benefits and risks of any available alternative treatments (including no treatment),

any samples of tissue that may be taken and any particular concerns of this individual.

The following leaflet/tape has been provided'.

31. The CP IPA's advice included discussions with the patient about the plan of care and the endoscopy consent process, both in terms of timing and involvement of the patient's family. The patient was told of a necessity for "*further tests"* but there is never a 'need' to do anything; rather, the patient should always be given the option of not proceeding with any suggested investigations or treatments. Invasive investigations should always be discussed in detail with patients. The CP IPA advised, '*ideally the patient should also be offered the option to have a relative/carer involved in these discussions for support'*; this could have been facilitated during Covid by telephone. I note the IPA advised it was also unclear if '*the patient was given adequate information to make an informed decision'* about proceeding with an endoscopy which, in the CP IPA's opinion was '*unreasonable'*.

32. The CG IPA's advice included the CT findings; the decision to undertake an endoscopy, including the timing of this; and the endoscopy consent process. The CG IPA advised the CT scan was '*highly suggestive of a malignancy, assumed duodenal, with very extensive metastatic spread, with a huge lesion in the liver'.* In the CG IPA's opinion, the decision to perform the endoscopy was correct; however, he *'question[ed] the timing'.* In his further advice, following responses to the draft investigation report, the CG IPA advised, *'the Trust did inform the patient about 'the possibility of cancer' and the Trust informed the patient of the CT findings; however, there is no evidence she was informed that the probable diagnosis was 'metastatic malignancy' and 'likely a cancer'. Therefore, the patient was not given adequate information about the likely prognosis. Also, the records do not evidence that the patient's family were aware of the most likely diagnosis and prognosis'.* I note the CG IPA's advice, the patient *'was, therefore, not fully informed to make a decision about the endoscopy'* and*, 'because there is no evidence the Trust informed the patient's family about her diagnosis and prognosis, if the Trust had given the patient the*

opportunity to involve her family is support for her decision about the procedure, the patient's family did not have adequate information about her diagnosis and prognosis to enable a supported informed decision'. In consideration that the patient was reluctant for an endoscopy, the CG IPA advised, it was '*therefore … reasonable to conclude the patient may not have agreed if she had been fully informed about the prognosis'.*

33. I note the CG IPA's advice the information given to the patient before the endoscopy '*should have been more detailed'.* There was no additional information other than the standard diagnostic endoscopy consent form.

34. I consider the records indicate the patient's next of kin was not aware of the patient's diagnosis and prognosis prior to the endoscopy consent process. I also consider the endoscopy consent form does not clearly evidence the patient was provided with all the appropriate details.

35. I also accept the CG IPA's advice and am satisfied the Trust did not provide sufficient information to the patient about her prognosis. I also consider there is no evidence the patient was offered the opportunity to involve her family in the decision about the endoscopy. Further, I accept both the CP and CG IPAs' advice it was not evident the patient was given adequate detail to make an informed decision. I refer to the GMC Consent Guidance cited at paragraph 29 above. I consider this constitutes a failure in care and treatment.

i. The consent process for the endoscopy procedure: the timing of the endoscopy

36. I note the GMC Consent Guidance states patients are to be given '*time and opportunity to consider … before and after making a decision'.*

37. I note, in the CP IPA's opinion, the patient was given very little time, less than 24 hours, to make an informed decision.

38. I note the CG IPA advised*, 'the endoscopy was performed somewhat in a rush.'*

39. I accept both the CP and CG IPAs' advice and am satisfied the Trust did not give the patient adequate time to make a decision about the procedure. I consider this constitutes a failure in care and treatment.

i. The consent process for the endoscopy procedure: The parameters of the procedure to be undertaken within the consent process

40. I note the GMC states, '*you must be clear about the scope of decisions so that patients understand exactly what they are consenting to. You must not exceed the scope of a patient's consent, except in an emergency. Agreeing the scope of a patient's consent with them in advance is particularly important if: there may be opportunity, once an intervention is underway and the patient's decision-making ability is compromised, to carry out another intervention'.*

41. I refer to the patient's medical records. I also refer to paragraph 30 above. The endoscopy consent form's pre-printed points include '*possible additional procedures which may become necessary during the procedure*'. As also noted in paragraph 30, there is no indication this was specifically discussed with the patient because there are no notations, additional notes or detail of any additional procedures and there are no other relevant notes in the patient's other clinical records. I note there is only one procedure indicated on the consent form.

42. I refer to paragraph 33 above and the CG IPA's advice the information given to the patient before the endoscopy '*should have been more detailed'*. There was no additional information other than the standard diagnostic endoscopy consent form, including any additional procedures which might be performed. The CG IPA referred to the further procedure undertaken, '*changing endoscopes to a side-viewing duodenoscope which equated to two endoscopies in one procedure.*' He advised the procedure was '*a diagnostic endoscopy to visualise and biopsy the duodenal lesion'* but it was not intended to '*bypass the tumour by stenting'.* It was therefore not clear why an endoscopy '*with a conventional forward-viewing endoscope'* proceeded to '*a second endoscopy with a side-viewing duodenoscope to "get past" the tumour. This would only have been relevant if stenting was being considered at that time, which does not appear to have been the plan.'* I note the CG IPA's advice there was no evidence the patient knew there might be a "*double endoscopy*" during the procedure.

43. I note the Trust Consultant Gastroenterologist's comments, detailed at paragraph 26 above, he would have discussed all these aspects of the procedure with the patient. I refer to the records which do not include these details. Further, I accept the CG IPA's advice. In consideration of this advice, the GMC Consent Guidance included in paragraph 29 above, and in the absence of the documentation of these discussions, particularly those related to carrying out a duodenoscope, I am satisfied the Trust did not fully carry out an appropriate endoscopy consent process. I consider this constitutes a failure in care and treatment.

44. I refer to my findings at paragraphs 35, 39 and 43 above. I therefore uphold this element of the complaint.

Injustice

45. I considered carefully whether the failings caused an injustice to the patient and her family. I refer to the complainant's comments the patient '*was totally terrified … completely and utterly distressed'.* I consider the patient sustained the injustice of upset and distress. I also consider the patient's family sustained the injustice of upset and uncertainty about the patient's distress; and both the patient and her family sustained the injustice of a loss of opportunity to make an informed and supported decision about the endoscopy.

46. I refer to the complainant's comments about the consent for attendance of students at the endoscopy. I consider there is clear evidence only the Trust Consultant Gastroenterologist and three nurses attended the procedure. Therefore, there were no students in attendance.

Detail of Complaint

ii. The conduct of the endoscopy procedure

47. The complainant said the patient told him she felt her anus was penetrated during the endoscopy. The complainant said he was concerned, if the endoscopy had caused leakage from the patient's intestines, which he said are '*only one cell thick*', this can cause Sepsis, from which the patient died. The complainant said the patient was '*on Clopidogrel and her blood was so thin that*

taking 14 biopsies down her insides she must have been bleeding profusely' and which he said was another possible cause of the Sepsis. The complainant also said, 'f*ourteen times an endoscope was shoved down her throat … no pity'.*

Evidence Considered

Legislation/Policies/Guidance

48. I considered the BSG/AUGIS Endoscopy Standards.

Relevant records

49. I considered the patient's medical records from 16 to 21 October 2020; in particular, the endoscopy referral form and the endoscopy consent form.

Relevant Independent Professional Advice

CP IPA's Advice

50. The CP IPA provided advice on the patient's condition prior to the endoscopy.

CG IPA's Advice

51. The CG IPA provided advice about the Trust's actions prior to the endoscopy, the specific investigations undertaken during the procedure and the patient's post-operative care.

Responses to the Draft Investigation Report

The Trust response

52. The Trust stated the theatre management system data indicates the procedure began at 10:38 and finished at 11:08. The initial, standard, endoscopy took place between 10:35 and 10.50. The Trust asserted 15 minutes was a reasonable duration for a '*diagnostic OGD with biopsies of two lesions'.* The Trust further stated, the second procedure with the duodenoscope took place between 11.05 and 11.20. The Trust acknowledged 15 minutes for a duodenoscope '*is relatively long'*. The Trust stated the records indicate the patient tolerated the procedure *'well*'; however, her tolerance *'waned'.* The Trust Consultant Gastroenterologist stated, '*upon reflection it would have been*

appropriate [to have been] more mindful of the elapsed time and terminated the procedure sooner.' The Trust also provided additional records indicating it repeated blood tests prior to the endoscopy on 19 October 2020.

Analysis and Findings

53. I refer to paragraphs 30, 33 and 41 above related to the absence of the details of any additional procedures on the endoscopy consent form. The endoscopy referral form, dated 19 October 2020, details an '*Oesophagogastro Duodenoscopy'*[7] (OGD) *'needed for tissue diagnosis*' and the endoscopy consent form indicates '*OGD*', *'Biopsy'* and '*Diagnostic*'.

54. I refer to the CG IPA's advice at paragraph 42, although the consent form was for a standard diagnostic endoscopy without any additional procedures included, a further procedure was undertaken, '*which equated to two endoscopies in one procedure.'* I note the CG IPA advised the intended procedure was '*a diagnostic endoscopy to visualise and biopsy the duodenal lesion*' and not to *'bypass the tumour by stenting'.* Further, the procedure was '*unnecessarily prolonged'* and the additional procedure '*did not add to the diagnostic evidence'*. He advised, '*a single diagnostic endoscopy with the forward-viewing endoscope would have taken under 15 minutes'.*

55. The CP IPA advised the patient was '*medically unwell with infection and acute renal impairment prior to the procedure'.* Further, the CG IPA advised, *'there should have been a significant suspicion of infection'* because, on 18 October 2020*, 'there was evidence of an acute deterioration in renal function'.* Although in his further advice the CG IPA confirmed the Trust appropriately repeated these blood tests on 19 October 2020, prior to the endoscopy, these repeated tests also indicated '*renal impairment … but [the Trust] proceeded with the procedure when the indications were renal function was deteriorating. This was not appropriate'.* I note the CG IPA's advice that, in the context of the indications of '*severe acute renal failure …. [the endoscopy] presented a higher risk.'*

[7] Oesophagogastro duodenoscopy or endoscopy involves looking at the upper part of the gut which includes the oesophagus (food pipe), stomach and the first part of your small bowel (duodenum) with a narrow flexible tube called a gastroscope.

56. I note the CG IPA's advice *'the prolonged nature of the procedure undoubtedly increased the risk of an aspiration[8] pneumonia'*. The CG IPA advised neither the chest x-ray of 17 October 2020 nor the CT scan on 18 October 2020 indicated aspiration but it was evident on the chest X-Ray on 20 October 2020, following the endoscopy. He advised, aspiration '*is likely to have occurred during the endoscopies.'* Further, however, this might not be noticed during an endoscopy procedure. In the CG IPA's opinion, the records before the endoscopy indicate it was '*extremely unlikely that a life-threatening aspiration'* occurred before the endoscopy. He also advised, however, there was no evidence of bleeding. The CG IPA also referenced the patient's underlying condition and opined, '*the prognosis was very poor … even with optimal clinical care, she may have had a rapid deterioration … aspiration was a risk at any time and definitive, albeit palliative, management of her malignancy would have exposed her to all the risks of sepsis, renal failure and a poor nutritional state'.*

57. I note the BSG/AUGIS Endoscopy Standards recommend "*a standard diagnostic endoscopy is allocated a slot of a minimum of 20 min'.*

58. I refer to the Trust's comments at paragraph 52 above. I note the duration of 15 minutes for the first OGD is in line with the timelines outlined in the BSG/AUGIS Endoscopy Standards. However, I accept the CG IPA's advice and am satisfied there were effectively two endoscopies undertaken, with the second one extending outside the original parameters detailed in the consent form. I consider the records indicate the endoscopy was intended for diagnostic purposes. I accept the CP and CG IPAs' advice the patient was very unwell with poor renal function prior to the endoscopy. I refer to the BSG/AUGIS Endoscopy Standards. In consideration of this and the CG IPA's advice, I am satisfied the second procedure was '*unnecessarily prolonged*' and did not add to the diagnostic evidence; the duration of the procedure *'increased the risk of an aspiration pneumonia';* the patient's renal failure, which was clearly indicated, heightened the risk of performing an endoscopy; and the aspiration

[8] Aspiration is the drawing in of a foreign substance into the lungs. The primary concern of accidental aspiration is the development of a lung infection known as aspiration pneumonia. In most cases, aspiration pneumonia is the result of a bacterial infection. Whenever you aspirate a foreign substance into the lungs, bacteria not commonly found in the lungs can be carried along. This even includes saliva, which contains a plethora of aerobic bacteria (those needing oxygen to survive) and anaerobic bacteria (those that thrive without oxygen).

'*is likely to have occurred during the endoscopies.*' I also refer to my finding at paragraph 43, the consent process did not reflect the scope of the procedures undertaken. I therefore consider the conduct of two endoscopies, particularly in the context of the patient's failing renal function, constitutes a failure in care and treatment. I therefore partially uphold this element of the complaint.

59. I also accept the CG IPA's advice there was no evidence of bleeding and there was no penetration of the patient's anus.

Injustice

60. I considered carefully whether the failings caused injustice to the patient and her family. I refer to complainant's comments about the patient's distress about the procedure. I consider the patient sustained the injustice of distress and upset because of the unnecessary discomfort during the prolonged procedure. I also consider her family then sustained the injustice of upset and uncertainty in the knowledge of the patient's experience.

61. Further, I refer to the CG IPA's advice the evidence indicates it was '*likely'* the aspiration occurred during the '*unnecessarily prolonged*' endoscopies procedure but also the patient's underlying condition indicated a poor long-term prognosis and even with *'optimal care*', the patient faced future risks of sepsis, aspiration and renal failure. Therefore, whilst I consider, on the balance of probabilities, the endoscopy contributed to the patient's aspiration, I cannot definitively conclude whether the failings contributed to the overall outcome for the patient.

Detail of Complaint

iii. *Medication prescribed and administered to the patient*

62. The complainant said the patient '*was pumped full of Anti-Biotics including Gentamicin renowned to cause Renal failure'*. The complainant said, *'it is suggested in guides to antibiotics that people over seventy years old should not be over loaded with antibiotics full stop'.* The complainant also said the patient '*was also pumped full of Morphine … which again according to the*

guidance on the use of Morphine, is not to be used on patients over seventy as it causes problems with the breathing mechanism of the brain'.

Evidence Considered

Legislation/Policies/Guidance

63. I considered the BNF Guidance.

Relevant records

64. I considered the patient's medical records from 16 to 21 October 2020; in particular, the patient's medication records (Kardex).

Relevant Independent Professional Advice

CP IPA's Advice

65. The CP IPA provided advice about the medication prescribed to the patient, including the levels and appropriateness of this. This included the antibiotics and morphine prescribed.

Nurse IPA's Advice

66. The Nurse IPA provided advice about the medication given to the patient and whether this was in line with what was prescribed.

Analysis and Findings

67. The BNF Guidance documents the recommended dosage for Tazocin, by intravenous infusion, for adults is 4.5 g every eight hours, increasing to every six hours for severe infection; and for those with renal impairment, a maximum of 4.5 g every eight hours if creatinine clearance is 20 to 40 or every 12 hours if creatinine clearance is less than 20. In the BNF Guidance, the recommended dosage for Metronidazole by intravenous infusion is 500 mg every eight hours and there are no indications adjustments are to be made for renal impairment. For both antibiotics there are no adjustments listed for elderly patients and no side-effects listed related to breathing. In the BNF Guidance on Morphine, the lowest recommended dose orally or by subcutaneous injection, and which is the dosage listed for the elderly, is 5 mg

every four hours. I also refer to the BNF Guidance in which the criteria for screening of potentially inappropriate prescriptions for the elderly, associated with Morphine is detailed; I note these criteria did not apply in the patient's case.

68. The CP IPA provided advice on all the medication prescribed to the patient. She also detailed the medication which was prescribed but not administered. She advised where oral medication was not given, this was because the patient was fasting/nil by mouth. Enoxoparin was withheld after 18 October 2020 because of the patient's impaired kidney function. Further, although prescribed, there were no doses of Clopidogrel administered both because of the patient's fasting and because of the planned endoscopy/biopsy. I note the CP IPA advised this was *'reasonable*' because of the planned biopsy. The antibiotic, Tazocin 4.5g, was given intravenously three times each day from 17 to 19 October 2020 and then reduced to twice daily on 20 October 2020 because of the patient's kidney impairment. The other antibiotic, Metronidazole 500mg, was started intravenously on 20 October 2020, three times each day. Candesartan and Bendroflumethiazide were not given because of kidney function.

69. The CP IPA advised there was no evidence Gentamicin was ever prescribed or administered and *'this was reasonable'.* Morphine solution 5mg was prescribed orally every four hours as required from 17 to 19 October 2020, with the patient receiving four doses in total over the three days. Morphine 2.5mg subcutaneous injection, was prescribed two to four hourly as required from 20 October 2020, with the patient given two doses in total on 21 October 2020. The CP IPA advised she had '*no concerns about the medications that were prescribed*'. I note further, the CP IPA referenced the complainant's concern about the antibiotics and morphine, particularly for patients over 70 years old and advised, *'the regimes and doses prescribed appear reasonable in this case'* and *'morphine is frequently and safely used in patients of all ages when indicated'.*

70. The Nurse IPA detailed all medication given to the patient during the period. Tazocin was given once on 17 October 2020, three times on 18 and 19 October 2020, twice on 20 October 2020 and once on 21 October 2020. Metronidazole was administered once on 20 October 2020. Neither Neither Gentamicin nor Clopidogrel were administered at all. Oral Morphine was given twice on 18 and 19 October 2020 and on 21 October 2020 was given twice. The Nurse IPA advised the medications were given according to what was prescribed and when there were omissions, the reasons were recorded; for example, when the patient was admitted on 17 October 2020, she was nil by mouth until midday on 20 October 2020 which meant those medications to be taken orally were not given. The medications which were given to the patient were for '*symptom control (pain, nausea, acid reflux) or they were antibiotics (Tazocin and metronidazole)'.* The Nurse IPA also provided advice in relation to the Morphine administered in the context of the management of the patient's pain. This is referenced under element (vi) of the complaint below.

71. Review of the patient's Kardex and the relevant information detailed in both the CP and Nurse IPAs' advice indicates the dosage of Tazocin, Metronidazole and Morphine was in accordance with the BNF Guidance for each of these, including consideration of the patient's renal function and age. I note there is no evidence in the patient's Kardex the patient was either prescribed or administered Gentamicin. The records also indicate Clopidogrel was not given to the patient.

72. Based on the available evidence and the IPAs' advice I consider the dosage of antibiotics and morphine prescribed and administered was appropriate and there is no evidence the patient was given Clopidogrel or Gentamicin. I do not uphold this element of the complaint.

Detail of Complaint

iv. Facilitation and restriction of contact between the patient and her family

73. The complainant said, following the patient's admission, he was told he was not allowed into the hospital because of the COVID -19 Pandemic. The

complainant said he was '*married to [the patient] for 62 years*' and had '*always visited her in hospital and watched over her and here I was treated like a non person. [The patient] was terrified to be left on her own'*. The complainant said the patient had suffered ill-health for a long time and he was her constant carer. The complainant said they '*couldn't exist being apart*'. He said he was able to speak with the patient for a short time on 20 October 2020 but this was *'the first and last time*' he spoke with his wife from 16 October 2020.

Evidence Considered

Legislation/Policies/Guidance

74. I considered the DoH Covid Visiting Guidance.

Relevant records

75. I considered the patient's medical records from 16 to 21 October 2020. I also reviewed Department of Health records of Covid levels during the period of care and treatment.

Relevant Independent Professional Advice

CP IPA's Advice

76. The CP IPA provided advice about the Trust's actions in relation to the patient's contact with her family during the period of care.

Analysis and Findings

77. The DoH Covid Visiting Guidance states facilitation of physical visits to patients in hospital depended on the Covid surge levels at the time both regionally and locally. I note the DoH Covid Visiting Guidance also states '*virtual visiting remains the preferred option … To support this all areas will continue to facilitate virtual visiting'.* In a '*high surge*' level, which is documented as being *'extremely strict social distancing'*, the DoH Covid Visiting Guidance states, '*no face to face visiting – however following a risk assessment and ensuring a COVID free environment end of life visiting only may be considered'.*

78. I note the records of Covid surge levels in October 2020 indicated, throughout October 2020, the levels in Derry City and Strabane were the highest in the United Kingdom and the overall levels in Northern Ireland (NI) were, at that time, the highest to date. From 16 October 2020, the levels across NI were such that increased restrictions were re-introduced, including the closure of schools and hospitality. The region's Nightingale[9] hospital was also re-established at this time in response to the surge in demand. The records indicate the patient's family were able to be with the patient on 21 October 2020 prior to her passing.

79. The CP IPA referenced the DoH Covid Visiting Guidance and advised, given the period in question correlated to the second Covid wave, the Trust restrictions for in-person visiting '*would have been reasonable'*. The CP IPA referred to the requirement for facilitation of '*virtual visiting*' in the DoH Covid Visiting Guidance. I note she advised there was '*no evidence'* either of any attempts to facilitate virtual visiting or to afford the patient an opportunity to involve her family in discussions about her care and in providing support to her during this time and this was '*not reasonable'.* The CP IPA offered her opinion this '*would have been increased distress for the patient and her family'*, particularly in the context of the '*very bad news*' the patient had been given. She concluded, '*overall, engagement /communication with family ... were inadequate'.*

80. In the context of the records of the Covid levels locally, regionally and nationally, I consider it would be reasonable to conclude the surge level at that time was '*high'*. I consider, therefore, the corresponding requirements stipulated in the DoH Covid Visiting Guidance were there should be no in-person visiting except for end-of-life circumstances. I consider, in relation to the restrictions on in-person visiting, the Trust acted in accordance with the DoH Covid Visiting Guidance. Although the Trust's actions in relation to in-person visiting were appropriate in consideration of the DoH Covid Visiting Guidance, I recognise

[9] Across the UK, in response to concerns that Covid-19 would overwhelm the National Health Service's (NHS) critical care capacity, emergency NHS 'Nightingale' hospitals were established with the aim of supporting the NHS to cope with surging number of people with Covid-19.

how difficult it would have been for the patient and her family in being unable to be together at this time.

81. I also consider, however, the DoH Covid Visiting Guidance clearly requires the accommodation of 'virtual' visiting. I accept the CP IPA's advice there was no evidence this was facilitated or offered and this '*was not reasonable'*. I consider the Trust failed to act fully in accordance with the DoH Covid Visiting Guidance and this constitutes a failure in care because the patient did not have the opportunity to have contact with or the support of her family during this difficult time. I am concerned the Trust did not arrange virtual visiting for the family, particularly in these circumstances. While accepting the pressure on services during the COVID-19 pandemic at that time may have affected the provision of virtual visiting, it is important standards are maintained and patients and their families are shown empathy and compassion in circumstances which are difficult for everyone.

82. Therefore, I partially uphold this element of the complaint.

Injustice

83. I considered carefully whether the failing caused an injustice to the patient and her family. I refer to the complainant's comments the patient was '*terrified'* of being left on her own and the patient and her husband '*couldn't exist being apart*'. I concur with the CP IPA's advice about the lack of contact and how this would have increased the patient and her family's distress. I consider the failing caused the patient to sustain the injustice of upset and distress. I also consider the patient's family sustained the injustice of upset and uncertainty. Further, I consider the patient and her family sustained the injustice of the loss of opportunity to have more time together before the end of her life.

Detail of Complaint

v. Management of the 'do not resuscitate'(DNR) process

84. The complainant said, on 21 October 2020 after he was called to the hospital because of the patient's deterioration, he approached a female doctor to ask '*if anyone was caring for'* the patient and the doctor replied she wanted to '*write*

do not resuscitate on her sheet' but the complainant said '*no'*; however, the DNR authorisation was signed *'against [the complainant's] sincere refusal'*.

Evidence Considered

Legislation/Policies/Guidance

85. I considered the GMC DNR Guidance.

Relevant records

86. I considered the patient's medical records for 20 to 21 October 2020.

Relevant Independent Professional Advice

CP IPA's Advice

87. The CP IPA provided advice about the Trust's actions in relation to the decision to not attempt cardiopulmonary resuscitation (CPR).

Analysis and Findings

88. I note the GMC DNR Guidance states where there are disagreements about CPR, resolution mechanisms can include involving an independent advocate, obtaining a second opinion, holding a case conference, or using local mediation services. Further, the GMC DNR Guidance states if '*having taken these steps, there is still disagreement … you must follow any formal steps to resolve the disagreement that are required by law or set out in the relevant code of practice'* and which may include consultation with appropriate people, seeking legal advice and application to a legal authority.

89. The GMC DNR Guidance states discussions should be undertaken with the patient and these discussions should be undertaken with sensitivity and include information about the risks and benefits of cardiopulmonary resuscitation (CPR). This is also required with the patient's family, when either discussions with the patient are not possible or where the patient wants their involvement. Following these steps, the patient's views '*will usually be the deciding factor'.* I note the GMC DNR Guidance states if, however, CPR is still considered as not being '*clinically appropriate, there is no obligation to provide it in the*

circumstances envisaged' but in this case, any other options available to the patient should be explained, including their right to seek a second opinion. In cases where the patient's family is being consulted in lieu of the patient, this approach is also required. The GMC DNR Guidance states any discussions with a patient or the family about this and any decisions made should be documented in the patient's record.

90. On 20 October 2020 at 22:50 it is recorded in the patient's medical records the patient was 'confused/lethargic' when discussing the DNR and the complainant was then contacted. The complainant's objection to the DNR is recorded at this time. I note on 21 October 2020 00:00, further discussion about the DNR with the complainant was recorded, including his objection and the information provided to him about ongoing care and treatment as well as the risks of CPR.

91. The CP IPA advised, when the patient became very unwell on 20 October 2020, as the patient was unable to participate in the discussions, the DNR was discussed with the complainant who objected to the DNR. The CP IPA referenced the GMC DNR Guidance related to discussions required with a patient, legal proxy or family about the risks of CPR and the reasons for the proposal of a DNR. She advised this aspect of the GMC DNR Guidance was appropriately applied. The CP IPA further referenced the GMC DNR Guidance in relation to the steps to be taken when there are disagreements about CPR. I note she advised, whilst because the patient was deteriorating quickly it may not have been feasible to consider all the possible options included in the GMC DNR Guidance, including legal advice or mediation, the family *'should have been offered a formal second opinion in the first instance … in line with GMC {DNR] Guidance'*.

92. I consider the patient's medical records indicate the patient was unable to participate in discussions about CPR and in accordance with the GMC DNR Guidance, this was discussed with the complainant. I consider the records indicate the discussions included assurance of ongoing care and treatment, the reasons for proposing the DNR and the risks of CPR. I also accept the CP IPA's advice this aspect of the GMC DNR Guidance was appropriately applied.

I consider there is no evidence any of the options required by the GMC DNR Guidance when addressing disagreements about CPR were instigated. I also accept the CP IPA's advice, in consideration of the time constraints of the patient's condition, the family should have at least been offered the opportunity for a second opinion, '*in line with GMC [DNR] Guidance'.* I consider the doctors failed to act fully in accordance with the GMC DNR Guidance and this constitutes a failure in care and treatment. I therefore uphold this element of the complaint.

Injustice

93. I considered carefully whether the failing caused an injustice to the patient and her family. In consideration the patient herself was not conscious of the DNR decision, I find, because of the failing, the patient's family sustained the injustices of the loss of opportunity for a second opinion about the DNR decision and disempowerment because they felt their views were not appropriately considered.

Detail of the Complaint

vi. Management of the patient's pain and discomfort on 20-21 October 2020

94. The complainant said he was called to the hospital late on Tuesday 20 October 2020 because he was told the patient '*was unwell*'. He said because of this description, he was not expecting to find the patient '*writhing in agony her whole body every part arms legs and head jerking all over the bed. She couldn't open her eyes, she couldn't speak not even moan*'. The complainant said he told the nurse she needed oxygen for her breathing and which he said was obviously required and within five minutes another nurse administered oxygen. The complainant said, after this, the patient continued to '*writhe'* but this was reduced. The complainant said a nurse appeared and '*mumbled … eventually with sign language she wanted to move [the patient] out of the ward and this was my fault'.* The complainant said he was in a '*state of deep shock'.* He said the patient was moved to a single room, the oxygen was re-attached and the patient left there.

Evidence Considered

Legislation/Policies/Guidance

95. I considered the NMC Standards.

Relevant records

96. I considered the patient's medical records for 20 to 21 October 2020.

Relevant Independent Professional Advice

CP IPA's Advice

97. The CP IPA provided advice about the pain medication prescribed to the patient and about oxygen given to the patient.

Nurse IPA's Advice

98. The Nurse IPA provided advice about the pain medication administered to the patient and about the Trust's actions in relation to the patient's comfort.

Analysis and Findings

99. I note the NMC Standards state nurses should *'demonstrate the knowledge and skills required to identify and initiate appropriate interventions to support people with … discomfort and pain'*; *'observe and assess comfort and pain levels; take appropriate action to reduce or minimise pain or discomfort*'; and in meeting care needs at the end of life, '*observe, and assess the need for intervention … identify, assess and respond appropriately to uncontrolled symptoms and signs of distress including pain … restlessness, agitation'.*

100. The CP IPA advised the patient was prescribed appropriate analgesia; however, it was unclear whether it was given in an appropriate and timely way. The CP IPA referred to the Nurse IPA for advice on its administration. I note the CP IPA referenced the patient's state of drowsiness and possible confusion and advised she would expect the use of an alternative method of assessing pain,

for example the Abbey Pain Scale[10] and not merely record pain as a question mark.

101. The Nurse IPA provided details of pain medication administered to the patient. She advised, following the administration of Morphine at 14:20 on 19 October, the patient's pain score remained moderate until early on 20 October 2020. I note the Nurse IPA referenced the NMC Standards and advised, it would be *'expected, in line with the prescription chart and nursing standards that additional analgesia would have been given'.* She explained the prescription chart indicated the pain relief could be given every four hours. The Nurse IPA further advised, from the morning of 21 October 2020, no pain or nausea score was recorded but instead a question mark is noted. The patient's pulse and respirations were, however, high from the evening of 20 October until 21 October 2020 and which indicated '*uncontrolled pain*'. The Nurse IPA referenced the patient's National Early Warning Score (NEWS) charts which indicated additional pain relief should have been given on the evening of 19 October 2020. Further, '*at some point on 20th October (time not legible)'* the pain score was moderate, yet no Morphine was administered at all on that day. The Nurse IPA advised, on 21 October 2020, Morphine could have been given every two hours but although the patient's observations indicated there was *'uncontrolled pain*', this was only administered at 06:20 and 12:00.

102. The Nurse IPA provided information about mechanisms for assessing pain when the patient is unable to convey this. She referenced the Abbey Pain Scale and advised this '*should have been considered rather than merely documenting a question mark for pain. Had this been used, nurses may have attributed her high respirations and pulse to pain, rather than treating the patient with oxygen, which clearly did not work'.* I note the Nurse IPA concluded, because of the failure to administer or infrequently administer the appropriate pain medication from the afternoon of 19 to 21 October 2020, '*the patient was in pain*' which '*could have been eased by giving Oramorph or morphine. This was not in keeping with the nursing standards.'*

[10] The Abbey Pain Scale is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs, for example, patients with dementia, cognition or communication issues.

103. The Nurse IPA also provided advice on the administration of oxygen to the patient. She advised, from the evening of 20 October 2020, 4L of oxygen was administered, with 10L given from the early hours of 21 October 2020. I note the Nurse IPA referenced the patient's Kardex related to oxygen prescription and advised, *'the nurses did not act in line with the directions on the Trust documentation (Trust Policy)*' because oxygen was not recorded as prescribed and, therefore, the nurses should not have administered it. The oxygen was, however, only given over a short period of time and there would have been no negative impact on the patient. The Nurse IPA concluded, the administration of either a salbutamol nebuliser and/ or Morphine settled the patient rather than the oxygen.

104. Further to the Nurse IPA's advice about the administration of oxygen without prescription, the CP IPA provided additional advice about whether oxygen should have been prescribed. The CP IPA referenced the patient's Kardex and advised the Trust's policy of oxygen only being administered when prescribed is '*best practice*'; however, the patient's clinical records also indicate the nurses appropriately referred the patient to medical staff for assessment of the patient's breathing and the medical staff documented plans for oxygen for the patient in the clinical records. The CP IPA advised, in giving the patient oxygen, the nurses were therefore carrying out the medical staff's instructions. She concluded the plan for the initial four litres of oxygen was appropriate and the subsequent higher flow of ten litres of oxygen, whilst unnecessary, did not affect the outcome for the patient. The CP IPA noted, the lack of a documented prescription in this case did not cause any issues, although could be referred as a learning point for the future.

105. I accept the CP IPA's advice the patient was prescribed appropriate pain relief. I also accept the Nurse IPA's advice, from 19 to 21 October 2020, the patient was in '*uncontrolled pain*' and pain medication was not assessed and administered appropriately to address this. I refer to the NMC Standards cited in paragraph 99 above. I am concerned the nurses did not follow national guidelines and standards during this period and this constitutes a failure in care and treatment. I therefore uphold this element of the complaint.

Injustice

106. I considered carefully whether the failing caused an injustice to the patient and her family. I consider because of the failing, the patient sustained the injustice of distress because of the avoidable and unnecessary pain. The patient's family sustained the injustice of upset as they watched the patient in pain.

107. I also refer to the Nurse IPA's advice the administration of oxygen without prescription was not in accordance with the Trust Policy but also there was no impact on the patient. I accept the Nurse IPA's advice. I refer, however, to the CP IPA's advice, following the nurses' appropriate referral of the patient's breathing difficulties to medical staff, the medical staff documented plans for oxygen in the patient's clinical notes and therefore the nurses were following these instructions. Further, the CP IPA also advised the plan for four litres of oxygen was appropriate, the increase to ten litres of oxygen did not impact on the patient and so, in this case, the absence of a documented prescription of oxygen did not cause any issues. I accept the CP IPA's advice; therefore, I consider the failures to document the oxygen prescription and administer the oxygen without a prescription is an opportunity for improvement for the Trust's consideration.

Detail of the Complaint

vii. *Communication with the patient and her family about her cancer diagnosis*

108. The complainant said the CT scan showed the patient had a '*polyp on her Duodenum'* but the Trust *'tried their hardest to prove there was Cancer … just a polyp. There was no proof of a Malignant Cancer'.*

Evidence Considered

Legislation/Policies/Guidance

109. I considered the GMC Guidance.

Relevant records

110. I considered the patient's medical records for 16 to 21 October 2020.

Relevant Independent Professional Advice

CP IPA's Advice

111. The CP IPA provided advice about the Trust's actions in relation to communications with the patient's family about the CT findings and the patient's prognosis.

Analysis and Findings

112. I note the GMC Guidance states, *'you must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.'*

113. There are no clear records in the patient's medical notes to indicate the CT findings, possible diagnosis and prognosis were communicated to the family prior to the time when the patient's family were called to the hospital when the patient was nearing the end of her life on 20-21 October 2020. I note the record of 21 October 2020 00:00 states, '*[the complainant] was not aware'* of the CT findings.

114. The CP IPA referred to her advice related to the process of consent for the endoscopy and advised discussions with the patient's family about the CT findings did not *'seem to happen until they were called in when the patient was acutely unwell on the night of 20th/early morning of 21st Oct'*. The patient was informed of the CT findings on 19 October 2020. Whilst a patient's consent is required to share such information, I note the CP IPA advised, the patient should have been given the option to involve her family in discussing the investigation results; however, this did not appear to have been offered.

115. I consider the GMC Guidance indicates the doctors should have considered the needs of the patient's family in relation to providing them with appropriate information about the patient's condition, with the patient's permission. I consider there are no records to indicate the patient was afforded the opportunity to involve the family. Further, I accept the CP IPA's advice this action should have been taken. I consider patients and their families should be given timely, clear and accurate information about the extent of a cancer

prognosis and management options. I consider this constitutes a failure in care and treatment. I therefore uphold this element of the complaint.

Injustice

116. I considered carefully whether the failing caused an injustice to the patient and her family. I consider because the patient was not given the opportunity to involve her family in communications about her diagnosis and prognosis and her family was not aware of the circumstances until 21 October 2020, the patient and her family sustained the injustice of the loss of opportunity to prepare before the end of her life. The impact of this failure on the quality of the family's remaining time with the patient deeply saddens me.

Detail of the Complaint

viii. End-of-life care.

117. The complainant said he '*virtually begged for a Catholic priest*'. He said the patient's breathing was still rapid and there was no care evident.

Evidence Considered

Relevant records

118. I considered the patient's medical records for 20 to 21 October 2020.

Relevant Independent Professional Advice

CP IPA's Advice

119. The CP IPA provided advice about the Trust's actions in relation to the patient's clinical care on 20 and 21 October 2020.

Nurse IPA's Advice

120. The Nurse IPA provided advice about the Trust's action in relation to the patient's nursing and pastoral care on 20 and 21 October 2020.

Analysis and Findings

121. The CP IPA explained the patient as in receipt of active treatment during this period and no decision had been taken to initiate an end-of-life care approach.

The patient was prescribed medication which was suitable for symptoms associated with care towards the end of life, including Midazolam for distress and Cyclizine for nausea, as well as Morphine. I note the CP IPA advised these are *'recognised medications for that purpose'* and so had no concerns.

122. The Nurse IPA referred to her advice about the management of the patient's pain during this period. I note the Nurse IPA advised the patient's religious needs were addressed.

123. I refer to my findings about the management of the patient's pain during this period at paragraph 105 and how and when the patient's diagnosis and prognosis was communicated to her family at paragraph 115. In relation to other aspects of the patient's end-of-life care, including how her religious needs were met. I recognise the integrity of the complainant's feelings and perceptions in relation to his experience during this time, including that related to accessing a priest; however, it is recorded in the patient's records a priest came to the patient. I do not therefore uphold this element of the complaint.

CONCLUSION

124. I received a complaint about the care and treatment the Trust provided to the complainant's late wife during the period of hospitalisation from 16 to 21 October 2020. I upheld several elements of the complaint. I also identified one additional learning for improvement, which is noted as an observation for the Trust's consideration.

125. The investigation established:
    - The Trust failed to manage the endoscopy consent process in line with national guidelines. This included failing to: - give the patient sufficient information about her prognosis; give the patient the opportunity to have support from her family in making an informed decision; and give the patient adequate time to make the decision.
        - I recognise the failure caused the patient to sustain the injustice of upset and distress; the patient's family sustained the injustice of

upset and uncertainty about the patient's experience; and both the patient and her family sustained the injustice of the loss of opportunity to make a fully informed and supported decision about the endoscopy.

- The Trust undertook two endoscopies which was outside the scope of consent. This led to an unnecessarily long procedure, which contributed to aspiration in the patient.
    - I recognise the failure caused the patient to sustain the injustice of distress and unnecessary discomfort from a prolonged procedure. The patient's family sustained the injustice of upset and worry because of the patient's experience. I also consider the failure contributed to the patient's aspiration.

- The Trust failed to act fully in accordance with the DoH Covid Visiting Guidance because it did not appropriately facilitate virtual visiting and contact between the patient and her family.
    - I recognise the failure caused the patient to sustain the injustice of upset and distress and her family upset and uncertainty. I also recognise the patient and her family sustained the injustice of the loss of opportunity to have more time together before the end of her life.

- The Trust failed to act fully in accordance with the GMC DNR Guidance because it did not afford the patient's family the opportunity for a second opinion on the DNR.
    - I recognise the failure caused the patient's family to sustain the injustice of the loss of opportunity for a second opinion about the DNR decision. Further they sustained the injustice of disempowerment, as they felt their views were not appropriately considered.

- The Trust failed to appropriately assess and manage the patient's pain in line with national standards and guidelines.

- I recognise the failure caused the patient to sustain the injustice of distress due to the avoidable and unnecessary pain and the patient's family sustained the injustice of upset about the patient's experience.

- The Trust failed to communicate the patient's diagnosis and prognosis to her family in line with national standards and guidelines.
    - I recognise the failure caused the patient's family to sustain the injustice of the loss of opportunity to prepare before the end of the patient's life.

126. The investigation found there were no failings in relation to the Trust's care and treatment of the patient in relation to medication prescribed and administered to the patient; and her end-of-life care.

127. I recognise how difficult and upsetting this report may be for the patient's family to read and wish to offer my sincere condolences to the complainant and his family.

Recommendations

128. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustices caused because of the failures identified (within **one month** of the date of this report).

129. I recommend the Trust should ensure relevant staff are reminded of the importance of the GMC Consent Guidance; the GMC DNR Guidance; the GMC Guidance in relation to communication with patients and their families, *Domain three*, paragraphs 32 and 33 and the NMC Standards related to assessment and management of pain, *Platform four, Providing and Evaluating Care,* paragraph 4.8 and *Part 2: Procedures for the planning, provision and management of person-centred nursing care*, paragraphs 3.1, 3.5 and 10.1. This should be evidenced by records of information sharing and/or training.

130. I further recommend the Trust should ensure relevant staff are reminded of the importance of ensuring patients and their families are afforded appropriate opportunities for mutual contact in accordance with up-to-date guidance. This should be evidenced by records of information sharing and/or training.

131. I also recommend the Trust should ensure relevant staff are given the opportunity to reflect on the findings of this report and the full CP, CG and Nurse IPAs' advice in consideration of their own practice and which should be noted in appraisal documentation, with training undertaken where any gaps are identified. This should also be evidenced by records of information sharing.

132. I recommend 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. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate staff read and understood any related policies).

133. I refer the Trust to my observation below for consideration as a further opportunity for improvement.

Observation

134. I refer to paragraphs 103, 104 and 107 above about the administration of oxygen in line with medical staff plans but which was not documented in the prescription chart. Although on this occasion there was no impact on the patient identified, the Trust should consider any appropriate actions to ensure relevant staff are reminded that plans for medication are documented in the prescription records and oxygen is only administered when prescribed.

MARGARET KELLY
Ombudsman **13 November 2023**

Appendix One

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.