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

Report Reference: 202000972

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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

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Case Reference: 202000972

Listed Authority: Belfast Health and Social Care Trust

SUMMARY

The complaint was about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to her husband (the patient) in May 2019 in relation to how the Trust managed the patient's post operative care following elective surgery. I acknowledge the events were very distressing for the complainant and the patient.

The investigation established a failure in the patient's care and treatment. This related to the failure to have records of a documented discussion with the patient about the potential risks when surgery was proposed. I also found maladministration in relation to the recording of information within the medical records and the subsequent managing of these records.

I recommended the Trust provide the complainant with a written apology for the injustice caused as a result of the failures I identified in this report. I also made further recommendations for the Trust to address under an evidence-supported action plan to instigate service improvements and to prevent their further reoccurrence of the failings identified.

THE COMPLAINT

1. This complaint was about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to her husband (the patient) in May 2019 following elective surgery.

Background

2. The patient was admitted to the Royal Victoria Hospital (the hospital) on 6 May 2019 for elective vascular surgery[1]. He underwent this surgery on 7 May 2019 and was admitted to the High Dependency Unit (HDU) and Intensive Care Unit (ICU) during recovery. His condition deteriorated following this surgery and the patient developed an aneurysm[2] and lost blood flow to both legs. The Trust staff performed an emergency fasciotomy[3] on both legs on 8 May 2019. When receiving care and treatment in these units the patient developed sepsis[4] of the gall bladder and had skin graft surgery. He also developed C-Difficile[5]. The patient was discharged from hospital on 5 July 2019.

Issue of complaint

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

Whether the care and treatment the Trust provided to the patient was appropriate and in accordance with relevant standards and procedures.

INVESTIGATION METHODOLOGY

4. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process. Documentation was also requested from the patient's General Practitioner (GP).

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[1] The specialty in which diseases of the vascular system or arteries and veins are managed
[2] A bulge in the wall of an artery. If its gets large, it can burst and cause serious bleeding.
[3] A procedure where cuts are made around the muscle to relive pressure or tension in order to treat the loss of circulation.
[4] A serious condition that happens when the body's immune system has an extreme response to an infection and starts to damage your body's own tissues and organs.
[5] A bacterium that can infect the bowel and cause diarrhoea.

Independent Professional Advice Sought

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

    - A Vascular Surgeon Consultant with 27 years' experience of peripheral vascular disease [6](V IPA);
    - An ICU Consultant with clinical expertise in this area (C IPA); and
    - An ICU Nurse with 37 years' experience in both critical and acute care (N IPA).

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

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

Relevant Standards and Guidance

7. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those 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[7]:

    - The Principles of Good Administration

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

    The specific standards and guidance relevant to this complaint are:

    - The General Medical Council's Good Medical Practice, updated April

[6] The reduced circulation of blood to a body part other than the brain or heart.
[7] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

2014 (the GMC Guidance);

- The National Institute for Health and Care Excellence's Peripheral Arterial Disease: diagnosis and management, NICE Guideline 147, updated February 2018 (NICE CG147);
- The National Health Service rules on Consent to treatment (website) (Consent Rules);
- The GMC 2008 Consent Guidance (Consent Guidance);
- The Faculty of Intensive Care, Provision of Intensive Care Services (GPICS); and
- Royal College of Nursing (RCN) 'Guidance for Nurse Staffing in Critical Care' (2003) and British Association of Critical Care Nurses (BACCN) 'Standards for Nursing Staff in Critical Care (2009) (Critical Care Guidance).

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

9. 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.

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

Whether the care and treatment provided to the patient by the Trust was appropriate and in accordance with relevant standards and procedures.

In particular this will consider:

- Communication regarding surgery;
- Provision of epidural;[8]

[8] A procedure that injects a local anaesthetic into the space around the spinal nerves in your lower back.

- Monitoring of the patient post-surgery;
- Conservative management care plan; and
- Pain threshold

11. The investigation has been divided into two periods of care and treatment. Period one relates to the first operation carried out on 7 May 2019 for elective vascular surgery, review, and aftercare post-surgery. Period two relates to the second operation carried out on 8 May 2019, the review and aftercare post-surgery.

Period One: First operation carried out on 7 May 2019, review and aftercare post-surgery.

In particular this will consider:

- *Communication regarding Surgery*
- *Provision of Epidural*
- *Monitoring of the patient post-surgery*

Detail of Complaint

Communication regarding Surgery

12. The complainant said the Trust did not inform the patient of '*significant comorbidities and as a result of these medical complexities, he was high risk of developing post operative complications*.' She believed had the Trust explained these risks, he would have given more consideration in his decision to proceed with the surgery.

Evidence Considered

Legislation/Policies/Guidance

13. I considered the following polices and guidance;
    - Consent Guidance.

The Trust's response to investigation enquiries

14. The Trust stated it fully briefed the patient on the risks of the surgery which he consented to prior to his surgery.

Relevant Trust records

15. The Trust provided this Office with a copy of the consent form which the patient signed on 6 May 2019.

Relevant Independent Professional Advice

16. The V IPA advised there are two letters in the notes which document the decision to proceed with surgery. On 22 September 2017 the letter reports the patient is walking 25-50 yards (before the onset of pain) and this is '*seriously impacting his quality of life*'. She advised, the Trust organised a CT angiogram and the consultant reviewed the patient in clinic on 11 December 2017. The letter indicates that '*the best option is an aorto-right common femoral bypass* [9]*but a further fem-fem crossover* [10]*is an option if he is not fit for major surgery'.*

17. Although this letter documents the proposed operation, the V IPA advised *'it does not record any discussion with the patient nor the potential risks and complications*'. Upon the V IPA's review of the notes, she advised *'it is clear the patient had a long and extensive vascular history which would have been well knows to his consultant as he had been under his care for all previous surgeries including an attempt to bypass his right iliac blockage which resulted in major haemorrhage'.* However she advised '*although both consultant and patient were aware of his past history, discussion regarding the impact of this on the patient's proposed operation and its risk is not documented'*.

18. The V IPA referred to the Consent Guidance which states '*You must give patients clear accurate and up to date information, based on the best available evidence, about the potential benefits and risks of harm of each option, including the option to take no action.'*

19. The V IPA advised the consent form the patient signed on the day of his surgery included the following complications; "*bleeding, infection, risks of anaesthesia, MI (myocardial infarction) LRI (Lower, respiratory infection, stroke,*

[9] Used to bypass diseased large blood vessels in the abdomen and groin.
[10] Is a procedure which redirects blood flow around a blocked leg artery to ease pain and swelling from peripheral artery disease.

bowel or limb or buttock ischaemia. Damage to neighbouring structures. Need for further emergency procedure." The Surgical Registrar completed the consent form.

20. The V IPA advised the patient's co-morbidities were chronic obstructive airway disease[11] and osteoarthritis[12]. His walking was limited by a combination of pain in his leg and breathlessness. She advised he had a full pre-op assessment including echo-cardiogram and was deemed fit for surgery. The V IPA advised '*I don't believe his pre-existing co-morbidities put him at increased risk of complications, rather complications can occur in vascular surgery and possibly more likely if the surgery is revision surgery'.*

Analysis and Findings

21. The complainant believed that if the Trust had explained to the patient he was at risk of developing post-operative complications, he would have given more consideration to his decision to proceed with surgery.

22. The records document the Consultant Surgeon (Consultant A) and the patient's decision to proceed with the surgery on 22 September 2017. I note there was a delay of almost two years in the surgery taking place due to the waiting list at that time.

23. The patient had a CT angiogram and Consultant A reviewed the patient at the outpatient clinic on 11 December 2017. The clinic letter following this consultation documents the proposed operation but does not record any discussion with the patient nor the potential risks and complications. The GMC Consent Guidance states '*You must give patients clear accurate and up-to-date information, based on the best available evidence, about the potential benefits and risks of harm of each option, including the option to take no action.'* In line with GMC guidance medical staff are expected to keep full and complete records as other medical staff coming behind rely on them.

[11] The name for a group of lung conditions that cause breathing difficulties
[12] A degenerative joint disease, in which the tissues in the joint break down over time.

24. On 7 May 2019, which was the day of the surgery, the medical records document the patient signed a consent form. The consent form included the following complications; "*bleeding, infection, risks of anaesthesia, MI (myocardial infarction) LRI (Lower, respiratory infection, stroke, bowel or limb or buttock ischaemia. Damage to neighbouring structures. Need for further emergency procedure.'*

25. It is clear the patient was aware of potential risks because he signed the consent form just before his surgery. However in relation to the initial consultation which recommended surgery, the V IPA advised although the clinical letter '*documents the proposed operation, it does not record any discussion with the patient nor the potential risks and complications*.' I accept this advice. I am concerned there are no records of a documented discussion with the patient about the potential risks when surgery was initially proposed. As such, I cannot be satisfied that such a discussion took place. I consider this a failure in the patient's treatment and care. I partially uphold this element of complaint.

26. I cannot conclude that if Consultant A had discussed the potential risks and complications with the patient at the consultation on 22 September 2017 would have opted out of the surgery. However I consider this failure led to a loss of opportunity for the patient to make a fully informed decision prior to his attendance for surgery due to the lack of evidence of a documented discussion between Consultant A and the patient. I consider this failure led to uncertainty for the patient and the complainant. Although, I am satisfied the patient was aware of the potential risks as he signed a consent form just prior to surgery on 7 May 2019, it would have been preferable and appropriate to have allowed him to consider these risks at a much earlier stage.

27. I note the V IPA advised that she did not consider the patient's *'pre-existing co-morbidities put him at increased risk of complications, rather complications can occur in vascular surgery and possibly more likely if the surgery is revision surgery'.* I hope this goes some way to reassure the complainant that complications can arise following any surgery however, I appreciate it must

have been difficult for the complainant and her family to witness the patient's deterioration following both surgeries.

Detail of Complaint

Provision of epidural

28. The complainant said Trust staff did not discuss the use of an epidural with her as the patient's next of kin. She believed the Trust's staff may have discussed its use with the patient. However, she also believed the patient would not have had any understanding of a conversation or have any recollection of a discussion in relation to an epidural.

Evidence Considered

Legislation/Policies/Guidance

29. I considered the following policies and guidance:
    - Consent Rules; and
    - GMC Guidance.

The Trust's response to investigation enquiries

30. The Trust stated its staff gave the patient an epidural prior to his procedure in theatre and it continued to administer the epidural when he was in ICU to help with pain relief. It stated the Surgical Registrar would have made the patient aware of this as part of the consent process.

Relevant Trust records

31. I considered the patient's medical records for the period 6 and 7 May 2019 in particular the anaesthetic chart and the consent rules.

Relevant Independent Professional Advice

32. The V IPA advised '*the use of an epidural was discussed with the patient and he gave verbal consent*'. She advised '*it would not be considered necessary to inform the patient's next of kin*.' The V IPA advised this is because *'an epidural was put on prior to the patient's original surgery, he had full capacity to consent for the procedure'.*

33. The V IPA advised the patient had '*full capacity*' and *'could have refused the operation or any aspect of the anaesthetic but did not'*. All this took place before the patient's first procedure and she advised she could see no *'reason why capacity should be questioned'*.

Analysis and Findings

34. The complainant raised a concern about the consent process in relation to an epidural.

35. The GMC guidance states '*you must listen to patients, take account of their views, and respond honestly to their questions. You must give patients the information they want or need to know in a way they can understand.'* The medical records document Consultant A discussed an epidural with the patient prior to the first surgery. The pre-operative records document the patient provided his verbal consent to receive the epidural. These records also document the Consultant Anaesthetist (Consultant B) attended with the patient and discussed the use of anaesthetic.

36. I note the V IPA's advice that the patient had '*full capacity'* and '*there is no evidence in the records to suggest the patient's capacity should be questioned prior to the first surgery'.* He gave verbal consent prior to the surgery and it would have been open to him to have refused the operation or any aspect of the anaesthetic. Therefore, she advised '*it would not be necessary to discuss this with the next of kin*.' I accept the V IPA's advice regarding the provision of the epidural. I am satisfied the Trust's actions in relation to the consent process for an epidural were appropriate. Therefore I do not uphold this element of the complaint.

Detail of Complaint

Monitoring of the patient post-surgery

37. The complainant said the Trust's staff did not undertake appropriate observations of the patient post-surgery. She believed this contributed to the

aftermath and events that occurred thereafter, in that '*he developed sepsis of the gall bladder, c-diff and had skin graft surgery*.'

Evidence Considered

Legislation/Policies/Guidance

38. I considered the following policies and guidance:
    - GMC Guidance
    - GPICS

The Trust's response to investigation enquiries

39. The Trust stated the vascular team reviewed the patient in recovery at 17.30 on 7 May 2019. The Trust admitted the patient to the HDU / ICU at 19.32 and he received one to one nursing care at this time. A Consultant (Consultant C) completed an admission plan by 20.28 and the vascular team conducted an overnight review of the patient at 05.30 in HDU / ICU on 8 May 2019.

40. The Trust stated the admission plan completed in the HDU/ICU included the following:

    '*Analgesia, monitor peripheral pulses, [13]for prophylactic Clexanae [14]tonight confirmed with vascular SpR[15], Nil orally, sips of water only with meds, IV fluids, UO.30ml/hr, MAP>75, bloods and post op ECG*.' Following the patient's admission and during the first night in HDU/ICU his capillary refill was taken at the following times; 20.00, 21.00, 22.00, 00.00, 01.00, 02.00, 04.00, 05.00, 07.00, 08.00, 09.00, 10.00, 11.00, 12.00 and on each occasion was identified as being >3 seconds.

41. The Trust explained the patient also had dopplers[16] taken at the following times 22:00, 00:00, 02:00, 06:00. At each of these times a pulse was present in the left leg and at 22.00 and 02.00 a pulse was present in the right leg. The Trust

[13] The blood moving away from the heart and vessels at high pressure that provides a pulse that one can palpate.
[14] An injection which thins your blood and reduces the risk of developing blood clots.
[15] A speciality registrar
[16] A test used to detect blood flow. It shows whether a pulse is present and whether there is blood flow to a limb.

stated '*it was unsure if a pulse was identified in the right leg at 00.00 and 06.00.*' The vascular team assessed the patient repeatedly overnight and his condition was largely unchanged from the last review in recovery.

42. The Trust stated the patient had all standard observations taken in ICU/HDU either hourly or two hourly including temperature, heart rate, cardiac rhythm, glucose levels, limb movement, blood pressure, epidural monitoring, capillary refill[17], dorsal pulses, airway monitoring, blood gases, medication, line and wound monitoring.

43. The Trust also stated the Critical Care Team in ICU / HDU reviewed the patient at 06.35 on 8 May 2019. The Vascular Team reviewed the patient at 07:45 and again at 08.45. A computerised tomography angiography[18](CTA) was performed at 10.00 and the patient returned to ICU at 10.50. Following the Consultant Radiologist's speciality review and the verbal handover which stated the aorta was occluded[19] and the patient needed to return to theatre. The patient was in theatre by 12.00.

Relevant records

44. I considered the patient's medical records for the period 7 and 8 May 2019.

Relevant Independent Professional Advice

C IPA (ICU Consultant)

45. In relation to the standard protocol for patients introduced to HDU/ICU regarding neurovascular assessments the C IPA advised '*there is no standard protocol published by the Vascular Surgery Society or by NICE (The national institute for health and care excellence). It is usual that the operation note, documented after surgery by the surgery team, contains specific directions on post op care required.*'

[17] The time taken for color to return to an external capillary bed after pressure is applied to cause blanching.

[18] A type of medical test that combines a CT scan with an injection of a special dye to produce pictures of blood vessels and tissues in a part of your body.

[19] When blood flow in the aorta is blocked

46. The C IPA advised the post operative instructions state '*routine obs and analgesia, monitor pulse, NP, urinary output 30ml/hr and lower limb circulation, nil orally, normal meds with…'* However the C IPA advised '*beyond this I am unable to read it. The instructions do not state a frequency.'* In the recovery ward the nurse documented Consultant A's review of the patient's legs at 17.30 on 7 May. This record documents the nursing staff identified *'no dorsal pulse both feet'* and they were *'pale looking, cool to touch, advice to check capillary refill about 2-3 seconds noted.'*

47. The C IPA advised it is usual patients in critical care areas to have hourly observation recordings performed unless a different frequency is stated. Lower limb '*vascular' observations were documented at 20.00, 22.00, 00.00 and 02.00 when the patient was admitted at 19.32*. He advised there was a gap in the records until 06.00 and from then hourly until emergency theatre. The records document a *'capillary refill of >3 seconds'* each time they are documented. The records describe the patient's limbs as consistently '*cool.'* The records also document the patient's limb colour starts off as '*pale'* and moves to '*mottled'* for two observations then back to '*pale'* before theatre.

48. The C IPA advised the first documented critical care consultant review was at 12.05 on 8 May 2019. He advised at this time the patient was already diagnosed with aortic occlusion and booked for theatre. '*There is no other record documenting intensive care consultant review or involvement.*' The C IPA advised '*this is unusual'.* In his advice the C IPA referred to the GPICS guidance. He advised GPICS have as standard that consultants in intensive care medicine '*must undertake ward rounds twice per day, seven days per week.'*

49. The C IPA advised '*it would appear that the patient went 17 hours before being seen by a consultant in intensive care medicine.'* A vascular surgery registrar had seen the patient approximately five hours after admission and 12 hours after admission. The surgical team managed the patient and their consultant had reviewed him.

50. The C IPA advised '*there is no record of any ICU consultant involvement prior to the move to emergency theatre that can be found in the documentation.*' He advised even after emergency theatre on 8 May 2019, the next record of ICU consultant involvement is on 9 May 2019 at 11.32. He advised the '*GPICS consultant ward round standard is not met*.'

51. The C IPA advised it is unclear what impact, if any, this had on the patient's care other than potentially a delay in some aspect of care. '*There is no clear evidence from the notes this occurred.'*

N IPA

52. The N IPA advised between 19.32 on 7 May 2019 and 12.05 on 8 May 2019, the nursing staff reviewed the patients: heart rate, temperature, cardiac rhythm, blood pressure, airway, oxygen delivery, respiratory rate, percentage delivered oxygen observations recorded every hour with the exception of 10.00 on 8 May 2019, when the patient attended the radiology department for a scan. She also advised the nursing staff carried out observations of circulation of his foot every two hours except at 04.00 on 8 May 2019.

53. The N IPA advised the post operative notes document in the recovery ward one of the two nurses caring for the patient following surgery informed Consultant A they had '*checked DORSAL PULSE right and left NOT TAKEN. NEGATIVE'* and *'Reviewed by Surgeon NOTIFIED NO DORSAL PULSE Both feet pale looking, cool to touch ADVICE to check capillary refill about 2-3 seconds instead.'* Consultant B reviewed the patient's blood pressure following a request from the second nurse because it was documented to be low during this time.

54. The N IPA advised on 7 May 2019 at 19.15, blood gases were taken, the patient's BP had improved and he was transferred to HDU/ICU. The patient arrived in HDU/ICU at 19.32 She advised the nursing staff commenced two hourly observations at 19.32. These observations documented – 'Pulses to be absent (not palpable) and the feet '*cool, pale or mottled*.' She advised from 22.00 the nursing records document the pulses are to be identified intermittently, via a doppler, which measures the pulses by sound waves, when

they cannot be palpated. Capillary refill time is stated to be greater than 3 seconds (>3) throughout the night which would indicate poor/reduced perfusion as normal capillary refill time is less than 3 seconds.

55. The N IPA advised '*staff in the recovery ward recognised, documented and escalated that there were no pulses present at 17.30hrs.*' This was escalated to Consultant A at the time. On admission to HDU medical notes at 19.32 document '*peripheral pulses present. Toes a little cold on both feet, all other peripheries warm.'* On the speciality review form dated 8 May 2019 at 07.54 the review states '*vascular, unable to move leg **first noted at 11pm** but foot perfused with a pt pulse, contacted at 06.40 and review of patient, left leg warm but ankle fixed with no movement. No sensation but monophasic pt pulse found. ?epidural, stop epidural and we will review again mid-morning to see if improvement …'*

56. The N IPA advised *she could 'find no documentation to show whether the nursing staff in HDU continued to escalate their concerns to the vascular surgeons overnight or to the Intensive Care Unit (ICU) medical team following this*.' However, vascular observations continued every two hours, apart from at 04.00, which clearly showed cool, pale, mottled feet and not pulses at times. This would be a reason to escalate to the unit medical staff and/or the vascular surgeons unless nursing staff had been told otherwise.

57. The N IPA advised observations and narrative documented on HDU began at 19.32 on 7 May 2019. The records show '*vital signs observation of BP, heart rate, respiratory rate and oxygen saturations were carried out by nursing staff at 19.45, 20.00 and every hour except 11.00 on 8 May 2019 until the patient went back to the operating theatre at approximately midday*.'

58. The N IPA advised the lack of movement was '*clearly escalated'* as medical staff were aware of this at 23.00 but the documentation of the escalation in the nursing records is not in the evidence provided. From the electronic nursing records it does appear the nursing staff alerted the medical team to concerns they had about circulation to the patient's feet as they document '*Drs aware'* in

the recovery room at 17.30, on admission to HDU at 19.32 and in HDU at 02.45 on the early morning of 8 May 2019.

59. The N IPA advised at 05.30 on 8 May 2019, the review details from the medical notes state ‘*warm peripheries, good colour, posterior tibial and dorsalis pedis pulses present on doppler b/l, CRT 3s’* which suggests a medical review and that circulation to the left foot and pulses were present at this time. The foot appears to be warm and a good colour. However, nursing observations do not appear to reflect this as they state from 20.00 the night before that both feet are cool, pale and mottled at times with question marks where they are unsure that pulses are present.

V IPA

60. The V IPA advised as the additional assessment of vascularity on 7 May 2019 at 19.32, ‘*calves SNT (soft not tender) pulses present. Toes a little cool’, ‘did not raise a red flag that there was a vascular cause for concern, the management plan was correct.’*

61. The V IPA advised the clinical picture was confounding. The patient had loss of sensation in the left leg and it was assumed this was due to a persistent effect of the epidural. However she advised it is clear from subsequent progress this was due to an ischaemic injury to the patient’s sciatic nerve. She advised the remaining indicators of adequate vascularity were assessed to be normal. It was only the next day concern was raised about the vascularity of the legs and it was only flagged in the notes when the patient returned from the x-ray department after having a CTA.

62. The V IPA advised ‘*she would not have requested a CTA after the initial assessment, but as the symptoms did not improve over night, which ruled out a residual effect from the epidural, something clearly was not right*.’ She advised, had the Trust conducted the CTA earlier, the problem would have been detected earlier. However, she advised she ‘*does not believe it would have made a difference to the outcome*.’ This is because she advised the patient needed to go back to theatre and his surgery would probably been as extensive

if it had been done at 06.00 as it was when the patient was taken back to theatre at 12.00.

63. The V IPA advised the Surgical Registrar who reviewed the patient at 06.37 was '*concerned*' and had flagged the patient to the Vascular Registrar coming on duty and '*therefore he was seen at the beginning of the vascular ward round.'* Although the Vascular Consultant (Consultant D) did not attend the patient's bedside she advised a discussion between the Vascular Registrar and Consultant A did take place. The outcome of which was to request the urgent CT scan and the consultant would have been informed of the findings of the CTA. '*The speed at which things happened once the patient was seen by the vascular registrar was appropriate.*'

Analysis and Findings

Critical Care Team

64. The medical records document the post-operative instructions; '*routine obs and analgesia, monitor pulse, NP, urinary output 30ml/hr and lower limb circulation, nil orally, normal meds with…'* The C IPA advised there is no standard protocol published by the vascular society or NICE for patient's introduced to HDU/ICU regarding neurovascular assessments. The C IPA advised it is usual the operation note, documented after surgery by the surgical team contains specific directions on post operative care required. The C IPA advised '*the staff followed the surgical post operative instructions*'. However, the staff did not document observations in the frequency that is standard for critical care areas.

65. The medical records document the first critical care ICU consultant review was at 12.05 on 8 May 2019. The C IPA advised by this time the patient was already diagnosed with aortic occlusion and booked for theatre. The GPIS guidelines 3.1 state '*Consultant in Intensive Care Medicine led ward rounds must occur twice a day (including weekends and national holidays.'* The C IPA advised there is '*no record of any ICU involvement prior to the move to emergency theatre that I can find in the documentation provided. Even after emergency theatre on 8 May 2019 the next record of ICU consultant*

involvement is on 9 May 2019 at 11.32. I note from the records the surgical team was managing the patient and Consultant A had reviewed him. The C IPA advised the '*ICU consultant may not have contributed to the care*.'

66. During the time 19.32 on 7 May 2019 until the patient returned to theatre at approximately 12.05 on 8 May 2019, he had his heart rate, temperature, cardiac rhythm, blood pressure, airway, oxygen delivery, respiratory rate, percentage delivered oxygen observations recorded every hour except at 10.00 on 8 May 2019 when he attended the radiology department for a scan. Observations of circulation of the foot were carried out every two hours except at 04.00.

67. While in the recovery ward after the surgery the medical records document Consultant A completed a review of the patient's legs at 17.30. The patient was admitted at 19.32 to HDU and lower limb '*vascular*' observations were documented at 20.00, 22.00, 00.00 and 02.00. There is then a gap until 06.00, then 08.00 and from then hourly until emergency theatre. The C IPA advised it is usual that patients in critical care areas have hourly observation recordings performed unless a different frequency is stated. I note the C IPA advised the post-operative instructions do not record a frequency. I consider the Trust's failure to record a frequency of observations a service failure. I will consider record keeping further below in paragraphs 99 - 109.

68. The C IPA advised '*earlier identification of a thrombus formation may have allowed for an earlier CT angiogram and possibly an alternative, less invasive treatment to take place. This may, or may not, have made a difference to the patient's clinical course.*'

69. The C IPA advised there was no record of any ICU consultant involvement prior to the move to emergency theatre in the documentation provided. While I note the IPA's concerns, in response to the draft report the Trust subsequently provided records to evidence a consultant review taking place on 8 May 2019 at 19.22. It is regrettable my office was not provided with this record at an earlier

stage of the investigation. However, I accept the record the Trust has now provided and I am satisfied that this consultant review did take place.

*Nursin*g

70. The Critical Care Guidance state patients in ICU should have one nurse dedicated to their care (two patients to one nurse in HDU). The N IPA advised this should have allowed all of the patient's nursing care needs to be fully met. The N IPA advised the patient received 24/7 nursing care with the vital signs observations taking place on a two hourly basis. The N IPA advised '*observations are documented very frequently during the HDU and ICU admissions.*

71. From the electronic nursing records, it is recorded nursing staff alerted the medical team to concerns they had about the patient's circulation as it is documented '*Drs aware*.' This is recorded in the recovery ward at 17.30, on admission to HDU at 19.32 and in HDU at 02.45 on the morning of 8 May 2019. At 05.30 on 8 May 2019 the medical review details document '*warm peripheries, good colour, posterior tibial and dorsalis pedis pulses present on doppler b/l, CRT 3's'.* The N IPA advised this suggests a medical review and that circulation to the left foot and pulses were present at this time. The foot appears to warm and a good colour. However, the N IPA advised, the nursing observations do not appear to reflect this as they state from 20.00 the night before that both feet are cool, pale and mottled at times with question marks where they are unsure pulses are present.

72. The N IPA advised the lack of movement was clearly escalated as the medical staff were aware of this at 23.00 but the documentation of this escalation in the nursing records is not in the evidence provided.

73. I accept the N IPA's advice and I am satisfied nursing observations were completed frequently during HDU and ICU admissions and staff alerted the medical team to concerns about the patient's circulation. The patient was provided with appropriate care and treatment. I do not uphold this element of

complaint. I will refer to the nursing staff records in relation to escalation to medical staff below in paragraphs 99 - 104.

Vascular

74. The V IPA advised the additional assessment of vascularity on 7 May 2019 at 19.32 'calves SNT (soft non tender) pulses present. '*Toes a little cool' did not raise a red flag that there was a vascular concern, the management plan was correct*.'

75. The complainant said she had concerns about how at 07.45 on 8 May 2019 a Vascular Specialist Registrar was able to identify a doppler signal and adequately perfused yet later on there was nothing and the patient had an occluded aorta. The V IPA advised if signals were identified, this would have given reassurance the vascular supply to the foot was adequate. Loss of doppler signals should be a cause for concern and initiate further investigation such as a CT angiogram as was requested.

78. The V IPA advised during the night following his initial surgery the clinical picture was not clear. There were signs the blood supply to the feet was adequate but the sensation to the left leg had not returned. Assuming the patient had been taken to CT at that stage, the CT would have been done at 03.00 at the earliest and he would have been back on the operating table at 05.00. This is still 12 hours post-surgery and he would still have required the reconstruction and the fasciotomies.

79. The V IPA advised '..*no. I do not think the delay contributed significantly to his subsequent surgery*.' His surgery was required to re-establish flow in his legs and to protect the muscles of the calf from re-perfusion. I accept the V IPA's advice that while there was a delay to the patient returning to theatre, this delay did not contribute significantly to his subsequent surgery. The surgery was required and regardless if this has been at an earlier stage the patient still required reconstruction and the fasciotomies. The V IPA advised '*One could conjecture that if the CT angiogram had been done earlier, the problem would have been detected earlier, but I don't think it would have made a difference to*

the outcome. He needed to go back to theatre and his surgery would probably have been as extensive if it had been done at 6am as it was when he was taken back to theatre at midday.' I am satisfied the care and treatment he received from the Vascular team was appropriate.

80. Overall I identified a failure in the care and treatment in relation to a critical care review; however I note the C IPA advised '*it is unclear what impact, if any, this had on the patient's care other than potentially a delay in some aspect of care…….. There is no clear evidence from the notes this occurred*.' I accept this advice.

81. I acknowledge the nursing staff completed frequent observations and documented their concerns about the patient's circulation. While there was a delay in the patient returning to theatre the V IPA advised '*I do not think the delay contributed significantly to his subsequent surgery.'* I accept this advice. Based on the available evidence I am satisfied the patient received appropriate monitoring in the HDU/ICU post surgery.

Period Two: The patients second operation carried out on 8 May 2019, review, and post-surgery.
In particular this will consider:

- *Conservative management care plan*
- *Pain threshold*

Detail of Complaint
Conservative management care plan

82. The Complainant said she believed conservative management was what contributed to the patient's complications following the second surgery on 8 May 2019.

Evidence Considered
Legislation/Policies/Guidance

83. I considered the following policies and guidance:
   – GMC Guidance.

The Trust's response to investigation enquiries

84. The Trust stated it believed '*conservative management of the patient was the best option at this time.'*

Relevant records

85. I considered the patient's medical records for the period 8 and 9 May 2019. I enclose a summary of these records at Appendix four to this report.

Relevant Independent Professional Advice

86. The V IPA advised Consultant D reviewed the patient on 9 May 2019. The patient received extensive surgery the previous day and '*clearly the left calf muscle was cause for concern as it had suffered a severe ischaemic injury.*' She advised the Trust explained to the family that the next 24 – 48 hours were critical, that the patient was at high risk of cardiac/respiratory complications. She advised the Trust also explained to the family that he may have to go back to theatre if his leg deteriorated.

87. The V IPA advised that the patient was in intensive care and his bodily functions were being supported. The patient's leg was being observed this *'is not conservative management.'* As his leg was being observed. *' it was in the best interest not to rush in and do more surgery until he was more stable and until it was evident that further surgery was required. This was totally appropriate.'*

Analysis and Findings

88. The complainant raised concerns about whether the Trust's conservative management of the patient was the best care plan at this time given all the problems he encountered.

89. I considered whether the treatment plan provided to the patient following the second surgery on 8 May 2019 was appropriate. The V IPA advised the clinical

picture was not clear. This is because the records document there were signs that the blood supply to the feet was adequate but the sensation to the left leg had not returned. The V IPA advised Consultant D reviewed the patient on 9 May 2019. She advised Consultant D explained to the family that the next 24 – 48 hours were critical, and that the patient was at high risk of cardiac/respiratory complications. The patient was on a dialysis machine and having continuous renal replacement therapy (CRRT) as his kidneys were not working. It was explained to the family that he may have to go back to theatre if his leg deteriorated.

90. He was in intensive care and his bodily functions were being supported, '*this is not conservative management. His leg was being observed.'* While I note the complainant's concern, I accept the V IPA's advice that the patient's '*leg was being observed'* and it was in the best interest not to rush in and do more surgery until he was more stable and until it was evident that further surgery was required. She advised this '*was totally appropriate.' I am satisfied the care plan was appropriate.* Therefore I do not uphold this element of complaint.

Detail of Complaint

Pain threshold

91. The complainant said she raised concerns about how the Trust determined the patient's pain threshold on 9 May 2019.

Evidence Considered

Legislation/Policies/Guidance

92. I considered the following policies and guidance:
    - GMC

The Trust's response to investigation enquiries

93. The Trust stated its medical staff determined the patient's pain threshold by speaking with the patient.

Relevant records

94. I considered the patient's medical records for the 9 May 2019.

Relevant Independent Professional Advice

95. The C IPA advised he believed that at that time (9 May) the patient was sedated and ventilated, this included an intravenous opioid painkiller. He advised It was not possible to accurately assess a patient's pain threshold. This is because the patient's Richmond Agitation-Sedation Scale [20](RASS) is documented as -2 or light sedation at 17.22 on 9 May 2019.

Analysis and Findings

96. The medical records document that the patient was sedated and ventilated on 9 May 2019. The medical records also document that the medical staff assessed the patient using RASS which was recorded as -2 or light sedation. In response to this Office's enquiries the Trust stated the patient's pain threshold was determined by speaking to the patient. I note the medical and nursing records on 9 May 2019 do not document the patient advised medical or nursing staff that he was in pain.

97. Having considered the medical records and the RASS scale I accept the C IPA's advice the medical staff recorded the patient's pain threshold via the RASS. I am satisfied this is an appropriate scale in order to assess the patient's pain on 9 May 2019 as he was sedated. I do not uphold this element of complaint. However I am critical the Trust informed this Office that the patient's pain threshold was measured by speaking to him. As the patient was sedated this would not have been possible.

Record Keeping

98. At this point I consider it important to highlight the IPAs found numerous examples of poor record keeping by the Trust and also in the manner in which records were filed. This made it particularly difficult for the IPAs to review the advice in a timely and efficient manner. Further, it was disappointing that this

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[20] The Richmond Agitation Sedation Scale (RASS) is a medical scale used to measure the agitation or sedation level of a person.

Office also had to engage with the Trust numerous times to obtain the complete records which caused a significant delay to the investigation and the complainant's access to a response to his complaint to this Office. I consider it is a fundamental principle of information governance that public sector bodies, especially those responsible for providing health and social care services, can easily identify, locate and retrieve information relating to their service users. I also consider clinical records a valuable resource which is essential to the delivery of evidence based health and social care and enables effective complaint handling.

99. I note the IPAs raised the following concerns about records:

N IPA advised

100. 'It was difficult to specify what, if any, failings have occurred as the records provided of the nursing observations noted do not always reflect that which is documented in the medical records. The notes do not appear to be as detailed as required when a concern is escalated.'

101. '*From the documentation provided, it is impossible to know whether the nurses escalated, and this was not taken as seriously as it should have been or, as the Trust and morning medical review states, that pulses and circulation were present on the morning of the 8 May 2019, even though the nursing documentation suggests otherwise*.'

102. '*The record is opened by the critical care nurse at 02:06 hours and closed at 07:58 hours which makes it difficult to state the exact time of escalation and interaction with the medical team. The lack of movement was clearly escalated as the medical staff were aware of this at 23:00 hours but the documentation of this escalation in the nursing records is not in the evidence provided. I can see no further documented evidence of escalation after the electronic record input at 02:45 hours*.'

103. It is difficult to specify what, if any, further failings have occurred as the records provided of the nursing observations noted do not always reflect that which is documented in the medical records. The notes do not appear to be as detailed as required when a concern is escalated.

C IPA advised

104. '*There is a general paucity of clinical note keeping. This may be because events like consultant reviews did not occur, or because they were not documented, or they were documented poorly. This makes it difficult to be precise about whether gaps in care and patient impacts occurred. The general paucity of clinical note keeping needs to be addressed. The presence of an electronic patient record in the critical care areas should make this easier but seems not to have done in this case*.'

105. I note that the notes are legible and time stamped at least, but they also need to be organised in a coherent way that enables clinicians to understand the patient journey and the organisation to demonstrate that it has intervened at the appropriate times and in what way (if they did). The standards to apply are, as a minimum, that of the General Medical Council's Good Clinical Practice[21] document sections 19 to 21 inclusive. This is especially an issue for handwritten notes where, in the examples required to understand this patient journey, sections are illegible. Consultants should be exemplary.

106. There should be a policy setting out standards of care on the units that include the frequency of observations required and how to alter those standards if required, either increasing or decreasing the frequency. This may have enabled earlier identification of the thrombus. This could also include the frequency of consultant ward rounds. If staffing does not permit twice daily ward rounds, then there should be an entry in the Trust risk register to identify the gap and how it is being managed.

[21] GMC's Good Clinical Practice sections 19 to 21

107. Overall, the standard of recording within the records and subsequent filing of these records caused me significant concern throughout this investigation. The C IPA advised this made it difficult to identify gaps in the patient's care and the subsequent impact. The N IPA advised that it was difficult to identify further failings. I would ask the Trust to reflect on the IPAs comments about record keeping.

108. The Third Principle of Good Administration being '*open and accountable*' requires a public body to '*Keeping proper and appropriate records*.' I consider the Trust failed to meet these standards for the reasons outlined above. I am satisfied this failure constitutes maladministration. As a consequence of this failing the complainant and the patient sustained the injustice of frustration as they have not received a timely response to the complaint.

CONCLUSION

109. I received a complaint about the care and treatment the patient received from the Trust in relation to surgery he received in May 2019. I upheld elements of the complaint for the reasons outlined in this report.

110. The investigation found the Trust's actions in relation to the consent process for an epidural were appropriate and in line with relevant guidance. The patient's pain threshold was managed appropriately in accordance with the relevant guidance.

111. The investigation established nursing staff provided the patient with the appropriate care and treatment in relation to observations and alerting the medical team to concerns about the patient's circulation.

112. However, it is of significant concern to me that the investigation found there was no records of a documented discussion with the patient about the risks when surgery was initially proposed on 22 September 2017.

113. I consider it important to again highlight the IPAs found numerous examples of poor record keeping by the Trust. This made it particularly difficult for the IPAs to provide their advice in a timely and efficient manner.

Recommendations

114. 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 injustice caused as a result of the failures identified (within **one month** of the date of this report).

115. I further recommend, for service improvement and to prevent future reoccurrence, that the Trust:

I. Brings the contents of this report to the attention of all HDU/ICU staff emphasising the importance of maintaining appropriate records Trust staff involved in this case should evidence a reasonable level of reflection of the findings in the complaint:

II. The Trust discusses the findings of the report at senior governance level; and I would also ask the Trust to reflect on the comments about recording information in ICU/HDU and undertakes a review in relation to how the frequency of observations are recorded in the HDU/ICU;

III. I recommend that the Trust implements an action plan to incorporate these recommendations and 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 that staff read and understood any relevant policies).'

MARGARET KELLY
Ombudsman

May 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.

Appendix 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. **Getting it right**

- Acting in accordance with the law and relevant guidance, 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 learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing 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.

2. **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 where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. **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.

4. 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 and actions 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

5. 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.

6. 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 learning from complaints.

- Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.