Investigation Report

Investigation of a complaint against the South Eastern Health and Social Care Trust

NIPSO Reference: 19704

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

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.

TABLE OF CONTENTS

Page

SUMMARY ………………………………………………………… 4

THE COMPLAINT ………………………………………………. 6

INVESTIGATION METHODOLOGY …………………………. 7

THE INVESTIGATION ………………………………………….. 9

CONCLUSION …………………………………………………... 54

APPENDICES …………………………………………………… 58

Appendix 1 – The Principles of Good Administration

Appendix 2 – The Principles of Good Complaints Handling

SUMMARY

I received a complaint about the care and treatment of a patient in the Ulster Hospital. In considering the complaint, I established that the decision to admit the patient to an escalation bed was made in accordance with relevant guidance. However, the investigation established that the Emergency Department staff failed to adequately record staffing levels and acuity of patients on the receiving ward, and to document the reasoning for their decision. Furthermore, it failed to provide evidence to suggest that the patient was consulted prior to the decision being made, in accordance with policy.

The investigation also established that the ward nursing staff failed to meet the fundamental standards of care while treating the patient in the escalation bed. This included the provision of access to a nurse call bell, failing to record hourly observations of the patient, and to ascertain his wishes in relation to being accompanied while in the bathroom and being washed following an episode of incontinence. The investigation established further failures in the prescription and administration of oral medication and intravenous fluids for the patient. I established that the Trust staff failed to give sufficient consideration to the patient's human rights and to adhere to the FREDA principles of respect, dignity and autonomy.

The investigation also established failings in the Trust's handling of the complaint.

I recommended that the Trust apologise to the patient and to the complainant for the failures identified. I made recommendations for service improvements in relation to record keeping and the care and treatment of patients admitted to escalation beds. I would also have made recommendations relating to the Trust's Full Capacity Protocol. However, the Trust confirmed that it completed a review of the Protocol and a revised version was implemented.

I also made a recommendation for a small consolatory payment.

I am pleased to note that the Trust accepted my findings and recommendations.

THE COMPLAINT

1. The complaint is about the actions of the South Eastern Health and Social Care Trust (the Trust) in relation to the care and treatment the staff of the Ulster Hospital (UH) provided to the complainant's partner (the patient.)

Background to complaint

2. The patient was taken by ambulance to the emergency department (ED) of the UH on the morning of 28 January 2018. He presented with double vision, clumsiness, stumbling, general feeling of unwell, slurred speech, and bilateral[1] tingling of his upper limbs. The medical team noted a working diagnosis of a possible posterior stroke[2] and further tests were undertaken. He was admitted to an escalation/corridor bed[3] on Ward 13 (a 20 bedded respiratory ward) later that afternoon.

3. The complainant complained, on behalf of the patient, about the care and treatment he received while in the escalation bed. This included that the patient did not have access to an emergency call bell[4] until he was moved to a designated bed space. She also complained that the patient was returned to the escalation bed following a lumbar puncture[5] procedure. The complainant further complained that the patient was prescribed and administered oral medication when he had difficulty swallowing. She also complained about the delay in administering intravenous[6] fluids to the patient and about the irregular observations taken. She further complained that a nurse did not accompany the patient in the bathroom where he had a fall. The patient remained on Ward 13 until 31 January 2018 when he was transferred to the Intensive Care Unit.
4. The complainant further complained about the time the Trust took to respond to her complaint. She also sajid that the ward manager in charge of staff on Ward

---

[1] Affecting both sides.
[2] The stroke affects the back area of the brain. This includes the brain stem, the area responsible for balance and coordination, and the area responsible for vision.
[3] Beds used in addition to permanent bed stock to provide capacity for limited periods in temporary or repurposed wards or as additions to existing wards.
[4] A bell located beside patients' beds to gain attention from the medical staff on the ward.
[5] A medical procedure in which a needle is inserted into the spinal canal, most commonly to collect cerebrospinal fluid for diagnostic testing.
[6] A therapy that delivers fluids directly into a vein.

13 undertook the investigation of her complaint.

Issues of complaint

5. The issues of complaint accepted for investigation were:

Issue 1: Whether the patient received appropriate care and treatment in the Ulster Hospital from 28 to 31 January 2018?

Issue 2: Whether the Trust handled the complaint raised by the complainant in line with its policy and appropriate standards?

INVESTIGATION METHODOLOGY

6. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

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

- An emergency medical consultant for 33 years (E IPA);
- A senior nurse with 18 years nursing and managerial experience across both primary and secondary care (N IPA); and
- A consultant in respiratory and internal medicine for 15 years (R IPA).

8. The information and advice which have informed the findings and conclusions are included within the body of this report. The IPAs have provided 'advice'; however how this advice has been weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

9. In order to investigate complaints, we must establish a clear understanding of

the standards, both of general application and those which are specific to the circumstances of the case.

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

- The Principles of Good Administration
- The Principles of Good Complaints Handling
- The Public Services Ombudsmen Principles for Remedy

10. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional judgement of those Trust staff whose actions are the subject of this complaint.

11. The specific standards relevant to this complaint are:
    - The Nursing and Midwifery Council's (NMC) Code: Professional standards of practice and behaviour for nurses and midwives, March 2015 (the NMC Code);
    - The Nursing and Midwifery Council's (NMC) Standards for Medicines Management, 2007 (the NMC's Standards for Medicines Management);
    - The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
    - Royal College of Physicians' (RCP) National Early Warning Score (NEWS[8]) 2: Standardising the assessment of acute-illness severity in the NHS, 2017 (the RCP NEWS guidance);
    - The Department of Health, Social Services and Public Safety's (DHSSPS) Improving the Patient and Client Experience Standards, November 2008 (the DHSSPS Standards);
    - The National Institute for Health and Care Excellence's (NICE) Clinical Guideline [CG174] Intravenous Fluid Therapy in Adults in Hospital, as updated May 2017 (NICE CG174);
    - The South Eastern Health and Social Care Trust's Prevention of Falls and

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

[8] A guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs.

Essential Care after a Fall for all Patient/Clients in the South Eastern Trust, December 2018 (the Trust's policy on falls prevention);

- The South Eastern Health and Social Care Trust's Full Capacity Protocol for the Ulster Hospital, December 2017 (the Trust's Full Capacity Protocol); and
- The South Eastern Health and Social Care Trust's Medicines Policy, September 2014 (the Trust's medicines policy).

12. I have not included all of the information obtained in the course of the investigation in this report but I am satisfied that everything considered to be relevant and important has been taken into account in reaching the 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.

INVESTIGATION

Issue 1: Whether the patient received appropriate care and treatment in the Ulster Hospital from 28 to 31 January 2018?

Detail of complaint

14. The complainant said that the patient was admitted to an escalation bed on Ward 13 of the UH with no access to an emergency call button. She also complained that he was returned to the escalation bed following a lumbar puncture procedure and placed on his back. The complainant further said that the patient was prescribed and administered oral medication when he had difficulty swallowing. She also complained about the delay in administering intravenous fluids and about the irregular observations taken. The complainant further complained that a nurse did not accompany the patient in the bathroom where she said he had a fall.

Evidence Considered

Legislation/Policies/Guidance

15. I refer to the following legislation, policies and guidance which were considered as part of investigation enquiries.

    i. I considered the NMC Code and identified the following relevant extracts:
    '[*Standard 1] Treat people as individuals and uphold their dignity*
    To achieve this, you must:
    1.1 treat people with kindness, respect and compassion
    1.2 make sure you deliver the fundamentals of care effectively
    1.3 avoid making assumptions and recognise diversity and individual choice
    1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay, and
    1.5 respect and uphold people's human rights…

    [Standard 10] Keep clear and accurate records relevant to your practice…
    10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

    [Standard 13] Recognise and work within the limits of your competence
    To achieve this, you must:
    13.2 …make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment..'.

    ii. I considered the NMC's Standards for Medicines Management and identified the following relevant extracts:
    '*Standard 8: Administration*
    As a registrant, in exercising your professional accountability in the best interests of your patients:
    …• you must contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are

discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable…

• You must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible. It is also your responsibility to ensure that a record is made when delegating the task of administering medicine.

In addition:

• Where medication is not given, the reason for not doing so must be recorded.

iii. I considered the RCP NEWS guidance and identified the following relevant extracts:

'The NEWS was developed to improve the detection of and response to clinical deterioration in patients with acute illness. The original NEWS was released in 2012 and has been widely implemented across the NHS and in other healthcare settings across the world…The NEWS was created to standardise the process of recording, scoring and responding to changes in routinely measured physiological parameters in acutely ill patients. The NEWS was founded on the premise that (i) early detection, (ii) timeliness and (iii) competency of the clinical response comprise a triad of determinants of clinical outcome in people with acute illness...

We recommend four trigger levels for a clinical alert requiring clinician assessment based on the NEWS:

• LOW score: an aggregate NEW score of 1–4

• A single red score: an extreme variation in an individual physiological parameter (a score of 3 in any one parameter, which is colour-coded red on the NEWS2 chart)

• MEDIUM score: an aggregate NEW score of 5 or 6. A NEW score of 5 or more is a key threshold and is indicative of potential serious acute clinical deterioration and the need for an urgent clinical response

• HIGH score: an aggregate NEW score of 7 or more...

The NEWS and frequency of clinical monitoring

37 - The NEWS should be used to inform the frequency of clinical monitoring, which should be recorded on the NEWS chart.

38 - We recommend that for patients scoring 0, the minimum frequency of monitoring should be 12 hourly, increasing to 4–6 hourly for scores of 1–4, unless more or less frequent monitoring is considered appropriate by a competent clinical decision maker.

39 - We recommend that the frequency of monitoring should be increased to a minimum of hourly for those patients with a NEW score of 5–6, or a red score (ie a score of 3 in any single parameter) until the patient is reviewed and a plan of care documented.

40 - We recommend continuous monitoring and recording of vital signs for those with an aggregate NEW score of 7 or more'.

iv. I considered the GMC Guidance and identified the following relevant extracts:

'[Standard] 19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards…

[Standard] 21 Clinical records should include:

a relevant clinical findings

b the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c the information given to patients

d any drugs prescribed or other investigation or treatment

e who is making the record and when'.

v. I considered the DHSSPS Standards and identified the following relevant extracts:

'Patients and clients have a right to experience respectful and professional care, in a considerate and supportive environment, where their privacy is protected and dignity maintained. This principle should be promoted and supported by all health and social care organisations and professional bodies, enabling staff to provide a quality service. There are

many complex factors relevant to the quality of patient and client experience. The following five areas have been identified as important towards ensuring a positive patient or client experience:
Respect, attitude, behaviour, communication, and privacy and dignity.

Respect

This is demonstrated by:

- *Patients' and clients' wishes being respected…*
- *Patients and clients being actively involved in decisions regarding their care*
- *Members of staff providing care that is personalised…*

This standard is achieved when:
Patients and clients report experience of being respected and involved in decision making regarding their care and treatment…

Behaviour

This standard will be recognised when all members of staff involve patients and clients in their care, respecting their wishes and showing professional and appropriate behaviour.
This is demonstrated by:

- *Staff seeking patient and client consent when appropriate…*

Privacy and dignity

This standard will be recognised when staff members ensure that all environments where care is provided protect the privacy and dignity of patients and clients.
This is demonstrated by:

- *Staff ensuring that the modesty of patients and clients is protected respecting cultural diversity*
- *Staff receiving training and development relevant to their needs to support the maintenance of patients' and clients' privacy and dignity…*

This standard is achieved when:
Patients and clients report that their privacy and dignity has been protected throughout their health and social care experience.

Evidence shows organisational arrangements exist which are aimed at protecting privacy and dignity for patients and clients...'

vi. I considered NICE CG174 and identified the following relevant extracts:

'*1.1 Principles and protocols for intravenous fluid therapy*

The assessment and management of patients' fluid and electrolyte needs is fundamental to good patient care.

1.1.1 Assess and manage patients' fluid and electrolyte needs as part of every ward review. Provide intravenous (IV) fluid therapy only for patients whose needs cannot be met by oral or enteral routes, and stop as soon as possible…

Assess the patient's likely fluid and electrolyte needs…

Can the patient meet their fluid and/or electrolyte needs orally or enterally[9]?

[If no] Algorithm 3: Routine Maintenance

Give maintenance IV fluids

Normal daily fluid and electrolyte requirements:

- *25-30 ml/kg/d water*
- *1 mmol/kg/day sodium, potassium, chloride*
- *50-100 g/day glucose (e.g. glucose 5% contains 5 g/100ml)*'.

vii. I considered the Trust's policy on falls prevention and identified the following relevant extracts:

'***Key Policy Principles***

- ***Risk assessment and management of adult in-patients***
  A moving and handling risk assessment must be completed for all patients/ clients and a moving and handling care plan

[9] Food or drug administration via the human gastrointestinal tract.

recorded for all patients who are not independent for moving and handling activities…

- *Patients/clients admitted to a hospital ward/unit/residential facility must be made familiar with the layout of the area e.g. call bell system, location of the toilets etc. by the admitting nurse. On admission consideration must be given to the risk assessment/supervision of those patients with cognitive impairment and the ward layout.*
- *If applicable to your area patient/clients must be shown how to use the call bell system. The call bell must be in sight and in reach of the patient/client. Patient/client must be reassured that using the call bell maybe a safer option than trying to mobilise.*
- *If a patient/client has cognitive impairment, communication problems and/or lacks capacity to use a call bell, there must be a documented alternative plan to ensure patients individualised needs and requirements are met…*
- *Toileting needs must be assessed and a method of ensuring patients have a means of communication, which is accessible and useable, when assistance is required. Those patients/clients with cognitive impairment may need supervision during toileting; however dignity must be maintained at all time.'*

viii. I considered the Trust's Full Capacity Protocol and identified the following relevant extracts:
'As demand rises and the number of patients waiting for a bed in the Emergency Department increases, we will implement our escalation policy as appropriate. Following implementation of this policy, we may need to consider use of Full Capacity Protocol. This will be considered and implemented when the Emergency Department (ED) can no longer deliver care in a safe environment due to the number of patients awaiting admission. At that time, those patients deemed appropriate will be transferred to a non-designated bed within a ward...In times of escalation when non-designated beds are already in use but the risk in the

Emergency Department remains high the following Senior Managers need to be made aware of the situation and take action as required.

2.3.1 In- hours: Clinical Manager ED, Emergency Care Reform Manager, AD Medicine, Director of Hospital Services, Medical Director…

Only patients considered suitable should be admitted to a non-designated bed (see section 4.0). This will be determined by Senior Medics in ED, in conjunction with senior nurse in ED and Patient Flow team, in line with the 'exclusion' criteria...

Where possible, patients should be nursed in a non-designated bed for no longer than 1 night. Thereafter, the patient should be prioritised for transfer to a designated bed. In exceptional circumstances, if ED remains unsafe, and doesn't have any other patients suitable for a non-designated bed, the patient may be asked to stay in the non-designated bed. Patient consent should be documented in the multidisciplinary progress notes. At all times, ward staff will keep the patient and / or family fully informed of this. The placement of patients in a non-designated bed will be actioned by the Patient Flow Team with the full support of the Control Room, the Director/Assistant Director of Hospital Services and Senior Medical and Nursing staff as appropriate…

3.0 Implementation of the Protocol

….Decisions to place a patient in a non-designated (interim) bed within a ward must also take into consideration staffing levels and acuity of the patients within the ward at that particular time.

Decision in relation to where to place additional beds will consider staffing within wards, utilising Safe Care to inform areas that are most appropriately staffed to manage an extra patient.

4.0 Clinical Guidelines for Selection of Appropriate Patients

Identification and selection of appropriate patients for non-designated beds is critical to ensuring safety of all our patients. The following list outlines guidelines to be considered in selecting appropriate patients for non-designated beds. When considering appropriateness of patient,

consider the following list of criteria which may make patient not appropriate:

• Patients being transferred out of ICU/HDU [Intensive Care Unit/High Dependency Unit]

• Patients who are confused

• Patients with a high infection risk who require isolation e.g. as a result of vomiting and diarrhoea

• Patients requiring negative pressure room ie Active TB [tuberculosis[10]]

• Patients requiring significant oxygen therapy, NIV[11][non-invasive ventilation] or Airvo[12]

• Patients requiring suctioning[13]

• Patients with a spinal injury

• Patients with end of life palliative[14] care needs

• Patients with incontinence

• Previous history or current presentation of aggression

• Patients who require invasive procedures ie Lumbar Puncture

This list is not exhaustive; all patients should be assessed on clinical need Individual risk assessment using the screening tool 'Admission to a non-designated bed' should be completed on every patient deemed suitable for a non-designated bed…

It is considered good practice to keep patient and or family fully informed of all the decisions taken and should be documented in the Emergency Department Clinical record. The Patient/Carer must be given the information leaflet on use of Non-designated (interim beds)'.

ix. I considered the Trust's medicines policy and identified the following relevant extracts:

'*9.4.7 If a prescribed medicine is not given, the reason must be recorded clearly on the administration and 'doses omitted' section of the prescription chart (using the standard codes) and the responsible doctor*

[10] A bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person.
[11] The use of breathing support administered through a face mask or nasal mask.
[12] A humidifier that delivers warmed and humidified respiratory gases to spontaneously breathing patients.
[13] Suction may be used to clear the airway of blood, saliva, vomit, or other secretions so that a patient may breathe.
[14] Care that focuses on providing relief from the symptoms, pain, physical stress, and mental stress at any stage of illness.

informed in the appropriate timescale. The standard codes for recording omitted doses are as stated and must be circled to avoid confusion with signatures.

9.10 Administration to patients with swallowing difficulties

…9.10. 7 Prescribers must assess the patient and decide:

• Is the situation likely to be long term or would it be safe to temporarily hold medication?

• Are all medications necessary or can any be stopped withheld for a period of time?

• Can any of the medicines be changed to a different formulation ie suspension[15], solution, buccal[16], soluble, topical preparation[17]?

• Could any of the patients' medication be implicated in causing or exacerbating dysphagia[18] ie tricyclic[19] antidepressants?

• Is there an alternative drug/class of drug which is available in a licensed formulation?'

The Trust's response to investigation enquiries

13. The Trust explained that *'clinical staff within the Emergency Department'* made the decision to admit the patient to an escalation bed on Ward 13. However, the Trust was unable to determine which clinician made the decision as '*there is no evidence stating who made the decision to place the patient in an escalation bed'*. It further explained that *'The patient was admitted for further investigation as initial investigations were normal including the CT scan'.*

14. The Trust explained that '*the Ulster Hospital frequently experiences unprecedented levels of activity within the Emergency Department, resulting in greater numbers of patients requiring admission than there are available ward beds. In these situations, patients deemed less acute who are mobile and fit within certain clinical criteria, are assessed as suitable for admission to an escalation (corridor) bed on one of the wards. The decision regarding clinical*

[15] A liquid with small pieces of drug.
[16] A medicine given between the gums and the inner lining of the mouth cheek.
[17] A medication that is applied to a particular place on or in the body.
[18] The medical term for swallowing difficulties.
[19] A class of medications that are used primarily as antidepressants.

suitability for an escalation bed is carried out by a consultant or senior doctor in conjunction with senior nursing staff. This decision should be discussed with the patient and documented in their medical notes. We apologise if this did not happen. When a patient leaves the Emergency Department to go to an escalation bed, they should be provided with some information regarding the facilities they can expect on arrival to the ward, and again we apologise if this did not happen'. The Trust added that *'unfortunately there is no documented evidence to support this decision making process'.* It also explained that *'when a patient is offered an escalation bed, they have the right to refuse, and this should be documented in the patient's notes by the ED staff.'*

15. The Trust was asked why it was deemed that the patient met the criteria to be admitted to an escalation bed. The Trust referred to the criteria outlined in its Full Capacity Protocol and explained that '*at the time of admission, the patient did not display any of these clinical criteria. In addition, there is clear clinical examination of NEWS 0, GCS [Glasgow Coma Scale] 15*[20] *and a normal CT brain which gives enough information that the patient was a lower risk patient at the time of admitting to an escalation bed. It is recognised by the Royal College of Emergency Medicine that the risks to a patient are greater in a crowded Emergency Department, than the risk of admission to an escalation bed'*. It added that '*unfortunately, there is no documented evidence to support the decision making regarding the suitability for a non-designated bed, but the consultant in Emergency Care would comment that there is sufficient clinical information to support his suitability as outlined above'*.

16. The Trust was asked to provide evidence that staffing levels were considered as part of the decision to place the patient in an escalation bed. The Trust explained that '*Bed pressure meetings are held three times daily on weekdays, and twice daily at weekends. Staffing in medical and surgical clinical areas is discussed as part of the meeting plan, amongst other considerations. The lead nurse for specialities complete a staffing template daily…The available information is then reviewed at each meeting, and balanced against other*

[20] A neurological scale for recording the state of a person's consciousness. 15 is the maximum (best) score.

considerations, such as ward staffing skill mix, acuity of existing ward patients, and ED pressures'

17. The Trust also explained that the *'AM and PM shifts on both the 29th and 30th January were short 1 registered nurse. Night duty shifts on 28, 29, 30 and 31 January 2018 had a shortfall of 1 staff nurse. On each of these dates a HCA [Health Care Assistant] was rostered to provide supportive cover.'*

18. The Trust was asked if the decision to admit the patient to an escalation bed was reviewed during his time on Ward 13. It explained that '*the decision to nurse [the patient] in an escalation bed was reviewed on a daily basis by both the medical and nursing staff within Ward 13. Unfortunately there is no documented evidence that these reviews took place, however, nursing staff are now encouraged to record the ongoing review of patients in escalation beds'*.

19. In relation to the complaint that the patient did not have access to a nurse call button, the Trust explained that '*the escalation bed in Ward 13 is situated beside Bay 3 in the main corridor of the ward in view of staff. It is documented that [the patient] was able to communicate needs, which was documented in the nursing notes. The patient did not have access to a nurse call button when in the escalation bed. The Trust has subsequently addressed this issue and all patients now nursed in escalation beds have access to a nurse call alarm, privacy screens, an eye mask and ear plugs if required'*. It added that '*all patients admitted to an escalation bed should have access to a nurse call button. There is no documented evidence that [the patient] had access to a nurse call button. I apologise for this shortfall in his care and would seek to assure [the patient] that this has been addressed locally in Ward 13 and across the wider Medical Directorate. Ward 13 undertake regular checks to ensure each patient has and can access a nurse call alarm'*.

20. The complainant said that the patient was returned to the escalation bed following his lumbar puncture procedure. In response to enquiries, the Trust explained that '[*The patient] went to a clinical room in MAU [medical assessment unit] for his lumbar puncture. Following the procedure he returned to the escalation bed in Ward 13. He moved to a bed in Bay 2 Ward 13 around*

6pm when a bed space became available. In hindsight, [the patient] should have been moved to a bed space following his lumbar puncture because his condition was deteriorating. We apologise for this. The Trust is currently drafting a policy to provide guidance to staff regarding the criteria for patients nursed in escalation beds'.

21. In relation to the complaint that the patient was prescribed oral medication when he had difficulty swallowing, the Trust explained that '*there is no documented handover from the Emergency Department regarding [the patient's] swallowing difficulties. The nursing evaluation notes that [the patient] was given a meal and it is documented that he was eating and drinking on admission to Ward 13. The patient, although he was unable to take breakfast, managed to take his morning medication. This is referenced in the nursing documentation and medicine Kardex[21]. Nursing progress notes record that [the patient] was unable to swallow his medication and was complaining of swallowing difficulties on the morning of 30 January 2018 and was subsequently placed nil by mouth and referred to the Speech and Language Therapy[22] (SLT) Team. [The patient] was assessed by the SLT Team on 30 January 2018 at 12.20pm. It was recommended that he remained nil by mouth, not for NG[23] [nasogastric] at present and further review in one day'*.

22. In relation to the complaint that the patient's observations were not taken on an hourly basis, the Trust explained that '*review of the patient's clinical records / NEWS chart document that from 7pm on 30 January 2018 until his transfer to ICU on 31 January 2018, The patient's clinical observations were largely recorded on an hourly basis. During this period two sets of observations were recorded on a two hourly basis'*.

23. The complainant further complained that the patient was not given IV fluids until 30 January 2018. In response to enquiries, the Trust explained that '*on review of The patient's clinical notes and fluid balance charts, on 29 January 2018, it is documented that he was able to take some water with his medication in the*

---

[21] Medication administration record.

[22] A team that provides treatment, support and care for children and adults who have difficulties with communication, or with eating, drinking and swallowing.

[23] A nasogastric tube is used for feeding and administering drugs and other oral agents.

morning and from then on was unable to manage oral fluids. Following a medical review, IV fluids were commenced at 6pm on 29 January 2018- one litre over six hours and the next litre over 12 hours. On 30 January 2018, another two litres were prescribed and infused'.

24. The complainant said that a nurse did not accompany the patient in the bathroom, where he fell and became incontinent. She further complained that the patient was put back to bed without being washed or changed. The Trust explained that '[*The patient] was assessed as requiring assistance of one to mobilise at this stage due to unsteadiness and as such did not require direct supervision when using the toilet. The toilet that he used is in the main corridor of Ward 13 at the nurses' station. [The patient] had been mobilising with the assistance of one to the toilet the previous day. The nurse call system was explained and was accessible within the toilet. [The patient] was left alone for privacy and dignity. At this point there was still no working diagnosis. On reflection, due to his unsteadiness, [The patient] should have been supervised in the toilet. We apologise for any distress and embarrassment this caused'*.

25. In relation to learning identified, the Trust explained that '*the Protocol for the Admission of Patients into a Non-Designated (Interim) Bed within Trust Hospitals has been drafted and currently has been circulated for consultation. The protocol will provide staff with guidance when hospital capacity is limited and the Emergency Department is facing increasing pressure due to the number of patients awaiting admission to a hospital bed. When a patient leaves the Emergency Department to go to an escalation bed, they should be provided with some information regarding the facilities they can expect on arrival to the ward. Escalation beds are now equipped with two movable screens to ensure privacy and dignity, a patient locker for storage, a call bell to alert staff, and information regarding the nearest toilet. Patients nursed in an escalation bed are provided with an eye mask and ear plugs if required*'.

Clinical Records

26. The admission documents and the patient's clinical records were carefully considered.

27. The patient's ED records document that he presented with double vision, clumsiness, stumbling, general feeling of unwell, slurred speech, and bilateral tingling of his upper limbs. The patient flow admission form, dated 28 January 2018, documents that the patient was deemed suitable for a corridor/escalation bed. The ED records also document his medical review undertaken by a Senior House Officer (SHO) and nursing notes, which state that the patient was to be admitted to Ward 13.

28. The patient's admission records document that he was at a '*high risk of malnutrition'* and '*needing support with moving and handling'*. They also document that the patient did not have any concerns with his nutrition, hygiene and mobility. The admission records further document that the patient's nurse call bell was working and within his reach.

29. The clinical records, dated 28 January 2018, document that the patient felt he was '*unable to eat/drink or take [blank] when sitting upright'*.

30. The clinical records document that the patient refused to be washed on the morning of 29 January 2018. The records also document that at 11:10 am on 29 January 2018, the patient '*refused dietary input as stated he can't swallow. SALT referral has been completed for swallow assessment'*. The patient's clinical records document that IV fluids were commenced at 18:00 on 29 January 2018.

31. The clinical records document that the patient refused medication at 22:00 on 29 January 2018. They further document that the patient was assessed by a SHO at 10:35 on 30 January 2018 and it was noted that he was unable to swallow his medication.

32. The clinical records document that the complainant complained to the nursing

team on 30 January 2018 that the patient was not offered a wash following an episode of incontinence the previous day. They further document that '*staff had offered [the patient] assistance to wash yesterday morning but he had refused'*. They also document that '*night staff had wheeled [the patient] to the toilet last night, he had been incontinent but the staff had assisted him to change and wheeled him back to his bed'*.

33. The records document that the patient was assessed by SALT at 12.20 on 30 January 2018 and '*nil by mouth'* was recommended.

34. The clinical records document that the patient underwent a lumbar puncture procedure on 30 January 2018. The records also document that he was returned to the escalation bed following a lumbar puncture procedure and placed on his back in bed.

35. The clinical records document that the patient was reviewed by the Critical Care Outreach Team at 15:15 on 30 January 2018. He was transferred to a designated bed space following this review (exact time not documented).

36. The patient's records document that he was transferred to the high dependency unit at 15:10 on 31 January 2018.

37. I also considered the National Early Warning Score (NEWS) charts for the patient while he was in Ward 13 provided by the Trust. A list of the scores, and the times these were taken, is documented at Appendix five to this report.

Relevant Independent Professional Advice

38. As part of investigation enquiries, the advice of an independent emergency medicine consultant was obtained (E IPA).

39. In relation to The complainant's complaint that The patient was admitted to an escalation bed following his admission, the E IPA advised that '*the bed management sheet for the day records that The patient had arrived at 10:13 and been booked for a bed at 13:37, the diagnosis being 'cerebral[24] symptoms'*

[24] Of the brain.

(the rest of this part of the entry is unclear). The patient was admitted under the duty medical team; it is recorded that the bed was ready at 16:00 in 13 CB, which I take to mean Ward 13 corridor bed (CB). In the Comments section of the admission sheet there is an entry which I read as 'suitable CB'. There is an arrow from this towards a similar entry for the patient listed above which is an unclear entry but which I read as 'as per consultant A&E'. Whether these two entries are supposed to indicate that The patient as well as the patient prior to him had been judged suitable for corridor beds with the agreement of the Consultant in the Emergency Department is not completely clear but I assume this is the meaning'. She further advised that '*altogether there are 14 patients on the admission sheet. There is a Comment beside ten of them. Of these Comments, 5 state 'suitable CB' and 3 state 'NSF CB' which I take as 'not suitable for corridor bed'. The ward column records that 5 patients were admitted to corridor beds on wards 17, 6 and 13'*.

40. The E IPA was asked if she could identify which member of the clinical team took the decision to admit the patient to an escalation bed. She advised, '*from my analysis of the notes, the decision was taken by the bed management team having discussed it with the Emergency Department Consultant. I see no reference to a nurse being formally involved but the senior doctor and nurse in the Emergency Department would normally consult each other about such a matter'*.

41. In relation to the recording of this decision, the E IPA advised that '*it was recorded in the admissions sheet but not in the clinical notes as such. The transfer form of the Full Capacity Protocol should have been filled in and filed in the notes. Having said this, the bed management team usually work in a different part of the hospital from the Emergency Department and visit as needed. This may well mean that the forms were kept in the Admissions office and not placed in the Emergency Department notes. The Admissions team could be asked if they fill in and keep the forms and, if so, whether they have one for the patient'*. The E IPA was asked who ought to have recorded this decision. She advised that '*Section 1 of the transfer form does not state who*

should fill it in (Section 2 specifies the ward nurse). It would be reasonable for either the Emergency Department staff or the Admissions team to fill it in'.

42. The E IPA was asked if she considered that the patient met the criteria to be admitted to an escalation bed. She advised that '*the Exclusion Criteria of the Full Capacity Protocol guidance for the use of corridor beds were: patients being transferred out of ICU/HDU, patients who are confused, patients with a high infection risk who require isolation, patients requiring a negative pressure room, patients requiring significant oxygen therapy, NIV or AIRVO, patients requiring suctioning, patients with a spinal injury, patients with end of life palliative care needs, patients with incontinence, patients with a previous history or current presentation of aggression, patients who require invasive procedures and patients with delirium/dementia. The patient did not meet any of these exclusion criteria on admission'*.

43. In conclusion, the E IPA advised that '*the decision to place the patient in a corridor bed was appropriately made. It was, however, not fully documented by either the bed management or the Emergency Department staff (Section1 of transfer form). The ward admission notes on the ward did not document the corridor bed facilities (Section 2)*'. In relation to learning identified, the E IPA advised that staff ought to ensure they '*document that they have followed, and complete the paperwork of, the Full Capacity Protocol'*.

44. As part of investigation enquiries, the advice of an independent nurse was obtained (N IPA).

45. In relation to the complaint that while the patient was in the escalation bed, he did not have access to a nurse call button, the N IPA advised that '*patients who have just been admitted to hospital are at increased risk of clinical deterioration compared to those who are receiving treatment for a known condition on a hospital ward; this is because they are acutely unwell and have not yet started treatment for their illness or injury; it is therefore crucial that they are able to call for help if and when it is needed'*.

46. The N IPA advised that '*most safety guidance makes reference to the provision of a call bell; for example falls prevention guidance discusses 'modifiable risk factors' in reference to factors that can be changed to reduce the incidence of falls, one of those factors is ensuring that the patient can reach their call bell'.* The N IPA further advised that '*with reference to local guidance; the Trust's own 'Falls Prevention' policy states that the patient must be assessed within six hours of admission and that the call bell should be working and within reach (Falls Prevention risk assessment)*'. The N IPA advised that, '*for reasons including safety and dignity; all Hospital in-patients should have access to a working call bell, including those in non-designated bed spaces such a corridor beds'*.

47. The N IPA was questioned as to whether the patient was able to communicate with the nursing staff while he was in the escalation bed. She advised that '*on reviewing the location of the corridor bed I note that it was in view of the nurses' station. However, with the absence of a nurse call bell, the patient would not have been able to communicate with the nursing staff on the ward unless they were looking his way or could hear him shout'*. The N IPA further advised that '*The patient would only be able to alert nursing staff by shouting or making a loud noise'*.

48. The N IPA was questioned as to whether she considered the patient had a 'choking fit' while in the escalation bed. The N IPA advised that '*the clinical documentation demonstrates a rapidly deteriorating swallow capacity overnight (28th – 29th); whereby on admission to the corridor bed The patient was eating but by the 11:10 in the morning he was unable to swallow. It is thus possible that the patient experienced swallowing difficulties (referred to by his partner as a 'choking fit') overnight; although there is no documentation to either confirm or refute this'*.

49. In relation to the claim that the patient had to 'bang' on the bedside locker to get the attention of the nursing staff, the N IPA advised that '*in the absence of a nurse call bell, the patient would have had to make some noise in order to gain nurses' attention. It is documented that he had a sore throat and pain on swallowing when he was still on the corridor bed (morning of 30.01.2018) it is*

therefore unlikely that he would have wanted to shout, even if he were able. Thus, on the balance of probabilities, he would have had to bang for attention'.

50. The N IPA was asked if she considered that the patient received a lesser standard of care from the nursing team because he was in an escalation bed. She referred to Sections 1 and 13 of the NMC Code (2015) and advised that '*nursing care is of a good standard when it is individualised to meet a patients specific nursing needs. In order to provide individualised nursing care, there should be evidence of assessment and care planning. Furthermore, the patient should be re-assessed if their condition changes'*. The N IPA further advised that '*The patient's nursing needs were assessed on 28.01.2018. At this time, he was assessed as having a high risk of malnutrition (secondary to his acute illness) and as needing support with moving and handling. Both of these should prompt care planning so that staff know how to meet the patient's individual needs. Furthermore, if a patient needs support with moving and handling, they will need support with their hygiene; specifically when they are in a corridor bed that arguably lacks the privacy of a designated bed space…care plans were not commenced for The patient until 30.01.2018 and thus were not in place for when he was in the corridor bed'*.

51. The N IPA also advised that '*in accordance with local guidance, following on from the nursing assessments, the 'Checklist of Clinical Problems Identified on Admission' should be completed...this gives staff a quick summary of the patient's needs in order for care delivery to be focused and individualised. The patient's checklist incorrectly identifies that he had no problems with nutrition, no problems with hygiene and no problems with mobility'*. She further advised that '*when a patient's nursing needs change, there should be a re-assessment of their needs…on 29.01.2018 the patient was refusing dietary intake as he could not swallow. Whilst he was referred to SALT for a swallow assessment; his nutritional needs were not reassessed and he was not referred to a dietician (all high risk patients should be referred to a dietician as per Trust policy*)'.

52. In relation to the care and treatment the patient received while in the escalation bed, the N IPA advised that he '*was acutely unwell and deteriorating as*

evidenced within the clinical documentation. Despite this, his physiological observations and escalation to the medical team was in line with national guidance…however, he did not have any nursing care plans in place to cover this period and there is no documentation to show that his hygiene needs were consistently met. The impact on him was related to the fundamental aspects of nursing care and his dignity and privacy'.

53. In relation to the complaint that the patient was returned to the escalation bed and placed on his back following his lumbar puncture procedure, the N IPA advised that '*on 30.01.2018 it is documented that The patient "has just had L.P. Lying on his back post L.P"…it cannot be known if this was nursing, medical or the patient that was responsible for this'*. The N IPA was questioned if she considered that The patient started choking at this time. She advised that she was '*unable to say as there is no documentation relating to this'*.

54. The N IPA was asked if the nursing team ought to have repositioned the patient following this procedure. She advised that '*if nursing staff were aware that the patient was lying on his back they should have repositioned him. This would be for comfort and safety reasons. He had just had an LP and one of the known side effects is swelling and lower back pain where the needle was inserted. Furthermore, he was experiencing swallowing difficulties and although he was still NBM (nil by mouth), he would need to clear his oral secretions; this is difficult to do when you are lying flat on your back'*. In relation to the impact this may have had on the patient, the N IPA advised that '*the patient was reviewed after the LP by the CCOT (critical care outreach team) when he was still lying on his back. There are no documented problems from this and thus no apparent impact on the patient'*.

55. The N IPA was questioned if she considered that the patient was unable to swallow during the stated time. She advised that '*in accordance with the clinical records, the patient complained that he could not swallow from 11:10am on 29.01.2018: "refused dietary input as he cannot swallow"'*.

56. In relation to the types of oral medications administered to the patient, the N IPA advised that '*in accordance with the medication charts, the patient was*

given oral Paracetamol on 29.01.2018 at 09:10. He was also given oral omeprazole[25] *(proton pump inhibitor; used to protect the stomach), ramipril*[26] *(anti-hypertensive), doxazosin*[27] *(anti-hypertensive) on the morning on 29.01.2018 as per the medication charts. He was offered oral atorvastatin*[28] *(for raised cholesterol) and ranitidine*[29] *(reduces stomach acid) at 22.00 but it is indicated by a code 2 that these were refused. No further oral medications were given over the timeframe indicated…the reason for the refusal is not documented; however on the morning on 30.01.2018 it was documented by Dr (A) that he [the patient] could not swallow his tablets'*. She further advised that '*given that it is documented at 11:10am on 29.01.2018 that he could not swallow, and it is documented on 30.01.2018 that he could not swallow his medications; the likely reason for his refusal was that he was unable to swallow'*.

57. The N IPA advised that '*over this timeframe the medications were administered in line with NMC (2009) Standards for medicines management (p6-7). This is because it is known when they were taken and when they were not. However, on the evening of 29.01.2018 when it was known that he could not swallow, it was documented that he 'refused' his medication. This was not entirely accurate; the reason for the refusal was that he could not swallow. It is expected, in line with national standards, that when a patient cannot take their medications that the prescriber is informed (NMC 2009 'Standards for medicines management' page 7). [Dr A] knew by 30.01.2018 that the patient could not swallow his tablets, however this should have been escalated to the medical team the day before (11:10 on 29.01.2018 when it was documented that he could not take oral diet)*'.

58. In relation to the referral made to the SALT, the N IPA advised that '*[the patient] was referred to SALT at 11:10 in accordance with the documentation. This was the first documented instance that he had difficulties with swallowing'*.

---

[25] A medication used in the treatment of gastroesophageal reflux disease.
[26] A medication used to treat high blood pressure, heart failure, and diabetic kidney disease. Also used to prevent cardiovascular disease in those at high risk.
[27] A medication used to treat symptoms of an enlarged prostate and high blood pressure.
[28] A medication used to prevent cardiovascular disease in those at high risk and treat abnormal lipid levels.
[29] A medication which decreases stomach acid production.

59. In relation to the impact the administration of oral medication had on the patient, the N IPA advised that '*The patient could not take his oral medications after the morning medication round on 29.01.2018, however the doctor was aware of this from the morning of 30.01.2018 and thus the impact from this was that he could not take his evening medications on 29th. Given that these were for his long term management (cholesterol and stomach acid); and that Ranitidine was assessed as not to be restarted until 05.03.2018 and atorvastatin was not restarted at all (see further medications charts after HDU admission); there was no impact on The patient for this omission*'.

60. In relation to the administration of fluids for the patient, the N IPA advised that '*minimal oral intake was documented on 29.01.2018 and then no oral intake on 30th and 31st. Consequently, [the patient] needed IV fluids to maintain his hydration…IV fluids were prescribed from 18:00 on 29.01.2018*'. The N IPA further advised that '*there was a seven hour gap between the patient raising his concerns and fluids being prescribed. This should have been escalated sooner as per national standards*'. In relation to the impact this had on the patient, the N IPA advised that '*whilst this may not have impacted on his hydration; it may have increased his anxiety about the level of care that he was receiving*'.

61. In relation to the patient's visit to the bathroom on 30 January 2018 during which he fell and became incontinent, the N IPA advised that '*The patient's nursing needs were assessed on 28.01.2018. At this time, he was assessed as needing support with moving and handling; however the actual level of support needed is not indicated and thus the assessment is inadequate…this was not indicated on his 'Checklist of Clinical Problems Identified on Admission' as this documents that he had no problems with mobility. Falls prevention was also completed on 28.01.2018, this too was inadequate as it had been ticked to say that the call bell was working and within reach, when it is known that there was no call bell on the corridor bed. Accordingly, falls prevention and moving and handling risk assessments were not in line with national guidance for the reasons identified above*'.

62. The N IPA was asked if she considered that the patient ought to have been supervised by nursing staff while using the bathroom. She advised that '[*the patient] should have been asked if he wanted to be supervised whilst in the bathroom. He had the capacity to make such a decision as defined by the Mental Capacity Act 2005…The patient should not be supervised in the bathroom without his consent; however, neither should he be left in the bathroom without asking if he wanted supervision'*. In relation to the Trust's response which stated that the patient was not supervised to maintain his privacy and dignity, the N IPA advised that '*it is not for the Trust to decide what constitutes privacy and dignity for individual patients who have the capacity to make that decision for themselves. This is in accordance with the Mental Capacity Act 2005; which states that capacity is decision specific and that a person may have capacity in one area but lack capacity in another; furthermore, a patient should not be classed as lacking capacity just because they make an unwise decision. The NMC code: (2015) 'The Code. Professional standards of practice and behaviour for nurses and midwifes, states that you should 'avoid making assumptions and recognise diversity and individual choice' (page 6)*'. The N IPA advised that '*The patient should have been asked if he wanted supervision whilst using the toilet. It is not clear what the impact on him was. This is because I cannot be certain that he would have wanted supervision'*.

63. In relation to the fall, which the complainant said occurred when the patient was alone in the bathroom, the N IPA advised that '*there is no reference to a fall'* in the medical notes. The N IPA further advised that '*it is documented that he was assisted to change after an episode of incontinence in the bathroom. There is no reference to a wash on that occasion…the documentation states that he had been offered a wash 'yesterday morning' (29th) but he had refused'*. The N IPA referred to page six of the NMC Code (2015) and advised that '*despite previous refusals, [the patient] should still have been offered a wash after the episode of incontinence'*. The N IPA further advised that '*whilst it is less likely that he would not have been incontinent had he been supervised, it is not a certainty'*.

64. In relation to the nursing staff's clinical observations of [the patient], the N IPA advised that '*[the patient's] plan exceeded the frequency advised by national guidance (Royal College of Physicians 2012 'National Early Warning Score [NEWS]. Standardising the assessment of acute-illness severity in the NHS')'…from 29th to the evening of 30th January, the timeframes set for The patient's NEWS was reasonable given that he was physiologically stable when he was medically assessed on 30.01.2018...this remained the case until he was reviewed by the critical care outreach team (CCOT) at 15:15 on 30.01.2018'*.

65. The N IPA advised that '*[the patient's] NEWS was 5 at 20:00 on 30.01.2018 (hourly repeat), and then 5 again when it was repeated at an unknown time (unable to decipher the documented time). It was 4 at 23:30. Therefore, these timeframes were not within the national hourly guidance; this is because if they were, the first repeat after 20:00 would be 21:00 and the second repeat would be 22:00 and we know that this was not done until 23:30. Following this, [the patient's] NEWS was repeated hourly, despite him scoring under 4 (4-6 hourly repeat as per national NEWS guidance). This was reasonable as he was deteriorating and was under CCOT review who had advised 'continue close observations'*. The N IPA advised that she agreed that the patient '*had 'close observations' that were either in line with national guidance or his medical plan'*.

66. The N IPA advised that '*the impact of these failings on the patient was that his dignity and safety was compromised whilst he was on the corridor bed. He had a LP [lumbar puncture] whilst still on the corridor bed which was unsafe (he had no call bed should he have suffered any post procedure complications should as pain or bleeding). He was reduced to banging for attention, which is undignified'*.

67. In relation to learning identified, the N IPA advised that '*nursing assessments should accurately reflect the patient's identified needs and should be completed in a timely manner and in accordance with local guidance. This is important as it informs care planning. Corridor beds should only be used for low risk patients and not for those with an undiagnosed and deteriorating condition such as the patient's. In order to ensure that patients are adequately hydrated, the medical team should be informed if they are unable to swallow fluids. A patient with*

mobility needs should be asked if they require supervision whilst using the bathroom – their preference should be documented…in order to improve from the patient's complaint, the Trust should reflect on the issues raised and plan to address the learning / service improvements identified'.

68. As part of investigation enquiries, the advice of an independent respiratory consultant was obtained (R IPA).

69. The R IPA agreed that the patient was returned to the escalation bed following the lumbar puncture procedure on 30 January 2018. The R IPA advised that the medical team ought to have been placed into a hospital bed in a bay when he returned from the procedure. He advised that '*the Trust full capacity protocol lists lumbar puncture as a contraindication for transfer into an escalation bed'*. In relation to the impact this had on the patient, the R IPA advised that '*the lumbar puncture took place on 30/1/18 but is not timed. It appears from the records to have taken place between 13:10 and 15:15. [The patient] was reviewed by the critical care outreach team at 15:15 at the request of the nursing staff. A thorough review was undertaken. There is no evidence from this review that [the patient] had come to harm from transfer to an escalation bed following the lumbar puncture. [The patient] had a set of observations recorded at 16:00. The NEW score at that time was 1 which is low'*.

70. The R IPA was asked to consider the complaint that the patient was prescribed oral medication when he was unable to swallow. The R IPA advised that the patient '*was prescribed five oral medications on the 28 January 2018. They were signed as given at 22:00 on the 28 January, and at 8:00 and 22:00 on the 29 January'*.

71. The R IPA was asked if these medications ought to have been prescribed to the patient given his symptoms. He advised that '*on 28 January 2018 at 19:00 the records state that [the patient] felt he was unable to eat, drink or take (blank - tablets?) when sitting upright. On 29 January 2018 at 11:10 the records state that medications were given but [the patient] refused dietary intake as unable to swallow. A SALT referral was made. On 30 January 2018 (untimed) [DR (A)]*

noted a new cough and difficulty in swallowing. At 10:35 the records state that [the patient] was unable to swallow his medications and was nil by mouth. At 12:20 a SALT assessment was performed which concluded [the patient] was at risk of aspiration of all oral intake and recommended that he be kept nil by mouth'. The R IPA referred to the Trust's medical management policy and advised that he '*cannot see any evidence in the records that [the patient] was assessed as per the Trust policy when he first mentioned swallowing problems on the evening of the 28 January. Without this assessment, he should not have been prescribed or given oral medications as from 19:00 on the 28 July'*.

72. In relation to the impact this had on the patient, the R IPA advised that he '*did not find any evidence in the records that the six doses of oral medication that were given after 19:00 on the 28 July had any harmful effect on [the patient]*.

73. In relation to the prescription of fluids for the patient, the R IPA advised that he [the patient] '*was unable to take oral fluids from 09:00 on 29 January 2018 until his transfer from the ward to the intensive care unit'*. The R IPA was asked when the patient was first prescribed fluids. He advised that '*the fluid prescription chart shows that two bags of IV fluid were prescribed on 29 January 2018. The prescription is not timed. The fluid balance charts record that IV fluids were given as from 18:00 on 29 January 2018'*.

74. The R IPA further advised that '*the Trust's Fluid Balance policy describes how and when to record fluid balance but does not refer to when IV fluids should be prescribed'*. He referred to the NICE CG174 and advised that the patient '*was unable to meet his fluid and electrolyte needs from the time that he was made nil by mouth (09:00 29 January 2018) and therefore routine maintenance fluids should have been prescribed at that time, in line with the NICE guidance'*. The R IPA was asked if the medical team's actions regarding the prescription of fluids for the patient was appropriate. He advised that '*the first ward medical review in the records is at 11:00 on 29 January 2018. This was a ward round undertaken by Dr (B). This does not mention the swallowing and oral intake problems that were documented by the nursing staff on the previous page and on the fluid balance charts. There is no documentation of an assessment of [the*

patient's] fluid status. This is not in line with the NICE guidance outlined above and therefore I do not consider that appropriate action was taken regarding the IV fluids for [the patient] at that time. However, IV fluids were prescribed and administered later the same day. There is no documentation in the records as to how this happened'.

75. In relation to the impact this had on the patient, the R IPA advised that *[the patient] was unable to take oral fluids for 9 hours before the intravenous fluids commenced on the 29 January 2018. The most common impact of going without fluids is dehydration which may manifest in thirst, altered mental status, low blood pressure, poor urine output and deteriorating renal function. The observations chart in the records did not demonstrate a drop in blood pressure during the time that [the patient] was without fluid. The fluid balance chart states that [the patient] passed urine at 10:00 and 17:00 on the 29 January 2018 but the volume is not recorded so it is not possible to determine if the urine output decreased. The clinical review at 19:00 on 29 January 2019 did not record any change in [the patient's] mental status. There are no renal function results in the records. Based on the above I consider it unlikely that the delay in administering IV fluids on the 29 January resulted in harm to [the patient]'*.

76. The R IPA concluded that he '*identified failings in care relating to the recognition of [the patient's] inability to swallow his usual tablets and adequate fluids. However, I do find any evidence that [the patient] came to harm as a result of this'*. In relation to learning identified, the R IPA suggested that the Trust '*ensure[s] that all patients in whom concerns are expressed regarding oral intake due to swallowing problems are assess[ed] promptly by the SALT team and that as soon as it is noted that oral intake is inadequate then intravenous fluids should be prescribed in line with NICE guidance'*.

77. The full independent professional advice received was shared with the Trust. In response, it explained that the ED doctor and the sister ought to make the decision to admit a patient to an escalation bed. It further explained that this decision ought to be documented in the patient's clinical records along with a note that it was discussed with the patient and whether or not they agreed with

the decision. The Trust also explained in its response that '*[the patient] did not display any of the clinical exclusions for using an escalation bed'*.

Analysis and Findings

Decision to admit [the patient] to an escalation bed

78. I note that the Trust's Full Capacity Protocol lists criteria for circumstances when admission to an escalation/corridor bed would not be suitable for a patient. Having reviewed the patient's clinical records, I accept the E IPA's advice that '*[the patient] did not meet any of these exclusion criteria on admission'*. I consider that the decision to admit the patient to an escalation bed upon admission was in accordance with the Trust's Full Capacity Protocol.

79. I examined the patient's clinical records in relation to the decision to admit him to an escalation bed. I note the Trust's explanation that this decision ought to be documented and retained within their clinical records (rather than in the admission records). I note that the patient flow admissions form, dated 28 January 2018, documents that the patient was deemed suitable for a corridor bed. I also note that the patient's ED records contain handwritten notes from a locum Senior House Officer and the nurse who treated him. However, there is no reference to the decision to admit the patient to an escalation bed. I would expect these notes to be entered by the Consultant and/or Sister as the senior doctor and nurse responsible for making the decision. However, it is not clear from the records which Consultant or Sister made the decision.

80. I note that the complainant said '*we were told that [the patient] was going to ward 13, we didn't realise we could have refused'*. I also note that there is no record to suggest that the patient or his family were informed that he could withhold his consent to be admitted to an escalation bed in accordance with the Trust's Full Capacity Protocol. In the absence of this record, and on the balance of probabilities, I am satisfied that the patient's consent to be admitted to an escalation bed was not sought by the ED staff.

81. I also note that the Trust's Full Capacity Protocol states that '*where possible, patients should be nursed in a non-designated bed for no longer than 1 night. Thereafter, the patient should be prioritised for transfer to a designated bed…the patient may be asked to stay in the non-designated bed. Patient consent should be documented in the multidisciplinary progress notes. At all times, ward staff will keep the patient and / or family fully informed of this"*. I note that the patient remained in the escalation bed for a period of two nights. However, there is no evidence in the clinical records to suggest that the patient's consent to remain in the bed was sought, or that he or his family were informed of the decision. There is also no evidence that the Trust took into account staffing levels and acuity of the patients within ward 13 at that time. I consider that this is not in accordance with the Trust's Full Capacity Protocol. A lack of appropriate records will necessarily limit the availability of clinical information to any additional clinicians who would become involved in the patient's care and treatment. I consider the lack of records relating to the decision to admit the patient to an escalation bed amounts to a service failure by the Trust in failing to document key factors and decisions as required by its Full Capacity Protocol.

82. I also considered the care and treatment the patient received while he was in the escalation bed. I note that the N IPA advised that the patient was assessed on 28 January 2018 as having a '*high risk of malnutrition'* and '*needing support with moving and handling'*. I further note that the N IPA advised that '*both of these should prompt care planning so that staff know how to meet the patient's individual needs'*. However, I note that the clinical records document that a care plan was not put in place until after the patient was transferred to a designated bed space on 30 January 2018. Furthermore, I note that the patient's clinical records documents that he had no concerns with nutrition, hygiene and mobility. I note the N IPA's advice that '*on 29.01.2018 the patient was refusing dietary intake as he could not swallow. Whilst he was referred to SALT for a swallow assessment; his nutritional needs were not reassessed and he was not referred to a dietician'*. I also note the N IPA's advice that '*there is no documentation to show that his hygiene needs were consistently met'*.

83. The NMC Code states that nurses ought to '*accurately assess signs of normal or worsening physical and mental health in the person receiving care'*. It also requires nurses to '*make sure you deliver the fundamentals of care effectively'.* There is no evidence in the clinical records to suggest that the nursing team treating the patient put in place a care plan for him, or reassessed his nutritional and hygiene needs. I consider that the nursing team failed to meet the fundamental standards of care while treating the patient when he was in the escalation bed. I consider that this is not in accordance with good nursing practice as detailed in the NMC Code. I am satisfied that this constitutes a failure in the patient's care and treatment.

84. I am unable to conclude if the failures identified were as a result of the patient being admitted to an escalation bed. However, I consider that the nursing staff ought to have considered the lack of privacy that comes from a patient being in a non-designated bed space. There is no evidence that this was considered and appropriate action taken. The N IPA advised that *'the impact on him [the patient] was related to the fundamental aspects of nursing care and his dignity and privacy'*. I am satisfied that this represents a failure in the patient's care and treatment. I will consider the injustice to the patient later in this report.

85. I consider that the five core standards outlined in the DHSSPS' Patient and Client Experience document are relevant in this case. These also reflect the human rights principles of fairness, respect, equality, dignity and autonomy (FREDA). I consider that the Trust failed to meet these principles in their care of the patient while he was in the escalation bed. I also consider that the nursing team on Ward 13 did not give sufficient consideration to the patient's human rights and did not adhere to the FREDA principles of respect and dignity.

The patient's access to a nurse call bell

86. The complainant said that the patient did not have access to a nurse call bell when he was in the escalation bed. I note that the Trust agreed that the patient did not have access to a nurse call bell until he was moved into a designated bed space.

87. The complainant said that the necessity for a call bell was demonstrated when the patient experienced a '*choking fit'* while he was in the escalation bed. This meant that he had to '*bang*' on the bedside locker to attract the nurses' attention as he did not have access to a call bell. I note that the Trust explained that the escalation bed is located '*in the main corridor of the ward in view of staff'*. However, upon review of the location of the bed in the ward, I accept the N IPA's advice that the patient '*would not have been able to communicate with the nursing staff on the ward unless they were looking his way or could hear him shout'*. Given that the patient experienced difficulties with swallowing, on the balance of probabilities, I consider it likely that he did have to '*bang*' on the bedside locker to attract the attention of the nursing staff.

88. I note that the Trust's policy on falls prevention states that *'the call bell must be in sight and in reach of the patient/client'*. I am satisfied that by not providing the patient access to a nurse call bell while he was in the escalation bed, the Trust did not act in accordance with its guidelines. I do not consider it appropriate for the Trust to expect a patient to attract attention from the nursing team in any way other than by pressing the call bell. This right was taken away from the patient while he was in the non-designated bed space. I am satisfied that this represents a failure in the care and treatment of the patient. I uphold this element of the complaint. I will consider the injustice to the patient later in this report.

89. I again considered the FREDA principles in relation to this element of the complaint. I consider that the Trust failed to give sufficient consideration to the patient's human rights and did not adhere to the FREDA principles of dignity and autonomy.

90. It has been established that the patient did not have access to a call bell while in the escalation bed. However, I note with some concern, that the Falls Prevention form completed for the patient at admission states that the call bell was working and within his reach. I am unable to determine the reason why this section of the form was ticked when it was known that he did not have access to a bell. Standard 10.3 of the NMC Code states, '*complete records accurately and without any falsification'*. I consider the failure to complete this

record accurately is a service failure and gives me concern about the accuracy of records created by Trust staff.

The patient's return to the escalation bed following his lumbar puncture procedure

91. The complainant said that the patient was returned to the non-designated bed space after he underwent a lumbar puncture procedure. She further complained that the patient was placed on his back on the bed following his return, causing him to '*choke*'.

92. I note that the Trust acknowledged that the patient was returned to the escalation bed following the procedure. I also note that it explained that '*in hindsight, [the patient] should have been moved to a bed space following his lumbar puncture because his condition was deteriorating*'. I note that the Trust's Full Capacity Protocol states that patients who require '*invasive procedures i.e. lumbar puncture'* may not be considered appropriate for admission to a non-designated bed space. Furthermore, I again note that by this stage, the patient had remained in the escalation bed for two nights, which is longer than the time recommended by the Trust's Full Capacity Protocol. Therefore, I accept the R IPA's advice that the patient ought to have been placed in a designated bed space following the lumbar puncture procedure.

93. I note that the clinical records document that the patient was placed on his back on the bed following his return from the lumbar puncture procedure. I am unable to determine from the clinical records whether or not the patient started to '*choke*' at this time, as it is not documented. However, I accept the N IPA's advice that '*if nursing staff were aware that [the patient] was lying on his back they should have repositioned him. This would be for comfort and safety reasons. He had just had an LP [lumbar puncture] and one of the known side effects is swelling and lower back pain where the needle was inserted. Furthermore, he was experiencing swallowing difficulties and although he was still NBM (nil by mouth), he would need to clear his oral secretions; this is difficult to do when you are lying flat on your back'*.

94. I consider that the clinical team ought to have moved the patient into a designated bed space once he returned from the lumbar puncture procedure in accordance with the Trust's Full Capacity Protocol. I also consider that the nursing team ought to have repositioned the patient so that he was not lying on his back following the procedure. I am satisfied that this represents a failure in the patient's care and treatment. I uphold this element of the complaint. In relation to the impact this had on the patient, I accept the N IPA's advice that he '*was reviewed after the LP [lumbar puncture] by the CCOT (critical care outreach team) when he was still lying on his back. There are no documented problems from this and thus no apparent impact on the patient'*. I will consider the injustice to the patient later in this report.

The prescription and administration of oral medication

95. The complainant said that the patient was prescribed and administered oral medication despite having difficulty swallowing. I note that the admission notes in the clinical records document on 28 January 2018 that the patient felt he was '*unable to eat/drink or take [blank] when sitting upright'*. I further note that the clinical records document that at 11:10 am on 29 January 2018, the patient '*refused dietary input as stated he can't swallow'*. The records also indicate (using the coding system) that the patient refused medication at 22:00 on 29 January 2018. Having considered the clinical records, I accept the N IPA's advice that *'this was not entirely accurate; the reason for the refusal was that he could not swallow'.* I consider that this additional reason ought to have been documented in the records.

96. I note that the NMC's Standards for Medicines Management, the guidance relevant at that time, states that '*you must contact the prescriber or another authorised prescriber without delay where contra-indications to the prescribed medicine are discovered, where the patient develops a reaction to the medicine, or where assessment of the patient indicates that the medicine is no longer suitable*'. I note from the clinical records that Dr (A) was aware that the patient could not swallow his medication from the morning of 30 January 2018. However, I am unable to find any evidence to suggest that this was escalated

by the nursing team at the time the patient raised his concerns on 29 January 2019. I accept the N IPA's advice that '*this should have been escalated to the medical team the day before (11:10 on 29.01.2018 when it was documented that he could not take oral diet)*'. I consider that this represents a failure in the patient's care and treatment.

97. I note that the Trust's medicines policy states that for patients who have difficulty swallowing, the '*prescriber must assess [the patient']*. However, there is no evidence in the clinical records to suggest that the medical team undertook any such assessment. I accept the R IPA's advice that *'without this assessment, he [the patient] should not have been prescribed or given oral medications as from 19:00 on the 28 July (sic) [January]'*. I consider that the medical team treating the patient ought to have assessed the patient in accordance with paragraph 9.10.7 of the Trust's medicines policy once they became aware of his difficulties. I further consider that the medical team ought to have taken appropriate action in relation to the type of medication prescribed. I consider that this represents a failure in the patient's care and treatment by the medical team.

98. In relation to the impact the administration of oral medication had on the patient, I accept the R IPA's advice that he '*did not find any evidence in the records that the six doses of oral medication that were given after 19:00 on the 28 July had any harmful effect on [the patient]*. Furthermore, I note that the N IPA advised that *'these [medications] were for his long term management (cholesterol and stomach acid); and that Ranitidine was assessed as not to be restarted until 05.03.2018 and atorvastatin was not restarted at all'*. I accept the N IPA's advice that *'there was no impact on the patient for this omission'*.

Delay in prescribing and administering intravenous fluids

99. The complainant said that there was a delay in the administration of IV fluids for the patient. I note that the patient first reported that he was '*unable to eat/drink…when sitting upright'* on 28 January 2018. I also note that he '*refused dietary input as stated he can't swallow'* at 11.10 on 29 January 2018.

100. I examined the clinical records and note that IV fluids were commenced for the patient at 18:00 on 29 January 2018. However, the clinical records do not reference when the IV fluids were prescribed or by whom. I accept the R IPA's advice that '*there is no documentation in the records as to how this [administration of IV fluids] happened'.* I consider that the failure to document this record is a service failure.

101. I note that the Trust explained that fluids were commenced for the patient following a '*medical review'*. However, I note that the only medical review documented on 29 January 2018 prior to the patient commencing fluids was the clinical ward round undertaken by Dr (B) at 11:00 on 29 January 2018. This was seven hours before fluids were commenced. Furthermore, I am unable to find any evidence to suggest that Dr (B) assessed the patient's fluid status during this ward round. I am also unable to find any evidence to suggest that Dr (B) considered the oral intake problems reported on 28 January 2018. I note that NICE CG174 states, '*assess and manage patients' fluid and electrolyte needs as part of every ward review'.* I accept the R IPA's advice that the failure to consider The patient's oral intake *'is not in line with the NICE guidance…therefore I do not consider that appropriate action was taken regarding the IV fluids for [the patient] at that time*'.

102. Having reviewed the relevant guidelines, the patient's clinical records and the independent professional advice provided, I consider that the time taken to prescribe and administer IV fluids for the patient was unacceptable. I consider that the nursing team ought to have escalated concerns about the patient's oral intake to the medical team at the time it was reported (the morning of 29 January 2018). There is no evidence to suggest that this occurred. Furthermore, I consider that Dr (B) ought to have assessed the patient's fluid status during the ward round at 11:00 on 29 January 2018 in accordance with NICE CG174. This may have prompted staff to prescribe and administer IV fluids to the patient prior to the evening of 29 January 2018. I am satisfied that this represents a failure in the care and treatment of the patient. I uphold this element of the complaint.

103. In relation to the impact this failure had on the patient, I note the R IPA's advice that it is '*unlikely that the delay in administering IV fluids on the 29 January resulted in harm [to the patient]'.* I am unable to conclude whether or not this delay contributed to the deterioration of the patient's health. However, I accept the N IPA's advice that '*it may have increased his anxiety about the level of care that he was receiving'*. I will consider the injustice to the patient later in this report.

Frequency of observations taken

104. The complainant disputed that the patient's observations were taken on an hourly basis.

105. I note from the clinical records that the patient's NEWS was recorded as between zero and three from his admission on 28 January 2018 until 19:45 on 30 January 2018. I also note that the clinical records document that observations of the patient were recorded on a four to six hourly basis for this period. I consider that this was in accordance with the RCP NEWS guidance.

106. I note from the clinical records that the patient's NEWS increased to five at 20:00 on 30 January 2018. I also note that the clinical records document that observations of the patient were largely recorded on an hourly basis for the remainder of his stay on Ward 13. However, I note that there were two occasions in which the observations were not taken hourly. The records document that observations were taken on 30 January 2018 at 20:00, then again at a time that is unclear on the records, and a third time at 23:30. I accept the N IPA's advice that '*these timeframes were not within the national hourly guidance; this is because if they were, the first repeat after 20:00 would be 21:00 and the second repeat would be 22:00 and we know that this was not done until 23:30*'.

107. I note a second occasion in which the observations were taken outside of the hourly timeframe. This was on 31 January 2018 when observations were taken at 09:30 and again at 11:00. I note that at this time the patient's NEWS was recorded as two, which was outside the level requiring hourly monitoring. I note that the Critical Care Outreach Team (CCOT) recommended close monitoring

for the patient at this time. However, it is not clear whether the CCOT required the hourly monitoring of the patient to continue.

108. I accept the N IPA's advice that the patient had '*close observations that were either in line with national guidance or his medical plan'*. However, I note that there was at least one occasion in which observations of the patient were not taken in accordance with the RCP NEWS Guidance. This guidance was developed '*to improve the detection of and response to clinical deterioration in patients with acute illness'*. I consider that the failure to record the patient's observations in accordance with the RCP NEWS Guidance on the evening of 30 January 2018 represents a failure in his care and treatment. I will consider the injustice experienced by the patient as a result of this failure later in this report.

Decision not to accompany the patient while attending the bathroom

109. The complainant said that a nurse did not accompany the patient while he was using the bathroom. She explained that while in the bathroom, the patient became '*frightened and confused'*, collapsed and had an episode of incontinence. The complainant further complained that the patient was returned to his bed '*unwashed or changed'*. In relation to the complaint that the patient fell while using the bathroom, I am unable to conclude whether or not this fall occurred. There is no reference to this incident in the clinical records. Nor is there any other evidence to suggest that it occurred.

110. I note that the Trust explained in its response to the complaint that the nursing team assessed the patient as not requiring assistance while in the bathroom. However, it also explained that '*on reflection, due to his unsteadiness, [the patient] should have been supervised in the toilet. We apologise for any distress and embarrassment this caused'*.

111. I considered the Trust's policy on falls prevention. I note that it states *'toileting needs must be assessed and a method of ensuring patients have a means of communication, which is accessible and useable, when assistance is required. Those patients/clients with cognitive impairment may need supervision during toileting; however dignity must be maintained at all times'*. I note from the

clinical records that the patient was assessed as requiring support with moving and handling. However, I also note that the level of support was not indicated. Furthermore, I note that the Checklist of Clinical Problems Identified on Admission documents that the patient did not have problems with mobility. However, it is clearly documented within the records that the patient experienced problems with his vision and balance from the time of his admission. Having reviewed the clinical records and the Trust's policy, I accept the N IPA's advice that this assessment of the patient was '*inadequate'*.

112. The Trust explained that the patient was left alone in the bathroom for his '*privacy and dignity'*. I note the N IPA's advice that '*it is not for the Trust to decide what constitutes privacy and dignity for individual patients who have the capacity to make that decision for themselves*'. I have examined the clinical records and there is no evidence to suggest that the patient was asked if he wished to be accompanied by a nurse while in the bathroom. Therefore, I consider that the nursing team assumed that he did not wish to be accompanied. I consider that this action is not in accordance with the NMC Code, which states '*avoid making assumptions and recognise diversity and individual choice'*.

113. The complainant also said that the patient had an episode of incontinence and was returned to his bed without being washed or changed. I note that the clinical records document that the patient was changed after the incident. However, the records do not document that he was washed. I also note from the records that the complainant raised her concern and this was shared with the nursing staff. In response, the nursing team explained that the patient refused a wash the previous day. I accept the N IPA's advice that '*despite previous refusals, [the patient] should still have been offered a wash after the episode of incontinence'*. I, again, consider that the nursing team assumed that the patient did not wish to be washed based on his wish the previous day. I also consider that making this assumption was not in accordance with good nursing practice as detailed in the NMC Code.

114. I am unable to conclude whether or not the patient would have been incontinent if he was accompanied by a nurse while using the toilet. However, I consider

that he ought to have been asked if he wished to be accompanied. I also consider that the nursing team ought to have offered the patient a wash after the incident. There is no evidence to suggest that this occurred. I consider that this represents a failure in the patient's care and treatment by the nursing team.

Summary of analysis of findings for Issue One

115. The investigation of the complaint has identified concerns regarding the nursing and medical care provided to the patient between 28 and 31 January 2018. I acknowledge that there are occasions in which the Trust experiences increased capacity and there is a need to initiate its Full Capacity Protocol. However, this ought not to compromise a patient's medical care or basic human rights. I am concerned that the failures experienced by the patient occurred, to a large part, while he was in an escalation bed. It is clear that some of the failures of the patient's care related directly to him being in an escalation bed, particularly his access to a nurse call bell. The use of escalation beds also raises issues with respect to dignity and privacy, which the Trust has acknowledged. I note that the Trust explained that these issues have been '*addressed locally in Ward 13 and across the wider Medical Directorate. Ward 13 undertake regular checks to ensure each patient has and can access a nurse call alarm'*. I welcome this learning already identified by the Trust following the complainant's complaint.

116. I am also concerned that the patient was placed on an escalation bed in a ward without its full complement of nursing staff. The review of the records as part of this investigation has not identified how staff levels and acuity of patients was considered prior to the decision to place the patient in an escalation bed on ward 13. The extent to which this reduced level of nursing cover impacted on the care and treatment received by the patient is difficult to determine but it is clear there were failures in the basic nursing care provided to the patient. I note the Trust have indicated that an additional HCA was deployed on the ward during the period in question however this is no substitute for a qualified nurse.

117. I am unable to conclude whether or not the failures experienced contributed to the deterioration of the patient's condition. However, I consider that failings such as these can lead to a lack of confidence on the part of the patient and

relatives about the adequacy of the care and treatment being provided. I am satisfied that the patient experienced injustice as a consequence of the failings identified. I consider that the patient experienced the injustice of distress and upset. I accept the N IPA's advice that the care provided by the nursing team while the patient was in the escalation bed caused his '*dignity and safety [to be] compromised*'.

118. I consider that the FREDA principles are relevant in this case. I consider that the Trust failed to meet these principles in its care of the patient while he was in the escalation bed. I also consider that the staff on Ward 13 did not give sufficient consideration to the patient's human rights and did not adhere to the FREDA principles of respect, dignity and autonomy.

Issue 2: Whether the Trust handled the complaint in line with its policy and appropriate standards?

119. The complainant said that the Trust took too long to respond to her complaint. She also complained that the ward manager in charge of staff on Ward 13 undertook the investigation of her complaint.

Evidence Considered

Legislation/Policies/Guidance

120. I referred to the following guidance which was considered as part of investigation enquiries:

   i. I considered the DoH's Complaints Procedure. The following relevant extracts were identified:

   '3.25 An investigation into a complaint may be undertaken by a suitable person appointed by the HSC organisation…

   3.37 Whatever the reason, as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response

and not the speed of response, the HSC organisation should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements.

Responding to a complaint
3.38 A full investigation of a complaint should normally be completed within 20 working days…

3.42 The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:
• address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
• include an apology where things have gone wrong…

STANDARD 5: INVESTIGATION OF COMPLAINTS
All investigations will be conducted promptly, thoroughly, openly, honestly and objectively…
5. People with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint…
STANDARD 6: RESPONDING TO COMPLAINTS
All complaints will be responded to as promptly as possible and all issues raised will be addressed…
Criteria
1. *The timescales for acknowledging and responding to complaints are in line with statutory requirements;*
2. *Where any delays are anticipated or further time required the HSC organisation will advise the complainant of the reasons and keep them informed of progress…'*

The Trust's response to investigation enquiries

121. In its response to enquiries about the delay in responding to the complaint, the Trust explained that '*while the Trust endeavours to respond to complaints as soon as possible, unfortunately in this case, staffing levels did have an impact on our ability to carry out the investigation. We apologise for the delay in responding to the complainant'*.

122. In relation to the complaint that the ward manager undertook the investigation into her complaint, the Trust explained that '*it is common practice across Health and Social Care that the person with managerial responsibility for the service is asked to investigate a complaint in his or her area. In this case, the ward manager was asked to investigate and it was then discussed with the lead nurse for the area and the clinical manager, who compiled the response'*.

The Trust's records

123. I carefully considered the Trust's records relating to the complaint.

124. I considered the Trust's written response to the complaint, dated 11 October 2018. The letter stated, *'…apologise for the delay in responding to you. The medical directorate has, unfortunately, lost two of its three senior nurse managers in the past year and the process to replace them has been much slower that (sic) we would have hoped for. Regrettably, this has had a significant impact on our ability to cover all the tasks we need to carry out, including responding to complaints'*.

125. The letter also states, '*I apologise for any distress caused to you or your partner at this time. We always strive to ensure that our patients are well cared for and I am saddened that this was not your experience on Ward 13. [The Sister] is disappointed that the care provided to your partner did not meet your expectations and she would seek to assure you that the team will use this feedback to improve care for future patients'*.

Analysis and Findings

126. I note that the complaints process was initiated following the Trust's receipt of the patient's consent to share his confidential information with the complainant

(who raised the complaint on his behalf). The Trust received this on 29 June 2018.

127. I note that the Trust forwarded its initial response to the complainant 70 working days after the patient provided his consent for the complainant to act on his behalf (11 October 2018). I also note that this was further to the complainant contacting this office (in September 2018) to raise her concerns with the delay she had already experienced at that time.

128. I note that the DoH Complaints Procedures states that *'a full investigation of a complaint should normally be completed within 20 working days'*. I have carefully considered the records contained within the complaints file. I note that the complaints team made significant efforts to achieve a response from the medical personnel investigating the complaint. However, the investigators did not provide their response to the complaints team until 4 October 2018. I acknowledge the Trust's reasons for this significant delay, which were outlined to the complainant in its response. However, I do not consider that those involved in the investigation demonstrated sufficient urgency to respond to the complaint. I accept that it may not always be possible for the Trust to fully respond to a complainant within the stated 20 working day timeframe. However, I consider that the Trust's delay in responding to the complainant's complaint was significant and unacceptable.

129. I note that the Trust informed the complainant during this time that the investigation experienced delays. However, I also note that it did not advise the complainant when it expected to provide her with an outcome or with an explanation for the delay. I note that the DoH Complaints Procedure states that '*as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales'.* I note that the personnel investigating the complainant's complaint did not provide any explanation for the significant delay or any expected date of completion to the complaints team for the duration of the investigation. I accept that this would have made it difficult for the complaints team to meet this objective. I consider

that the personnel investigating the complaint ought to have provided the complaints team with this information. This would have allowed the complaints team to provide the complainant with the reason for the delay and a revised timescale in accordance with the DoH Complaints Procedure. I uphold this element of the complaint.

130. The First Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned'*. The Second Principle of Good Complaint Handling, 'being customer focused', requires bodies to deal with '*complainants promptly and sensitively, bearing in mind their individual circumstances*'. I consider that the Trust failed to act in accordance with these Principles in its handling of the complaint. As a consequence, I am satisfied that the maladministration identified caused the complainant and the patient to experience the injustice of frustration, uncertainty and the time and trouble of bringing their complaint to this office.

131. The complainant also said that the ward manager in charge of staff on Ward 13 investigated her complaint. I note that the DoH Complaints Procedure states that *'people with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint*'. I also note the Trust's response to this element of the complaint that '*it is common practice across Health and Social Care that the person with managerial responsibility for the service is asked to investigate a complaint in his or her area'.* I am satisfied that the Trust considered the ward manager to have the knowledge and expertise in the relevant area to undertake the investigation into the complaint. I do not consider that there is any evidence to suggest that the Trust's decision was inappropriate. Therefore, I consider that the decision to appoint the ward manager as the investigator of the complaint to be reasonable and in accordance with the DoH Complaints Procedure. I do not uphold this element of the complaint.

CONCLUSION

132. The complainant submitted a complaint on behalf of her partner about the actions of the Trust regarding the care and treatment provided to him by staff of the Ulster Hospital between 28 and 31 January 2018. She also complained about the Trust's handling of her complaint.

Issue One

133. The investigation of the complaint did not find a failure in the decision to admit the patient to an escalation bed. However, the investigation established failures in the care and treatment and maladministration in relation to in relation to the following matters:

  i. The lack of ED records documented by the clinical team relating to the decision to admit the patient to an escalation bed and involve him in the decision;
  ii. The lack of records relating to staffing levels and acuity of patients on ward 13 prior to making the decision to place the patient on the ward;
  iii. The failure of the nursing team to meet the fundamental standards of care while treating the patient when he was in the escalation bed;
  iv. The failure to provide the patient with access to a nurse call bell while he was in the escalation bed;
  v. Failures in the prescription and administration of oral medication for the patient;
  vi. Failures in the prescription and administration of intravenous fluids for the patient;
  vii. The failure to record hourly observations of the patient in accordance with the RCP NEWS Guidance;
  viii. The failure to ascertain the patient's wishes regarding being accompanied while he was in the bathroom and to be washed following an episode of incontinence; and
  ix. The failure to give sufficient consideration to the patient's human rights and to adhere to the FREDA principles of respect, dignity and autonomy.

134. I am satisfied that the maladministration and failures in care and treatment I

identified caused the patient to experience the injustice of distress and upset.

Issue Two

135. The investigation established maladministration in relation to the following matter:
    i. The Trust's handling of the complaint.

136. The investigation did not find maladministration in relation to the following matter:

    i. The decision to appoint the ward manager as the investigator for the complaint.

137. I am satisfied that the maladministration identified caused the complainant and the patient the injustice of frustration, uncertainty, and time and trouble by bringing a complaint to this office.

Recommendations

138. The Trust explained that '*the Protocol for the Admission of Patients into a Non-Designated (Interim) Bed within Trust Hospitals has been drafted and currently has been circulated for consultation. The protocol will provide staff with guidance when hospital capacity is limited and the Emergency Department is facing increasing pressure due to the number of patients awaiting admission to a hospital bed. When a patient leaves the Emergency Department to go to an escalation bed, they should be provided with some information regarding the facilities they can expect on arrival to the ward. Escalation beds are now equipped with two movable screens to ensure privacy and dignity, a patient locker for storage, a call bell to alert staff, and information regarding the nearest toilet. Patients nursed in an escalation bed are provided with an eye mask and ear plugs if required*'. I welcome this learning already identified by the Trust.

139. I recommend within **one** month of the date of this report:
    i. The Trust provides The patient with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the distress,

concern and loss of dignity experienced caused to him as a result of the maladministration and failures in care and treatment identified;

ii. The Trust provides to the patient a payment of £300 in solatium for the injustice of distress, concern and loss of dignity experienced;

iii. The Trust also provide the patient and The complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the frustration, uncertainty, and time and trouble caused to them as a result of the maladministration identified relating to its handling of the complaint;

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

v. The Trust's Chief Executive reminds staff charged with the responsibility of investigating complaints of the need to provide a response within a reasonable timeframe to enable the Trust to meet the target timeframe set out in relevant guidance.

140. I further recommend that the Trust implements an action plan to incorporate the following recommendations and should provide me with an update within **six months** of the date of my final report. That action plan is to be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings) to:

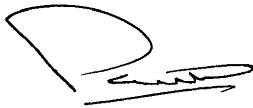
i. Undertake an audit of record keeping to include a review of a random sample of records relating to the admission of patients to escalation beds within the UH. These records ought to be benchmarked against the GMC Guidance. The Trust ought to include any recommendations identified in its update to this office;

ii. Undertake an audit of nursing records to include a review of a random sample of nursing assessments of patients admitted to Ward 13 of the UH. These records ought to be benchmarked against relevant Trust policies and the NMC Code. The Trust ought to include any recommendations identified in its update to this office;

iii. Provide training to relevant staff to improve communication with patients requiring assistance with their mobility; and

iv. Undertake a review of relevant Trust policies to ensure that patients experiencing difficulties with their oral intake are assessed promptly and appropriate action is taken.

141. The Trust accepted my findings and recommendations.



PAUL MCFADDEN
Acting Ombudsman **March 2020**

Appendices

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

APPENDIX TWO

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being Customer focused

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

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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