# Investigation of a complaint against the Southern Health & Social Care Trust

**Report Reference: 202002974**

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## The Role of the Ombudsman

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

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

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

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

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

## Reporting in the Public Interest

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

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

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## SUMMARY

I received a complaint about the care and treatment the Southern Health and Social Care Trust (the Trust) provided to the complainant's late husband, (the patient) from 20 January 2020 until the patient's passing on 10 August 2021.

The complaint relates to the follow-up reviews and CT scans the patient was due to receive following the identification and treatment of rectal cancer. It also relates to clinicians' decision to discharge the patient to a residential home, Crozier House.

My investigation found the following failures in the patient's care and treatment:

- Failure to ensure a three month review for the patient nor indeed any review until he came to an Emergency Department 12 months after having last been seen;
- Failure to appropriately review the patient as soon as possible after resumption of face to face review appointments with a corresponding impact on the opportunity for earlier optimal treatment;
- Failure to carry out a CT scan during the patient's admission to Daisy Hill Hospital from 31 December 2020 to 3 January 2021;
- Lack of documentation within patient's Emergency Department records dated 15 January 2021; and
- Failure to provide the patient and/or complainant with clear (documented) information to support them in making an informed decision on discharge when the patient clearly required both complex and end of life care.

These failures meant the patient experienced the loss of opportunity to have adequate monitoring and early optimal treatment and, to make an informed decision about his discharge with appropriate and compassionate end of life care. I also recognised the upset these failings caused the complainant. This included the continuing uncertainty of not knowing what difference any earlier treatment may have made to the patient's clinical pathway or, if clinicians considered referring the patient

to the surgical team when he attended the Emergency Department on 15 January 2021

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

## THE COMPLAINT

1. I received a complaint about the care and treatment the Southern Health and Social Care Trust (the Trust) provided to the complainant's late husband (the patient) from 2 January 2020 following a diagnosis of rectal cancer.

### Background

2. In March 2019, via the colorectal screening programme, clinicians diagnosed the patient with rectal cancer. Following completion of radiotherapy treatment, Consultant A, Consultant General Surgeon, undertook a Hartmann's resection[1] of the patient's rectal tumour on 18 September 2019 in Craigavon Area Hospital (CAH). Consultant A reviewed the patient on 10 October 2019 and 2 January 2020. Following the review on 2 January 2020, Consultant A planned a further review of the patient in three months and planned to order a CT scan[2] at this point. However, due to the Covid-19 Pandemic this review did not take place.

3. On 31 December 2020 the patient attended the Emergency Department (ED) of Daisy Hill Hospital (DHH) with abdominal pain, vomiting and variable stoma output. Clinicians discharged the patient home on 3 January 2021. The patient also attended the same ED on 15 January 2021, with similar symptoms as his previous visit. Clinicians discharged him the same day. On 15 March 2021 the patient had a CT scan taken privately and saw Consultant A, again privately, on 18 March 2021. Following this consultation, clinicians admitted the patient to CAH, on 31 March 2021, for a laparotomy[3] and small bowel resection[4]/bypass.

4. On 28 May 2021, clinicians admitted the patient to CAH with worsening renal function and he required a bilateral ureteric stent insertion[5]. The Royal Victoria Hospital (RVH) carried out this procedure and on 2 June 2021, the patient transferred back to CAH. In CAH, on 13 June 2021, the patient underwent a

[1] Surgery to remove the section of bowel affected by the disease following which one end of the remaining bowel is brought out onto the surface of the skin as a colostomy (stoma). The colostomy allows waste from the body to pass out through the abdomen and into a stoma bag.
[2] A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body.
[3] Surgical incision into the abdominal cavity to examine the abdominal organs and aid diagnosis of any problems.
[4] A surgery to remove a part of your small bowel that is blocked or diseased.
[5] A thin, flexible tube placed in both ureters to hold them open. This allows urine to drain from the kidneys into the bladder.

palliative laparotomy and defunctioning loop ileostomy[6]. On 7 July 2021, the Trust discharged the patient to Crozier Houser (a residential care home) for further support and recovery before returning home. While in Crozier House the Trust organised input from district nurses for renasys[7] and nephrostomy[8] dressing changes. On 13 July 2021, due to dehydration and high stoma output, the patient was readmitted to CAH via the ED. However, the patient's condition did not improve, and he sadly passed away on 10 August 2021.

### Issue of complaint

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

**Whether the Trust provided appropriate care and treatment to the patient from 2 January 2020 to 13 July 2021.**

## INVESTIGATION METHODOLOGY

6. 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.

### Independent Professional Advice Sought

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

- A Consultant General and Colorectal Surgeon with over 20 years' experience. (G IPA)
- A Consultant in Emergency Medicine, MD, MPH, FRCEM. (ED IPA)

[6] A surgical procedure adopted for faecal diversion in colorectal surgery to prevent anastomotic leakage (a post-surgery complication that arises from procedures such as bowel resection)

[7] A dressing system that uses controlled negative pressure (vacuum) to help promote wound healing.

[8] A nephrostomy is a tube that lets urine drain from the kidney through an opening in the skin on the back.

8. 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**

9. 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[9]:

- The Principles of Good Administration

10. 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 Department of Health, Social Services and Public Safety: Integrated Elective Access Protocol, 30 April 2008, (the 2008 Access Protocol);
- Department of Health: Integrated Elective Access Protocol, June 2020, (the 2020 Access Protocol);
- The General Medical Council's Good Medical Practice, updated April 2014 (the GMC Guidance);
- The Health and Social Care (HSC), getting patients on the Right Road for Discharge. Guiding principles to enable the effective Discharge planning for Adults from Hospital and Transition settings, 2015, (HSC's Guiding Principles); and

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

- The National Institute for Health and Care Excellence (NICE): Quality Standards [QS13] End of life care for adults, November 2011 (QS13).

**Trust records**

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

12. 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.

13. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

## THE INVESTIGATION

**Whether the Trust provided appropriate care and treatment to the patient from 2 January 2020 to 13 July 2021. This considered:**

- **Reviews of the patient following his consultation on 2 January 2020; and**
- **Decision to discharge the patient from Craigavon Area Hospital**

These issues are addressed separately below.

**Detail of Complaint**

*Reviews of the patient following his consultation on 2 January 2020*

14. The complainant said following the patient's review appointment on 2 January 2020 he did not receive any reviews or follow-up scans due to Covid-19.

However, despite Covid-19 the complainant believed the patient should have received a follow-up scan sooner.

**Evidence Considered**

**Policies/Guidance**

15. I considered the following policies/guidance:
    - the 2008 Access Protocol;
    - the 2020 Access Protocol and
    - the GMC Guidance.

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

**Trust's response to investigation enquiries**

16. The Trust explained: Following an outpatient review appointment with Consultant A on 2 January 2020 the plan was for the patient to attend a further review appointment in three months and to arrange for a follow up CT scan at this review. *'…This appointment should have taken place in March 2020; however, this coincided with the first wave of the Covid pandemic…As [the patient's] outpatient appointment did not take place…'* Consultant A did not request this follow up CT scan. As a result of adhering to guidance, the Trust temporarily ceased *'…almost all elective activity including outpatient reviews, in order to deal with the emergency Covid workload.'*

17. General Surgery face-to-face outpatient clinics re-commenced week commencing 27 July 2020 and *'…were booked according to clinical urgency then chronologically…Unfortunately, due to demand outweighing capacity for General Surgery appointments, a backlog of review appointments had accrued prior to the pandemic. This review backlog was exacerbated further during the Covid pandemic alongside the backlog accruing for new patient appointments… [The Patient's] intended review appointment was not rescheduled and he remained on [Consultant A's] urgent waiting list for his review appointment from the original date…'* The patient *'…did not receive an*

*offer of an appointment prior to the CT scan in March 2021[10]…which then started [the patient] on a new patient pathway.'*

18. In relation to the patient's admission to DHH on 31 December 2020 the Trust explained that the surgical form from this date and the nursing records of 1 January 2021, at 02:00 indicate that *'…it was not definitive that a CT was required…'* It also referred to the patient's updated management plan to '…*1. Observe 2. Fluid diet.'* following the post ward round on 1 January 2020 at 10:00.

**Relevant Independent Professional Advice**

19. The G IPA advised: following the patient's surgery, in September 2019, Consultant A saw him around three months after discharge. This was a standard follow-up *'…generally done to review recovery from surgery and progress. Healing wounds, managing stoma, discussion of result and plans and investigations etc. and opportunity to discuss prognosis etc…'* The main outcome of this review was to arrange a CT scan in three months, which would '…*be approximately six months post resection. Since this resection was not likely to be curative, there was a possibility that recurrence can be detected at about six months and usually within 18 months of surgery in about 85% of cases. Early recurrence was more likely in this case…Had copies of [clinic] letters been shared with the patient, communication would have been more effective and the patient would have been more aware…'*

20. In relation to whether it was appropriate for Consultant A to arrange a CT at the patient's next review appointment the G IPA advised: Consultant A had two options - either to book the CT in advance and see the patient at the review with the CT scan result, or to book the CT at the time of the follow-up review. It is more *'…effective and expedient...*' to have arranged a CT scan for the patient in March 2021 and then pre book a clinic appointment within 2 weeks which is usually sufficient for reporting and seeing with the results. *'…This is viewed as good and effective practice and means that the patient will be seen with the*

[10] This CT scan was arranged privately by the patient.

*results and plan follow up accordingly.* This more effective practice means the patient *'…likely would not have missed the proposed CT scan plan or at least would have been prioritized during the subsequent pandemic as urgent cancer follow up case.***'**

21. In relation to the Trust's capacity issues to facilitate appointments following the Covid-19 Pandemic the G IPA advised**:** *'…the obvious need here is for a CT scan and not a clinic appointment to see and book a CT scan. Purely [on] this basis, it is logical to book the investigation and plan review (virtual or face to face) depending on the results. Given the scale of the pandemic's impact any other option is redundant or not clinically advisable…'* However, the G IPA also advises *'…This patient could have had a virtual appointment with the caveat that the investigation could have been booked away…'*

22. In relation to the patient's admission to DHH on 31 December 2020 the G IPA advised clinicians admitted the patient as *'…There was a possible diagnosis of bowel obstruction and acute kidney injury…'* Due to the patient's previous surgery and that he presented just over a year later with obstructive symptoms that required admission. *'…These are clear indications for a CT scan…*' The CT scan *'…would have been helpful with establishing the diagnosis and with the concern of recurrent cancer that may cause his symptoms either diagnosing recurrence or not…On the abdominal x-ray there were dilated small bowel loops. With the presentation, this was consistent with symptoms of a bowel obstruction (incomplete or complete). A CT scan should have been carried out in managing bowel obstruction as well as concern for recurrent cancer.'*

23. Commenting on the impact to the patient as a result of not having a CT scan before March 2021 the G IPA advised: *'…There was a strong likelihood that this patient would develop recurrent cancer…*' and the histology features of his cancer indicated *'…poor prognosis…'* and *'…a relatively aggressive cancer. Early scanning at 6/12/18 months would have monitored the situation and if there was recurrence this could be considered for treatment. It is difficult to precisely state how different the outcome would be had recurrence been found earlier. There is evidence that those suitable for treatment both do equally well*

*in early or late recurrence…'* However, it is important that any recurrence *'….is found early for optimal treatment…On balance given that this was an R1 resection[11], had CT scans been performed earlier, there was potential that the outcome could have been different although the chances are still relatively small…'* However, treatment success is also dependent on whether an occurrence is localised**,** if the patient is suitable for extensive surgery and the tumour biology. Even after surgery *'…the success is also less than 20%...On balance the prognosis for this patient was poor and given the overall picture it is possible that even earlier diagnosis of regrowth would not have changed the outcome.'*

24. In relation to additional treatment options the G IPA advised *'…Had scans been done earlier and local recurrence been found, there was an option to consider more extensive surgery. It is unlikely that chemotherapy would have had a significant impact… Further even if extensive surgery (pelvic exenteration) were undertaken the 5-yr survival overall is less than 20% ...the disease in this case appears to be poor prognosis and it is unlikely that an earlier CT scan would have altered the outcome.'*

25. The G IPA further questioned the value of the patient's surgery in June 2021, following the March 2021 CT scan, as the patient was likely to re-obstruct. *'…Further the significant disease progression made the stoma formation and consequences questionable. This patient's outlook was poor and terminal. The risk of complicated high output stoma with difficult management solution was high. This should be reflected upon. The focus should have been on managing a terminally ill patient and ensuring good end of life care rather than futile surgery.'*

**Complainant's response to draft report**

26. The complainant highlighted the patient had a further ED visit to DHH on 15 January 2021 with the same symptoms he had experienced on 31 December 2021. She said clinicians carried out an x-ray but sent the patient home the

[11] the removal of all macroscopic disease, but microscopic margins are positive for tumour.

same day with no follow-up. She welcomed the recommendation for the Trust to facilitate a meeting with Consultant A as, she believed Consultant A had not previously given the full information about the patient's prognosis. The complainant also highlighted how the experience of husband's care within the Trust was a *'… traumatising experience…'* causing *'…great anxiety…'*

**Further Independent Professional Advice Received.**

27. Following receipt of the information that the patient had a further ED visit on 15 January 2021, I obtained advice from an ED IPA. I enclose the additional clinical advice received at Appendix two to this report.

28. The ED IPA advised: the patient attended the ED on 15 January 2021, was examined and had a number of tests undertaken including an abdominal x-ray. Given the information it was his opinion there was *'…not a clear indication for emergency CT scanning, in the emergency department...'*

29. However, the care the patient received during his ED visit on 15 January 2021 *'…was not appropriate…'* This is because:-

- *'…the standard of documentation is barely acceptable with no differential diagnosis, or apparent consideration of serious pathology and missing interpretation of some diagnostic tests that were undertaken…*
- *…on the evidence presented…the patient warranted at least discussion with the inpatient surgical team with a view to either a period of inpatient observation and/or further diagnostic tests…*
- *…the formal X-ray report suggested significant abnormality which may have prompted further investigation. The formal report takes 16 days to be done which seems an unduly long time for formal reporting on an emergency diagnostic test…'*
- *…there also then seems to be no documented review of the case by clinicians, in light of the abnormal X-ray report. The Royal College of Emergency Medicine suggest this should be done within 72 hours of*

*an abnormal result being received on a patient that is discharged from ED...'*

**Trust's response to draft report and additional IPA advice**

30. The Trust agreed with the findings of the draft report.

31. In relation to the additional ED IPA advice received the Trust agreed that *'…the documentation in the ED records is poor, with no documentation of review of the abdominal x-ray, no differential diagnosis…'* The clinician involved discussed the patient's care with a consultant in the ED '…*however there is no documentation of the details of this discussion.* Given the lack of documentation *'…it is difficult to comment on whether a referral to the surgical team was considered. It would be standard practice within the department for trainees to discuss a patient's care with the Emergency Medicine consultant or senior doctor initially, before contacting any inpatient specialty teams for advice.'*

32. The Trust agreed *'…there was no indication for emergency CT scan…'* In relation to the formal reporting of the patient's abdominal x-ray the Trust explained the formal report was *'...completed on 31st January 2021 and sent to the ED for review. This report was reviewed by an EM consultant on 2nd February 2021 and is documented that a copy be forwarded to the patient's GP.'*

**Consultant B's response to draft report**

33. Consultant B extended his *'…deepest condolences to the complainant for the loss of her husband.'* Consultant B accepted the conclusion that a CT scan should have been performed on the patient during his admission to DHH on 31 December 2020 and on accepting the conclusions of the report he had taken on board the recommendations and *'…had used this opportunity to reflect on [his] role in managing this case, and on various aspects of the clinical decision-making, and will continue to do so…'*

34. Notwithstanding the above, Consultant B wished to highlight information from the clinical records, not included within the G IPA's advice, that would *'…better*

*qualify…'* the Trust response at paragraph 18 as to why a CT scan was not definitely required. This information included:

- The patient's medical notes also documented the patient had *'… "two weeks of high stoma output 2 bags/ day from BG of 1 bag/ day" and 2-3 days of "more normal consistency, 1 bag/ day". Furthermore, the clinical examination notes from the same episode state "…the abdomen was not distended, bowel sounds were present and normal in character, and there was a "small volume fairly formed faeces in stoma bag…". As such, the complete clinical picture is more in keeping with an erratically functioning stoma rather than definitive bowel obstruction.*'
- The G IPA refers to an abdominal x-ray showing dilated bowel loops, suggestive of bowel obstruction. However, the consultant radiologist report on this x-ray, not included in the G IPA advice, states *"Bowel gas pattern is within normal limits. No abnormal soft tissue shadowing".*
- CT scans for suspected bowel obstruction involve administering intravenous contrast, which aggravates kidney injury. The patient's admission management plan on 31 December 2020 mentions *"…CT/ US if deterioration"* evidencing that *'…a CT scan was considered but purposefully avoided in light of the clinical picture…'* i.e. the patient exhibited evidence of acute kidney injury on admission blood test results, most likely secondary to dehydration from high stoma output. (as recognised by the G IPA)*. '…As it transpired, the patient's condition improved and he was discharged home within three days.'*
- There were strict Covid restrictions in place and *'…Clinical decision making during this time…had to cater for isolation and barriers on various wards, minimising movement within the hospital, and minimising in-hospital stays in the interest of preventing COVID exposure. Any scans not relevant to a patient's immediate management would have been postponed to the post-lockdown period.'*

**Analysis and Findings**

35. The complainant said following the patient's review appointment on 2 January 2020 he did not receive any reviews or follow-up scans due to Covid-19. She believed, even given the impact of the Covid-19 pandemic, the patient should have received a follow-up scan sooner. The complainant has also indicated she would appreciate a face-to-face meeting with Consultant A to help her clarify events.

36. I examined the Trust's records and noted following a review of the patient, on 2 January 2020, Consultant A planned to order a CT scan at a review in three months. The patient subsequently did not have this follow-up review but arranged for a private CT scan which was carried out on 15 March 2021. I also note, that prior to this CT scan, clinicians admitted the patient to DHH on 31 December 2020 with reduced stoma output and abdominal pain. Following an x-ray, which indicated '…*Prominent loops of small bowel…*', Consultant B, (Consultant General Surgeon) monitored the patient and subsequently discharged him on 3 January 2021. I further note the patient attended the ED of DHH on 15 January 2021, experiencing similar symptoms. Clinicians diagnosed the patient with Gastroenteritis and sent him home the same day. I also note a formal report of the patient's abdominal x-ray was annotated indicating that a copy be sent to the patient's GP on 2 February 2021.

37. I note the Trust comments that as the patient's review appointment coincided with the first wave of Covid-19, it did not take place, as the Trust had temporarily ceased *'…almost all elective activity…'* in line with guidance. I also note the Trust comments in paragraph 17 which set out the reasoning why the patient remained on Consultant's A urgent list following the re-commencement of outpatient clinics in July 2020. I further considered the Trust's comments in relation to the patient's admission to DHH on 31 December 2020 that *'…it was not definitive that a CT was required…'* I also considered the Trust's comments in relation to the patient's ED visit on 15 January 2021. While it accepted *'…the documentation in the ED records is poor…'* the clinician did discuss the patient's care with the ED consultant. However, as this discussion was not documented *'…it is difficult to comment on whether a referral to the surgical*

*team was considered…'* but it would be standard practice to discuss patient care with ED consultant prior to contacting any inpatient speciality teams. I further note the Trust comments that a consultant reviewed the patient's X-ray report on 2 February 2021 and a copy of the report sent to the patient's GP.

38. I considered the G IPA's advice and note, since the patient's initial resection '…*was not likely to be curative*…*Early recurrence was more likely in this case…'* I further note the G IPA considered it would have been more *'…effective and expedient...*' to have arranged a CT scan for the patient in March 2020 and then pre book a clinic appointment. This would have meant the patient could be seen with the results (either face to face or virtually) and a further follow-up arranged accordingly. I note the G IPA viewed this as *'…good and effective practice…'* which meant the patient *'…at least would have been prioritized during the subsequent pandemic as urgent cancer follow up case.'* I also note the G IPA's advice that the patient *'…could have had a virtual appointment…'*

39. I considered the G IPA's advice that given the patient's presenting symptoms on 31 December 2020 to DHH, and his previous surgery, '…*A CT scan should have been carried out...' I further note the G IPA's advice that while early scanning of the patient would have monitored his situation and identified and cancer recurrence there are a several factors, as detailed in paragraph 23, which would have impacted on the success of treatment on any cancer recurrence. Also, '…On balance the prognosis for this patient was poor… and it is unlikely that an earlier CT scan…' and earlier diagnosis of any regrowth '…would have altered the outcome.' and given the overall picture it is possible that even earlier diagnosis of regrowth… would not have changed the outcome.'*

40. I also note the ED IPA's advice about the standard of the ED documentation and that '…*on the evidence presented…the patient warranted at least discussion with the inpatient surgical team…'* I further note his comments on the reporting and subsequent review of the patient's abdominal x-ray.

41. I acknowledge the Trust's comments that it postponed *'…almost all…'* outpatient review clinics due to the emerging Covid-19 Pandemic. I also acknowledge when these outpatient clinics recommenced the Trust scheduled patients in line with the 2020 Access Protocol, but this process was hampered by capacity demands. However, given the patient was on the urgent review list, I accept the G IPA's advice that he could have had a virtual appointment with a CT scan arranged at this point. I am satisfied the patient should have had a review as close to three months as possible. I consider this a failure in the patient's care and treatment.

42. I acknowledge the Trust's comments that *'…it was not definitive that a CT was required…*' when the patient was in DHH from 31 December 2021 as well as the additional comments provided by the Consultant B. While this additional information did not appear in the G IPA's advice, he did have a full copy of the patient's medical records which included this information. However, given the patient's history and outstanding out-patient Consultant review and CT scan, I accept the G IPA's advice and I am satisfied that Consultant B should have arranged for a CT scan to be carried out during this admission. I view this as a potential opportunity for clinicians to diagnose, at that point in time, cancer recurrence. I consider this a failure in the patient's care and treatment. I acknowledge the G IPA's advice that even if an earlier diagnosis of regrowth been made '…*On balance…the prognosis for this patient was poor and…would not have changed the outcome.'*

43. I acknowledge the Trust's acceptance about the standard of the ED documentation on 15 January 2021, its comments around the difficulty in determining whether clinicians considered a referral to the surgical team and, that it would be standard practice to discuss patient care with ED consultant prior to contacting any inpatient speciality teams. I accept clinicians discussed the patient's care with the ED consultant. While I acknowledge the ED IPA's advice that '…*on the evidence presented…the patient warranted at least discussion with the inpatient surgical team…'* given the poor standard of recording keeping I am unable to determine whether clinicians even discussed/considered a referral to the in-patient surgical team. I consider this

lack of documentation within the ED records of 15 January 2021 a failure in the patient's care and treatment. However, I accept the ED IPA that there was '…*not a clear indication for emergency CT scanning, in the emergency department...'*

44. I acknowledge the ED's IPA advice about the reporting and subsequent review of the patient's abdominal x-ray. However, on review of the records I accept the Trust comment's that a consultant reviewed the patient's X-ray report on 2 February 2021 and a copy of the report sent to the patient's GP. However, I would ask the Trust to reflect on the length of time taken to formally report on patient's abdominal x-ray.

45. It is my view as a consequence of the failures identified in paragraphs 41, 42, the patient experienced the loss of opportunity to have adequate monitoring and have optimal treatment options considered at an earlier stage. I also consider the complainant sustained the injustice of uncertainty and upset. This is because the complainant will always question what difference any earlier treatment may have made to the patient's clinical pathway.

46. As a consequence of the failure identified in paragraph 43 it is my view the complainant sustained the injustice of uncertainty and upset. This is because the complainant will always question whether clinicians considered referring the patient to the inpatient surgical team during his visit on 15 January 2024.

47. Therefore, I uphold this element of complaint.

48. I would like to draw the Trust's attention to the G IPA's comments that it would have been more *'…effective and expedient...'* and *'…good and effective practice…'* to have arranged a CT scan for the patient in March 2021 and then pre book a clinic appointment. While I acknowledge that neither the 2008 or 2020 Access Protocols provide clear guidance on this practice, they do state '…*Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the consultant…'* and relevant individuals within the Trust have a role in *'…treating patients and delivering a high quality,*

*efficient and responsive service…'* Given this I do consider the practice the G IPA identified would help ensure patient pathways are optimised. I would ask that the clinicians involved reflect on the G IPA's comments.

49. I also refer to the G IPA's comments about sharing clinic letters with patients. Following a 'Own Initiative'[12] investigation by my office into communications with patients on healthcare waiting lists, the Department of Health and Health and Social Care Trusts are considering/actioning a recommendation to copy clinic letters to patients. I would strongly urge the Trust to implement this recommendation as soon as possible.

**Detail of Complaint**

*Decision to discharge the patient from Craigavon Area Hospital*

50. The complainant said clinicians made the *'…wrong decision…'* when they discharged the patient to Crozier House as he was weak and a palliative care patient. She believed that because of the decision to discharge, the patient was readmitted back to hospital.

**Evidence Considered**

**Policies/Guidance**

51. I considered the following policies/guidance:
    - the GMC Guidance;
    - the HSC's Guiding Principles; and
    - QS 13.

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

**Trust's response to investigation enquiries**

[12]This function allows the Ombudsman to investigate issues even if the complaints have not been received from members of the public.

52. The Trust explained: *'…The Hospital Social Work Team records that early in [the patient's] admission he was requiring assistance of two to mobilise, and a Physiotherapist was considering inpatient rehabilitation. However, [the patient's] functional mobility improved and the Physiotherapist determined a referral for inpatient rehabilitation was no longer required…[The patient] was initially considered for a return home with support from the Reablement Team. However, the Multidisciplinary Team determined a referral to the Intermediate Care Scheme for a short-term placement to Crozier House would be beneficial…The Physiotherapist via Discharge to Assess referred the patient on 7 July 2021 to Crozier House, with records advising patient and family… were in agreement…and no concerns were raised…From a Hospital Social Work perspective, discharge is always agreed with the patient and family once Medical staff have determined it, and this was the case for [the patient] at the time. There is reference to [the patient] being medically fit for discharge throughout the handwritten notes provided…Of note [the patient] was independent with emptying his nephrostomies and District Nursing were organised to support him in Crozier House…'*

**Relevant Independent Professional Advice**

53. The G IPA advised: at the time of time of discharge the patient *'…was either for home or an intermediate facility if there are no medical needs with and expectation for palliative care…'* The patient required '...*wound care, management of a nephrostomy…'* and this was *'…against a background of being terminally ill with an advanced and growing malignancy…*' Crozier House is *'…listed as a residential care home. Not a facility for 'rehabilitation' per se where the expectation is 'return to health as before admission…'* which *'…not possible for this patient…'* However, documentation indicated that *'…patient and family were 'keen' on this however, it was not a realistic recommendation and subject to professional advice…'*

54. While the discharge records '…*states that he was managing his stoma although there was little evidence to state this comprehensively. His stoma output on review of the records was not likely to remain stable and episodes of high output, risk of leak, electrolyte disturbances were likely to occur. The*

*records in Crozier house shows little evidence that the patient was self-managing his stoma and there was frequent leakage…'* There was an arrangement for District Nurse visits to support the patient's *'…stoma care including nephrostomy tubes, and vac dressing.* These are complex needs and *'…Crozier house it would appear do not provide this inpatient facility…'* The patient required *'…intensive support more suited to a nursing home environment rather than community care…'*

55. The G IPA further advised that overall, the patient's needs *'…would have to be regarded as unmet…'* as *'…stoma care, wound care, physiotherapy input we below expectations in context.'* Given the patient's prognosis *'...recovery with aid of Rehab was not expected. Deterioration was inevitable with option either for palliative home care, hospice care or not ideal back in hospital…'* While Palliative care/treatment was mentioned in CAH and Crozier House records it does *'…not seem to be seriously discussed or focused upon...Ensuring good end of life care…There was no clear discussion on the futility of treatment to date and the obvious likelihood that [the patient] would [not] recover to any degree to be considered for palliative chemotherapy which realistically would not have been beneficial in survival.'*

56. In relation to the patient's re-admittance to CAH the G IPA advised: *'…The timing of discharge would not have changed the possibility of return to CAH…'* When readmitted in July 2021 a further CT scan showed more disease. The patient's palliative care needs were not addressed with this being *'…unsatisfactory care rather than planning toward 'a good death'.'*

**Complainant's response to draft report**

57. The complainant disagreed with the Trust response at paragraph 52 that indicated the family agreed with the admission to Crozier house with no concerns raised She felt *'…aggrieved that we as a family are somehow being made to feel responsible for the admission to Crozier House…'* The family *'…depended heavily on…'* and took advice *'…from medical professionals whom [they] believed would be placing the best interests of [the patient] at the forefront of any recommendation they made….'* However, the complainant said

she felt *'…their main priority in this situation was to free a bed and as such were encouraging the move to Crozier House to achieve this outcome.* The complainant also said the family found it difficult to contact Consultant A to obtain further information on the patient's case and when information was provided it was limited.

58. The complainant also wished to highlight that she did have concerns about. The patient's move to Crozier House and its suitability to care for him given his medical state at that time but she *'...did not proceed to fight the transfer as he was happy to be getting closer to home...*' However, within five to six days of the patient's move to Crozier House he had deteriorated and, the complainant had to request a GP visit. The patient was subsequently re-admitted CAH with an infection.

**Trust's response to draft report**

59. The Trust agreed with the findings of the draft report.

**Analysis and Findings**

60. The complainant said it was the *'…wrong decision…'* to discharge the patient to Crozier House as he was weak and a palliative care patient. She believed that because of the decision to discharge, the patient was readmitted back to hospital.

61. I examined the Trust's records and noted on 14 June 2021 clinicians had a discussion with the patient's family about; palliative care options, that he may not survive the current admission and, that his cancer was not curable. On 21 June 2021 clinicians told the family it would be difficult to give a time for prognosis. However, the patient had *'…made a good recovery...'* but, remained frail and would be reviewed in the incoming weeks to determine if chemotherapy would be considered. I further note clinicians recorded the patient as medically fit for discharge and he was subsequently discharged to Crozier House, a Residential Home, on 7July 2021 with the District Nurse care arranged to change the patient's Renasys and nephrostomy dressings. I also

note that on 5 July 2021 the Physiotherapist recorded patient was *'…keen for discharge to Crozier house for rehab prior to home…'* discharge and the complainant was *'…keen for same…'*

62. I note the Trust comments that the patient and his family *'… were in agreement…'* with his discharge to Crozier House and the medical notes referenced he was medically fit for discharge. I also considered its comments that the patient was independent with emptying his nephrostomies and that District Nursing had been organised to support him in Crozier House. However, I also acknowledge the additional information provided by the complainant about the patient's discharge to Crozier House.

63. I considered the G IPA's advice and note the patient had *'…complex needs…'* which Crozier House (although in conjunction with agreed District Nurse and Physiotherapist input) were unable to meet and were *'…more suited to a nursing home environment…*' I further note the G IPA's advice discharge to Crozier House was *'…not a realistic recommendation and subject to professional advice…*' I also note that the patient's *'…deterioration was inevitable…'* with possible options of *'…either for palliative home care, hospice care or not ideal back in hospital…'* However, I also note the G IPA's advice that the timing of the patient's discharge to Crozier House did not impact his readmittance to CAH.

64. I also considered the G IPA's advice that while Trust Staff mentioned palliative care/treatment in both CAH and Crozier House it does *'…not seem to be seriously discussed or focused upon…ensuring good end life care…'* and *'…planning toward 'a good death'.'*

65. I acknowledge t the Trust's comments that both the patient and his family were happy for discharge to Crozier House and, that clinicians considered the patient medically fit for discharge. However, I accept the complainant's comments that family acceptance of Crozier House relied on the information supplied by the clinicians at the time. I also accept the G IPA's advice that the patient had complex needs which were more suited to a nursing environment and a

discharge to Crozier house was not recommended and should have been subject to professional advice., It is important that in line with the HSC's Guiding Principles clinicians *'…provide the patient, family and/or carer with clear information to support informed decisions and choices regarding discharge…'* On review of the records, I have been unable to identify if the patient and family were fully aware of the limitations of care (even with District Nurse and Physiotherapist input) that Crozier House could provide given the patient's complex needs. I consider this a failure in the patient's care and treatment. It is my view, as a result, of this failure the patient and the complainant experienced the loss of opportunity to make an informed decision about the patient's discharge. I also consider the complainant sustained the injustice of uncertainty and upset as she will always question the suitability of Crozier House for the patient's discharge.

Observation

66. I would draw the Trust's attention to the G IPA's comments about the patient's June 2021 and July 2021 surgeries and that *'…The focus should have been on managing a terminally ill patient and ensuring good end of life care rather than futile surgery…'* While I acknowledge the G IPA's comments, I recognise clinicians have to judge any benefit to the patient when deciding whether to carryout a treatment on patient who is approaching end of life[13] to manage/treat their symptoms and to ensure they are supported to live as well as possible until they die and to die with dignity. However, I would ask the clinicians involved in the patient's care to reflect on the G IPA's comments.

## CONCLUSION

67. I received a complaint about the care and treatment the Southern Health and the Trust provided to the complainant's late husband.

68. For reasons outlined in the report the investigation established failures in the care and treatment in relation to the following matters:

[13] Likely to die within the next 12 months

- Failure to ensure a three month review for the patient nor indeed any review until he came to ED 12 months after having last been seen;
- Failure to appropriately review the patient as soon as possible after resumption of face to face review appointments;
- Lack of documentation within the patient's ED medical records dated 15 January 2021; and
- Failure to provide the patient and/or complainant with clear (documented) information to support them in making an informed decision on discharge when the patient clearly required both complex and end of life care.

69. I recognise the failures caused the patient experienced the loss of opportunity to have adequate monitoring and have optimal treatment options considered at an earlier stage. I further consider the patient and complainant experienced the loss of opportunity to make an informed decision about the patient's discharge. I also consider that the complainant sustained the injustice of uncertainty and upset.

**Recommendations**

70. 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).

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

- Discusses the findings of this report with relevant clinicians involved in the patient's care in a supportive way for reflection and learning and to inform future decision making;
- Reminds all ED clinicians of the importance of fully documenting patient care discussions with ED Consultants, reviews of x-ray, and differential diagnosis;

- Carries out a random sampling audit of patients' discharges from Ward 4 South to ensure clinicians have provided (and documented) information to a patients/family members to enable informed decisions to be made regarding discharges for those patients with complex needs; and
- In line with the complainant's wishes, organise a meeting for her with Consultant A.

The Trust should take action to address any identified trends or shortcomings within the sampling audits and should include any recommendations identified in its update to this office.

72. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. 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 related policies).

73. I offer through this report my condolences to the complainant for the loss of her husband and recognise the ongoing distress she experiences as a result of her husband's death. It is clear from my reading of the records how involved she was in the patient's care.

**MARGARET KELLY**
**Ombudsman** **August 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.