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

Report Reference: 202002111

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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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Appendix 1 – The Principles of Good Administration

Case Reference: 202002111
Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust) in relation to the care and treatment provided to the complainants' late mother (the patient) from 8 October 2017 to 17 October 2017.

The complainants raised concerns with the treatment Royal Victoria Hospital (RVH) staff provided to the patient following her admission after a fall at home.

My investigation found that nursing staff did not escalate the patient's ongoing symptoms of a facial droop, in the early hours of 12 October 2017, to doctors for further investigation. My investigation also identified a service failure in relation documenting clearly the reason for delay the patient's surgery.

My investigation did not establish failures in the timing of the patient's surgery or in the management of her Clexane medication.

I also wish to acknowledge that although I did not consider the patient experienced an injustice because of the failing identified, this in no way diminishes the experience of the patient or her family during the patient's time in the RVH.

I recommended that the Trust provides the complainants with a written apology because of the failure in care and treatment I identified. I also made a further recommendation to the Trust for service improvement and to prevent future recurrence.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust) in relation to the care and treatment, provided to the complainants' late mother (the patient) from 8 October 2017 to 17 October 2017.

Background

2. On 8 October 2017, after a fall at home, an ambulance brought the patient to the Royal Victoria Hospital (RVH) Emergency Department (ED). ED staff triaged the patient, and completed a medical assessment which included the request for several radiological assessments. These included x-rays of the patient's pelvis, hip, and a CT[1] scan of her brain and spine. The x-rays confirmed the patient had a fracture of her left intracapsular hip[2]. The CT scan identified a small intracranial bleed. Following these assessments, clinicians transferred the patient from the ED to Ward 4A, Trauma & Orthopaedic (T&O) ward, for preparation for surgery on her left hip.

3. Clinicians requested a repeat CT brain scan on 10 October 2017 and deemed the patient fit for fracture surgery. The patient had surgery on 12 October 2017. On 17 October, due to symptoms the patient was experiencing, clinicians requested a further CT scan. The CT scan identified a large right posterior cerebral artery territory subacute infarction[3]. As a result, clinicians transferred the patient to the RVH Stroke Unit. The patient remained in the Stroke Unit until her transfer, on 26 October 2017, to Whiteabbey Hospital (WAH) for further rehabilitation. The patient subsequently moved to a care home where sadly she passed away on 11 March 2019. A chronology detailing the events leading to the complaint is contained at Appendix five to this report.

Issue of complaint

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

[1] A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body.
[2] A fracture occurring within the capsule of the hip joint.
[3] Obstruction of the posterior cerebral artery.

Whether the patient received appropriate care and treatment from the Trust between 8 October 2017 and 17 October 2017.

INVESTIGATION METHODOLOGY

5. 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

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

- A Consultant in Emergency Medicine with 24 years' experience working in this field (EM IPA);
- A Consultant Neurosurgeon, with 12 years' experience in this role. Responsible for the acute management of emergency; neurosurgical patients as well as elective neurosurgical cases (NS IPA);
- A Consultant Orthopaedic surgeon, (O IPA); with over 15 years' experience working in this field; and
- A Senior Nurse with 21 years' experience across a variety of nursing contexts and settings (N IPA).

I enclose the clinical advice received at Appendix two to this report.

7. 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

8. 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[4]:

   - The Principles of Good Administration

9. 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 Good Medical Practice, 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 (NMC Code);
   - The Belfast Heath and Social Care Trust: Policy for the early recognition and management of a suspected head injury, November 2014, (the Trust's head injury policy);
   - The Belfast Heath and Social Care Trust: Thromboprophylaxis Policy, December 2015 (the Trust's Thromboprophylaxis Policy); and
   - The Belfast Health and Social Care Trust's Performance report, November 2017[5] (the Trust's performance report).

Trust records

10. I completed a review of the relevant Trust records. Relevant extracts from the records are included at Appendix four to this report.

[4] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[5] Report outlining Trust performance against key Draft Commissioning Plan objectives/goals.

11. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

12. I shared a draft copy of this report with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Whether the patient received appropriate care and treatment form the Trust between 8 October 2017 and 17 October 2017.

This considered the diagnosis and treatment of the patient's stroke, the timing of the patient's hip operation and the discontinuance of the patient's Clexane medication. These issues are addressed separately below.

Detail of Complaint

13. *Diagnosis and treatment of patient's stroke*
The complainants raised concerns about the time taken to diagnose and treat the patient's stroke. They believed that had clinicians diagnosed the patient's stroke earlier this would have resulted in a more positive outcome for the patient.

Evidence Considered

Policies/Guidance

14. I considered the following policies/guidance:
    - the GMC guidance; and
    - the NMC Code.

I enclose relevant sections of the guidance considered at Appendix three to this

report.

Trust's response to investigation enquiries

15. The Trust explained following the patient's ED medical assessment *'…the impression was that [the patient] had suffered a head injury and a fracture to her left hip…'* Radiological investigations *'…confirmed a fracture of her left intracapsular hip…'* The CT scan result showed no evidence of acute cervical spine injury but did *'…show signs of a small intracranial bleed (effectively a bleed or bruise in the left frontal lobe of her brain). This was likely due to her fall and the fact she was on blood thinning medication…'* At this time the patient showed '…*no evidence of a stroke*…' The ED Doctor discussed the findings of the CT scan with the neurosurgical registrar who *'…advised to hold all blood thinning medications including Aspirin, Ticagrelor and Enoxaparin*…' Following the investigations, clinicians referred the patient to the fracture team in preparation for admission.

16. Once on the T&O ward the Trust explained: there was no radiological evidence of a stroke *'…in the days before [the patient's] operation…'* Two CT brain scans carried out in the pre-operative period which, *'…showed no evidence of acute stroke.'* The Orthomedical team reviewed the patient in conjunction with the orthopaedic and anaesthetic teams. On 10 October 2017, the patient *'…appeared confused and agitated…'* and a repeat CT brain scan was performed, to ensure the bleed in her brain had not progressed which reported *'…The small bleed was…resolving and there was no other evidence of a new stroke event.'*

17. The Trust went on to explain: the patient's *'…immediate post-operative course appeared uneventful…Enoxaparin was still on hold at this point. This decision would have been made by the primary treating physicians based on their assessment of the risk and benefits to the patient at that time and taking account of the advice given by neurosurgery at the time of the patient's admission…'* After further discussion with the neurosurgical team on 16 October 2017 *'…the Orthopaedic team were content to commence a reduced dose of Enoxaparin as the bleed in [the patient's] brain was now fully resolved,*

however her Aspirin and Ticagrelor were to be kept on hold at this stage due to concerns about the risk of excess bleeding.' However, on 17 October 2017, the patient's condition warranted a further CT brain, and the report conclusion documented, *'…a large posterior cerebral artery territory sub- acute infarction. No acute intracranial haemorrhage identified…'* The neurology registrar assessed the patient and she *'…could not have ('clot buster') thrombolysis to treat this due to the fact she had major surgery, and the risk of [the patient] bleeding from the surgical site would have been life threatening...'*

Relevant Independent Professional Advice

18. The ED IPA advised: the ED doctor, following examination of the patient, identified *'…clearly relevant findings…'* and '…*three acute health issues requiring further assessment and/or treatment…'* which included a head injury. The management plan for these was '…*entirely appropriate…'* including discussions with '…*the Trauma & Orthopaedic service…'* and the '…*neurosurgical service…the ED clinician has considered the views of the neurosurgical clinician and followed their advice…Overall, I consider the actions of the ED doctor to be of an extremely high standard…'* The ED IPA identified potential learning for the Trust in relation the CT report and barriers to neurosurgical review.

19. The N IPA advised: '…*disturbances to the patient's speech, balance, vision, and level of consciousness may indicate a Stroke… The level of consciousness can be assessed using the Glasgow Coma Scale*[6] *(GCS). Weakness or numbness in one arm and a drooping of the face on one side may also indicate a Stroke. A deterioration in the patient's clinical condition can also affect their NEWS and an increased NEWS should be escalated in line with…guidance…'* From 8 to 11 October 2017 *'…there were potential signs of Stroke…such as drowsiness and 'falling' of the right side of the face*…On 10 October 2017, following an x-ray, the patient became confused and agitated and nursing staff asked for a medical assessment *'…it was decided that if the GCS fell to 13 or below that a CT brain scan would be arranged…At 19:40 GCS fell to 13 and*

[6] A practical method for assessment of impairment of conscious level in response to defined stimuli

nurses alerted medical staff and the patient consequently had a CT brain scan…'

20. The N IPA further advised: '…*On the evening of the 11th when the right side of the face had 'fallen' … At this time, nurses did not escalate the patient; they noted a low GCS of 11/15 and a low BM of 3.4 which was treated accordingly… a senior nurse (deputy sister) give dextrose for a low blood sugar and GCS was repeated… Low blood sugar (hypoglycaemia) can cause similar symptoms to a stroke and blood sugar should be checked as per national guidance…Following this, it is documented that the patient's BM improved to 9.7 and that her GCS was 13/15 at 19:00. Her condition had improved, she was chatting with family and opening her eyes... It is known that a TIA can resolve quickly, but given the hypoglycaemia and improvement after treatment, it would not be possible to say if this was a TIA...If the patient's condition did not improve after treatment, nurses should escalate, in line with nursing standards. It is noted however that at 19:00, just one hour later, her GCS was back to 13/15. However a facial droop is still documented at 01:35.*

21. The N IPA summarised: *'…clinically the patients' condition improved after the right sided facial droop was first documented at 18:00. Her BM (blood sugar) and GCS improved. Her NEWS was normal. She was alert and chatting to her family. However, at 01:35 it is documented that she still had a facial droop, and this should have been investigated further by escalating to doctors, as a TIA could not have been ruled out.'*

22. In relation to the patient's observations post surgery the N IPA advised: '*The patient remained drowsy but rousable after her surgery on 12th October 2017 up until 15th. NEWS was 0-1…and GCS was 13/15… The patient was referred to SALT… in line with nursing standards…due to possible swallow difficulty (coughing up food)… which can be a sign of Stroke,…on 14th…However…On 15th it is documented that she was 'much brighter', sat up in bed and answering all questions... and her GCS remained stable…There were no signs of Stroke until 17th and at that point the patient was medically reviewed, and a*

CT brain scan ordered…The actions taken by nurses was in line with national guidance and were therefore appropriate.

23. The O IPA advised: prior to the CT brain taken on 10 October 2017 orthopaedics, and orthogeriatric clinicians assessed the patient. The Ortho-medical doctor organised a renal review of the patient. There was no '…*indication for a scan on 9/10… with no concerns regarding a neurological deficit, until 10/10 at which point a CT scan was performed, with no evidence of a stroke on the scan…'*

24. In relation to the patient's symptoms on the evening of 11 October 2017 the O IPA advised: '…*These symptoms could be attributed to a low blood sugar, and if they resolved on admission of glucose, this would support that. A transient ischaemic attack (TIA or mini-stroke) however could also have accounted for symptoms as recorded…'* However, '…*this incident should have been escalated to medical staff, if not at the time, certainly the following morning… there was no mention of neurological abnormality on 12/10…or any new clinical signs…'* when a doctor reviewed the patient at 08:00. *There are multiple reviews thereafter with no mention of abnormal neurology other than drowsiness. I wonder if the abnormalities noted in the nursing notes therefore had resolved… in the absence of neurological deficiency on 12/10 it is likely that no further action would have been undertaken…There is nothing to suggest a stroke pre-op…'*

25. In relation to events after the patient's surgery the O IPA advised: '…*The patient was reviewed regularly…'* with reviews being *'...thorough and well documented. There was input from neurosurgery and renal medicine…Neurological examination on 17/10 triggered a further CT scan and the patient was then discussed with the stroke team…'* These actions were '…*appropriate.'* with '*no indication for an earlier CT scan…'*

Complainants' response to draft report

26. The complainants said the patient's medical records were not *'…exactly correct…'* and the *'…duty of care expected was not up to the required*

standard…' The complainants re-iterated their concerns that Trust staff had not diagnosed the patient's stroke in a timely manner. They said they raised *'…continuous concerns that were largely ignored…'* This included concerns made *'…on around 9th Oct…'* about the patient having a facial droop, not speaking or not being able to sit up to take a drink. As well as the patient being *'…unresponsive all night long despite nursing staff carrying out several tests [the patient] was not even able to rouse from state of unconscious condition…'* The complainants said their *'…concerns and exclamations fell on deaf ears…'* It was also the opinion of the complainants that the ignoring of these concerns, by both doctors and nursing staff, *'…played a large part in the incorrect treatment and diagnosis being provided to [the patient].* They firmly believed that had their *'…concerns been followed up as described in the FAST bulletins, earlier diagnosis would have resulted in a more positive outcome…'*

27. The complainants said that *'…an apology with the hope issues brought to light will improve continuity of care for others in the future…'* provided them *'…some small amount of reassurance.'*

Trust's response to draft report

28. The Emergency Care Service welcomed the view of the ED IPA that the level of care provided was of a high standard. This Service also acknowledged the two elements, related to other services, which the ED IPA regarded as a near miss and could lead to patient harm. The views of the ED IPA would be shared with the respective teams.

29. The Trauma & Orthopaedic Service agreed with the findings in the draft report in relation to their points of learning and said it would fully implement the recommendations, following receipt of the final report.

30. The Stroke team wished to express its sympathies to the family on the death of their mother. It said *'…The patient had complex medical issues that included an intracerebral bleed, for which their blood thinners were stopped, a fracture neck of femur following a fall and subsequently had a stroke. Balancing the risk of continuing blood thinners in a patient with a bleed and trauma is challenging,*

and whilst it was appropriate in this case, the Stroke team recognise that these challenges should have been explained to the family in detail and documented…' It also said the recommendations made would be taken onboard and the learning would be shared amongst the Stroke team.

Analysis and Findings

31. For ease of reference, I will consider the staffs' actions at three different points of the patient's journey before she was transferred to the stroke unit on 17 October 2017. I took overall consideration the Trust's comments that '...*there was no radiological evidence of a stroke '…in the days before [the patient's] operation…'* However, due to the patient's condition, following surgery, on 17 October 2017, a further CT scan showed*, '…a large posterior cerebral artery territory sub- acute infarction. No acute intracranial haemorrhage identified…'* I also considered the complainants' additional comments that they raised concerns about potential stroke symptoms in or around 9 October 2017.

i On arrival in ED until 10 October 2017

32. I considered the Trust's records and note the patient's CT brain scan result, completed on 8 October 2017, stated *'…no evidence of acute infarction…'* but showed a *'…shallow haematoma collection…'* I further note, on 10 October 2017, due to the patient's GCS falling below 13, nursing staff alerted clinicians and the patient underwent a further CT brain scan, the result of which documented the resolution of the previously noted bleed.

33. I considered the ED IPA's advice that the ED doctor identified three acute health issues, including a head injury. I further note the ED IPA's advice the ED doctor's findings were *'…clearly relevant…'* and the management plan *'…entirely appropriate…'*

34. I considered the N IPA's advice that before surgery the patient had '…*potential signs of Stroke…such as drowsiness and 'falling' of the right side of the face…'* On 10 October 2017 nursing staff escalated the patient to the medical team and a CT brain scan was subsequently carried out. The N IPA advised, at this point

in time, the nurses' actions *'…were appropriate and in line with national guidance…'*

35. I considered the O IPA's advice and note there were '…*no concerns regarding a neurological deficit, until 10/10 at which point a CT scan was performed, with no evidence of a stroke on the scan…'*

36. While I acknowledge the concerns of the complainants, given the available evidence I am satisfied that the patient did not have an acute stroke during this time period. I am also satisfied that, on 10 October 2017, nursing staff identified possible neurological symptoms (confusion and agitation) and appropriately escalated the patient to the medical team nursing staff. I am also satisfied the medical team took the appropriate action, following this escalation, i.e. ordering of a CT scan.

ii 11 and 12 October 2017

37. I considered the Trust records and note on the evening of 11 October 2017 nursing staff noticed the patient's right side of her face had fallen and she was not willing to open her right eye. Nursing staff treated this with 150ml of 10% dextrose. The patient had surgery on 12 October 2017.

38. I note the N IPA's advice about the actions of nursing staff on the evening of 11 October 2017 and that '…*Low blood sugar can cause similar symptoms to a stroke...'* which the senior nurse treated the patient for. The N IPA also advised *'…clinically the patients' condition improved…However, at 01:35 it is documented that she still had a facial droop, and this should have been investigated further by escalating to doctors, as a TIA could not have been ruled out.'*

39. I considered the O IPA's advice and note he agreed with the N IPA the patient's symptoms, on the evening of 11 October 2017, '…*could be attributed to a low blood sugar, and if they resolved on admission of glucose, this would support that...'* but that transient ischaemic attack (TIA or mini-stroke) could also have accounted for the patient's symptoms. The O IPA considered '…*this incident*

should have been escalated to medical staff, if not at the time, certainly the following morning…' This concurs with the N IPA advice. However, when a doctor reviewed the patient on the morning of 12 October 2017 *'…there was no mention of neurological abnormality…'* In these circumstances the O IPA advised *'… in the absence of neurological deficiency on 12/10 it is likely that no further action would have been undertaken.'*

40. Given the available evidence including CT scans and the IPAs' advice I am satisfied the patient did not have an acute stroke during this time period, but she did experience possible neurological symptoms on 11 October 2107. However, I acknowledge the advice of both the N IPA and O IPA that the patient's symptoms could have been related to low blood sugar but that a TIA could also have also accounted for the symptoms experienced. I also acknowledge the N IPA's advice the patient had clinically improved after treatment for low blood sugar. I note the O IPA agreed that if the symptoms resolved quickly then this would support the fact the symptoms were attributable to low blood sugar and, that doctors did not document any neurological abnormality on the morning of 12 October 2017 during their ward rounds.

41. Therefore, I am satisfied the treatment provided to the patient on the evening on 11 October 2017 was appropriate. However, I accept the advice of both the N IPA and O IPA that nursing staff should have escalated the patient's symptoms of ongoing facial droop (in the early hours of 12 October 2017) to doctors for further investigation in line with the NMC code. This would have allowed doctors to rule out a TIA. I consider this a failure in the patient's care and treatment. Despite this, given the O IPA's advice there was no neurological abnormality noted during ward rounds on 12 October 2017 and in the absence of such symptoms *'…it is likely that no further action would have been undertaken.'* I do not consider the patient sustained an injustice due to this failure. However, I consider the complainants' sustained the injustice of uncertainty due to concerns raised to this Office about the patient's symptoms and whether she received appropriate treatment at that time.

iii Post surgery

42. From the Trust records I note on 17 October 2017, following a clinical review, the stroke team reviewed the patient, and she had an urgent CT brain scan. I note the results of this CT brain scan documented '…*a large…sub- acute infarction*…'

43. I considered the N IPA's advice about the actions of nursing staff after the patient's surgery. She advised '…*There were no signs of Stroke until 17th…'* and *'…The actions taken by nurses was in line with national guidance and were therefore appropriate.'* I also note the O IPA's advice that post surgery the actions of the clinical team were '…*appropriate.'* with '…*no indication for an earlier CT scan…*'

44. In relation to the diagnosis and treatment of stroke symptoms after the patient's surgery. I note the O IPA's advice that post surgery the actions of the clinical team were '…*appropriate.'* with '…*no indication for an earlier CT scan…'* I accept the advice of both the N IPA and O IPA.

45. I am satisfied both nursing and clinical staff treated the patient's symptoms appropriately after surgery up until her condition deteriorated on 17 October 2017.

46. Given the failing identified at paragraph 41 I partially uphold this element of complaint. While I partially upheld this element of complaint, given the similarity of symptoms of low blood sugar and TIAs, I understand the complainants' concerns about the diagnosis of a possible stroke. It is my view that staff should take time to fully explain treatment they are giving for symptoms which may help elevate both patient and family concerns. It is unclear if this happened in this instance, and I would ask the Trust to reflect on my comments. I would also ask the Trust to reflect on the potential learning the ED IPA identified in Appendix two.

Detail of Complaint

Timing of patient's operation

47. The complainants raised concerns about the timing of the patient's hip operation and queried if clinicians took account of all her symptoms, including the advice of specialist clinicians and views/concerns of nursing staff prior to proceeding with the operation. The complainants also believed clinicians should not have carried out the patient's hip operation until treatment for a stroke had commenced.

Evidence Considered

Policies/Guidance

48. I considered the following policies/guidance:

- the GMC guidance;
- the NMC Code; and
- the Trust's performance report.

I enclose relevant sections of the guidance considered at Appendix three to this report.

Trust's response to investigation enquiries

49. The Trust explained: *'The decision to proceed with surgery was in [the patient's] best interest as delaying an elderly frail patient's hip fracture surgery unnecessarily can lead to a deterioration in their condition…'* While waiting for such surgery patients are at '…*at high risk of death mainly as a result of the complications of bed rest such as chest infections and clots…there was no radiological evidence of a stroke event on admission or in the days before [the patient's] operation so this had no bearing on the plan to proceed to surgery.* Clinicians carried out two CT brain scans in the pre-operative period and *'…showed no evidence of acute stroke…'* The Fracture surgical team, the Anaesthetic Consultant and the Orthomedical team discuss a patient's fitness before fracture surgery goes ahead. *'…The decision to go ahead with surgery may be reversed at any time if the patient's conditions change. Even if the patient were to deteriorate during their anaesthetic pre surgery, the decision would be made to postpone or cancel the surgery.'* The patient, although frail *'…was considered in detail and deemed stable enough, by all…involved to*

embark on surgery as a pain relieving procedure for her fractured neck of femur. Her condition remained stable immediately preoperatively and during her operation.'

Relevant Independent Professional Advice

50. The O IPA advised: '*There is an element of urgency to hip fracture surgery, with an aim for theatre within 48 hours, and evidence to suggest that delays can lead to complications or a poor result…*' A multi-disciplinary approach is required for these patients as they can be unwell and have *'…multiple medical issues…'* Multiple specialists were involved with the patient pre-operative and this *'…approach was appropriate...I do not think there were an [sic] expert opinions required, which were not sought for this patient.***'**

51. He went on to advise: '…*There is nothing to suggest a stroke pre-op…'* A number of doctors seen the patient *'…with no concerns regarding a neurological deficit, until 10/10 at which point a CT scan was performed, with no evidence of a stroke on the scan…The brain infarct (which I believe was a true stroke) seems to have developed post op…There were transient neurological signs noted by nursing staff…but these appeared to resolve, and may have been related to low blood sugar…'…In my opinion it was appropriate for this patient to undergo surgery.'*

52. The O IPA further advised '*There may have been an opportunity for surgery to have been undertaken on 9/10, with ward round from 9/10 simply states 'not for surgery today...await senior medical review'.* Other entries in the records show clinicians gave consideration, on 10 and 11 October 2017, to surgery. However, *'…It is not clear from the medical records why surgery did not proceed on 9/10, 10/10 or 11/10. I would have expected these reasons to be documented.* The standard of 48hrs in NI, was not achieved for this patient. '…*Overall, while there was a delay in proceeding to surgery, multiple specialities were involved in assessment and management of this patient. I have no concerns about this management. This patient was complicated, and some time to ensure they were medically optomised [sic] prior to surgery was appropriate…'*

In summary

53. The O IPA advised: *'…this patient was a complex case, with multiple issues, all of which in my opinion were appropriately managed…'*

Analysis and Findings

54. I considered the Trust's records and note the results of the patient's CT brain scans completed on 8 and 10 October 2017, as already detailed at paragraph 32. I also note clinicians considered the patient was not fit for surgery on 9 October 2017, but surgery was considered on 10 and 11 October 2017 as set out at Appendix four, paragraphs seven to nine and 11 to 13.

55. I considered the Trust's comments that two CT brain scans in the pre-operative period *'…showed no evidence of acute stroke…'* and note its reasoning for not delaying hip fracture surgery in elderly frail patients. I also note the Trust deemed the patient *'…stable enough, by all…involved to embark on surgery as a pain relieving procedure for her fractured neck of femur. Her condition remained stable immediately preoperatively and during her operation.'*

56. I considered the O IPA's advice that the aim is to have surgery within 48 hours. I also accept his advice that multiple specialists were involved with the patient pre surgery, and all opinions required, were sought. He also advised that '…*There is nothing to suggest a stroke pre-op…'* and '…*it was appropriate for this patient to undergo surgery.'* Given the available evidence, including my analysis at paragraphs 37 to 41, I am satisfied that the patient's hip surgery took place before she had an acute stroke and clinicians took account of all specialist advice prior to the surgery. Therefore, I do not uphold this element of complaint.

57. However, I also considered the O IPA's advice that '*There may have been an opportunity for surgery to have been undertaken on 9/10...'* but that it is not clear from the records *'…why surgery did not proceed on 9/10, 10/10 or 11/10…'* and he *'…would have expected these reasons to be documented…'* He also advised even given the time to complete the surgery he had no

concerns about the management of the patient and she needed time to be medically optimised. I refer to the GMC guidance which states clinical records should include *'…relevant clinical findings…'* and *the decisions made and actions agreed, and who is making the decisions and agreeing the actions.'*

58. In this instance, while there may well have been an explanation as to why clinicians did not commence the patient's surgery, in line the Trust's performance report, *(95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures*) I consider the records do not provide enough detail to explain why. Therefore, I accept the O IPA's advice, and I consider the absence of a more clearly documented reason to delay surgery a service failure. Although I do not consider there was any impact on the patient as a result of this service failure, I would ask the Trust to reflect on documenting such the reasoning to delay such surgery, more clearly in the future.

Detail of Complaint

Clexane medication

59. The complainants raised further concerns about the discontinuation of the patient's Clexane[7] medication as they believed change of medication could have increased the patient's susceptibility to a stroke.

Evidence Considered

Policies/Guidance

60. I considered the following policies/guidance:

- the Trust's head injury policy; and
- the Trust's Thromboprophylaxis Policy.

I enclose relevant sections of the guidance considered at Appendix three to this report.

[7] A product name for enoxaparin sodium used in the treatment of a number of medical conditions including blood clots; certain types of heart disease when used with aspirin; and the prevention of blood clots forming after an operation, during hospitalisation or extended bed rest or during purification of the blood by an artificial kidney.

Trust's response to investigation enquiries

61. The Trust explained: *'This would be standard initial advice for someone with a new head injury and new acute haemorrhage identified on a CT scan. If the anticoagulants were not placed on hold in the initial stages there would be a risk of progressive haemorrhage and a potential threat to life. The need for re-commencing of Clexane is made as part of an ongoing risk benefit decision by the primary treating team, obtaining advice from specialist teams as required…'* Post surgery, the patient's Enoxaparin was still on hold. *'…This decision would have been made by the primary treating physicians based on their assessment of the risk and benefits to the patient at that time and taking account of the advice given by neurosurgery at the time of the patient's admission… On the basis of further discussion with the neurosurgical team the Orthopaedic team were content to commence a reduced dose of Enoxaparin as the bleed in [the patient's] brain was now fully resolved…'*

Relevant Independent Professional Advice

62. The ED IPA advised '…*The ED clinician has documented the discussion with the neurosurgeon as recommending withholding aspirin, ticagrelor and heparin due to the left frontal subarachnoid haemorrhage, and these have subsequently been withheld…'*

63. The NS IPA advised: in advice to the ED doctor on 8 October 2017 the Neurosurgical Registrar said *'…to withhold antiplatelet and anticoagulant medication…Given the presence of intracranial blood on the initial CT scan...*' this advice *'…was entirely appropriate as its continuation would have carried significant risk of further intracranial bleed, which would have been potentially life threatening.'* The withholding of the Clexane medication *'…was appropriate, given the intracranial blood, but, of course, in so doing, this would increase the risk of thrombotic episodes, including stroke…The patient's comorbidities would put her at significant risk of both intracranial haemorrhage and thrombotic episodes and the balance of risk has to be weighed up by the treating Physician. Given the presence of intracranial blood however, I think the advice of the Neurosurgical Team was entirely appropriate.'*

64. The NS IPA further advised: on 16 October 2017 the Neurosurgical registrar said to *'…commence low dose Clexane, as the blood on the CT scan had resolved. I think this entirely reasonable, together with the decision to withhold the Aspirin and Ticagrelor (antiplatelet agents), as there would still have been a risk of intracranial bleeding. It is a balance of risk as to the risk of further intracranial bleeding and the development of thrombotic complications…'*

65. The O IPA advised: *'…DVT prophylaxis[8] was considered for this patient, discussed with neurosurgery and commenced on 16/10…Based on the hospital guidance, DVT prophylaxis should have commenced up to 12 hours post op. The patient does however seem to have been prescribed TED[9] stockings. While I accept the guidelines for DVT prophylaxis as presented were not followed, there is a requirement to balance risks and benefits of any treatment. The risk for this patient was that DVT prophylaxis would disturb healing of the known traumatic brain bleed, diagnosed on CT at the time of admission, potentially leading to further bleeding. This needed to be balanced against the risk of blood clots / DVT. The patient was prescribed DVT stockings, and opinion sought from neurosurgery prior to commencing chemical DVT prophylaxis. In my opinion this was appropriate management.'*

Analysis and Findings

66. I considered the Trust's records and note the ED doctor consulted with a Neurosurgical Registrar who advised to withhold the patient's Clexane medication until she was re-imaged in several days. I also note clinicians re-discussed the patient with the Neurosurgical Registrar, on 16 October 2017 and the Neurosurgical Registrar was content to recommence '…*20mg Clexane daily…'*

67. I acknowledge the Trust's comments that the withholding of Clexane medication would be *'…standard initial advice…'* for someone with a new head injury and new acute haemorrhage identified on a CT scan. I further note the

[8] The prophylaxis of Deep Vein Thrombosis is trauma practice in order to prevent the subsequent VTE (venous thromboembolism)

[9] Anti-embolism stockings (also known as 'compression stockings') are tight stockings specially designed to reduce the risk of DVT.

risks the Trust identified if clinicians did not withhold such a medication. The Trust also explained re-commencing Clexane is *'…made as part of an ongoing risk benefit decision by the primary treating team, obtaining advice from specialist teams as required…'*

68. I considered the ED IPA's advice that the ED doctor sought advice from a Neurosurgical Registrar and carried out their recommendations. The NS IPA also advised that the withholding of the Clexane medication '…*was entirely appropriate as its continuation would have carried significant risk of further intracranial bleed, which would have been potentially life threatening.'* However, I acknowledge the NS IPA's advice that this would *'…increase the risk of thrombotic episodes, including stroke…'* but that clinicians would have to balance this risk against further intracranial bleeding. I further considered the NS IPA's advice that the Neurosurgical Registrar's advice, on 16 October 2017, to commence a low dose of Clexane was '…*entirely reasonable…'* He also advised this would be a *'…balance of risk as to the risk of further intracranial bleeding and the development of thrombotic complications…'*

69. I considered and accepted the O IPA's advice that while taking into account guidelines *'…there is requirement to balance risks and benefits of any treatment…'* and the risk for this patient, post surgery, was *'…DVT prophylaxis would disturb healing of the known traumatic brain bleed, potentially leading to further bleeding. This needed to be balanced against the risk of blood clots / DVT.'* I also note his advice that *'…DVT prophylaxis was considered for this patient, discussed with neurosurgery and commenced on 16/10…'* and this was *'…appropriate management.'*

70. It is clear the management of the patient's Clexane medication required the exercise of professional judgement to balance the risk of further intracranial bleeding versus the development of thrombotic complications therefore informing the most appropriate plan of care. This balancing of risk is also borne out in the Trust's Thromboprophylaxis Policy. Given both the ED doctor and T&O clinicians sought specialist advice and any advice given implemented, on

balance, I am satisfied that the withholding and re-commencing of the patient's Clexane was appropriate. Therefore, I do not uphold this element of complaint.

CONCLUSION

71. I received a complaint about I received a complaint about the actions of the Trust in relation to the care and treatment, provided to the patient from 8 October 2017 and 17 October 2017.

72. The investigation established failures in the patient's care and treatment in relation to the following matter:

    - Escalation of patient's symptoms of ongoing facial droop (in the early hours of 12 October 2017) to doctors for further investigation.

    I do not consider that the failing identified caused the patient to experience an injustice. However, I consider the complainants sustained the injustice of uncertainty.

73. The investigation also established a service failure in relation to the following matter:

    - A more clearly documented reason to delay the patient's surgery.

    I do not consider there was any impact on the patient as a result of this service failure.

74. The investigation did not establish a failure in relation to the following matters:

    - Timing of the patient's surgery; and
    - Management of the patient's Clexane medication.

75. I offer through this report my condolences to the complainants for the loss of their mother.

Recommendations

76. I recommend the Trust provides to the complainants a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failure identified (within **one month** of the date of this report).

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

    i. Discusses the findings of this report with relevant staff members involved in the patient's care and provides evidence to this office that this has been completed.

78. I would also ask the Trust to reflect on the learning the ED IPA identified.

79. The Trust accepted my findings and recommendations.

80. It is clear from my reading of the records how involved the family were in the patient's care and I offer them my sincere condolences. I recognise the complainants may not fully agree with all of my conclusions. However, I wish to assure them these were reached only after the fullest consideration. I hope this report goes some way to address the complainants' concerns.

MARGARET KELLY
Ombudsman

28 March 2024

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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.