Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 201916450

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Appendix 1 – The Principles of Good Administration

Appendix 2 – The Principles of Good Complaints Handling

SUMMARY

I received a complaint about the South Eastern Health and Social Care Trust (the Trust). The complainant is the son of the patient who sadly passed away six weeks after a splenectomy. The complainant's primary issues of concern related to nutrition, medication and the placing of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order. He also complained about communication with the family.

I obtained all relevant information and procured independent professional advice from a consultant haematologist, a surgeon, a dietitian and a nurse. My investigation found that the clinical care provided by the haematology and surgical teams was good and met all relevant standards and there was evidence of continuity of care.

However, I found that there were gaps in the nursing records which made it difficult to assess the adequacy of the patient's food and fluid intake. There was a risk of refeeding syndrome because the patient's nutritional intake was so low. This is a potentially fatal condition if not managed, yet the dietitian did not complete a refeeding risk assessment. These failings pertained until nasogastric feeding commenced, and the refeeding risk was addressed, some weeks after admission.
I considered the failings in nutritional care and record keeping identified caused the risk of significant harm to the patient and uncertainty and upset to the complainant that his mother's nutritional needs were not adequately addressed.

The investigation identified several failings in communication with the complainant about the patient's deteriorating condition, and in particular, about the nutritional plan, the DNACPR notice and the commencement of palliative care. This led to uncertainty for the complainant about his mother's prognosis and left him unprepared for her death.

I recommended that the Chief Executive apologises to the complainant.
I also recommended that the Trust shares the learning from this complaint with the ward sister, dietitians and haematology team and provides evidence to confirm that appropriate action has been taken including, where appropriate, records of any meetings and training records and/or self-declaration forms which indicate that staff

have read and understood any related policies and guidance

THE COMPLAINT

1. I received a complaint about the actions of the South Eastern Health and Social Care Trust (the Trust). The complainant is the son of the patient who sadly passed away on 20 October 2017. The complaint concerns the care and treatment the patient received at the Ulster Hospital (UH) following surgery to remove her spleen on 8 September 2017. The complainant's primary issues of concern relate to nutrition, medication and the placing of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order. He also complained about communication with the family about his mother's prognosis.

Background

2. The patient was diagnosed with Autoimmune Haemolytic Anaemia (AIHA)[1] in July 2016. Her disease was resistant to medical therapy and she was transfusion-dependent. She developed life-threatening anaemia and required removal of her spleen. The care and treatment provided to the patient prior to surgery on 8 September 2017 is not within the scope of this investigation.

3. On 8 September 2017 the patient underwent a splenectomy at the UH. Post operatively, she developed respiratory failure with hypoxia[2] and shortness of breath. Active rectal (PR) bleeding prevented adequate anti-coagulation and the patient was unfit for exploratory surgery. The patient subsequently became very weak, lethargic, anorexic and bed ridden. She developed bilateral pulmonary embolisms[3] and portal vein thrombosis (PVT)[4]. The patient required nursing assistance with all activities of daily living. On 17 October 2017, following discussions with the patient and family, the doctor placed a DNACPR order. On 18 October 2017, the doctor made a referral to the palliative team. The patient died of

[1] Haemolytic anaemia encompasses a number of conditions that result in the premature destruction of Red blood cells.
[2] Low oxygen levels in the tissues
[3] A condition in which the pulmonary arteries in the lungs get blocked by a blood clot. This causes chest pain, breathlessness and cough.
[4] PVT is a blood clot of the portal vein, which allows blood to flow from the intestines to the liver. A PVT blocks this blood flow. Although PVT is treatable, it can be life-threatening.

pneumonia due to pulmonary embolism on 20 October 2017 before palliative care commenced.

Issues of complaint

4. The issues of complaint accepted for investigation were:

   Issue one: **Whether the care and treatment provided to the patient following her Splenectomy were consistent with good medical practice?**

   Issue two**: Whether communication with the patient and her family was consistent with good medical practice?**

INVESTIGATION METHODOLOGY

5. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its 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

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

   - A consultant haematologist MB BS FRCP FRCPath MBA, Qualified as a doctor in 1980. He has 41 years of experience in medicine, 32 years as a consultant haematologist with ward, outpatient and laboratory experience;
   - A consultant general and colorectal surgeon MBBS, FRCS , with experience of patients undergoing splenectomy as part of his routine practice:
   - Dietitian BSc (Hons) Human Nutrition and Dietetics ,Masters in Public Health, HCPC Registered Dietitian, a highly advanced specialist dietitian within the NHS, practicing at a band 7 level with experience working with highly complex

clinical cases, with particular expertise in mental health, weight management and nutrition support:

- BSc (Hons) Nurse Practitioner, MA Health Service Management, Registered General Nurse (RGN), Diploma in Adult Nursing, with twenty years nursing and managerial experience across both primary and secondary care.

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

7. I included the information and advice which informed the findings and conclusions within the body of this report. The IPAs provide 'advice'; however, how I weigh the advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

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

The general standards are the Ombudsman's Principles[5]:

- The Principles of Good Administration
- The Principles of Good Complaints Handling

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

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
- Nursing and Midwifery Council (2017) the Code. Professional standards of practice and behaviour for nurses, midwifes and nursing associates (the

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

NMC code);

- National Institute for Health and Care Excellence (NICE) Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition (2006, updated 2017) (NICE CG32).
- The Policy on Do Not Attempt Cardiopulmonary Resuscitation (Adult) April 2015 (DNACPR)

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

The Dietitian IPA also refers to the following guidance:

- The Parenteral and Enteral Nutrition Group (PENG) Pocket guide in nutrition (Current 2018 in circulation, however 2012 previously in circulation at time of case) (the PENG guide); and
- The British Dietetic Association (BDA) Guidance for Dietitians for Record and Record Keeping (2008) (the BDA guidance).

10. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that I took into account everything that I consider to be relevant and important in reaching my findings.

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

THE INVESTIGATION

Issue one:

Whether the care and treatment provided to the patient following her splenectomy were consistent with good medical practice?

Detail of Complaint

Post- operative care

12. The complainant believed that the Trust did not treat the patient's pneumonia adequately. He complained that the patient's bed was tilted almost flat and Ward 6A staff did not sit her upright to alleviate her discomfort.

13. The complainant questioned the treatment the patient received for the clots on her lungs.

Nutrition

14. The complainant said that the staff provided the patient with inadequate assistance and encouragement to eat. He said that she rarely received the food she ordered and was not always provided with food she could eat due to its texture or consistency. He believed staff made no effort to enquire why food was not eaten. While the Trust stated that it anticipates that relatives will help with eating, given the patient's swallowing problems and that she was at risk of choking, the complainant felt it was best not to help, but leave it to professional staff. He also believed that nursing staff did not identify or treat a mouth ulcer.

Medication

15. He complained that staff did not always ensure that medication was taken.

Hygiene

16. The complainant believed the patient did not have her gown changed daily and the Trust did not make efforts to help her with personal care such as brushing her teeth.

Evidence Considered

Legislation/Policies/Guidance

17. I considered the following:
    - NICE CG32
    - Do Not Attempt Cardiopulmonary Resuscitation (Adult) (DNACPR)
    - The NMC code
    - The GMC Guidance
    - The PENG guide; and

- BDA Guidance for Dietitians for Record and Record Keeping.

The Trust's response to investigation enquiries

18. I included extracts from the Trust's response at appendix seven.

Relevant Independent Professional Advice

Haematology IPA (H IPA)

19. The H IPA provided very detailed advice which I attach at appendix three. I will not repeat all of the H IPA's responses to specific questions 1-15 in the body of this report but will instead reflect his summary of the main issues that concerned the complainant.

Post operative care

20. The H IPA detailed the implications of the patient's diagnosis of AIHA and the forms of treatment required to manage this life threatening condition. He advised:
'This patient appears not to have reliably responded to medical measures to control her haemolysis and without an identified underlying cause it is my opinion that a splenectomy was a reasonable intervention.'
He also advised that the splenectomy was an uncomplicated procedure without excessive bleeding or complications and *'she commenced prophylactic anticoagulation immediately post-operatively in accordance with guidelines'.*

21. The Investigating Officer asked the H IPA to describe the recorded reasons for referral to ICU on 11 September at 00.45. He advised:
'*She had a period on the Intensive Care Unit (ICU) immediately post-operatively as would be routine given her complex condition and major surgery. She returned to the ward briefly but required readmission to the ICU on 11.9.17 due to signs of infection and Type 1 respiratory failure.'*
He also advised '*From the notes available to me it is apparent that the patient developed a fever, tachycardia (raised heart rate), hypotension (low blood pressure), raised respiratory rate and a reduced oxygen saturation in her blood.'*

22. He also advised *'During her ICU stay she was diagnosed with a portal vein thrombosis* [a recognised complication of splenectomy] *and pulmonary embolism*[6] *on 15.9.17. This was treated by increasing her anticoagulation from the lower prophylactic dose (enoxaparin 40 mg daily) to the therapeutic dose which is based on weight (enoxaparin 80 mg daily).'* The H IPA advised this was appropriate therapy.

23. The H IPA advised '*During her ICU stay she was diagnosed with a hospital acquired pneumonia which was appropriately treated with intravenous antibiotics'.* He also advised:
'In addition to her pneumonia, she developed a UTI. This is not uncommon, especially in female patients who are, or have been, catheterised. Both infections will have been made more likely by her immunosuppressed state and this may also have significantly compromised her ability to mount a response to infection and reduce the effectiveness of antibiotics. The notes record several discussions with microbiology specialists and, from what I can see, she was given appropriate and highly effective antibiotics both singly and in synergistic combinations.'

24. In relation to the possible cause of the patient's rectal bleeding, the H IPA advised: '*Unfortunately, she developed significant rectal bleeding on 23rd September and this continued intermittently over the next 9 days. The cause for this was not identified on a CT angiogram and she was not felt to be fit for a sigmoidoscopy*[7]*. The likelihood is that this originated from pre-existing diverticular disease which may have been exacerbated by increased venous congestion related to her portal vein thrombosis and would have been worsened by her anticoagulation. .. The decision to stop anticoagulation seems unavoidable. To continue in the face of significant and otherwise untreatable bleeding would be dangerous.'*

25. The Investigating Officer asked the H IPA if blood and urine tests were requested at appropriate stages. He advised:
'Overall I think the various blood and urine tests were done appropriately,

[6] Pulmonary embolism occurs when a piece of clot (thrombus) breaks away from a clot in a vein elsewhere in the body, travels through the right side of the heart and gets lodged in the lung.
[7] Sigmoidectomy surgery removes all or part of the sigmoid colon - the S-shaped part of the large intestine just before the rectum. Where possible the two healthy ends of the intestinal tract are then rejoined. If this is not possible then a stoma may be formed.

interpreted carefully and used to monitor her condition and drive changes in management to maintain safe levels.'

He also advised '*I think that there was judicious and appropriate use of blood transfusion'.*

26. The H IPA explained what may have caused the spike in NEWS from 13 October 2017 onwards when the scores reached 8/9. He advised the underlying causes were treated appropriately and explained:

    'These changes are most likely to be related to a developing severe infection. In retrospect it can be seen that around the 13th October her CRP began rising more rapidly and her haemolysis become more active…

    In my opinion her clinical deterioration was identified by the NEWS score and appropriate actions were taken at the time given the information that was available. Advice was sought from senior clinicians and alternative diagnoses were considered. She received a powerful combination of antibiotics and her condition and blood tests were closely monitored and reasonable actions taken. I cannot identify any delays or inadequate management that might have contributed to her outcome…I consider that the treatment for her pneumonia was timely, appropriate and had the best chance of being sufficient. I cannot identify from my knowledge and experience any inadequacy in the management of her pneumonia.'

27. The H IPA concluded:

    'In my view the patient died from bronchopneumonia which developed on or about 13.10.17 and failed to respond to treatment. Her bronchopneumonia was related to her previous pulmonary infarct caused by post-operative pulmonary embolism (and despite thromboprophylaxis) and her failure to respond was related to the immunosuppression related to treatment for her AIHA, including her splenectomy. I consider that her final illness commenced around 13.10.17…In my opinion The patient's family can be reassured that she was managed appropriately and that her various clinical problems were identified and treated well given the information available at the time. There was evidence in the records of good continuity of care from medical staff and of discussions with other appropriate specialists… Overall the quality of the notes, the recording of findings and decisions, and clinical management seems to be of high quality and I cannot identify any errors of commission or omission that contributed to her death.'

Medication

28. The Investigating Officer asked the H IPA what impact may there have been for the patient as a result of omitted does of medication, as recorded on the daily fluid balance and prescription charts. The H IPA advised:

    'Doses of medication may be omitted for a variety of reasons. This could be on medical advice to respond to some situation that might make omission necessary. Looking through the information provided to me, I cannot find any examples where an omission, for whatever reason, would have adversely affected her care or outcome.'

29. The complainant believed that treatment for pneumonia was withdrawn towards the end of the patient's life. The H IPA advised *'There is no indication that antibiotic therapy had been withdrawn immediately prior to her demise.'*

Nutrition

30. The Investigating Officer asked the H IPA if the decision for NG feeding on 28 September 2017 was recorded and appropriate. He advised:

    'She was assessed by a dietician who agreed that her oral food intake was inadequate and that naso-gastric (NG) feeding was appropriate as an adjunct, or 'top-up' to her oral intake. The rationale and means of doing this are very well recorded in the dietician note on 28.9.17 and hazards such as 'refeeding syndrome' were identified and taken into account. Over the next 3 weeks her albumin rose to 24 which is likely to reflect the success of the NG feeding.'

31. The complainant questioned why the tube remained in place when she was dying. The H IPA advised:

    'Withdrawal of support such as feeding and fluids is often a considerable anxiety for families, medical and nursing staff and the decision on this needs to be an individual assessment of benefits, utility and potential distress. In the patient's case the speed of her final deterioration probably means that no specific consideration had been made of the need for NG feeding and ideally the decision would have been made by the patient and/or family. Given the situation at the time I consider the replacement of the tube on the 18th and the continuing NG feeding to be appropriate.'

Nursing Adviser (N IPA)

Post-operative care

32. The Investigating Officer asked the N IPA whether NEWS observations were carried out at appropriate intervals and completed adequately and whether issues such as high heart rate and low blood pressure were escalated to medical staff as required on the following dates:

    10 September 2017

    'The NEWS demonstrates that her scores were high at between 6 – 9 throughout the day and night. The main contributing factor was the patients raised heart rate. This was escalated to medical staff. Hourly observations were recommended at 0600 and were recorded on NEWS'.

    11 Sept to 12 October 2017

    'The patient was transferred to ICU on 11/09 at 0045 due to her continued poorly condition. There are no concerns with monitoring over this timeframe'.

    13 October 2017 onwards

    '*The patient was reviewed frequently over 13th and 14th Oct due to raised NEWS, mottled rash on skin and a suspected PE (pulmonary embolism).*

    It should be noted that over this timeframe the patient had been clinically assessed and the recommended frequency for this individual patient was four hourly. NEWS supports rather than replaces clinical decision making. The NEWS frequency was therefore set for this patient by a competent clinical decision maker and given the frequent medical reviews and decision making that took place over this timeframe this was appropriate'.

Nutrition and mouth care

33. On admission on 31 August 2017, the person centred nursing care plan documented poor appetite due to mouth ulcers. The Investigating Officer asked the N IPA whether nursing staff administered appropriate mouth care during her admission. She advised:

    '*The nursing records show that on admission the patient advised nursing staff that*

she suffered from mouth ulcers and stated that she usually used mouthwash for this...In summary, during this admission, twice daily mouthwash was administered to the patient for oral hygiene, dry mouth and mouth ulcers. This was in line with the national standards applicable at the time of these events'. (See extract from NMC code appendix four).

34. The Investigating Officer asked the N IPA whether the MUST[8] scores on admission raised any concerns about nutrition that required action. The N IPA advised: *'The MUST score on admission concluded low risk of malnutrition. However, it was documented that the patient was suffering from low appetite and "?dietitian" (query referral to dietician needed) is documented. Therefore, the MUST was inaccurate. Nationally, when a poor oral intake is suspected, it is recommended to monitor food intake on food charts for at least five days (most Trusts, including this one, say three days). If any concerns regarding poor intake are observed, action should then be taken (this would include a referral to a dietitian). This is in line with national standards (see appendix four NICE CG32).*
I could not find any food record charts which pre-date 20/09/2017, three weeks after admission. The food charts which are within the records are incomplete and record keeping is poor; this means that whilst it is clear from the food charts that the patient had a low oral intake (eating only half or quarter of the foods documented), it is not possible to know how much food she was taking on board.'

35. The Investigating Officer asked the N IPA whether the referral to the dietitian was timely. She advised that '*"Needs referral to dietitian" is documented on 31.08.2017, the date of admission.'* However she was not referred to the dietitian until 14 September 2017[9]. The N IPA advised that the referral was therefore not timely, *'because it was not in line with the nursing assessment and NMC standards'.*

36. The Investigating Officer asked the N IPA if nursing staff followed the Dietitian's recommendations appropriately. She advised:
'The plan on 20/09/2017 was: "Encourage all oral intake/ offer milky puddings and yoghurts/ Start Ensure Compact, Procal shot and Forticreme/ continue food records

[8] Malnutrition Universal Screening Tool
[9] Dietetic records subsequently provided by the Trust document that the referral took place on 14 September 2017 and the dietetic review on 15 September 2017

chart and weigh when possible." It is not clear if assistance with nutritional intake was given at all mealtimes and with snacks, from 19th September, but supplements were administered. Food chart completion was poor. The patient was weighed when possible. The dietitians recommendations, therefore, were not consistently followed…There are no concerns with the frequency of patient weights given her poorly condition and the risks associated with transferring from bed to seated weighing scales'.

37. The Investigating Officer asked the N IPA whether Bristol stool charts, enteral feeding and urinary catheter records were completed adequately and observed appropriately. She advised that '*stool charts were fully completed. NG feed was not documented on 2nd and 7th Oct despite NG feed being administered. Catheter care was not documented on 2nd Oct. When comparing this to the progress records, this appears to be a documentation issue as the charts were not completed in line with national* [NMC] *standards'*

38. The Investigating Officer asked the N IPA whether there was evidence that the patient was encouraged or assisted to eat sufficiently. She referred to the relevant guidelines enclosed at appendix four, and advised that '*There should also be a system in place for highlighting that the patient needs assistance (for example delivering meals on a red tray and having protected mealtimes) and food intake should be documented at every mealtime. None of this can be seen within the patient's records...There is no evidence to demonstrate that assistance was given at all mealtimes from admission to the ward on 19th September through until the patient's death'.*

39. The Trust stated that visiting relatives are encouraged to assist patients with feeding. The Investigating Officer asked the N IPA if that was appropriate in this case. She advised:
'Most, but not all patients prefer to be supported at mealtimes by a loved one. Similarly, most but not all loved ones want to, and are able to, provide that support. There are two main issues therefore that must be checked before this can be considered appropriate. The first is consent and the second is safety. This patient did not have a care plan in place and therefore it is not known if the patient wanted

to be fed by relatives, or if relatives wanted and were able to, safely feed the patient'.

Medication

40. The Investigating Officer asked the N IPA to what standard were daily fluid balance and prescription charts completed. She advised:
'Fluid balance charts were completed from 01/09/17 to 06/09/17; 09/09/17 10 10/09/17 and 18/09/17 to 20/10/17… Some of the forms were partially completed and it was rare that the overall fluid balance was calculated'.
She also advised:
'My specific concerns regarding fluid balance monitoring are that there are two occasions within the records where the patient is on a fluid restriction (but this 'special instruction' has not been written on the fluid balance charts. It is not clear from the medical documentation on 23/09, how much the fluid restriction was (1 litre? 500ml?) and if it was communicated to the nursing team. On 13/10 it states 500ml – 1L within the medical notes, but the patient had more intake on this date as per the fluid balance charts…In summary, the patient was not fluid restricted on 13th. The special instructions were not written on fluid balance charts and therefore fluid balance was not completed in line with national standards [the NMC code].

41. In relation to prescription charts the N IPA advised:
'Nurses are expected to administer medications in line with the prescriber's direction. If there is any reason why the prescription cannot be followed, this should be clearly documented.
On reviewing the medication charts there are five occasions when medications were prescribed and not given, without an explanatory code'.

42. The Investigating Officer asked the N IPA if the omission of this medication would have had an impact on the patient. She advised:
'Osmolite plus is a fibre free feed, Biotene is a mouthwash and lactulose is a stool softener. These omitted doses over the whole of the patient's admission are unlikely to have impacted on her'.
She also advised that she could not find any record that the patient or her sons complained about medication left out of reach, within the progress notes.

Hygiene

43. The complainant believed that the patient wore the same night shirt for days, while the Trust stated she wore hospital gowns which were changed daily. The Investigating Officer asked the N IPA what the records suggested. She advised: *'The SKIN bundle/ care rounding charts indicate that repositioning was at least 4 hourly. It was more frequently when the patient was bleeding per rectum (every 30 minutes). Hygiene (incontinence management and personal hygiene) was delivered regularly as per these charts and the progress records'.*
    She also stated that pressure ulcer management was performed in line with national guidance.

44. The complainant stated that staff did not assist with brushing the patient's teeth. The N IPA advised:
    'When a patient has mouth ulcers and nursing staff are providing mouth care, a toothbrush should be avoided, because this can be painful for the patient. However, if the patient is able to brush her own teeth, she can continue with her preferred method and frequency of oral hygiene.'

Dietitian advisor (the Dietitian IPA)

Nutrition

45. The Dietitian IPA noted that the patient spent a day in ICU after the splenectomy on 9 August 2017. She advised '*Dietetics become involved following the ICU stay to provide nutritional support due to low oral intake and poor appetite. This was initially oral nutritional supplementation, and then due to [the patient] not being able to take these as prescribed, switched to an NG tube feed'.*

46. The Investigating Officer referred the Dietitian IPA to the nursing plan of care dated 31 August 2017, which indicated that the patient had poor appetite due to mouth ulcers and asked if the dietitian took this into account, along with the MUST scores. She advised:
    'The MUST scores taken on the 31st of August and the 7th of September both indicate low nutritional risk and a resulting score of 0. This screening takes into

account several factors including current weight, recent unintentional weight loss, and also 'other factors' which may cause the patient to struggle to eat and drink for the next 5 days. At each of these assessments they returned with no risk indicated, so a nutritional care plan or referral to the dietetic department was not indicated at these times.

47. The IPA advised that that the dietitian does not refer to mouth ulcers:
'The dietitian notes that poor oral intake has been noted by the ward, however, there is no indication of the cause of this. I can therefore conclude that the mouth ulcers did not form part of the nutritional care plan. I am unable to determine the impact that these may have had on The patient's oral intake as there are no further records of these made.'

48. The Investigating Officer asked the Dietitian IPA if the referral to a dietitian was made in a timely fashion. She advised**:**
'The need for a referral to a dietitian appears here to have been made on the 31/8/17. I can see that in the notes from the 31/8/17, that a referral to the dietitian was needed due to appetite being poor over the past 2 weeks. ..
I am not able to see the actual referral document that was made on the 31/8/17, only that on the 14/9 so I must conclude that this referral was not made to dietetics in August but nearly 2 weeks later. The dietitian appears to have responded to this in a prompt fashion and provided a timely assessment for the patient.'

49. The Investigating Officer asked the Dietitian IPA if the dietitian's recommendations were appropriate. She advised:
'The dietitian records reveal the full assessment which was provided for the patient on the 15/9 in the ICU along with the dietary recommendations that were being provided. The dietitian recommended for the ward to closely monitor oral intake, and to provide Ensure compact, which is a high energy, high protein oral nutritional supplement, if less than half meals are eaten… Overall the recommendations here appear appropriate.'

50. The Dietitian IPA also advised

'However, there is no consideration of refeeding risk[10] *which I would have expected to see, which is a potential risk, as this can be a fatal condition if nutrition is introduced too quickly in those who are high risk. The patient may have been assessed to not have been at risk, but I would expect to have seen this risk assessment completed'.*

51. The Investigating Officer asked the Dietitian IPA to comment on the Dietitian's plan of care on the ward on 20 September 2017. She advised that the review contains all the important information, including justifications for the decisions that the dietitian made in relation to the nutritional plan. Particularly:
    - Thorough review of anthropometric measurements and requirements completed by the dietitian, including the use of alternative measurements (MUAC) when weighing was not possible on the ward.
    - Review of oral intake that has been accepted, including issues with little handover of the nutritional plan from ICU noted
    - Justification of conversation with SN and the use of a trial of various types of supplements to determine the patient's preference.
    - Evidence of longer term plan using an NG noted

52. In relation to refeeding syndrome, the Dietitian *advised:*
    'There is also no consideration for refeeding risk here which I would expect to be considered with the phosphate being noted as being low, and [the patient] potentially having a poor intake in hospital. National guidance does indicate that refeeding risk should be assessed and indications of refeeding include phosphate and poor oral intake of more than 5 days.'

53. The Investigating Officer asked the Dietitian IPA if the Dietitian's recommendations on 25 September 2017 were appropriate. She advised:
    'This review shows evidence of taking into account the patient's preference, which is in line with national recommendations (NICE) to involve patients as much as possible in their nutritional care decisions... This is a detailed and comprehensive review which looks in detail at the food record charts, accepted supplements, and

[10] Refeeding syndrome is a metabolic disturbance that occurs as a result of reinstitution of nutrition in people who are severely malnourished, or metabolically stressed because of severe illness.

details a supportive conversation with the patient in regards to supplement preference'.

54. The Investigating Officer asked the Dietitian IPA if the patient was receiving sufficient nutrition and fluids from the combination of NG feeding from 28 September 2017 and oral intake. She advised:
'I would determine that it may have been appropriate at this time to consider an NG tube as [the patient] had not been able to meet her nutritional requirements through oral nutrition alone, even with the use of supplements. NG feeding would be an appropriate tool to support the patient's nutrition and prevent weight loss and malnutrition...*Initially the dietitian also takes into consideration the risk of refeeding here and promotes a gradual increase in nutrition, hence initially the feed is not provided to meet requirements. When looking at the regimen, the feed chosen provides 1.2kcal per ml, so the feed gradually builds nutrition from 600kcal, to 840 to 1200kcal in the feed. This is within refeeding guidance and appropriate for a refeeding plan.'*

55. The Investigating Officer asked the Dietitian IPA if weight and food record charts were appropriately reviewed when available. She advised:
'In the additional notes sent to me, I can see the request from the dietitian to keep strict food record charts. The dietetic notes do not contain the actual food record charts but the dietitian did review these, alongside fluid balance and acceptance and tolerance of the NG feed which included conversations with the patient re what she was managing to eat orally and how she was tolerating her feed. I can determine that the dietitian did a thorough and comprehensive review of the available information, making repeat trips back to the ward to review the patient and to attempt to speak with her directly.'

56. The complainant believed the patient was nursed on a bed that was too flat. The Dietitian IPA advised that '*Generally, the advice is to ensure feeding occurs at a minimum of 45 degrees to prevent aspiration of the feed, particularly overnight. This is recommended within NICE and PENG guidance, as well as Espen guidance and is appropriate and in line with evidence'.*

57. The Trust indicated that the patient's relatives were encouraged to assist with feeding when visiting at mealtimes but the complainant did not believe this was appropriate. The Dietitian IPA advised:

'It is noted within national guidance as above that seeking support from a patient's family can be a useful tool to promote oral intake. It can also be used as a tool to create a more normalised eating environment in hospital.

However, this has to be within the capacity of the family and if they are finding this distressing then [it] should not be encouraged... If the family was communicating distress or that they were unable to facilitate meals with the patient, then this should have been recorded by the staff and discussed with the dietitian.'

58. I note that the dietitian carried out six further dietetic reviews between 2 October and 16 October 2017 and the Dietetic IPA advised that these met all the expected parameters of relevant standards of care. She advised:

'On the 5th October the dietitian reviews the bloods, which is appropriate, and also notes the mental state of the patient and reflects the importance of setting small goals which is very good practice and patient centred. I am impressed by this practice and the dietitian should be commended for this approach.'

The records show that the dietitian discussed the care plan with the patient. She advised that there was no record that the Dietitian discussed the plan with the patient's family and this '*does not meet expectations*'.

59. The Dietetic IPA identified the following areas for improvement:

i. 'Improved referral process to dietetics on admission- there appears to have been contradictory reports in the notes regarding the need for dietetics and decreased oral intake

ii. Better handover of nutritional care plans from ICU to ward staff to ensure continuity of care in nutrition.

iii. Consideration for refeeding syndrome to be considered <u>at all new assessments</u>

iv. Improved involvement of patient and family in care and clear recording of this in dietetic notes''

60. The Dietitian IPA concluded *'The dietetic notes provided at the later date do detail an appropriate and high level of quality for dietetic record keeping, along with clinically appropriate plans for nutritional support.*

Further consideration of refeeding needs to be highlighted however.'

Surgical IPA

Post-operative care

61. The Investigating Officer asked the surgical IPA to explain why the patient was referred to ICU overnight after the splenectomy on 8 September 2017. He advised: *'The ICU admission letter from 8 September 2017 states that the patient was admitted "from theatre recovery as planned"... the ability for closer monitoring in a patient who has significant medical problems (such as the autoimmune haemolytic anaemia) associated with a major operation (splenectomy) would be sufficient reason to admit to ICU post-operatively.'*

62. The Investigating Officer asked the surgical IPA to review the reasons recorded for referral to ICU on 11 September. He advised:
'From the 10 to 11 September 2017, the patient was unstable, with a raised heart rate, a raised breathing rate, low blood oxygen levels, and a low blood count (haemaglobin). She was referred to ICU and treated with intravenous fluids, and antibiotics… On 15 September, she had a CT scan which showed that she had blood clots in both lungs (pulmonary emboli)... Because the patient did not require further surgical intervention for bleeding in the coming days, then it is unlikely that there was a surgical problem on 10 or 11 September.'

63. The Investigating Officer asked the surgical IPA what was the likely cause of the patient's rectal bleeding at end of September 2017. He advised:
'As the patient had bright red rectal bleeding, but was not persistently shocked (low blood pressure, high heart rate), then the likely cause of bleeding is from the colon (lower bowel). The CT scan that the patient underwent at the end of September 2017 did not identify a source of bleeding, and it is therefore impossible to say with certainty exactly where in the colon the bleeding is coming from'.

64. The surgical IPA was asked to summarise the surgical review and plan recorded on 23 September by ST5[11]. He advised:

[11] A doctor in fifth year of specialist training

'This review summarises the history of the rectal bleeding and notes the interventions organised by the haematologist. The review notes that the patient had stable observations (pulse 82, normal blood pressure), and that the bleeding had since settled. They noted that if there is further bleeding, then they should consider a CT angiogram (a specialised scan that would allow the localisation of the source of the bleeding).'
He advised that the review on 23 September 2017 is consistent with S15 of the GMC guidance and was appropriate.

65. The Investigating Officer asked the surgical IPA to comment on the reviews by the Colorectal surgeon on 26 and 27 September 2017. He advised:
'The first review noted that the bleeding had settled, and that the CT angiogram had not shown any evidence of bleeding. The second review noted that the bleeding had stopped and the observations were stable. Both reviews are reasonable, and are consistent with the GMC guidance above.'

66. The Investigating Officer asked the surgical IPA to comment on the reviews on 30 September and 1 October 2017. He advised:
'The review on 30 September 2017 does not mention fitness for surgery. In the Consultant surgeon review of 1 October, it is stated that the patient is "at high risk of mortality" and "would not be fit for operative intervention"… I can find no surgical entry after 3 October. After this, there was no need for further surgical opinion, as the bleeding had settled.'

Analysis and Findings

Post-operative care

67. The N IPA advised that nursing staff carried out NEWS observations at appropriate intervals and escalated issues such as high heart rate and low blood pressure to medical staff as required between 10 and 13 September 2017. She advised there were *'no concerns with monitoring over this timeframe'.*

68. I accept the concluding advice of the surgical IPA that '*there is no evidence of any failings in the plan to put the patient on ICU after the initial operation, nor in the*

assessment of the bleeding after the operation, or in the surgical assessments undertaken.'

69. I also accept the H IPA's advice that on 13 October 2017, *'Advice was sought from senior clinicians and alternative diagnoses were considered. She received a powerful combination of antibiotics and her condition and blood tests were closely monitored and reasonable actions taken'.*

70. The complainant questioned the treatment the patient received for the clots on both the lungs. The Trust described this as *'an impossible situation where PR active bleeding prevented adequate anti-coagulation for bilateral pulmonary embolisms and portal vein thromboses'.* I accept the advice of the H IPA that appropriate therapy was administered initially by increasing the anticoagulant from a prophylactic to a therapeutic dose, however following intermittent rectal bleeding for nine days the decision to stop anticoagulation was '*unavoidable'*.

71. The Trust stated that CT did not identify the source of the bleeding. The H IPA agreed that the decision not to operate was correct. The surgeon IPA advised that once the bleeding had stopped in early October, there was no reason for further surgical input.

72. The H IPA advised that the patient was appropriately treated with intravenous antibiotics for hospital acquired pneumonia. He also advised that medication was altered as required and there was no evidence that antibiotic therapy was withdrawn at any time. I accept the H IPA advice '*I cannot identify from my knowledge and experience any inadequacy in the management of her pneumonia.'*

73. I found no failings in the patient's post-operative care and did not uphold this element of the complaint.

Nutrition and mouth care

74. The complainant believed that mouth ulcers were not treated; the patient was not always provided with food she could eat due to texture or consistency and she was provided with inadequate assistance with feeding. The complainant believed that

the patient’s bed was positioned almost flat and Ward 6A staff did not sit her upright to alleviate her discomfort.

75. I note the Dietitian IPA’s advice that *‘feeding occurs at a minimum of 45 degrees to prevent aspiration of the feed’.* The Trust stated that there is no recorded evidence that the patient’s bed was on a tilt. I cannot conclude what way the bed was positioned therefore this is a failing in record keeping.

76. I note that the nursing plan of care dated 31 August 2017 recorded that the patient had poor appetite due to mouth ulcers. I accept the advice of the N IPA that nursing staff treated the patient with mouthwash twice daily. It is not clear whether the dietitian was informed of the mouth ulcers as she does not refer to them in her notes. However I am satisfied that nursing staff identified the mouth ulcers and treated the condition appropriately.

77. It is not clear how the referral to the dietitian was processed. The nursing plan dated 31 August 2017 identified the need but the referral was not made until 14 September 2017. Neither the N IPA nor the Dietitian IPA could identify an explanation for this time lapse. It is not clear whether the delay was due to an administrative error by the nursing staff or dietitian or a conscious decision to wait until the patient had recovered from the splenectomy.

78. I note that both the N IPA and the Dietitian IPA advised that the MUST scores on admission on 31 August 2017 were recorded as zero, indicating no concerns about nutrition. The Dietitian IPA advised that, as MUST scores on 31 August and 7 September 2017 identified no risk, no referral to the dietitian was made. However, the N IPA advised that the MUST scores were incorrect because the patient had declared a poor nutritional intake prior to admission. I accept the N IPA advice that nursing staff ought to have charted and monitored food intake for three days in accordance with Trust policy and considered whether a referral to the dietitian was necessary at that time. In fact, food charts did not commence until 20 September 2017, almost three weeks later, and after the intervention of the dietitian. I consider that these failings in care and treatment led to a loss of opportunity for the dietitian carry out an earlier assessment of the patient’s nutritional needs.

79. I accept the N IP advice that nursing staff administered food supplements from 19 September 2017, but the patient sometimes refused them. I note that staff did not complete food charts prior to 20 September 2017 and these were incomplete, with some sections blank. It was not clear if the patient received the assistance she needed at mealtimes. Both N and Dietitian IPAs advised that record keeping was poor therefore it was not possible to accurately measure the patient's intake and calculate suitable supplements. I consider that these were failings in record keeping contrary to the NMC guidance, which requires nursing staff to:
10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

80. Regarding the dietetic plan of care dated 20 September 2017, I accept the advice of the Dietitian IPA that the Dietetic plan did not follow all relevant guidelines as the refeeding risk was not considered as required by NICE and PENG guidelines. I consider this is a failing in care and treatment.

81. I accept IPA advice that the dietetic review on 25 September 2017 was detailed and comprehensive in line with the BDA standard of record keeping.

82. The Investigating Officer asked the Dietitian IPA if the patient was receiving sufficient nutrition and fluids from 28 September 2017 from the combination of NG feeding and oral intake. She advised that NG feeding was appropriate to support the patient's nutrition and prevent weight loss and malnutrition. She also advised that '*initially the dietitian also takes into consideration the risk of refeeding here and promotes a gradual increase in nutrition'* and that this was *'within refeeding guidance and appropriate for a refeeding plan'.* This is evidence of improving dietetic and nursing care. I accept the N IPA advice that weight measurement was not always possible due to the risks of transferring from bed to seated weighing scales.

83. I am pleased to note that the situation began to improve from 28 September 2017 after NG feeding was included and the risk of refeeding was appropriately addressed. The Dietitian IPA advised that the dietitian carried out six further dietetic

reviews between 2 October and 16 October 2017 and these met the relevant standards of care.

84. The Dietitian IPA concluded:
'Generally, the care provided from the dietetic department meets nutritional care standards although… there are some aspects which require improvement. I am not of the opinion that these improvements required impacted the safety or appropriateness of the care provided for the patient.'

85. I accept the advice of the H IPA that nasogastric feeding was appropriate to top up the patient's oral intake and the rationale for introducing this was recorded. The complainant questioned why the tube remained in place when the patient was dying. I accept the advice of the H IPA that '*the speed of her final deterioration probably means that no specific consideration had been made of the need for NG feeding'* and '*Given the situation at the time I consider the replacement of the tube on the 18th and the continuing NG feeding to be appropriate'.*

Medication and fluid balance

86. The complainant said that staff did not ensure that the patient took all her medication. I note that the Trust apologised to the complainant for any occasion when the patient's medications were either omitted or left out of reach. The Trust stated that the team in Ward 6A have undertaken a programme of audit in omitted and delayed medications and I welcome that.

87. The N IPA identified five occasions when prescribed medicines were not given; these were Osmolite plus, a fibre free feed; Biotene, a mouthwash and lactulose, a stool softener. Nursing staff did not record an explanatory code as required by the NMC standard. This is a failing. However, I accept the N IPA advice that '*these omitted doses over the whole of the patient's admission are unlikely to have impacted on her'.*

88. The H IPA also provided examples of when certain medications were omitted and the reason. I accept his advice that there was no evidence of an omission that would have adversely affected the patient's care or the outcome.

89. The N IPA advised there were two occasions, 23 September 2017 and 13 October 2017 where the patient was on a fluid restriction. However, the special instructions were not written on fluid balance charts and fluid was not restricted. It is not clear if nursing staff were aware of the restriction*.* I accept the N IPA advice and I am critical that nursing staff did not complete fluid balance charts in line with national standards [the NMC code]. I consider this record keeping failure a service failure.

90. I found failings in medication and fluid balance and upheld this element of the complaint. However I did not find that these failings had an adverse impact on the patient.

Hygiene

91. The complainant believed that Trust staff did not provide sufficient assistance to the patient with personal care and hygiene. I note the N IPA's advice that a toothbrush should be avoided, because this can be painful for the patient, unless the patient is comfortable using it herself.

92. The Trust stated that there are only two or three different pattern of gowns in the hospital and gowns were changed daily. The N IPA advised there is no specific record of when gowns were changed. The N IPA advised *'that repositioning was at least 4 hourly. It was more frequently when the patient was bleeding per rectum (every 30 minutes). Hygiene (incontinence management and personal hygiene) was delivered regularly as per these charts and the progress records'.*

93. There is no specific record of when gowns were changed. However, *t*he IPA advice indicates to me that nursing staff attended to the patient's hygiene needs appropriately therefore I do not find a failing relating to Hygiene management.

Injustice

94. Both N and Dietitian IPAs advised that record keeping was poor in several areas. Food charts were not maintained to monitor intake on admission therefore it was not possible to accurately measure the patient's food and fluid intake and calculate suitable supplements. There was no record that the patient's bed was maintained at the required 45 degree tilt. These failings caused the injustice to the patient of a missed opportunity to address her nutritional needs at the earliest opportunity.

95. I consider that the absence of a written refeeding risk assessment is evidence that the dietitians did not adequately address this risk in ICU or on the ward. This was particularly relevant prior to 28 September by which time NG feeding had commenced and the refeeding risk was addressed.

96. The Dietitian IPA noted that the patient's phosphate level dropped after slightly improved oral intake in ICU. She advised that this may have been a clinical manifestation of refeeding syndrome, however as there are many other causes of a drop in phosphate it is not possible to determine that it was due to refeeding syndrome on this occasion. I note that the low phosphate was appropriately treated with electrolyte replacement.

97. While I cannot determine that the patient did develop refeeding syndrome or suffered actual harm, I consider the failings in nutritional care and record keeping identified caused the patient the injustice of the risk of harm. The complainant also suffered the injustice of uncertainty and upset that his mother's nutritional needs were not adequately addressed.

Issue two:

Whether communication with the patient and her family was consistent with good medical practice?

Detail of Complaint

DNACPR and end of life care

98. The complainant said that clinicians did not properly explain complex health issues and treatment options and gave the patient conflicting advice. The complainant does not accept the patient was in a position to make fully and properly informed decisions in relation to her care particularly in relation to DNACPR and admission to ICU.

99. The complainant said that the patient '*wanted her sons to be present at all meetings to be able to understand and then explain later onto her what was happening. She also wanted her sons there as they were able to think of questions to ask.'*

100. The complainant also said that he informed nursing staff on 10 September 2017 that the patient was having breathing difficulties, but his concerns were dismissed. However 'o*n 11th September 2017 at 00:45 (AM) the Hospital called to explain due to the breathing issues the patient was transferred back down to ICU.'*

101. The records show that the consultant haematologist rang the complainant on 26 September 2017 to speak to him about a bleed. He complained that the consultant was '*incoherent as she was walking about while speaking to the complainant and was very softly spoken. He said he had to ask her to repeat herself a number of times as he found it was extremely difficult to understand her'.* However he understood from this conversation that '*the emergency splenectomy removed [the patient's] dependence on blood transfusions for the condition of Autoimmune Haemolytic Anaemia, and the discussions previously that all Doctors advised [the patient] and her sons that they were quite pleased with her recovery from this bleed.'*

102. The complainant said that the doctor informed him that '*she was being placed on a DNAR on Tuesday 17th October 2017, in-case the patient has another life-threatening bleed and in case of low blood count.'* He said *'She explained that going through a Crash-procedure (Resuscitation) isn't dignified or pleasant and there is no guarantee that it would save the patient and that if it does there is also no guarantee that the patient would recover.'*

103. The complainant believed that the Trust '*used the DNAR to cease all treatment'* and that he '*had confirmed with the doctor about the ICU and was told that it wasn't [the patient's] choice, that it was a medical decision about the DNAR and ICU'.* The complainant was '*concerned that the Hospital didn't do anything for [the patient] because of the DNAR that was only placed on her for "bleeding issues"'* and the Pneumonia was not treated.

104. The complainant said '*at no stage apart from Friday 20 October 2017 were the patient's sons told that the patient's condition was getting worse and that she was going to die'.* However he acknowledged that there was one other time over two weeks previously with the bleed on the 26 September 2017, however all Doctors

had advised the patient and her sons that they were quite pleased with the patient's recovery from this bleed.

He also stated that the consultant haematologist was quite positive on Thursday 19 October 2017.

Record keeping

105. The complainant said the patient's clinical records contain estimated times of events. He considered that times were often badly estimated and are imprecise by several hours.

Evidence Considered

Guidance

106. I considered the following

- The GMC Guidance (appendix three)
- The Trust DNACPR policy 2015 (appendix six)
- GMC Treatment and care towards the end of life: good practice in decision making (2010)

The Trust response to enquiries

107. Extracts from the Trust's responses to enquiries are attached at appendix seven.

Extracts from Clinical records

Clinical record 23 September 2017

108. This records active bleeding per rectum.

A consultant haematologist on call '*advised balance bleeding risk with risk of clotting.'* He referred her for a surgical review.

Clinical records 26 September 2017

109. The colorectal consultant recorded '*Have D/W* [discussed with] *patient and sons.'*

There is no record of the consultant haematologist's conversation with the complainant on the telephone on 26 September 2017.

Clinical record 17 October 2017

110. There is a lengthy entry in the clinical records from the doctor at 18:32 on 17 October 2017. It includes the following discussion with the patient with family present:

'Family present

- *Explained HAP (hospital acquired pneumonia)*
  Some improvement on Meropenem
- *Ongoing aggressive haemolysis*
- *Very difficult to treat*
- *May not survive this episode*
- *ICU not appropriate (patient doesn't want ICU)*
- *DNAR appropriate as resuscitation likely not appropriate and not likely to be successful.'*

Relevant Independent Professional Advice

N IPA

111. The Investigating officer asked the N IPA if there was evidence of communication with the patient and her sons in the nursing progress notes. She advised that she *'could not see any reference to nursing discussions with the patients family'* and '*there is no national standard that states that such communication should be documented'.*

112. The Investigating Officer asked what alerted nursing staff to the patient having respiratory difficulties on return from ICU on 10 September 2017. She advised that *'The patient was escalated to medical staff due to a raised NEWS of 9. The action taken was in line with national standards'.*

Dietitian IPA

113. The complainant did not believe that it was appropriate that family were expected to assist with feeding while visiting. The Dietitian IPA advised:

‘If the family was communicating distress or that they were unable to facilitate meals with the patient, then this should have been recorded by the staff and discussed with the dietitian.’

The Dietitian IPA also advised there was no record that the dietitian discussed the plan of care with the patient’s family. She recommended that there should be improved involvement of the patient and family in the care and clear recording of this in the dietetic notes.

114. She also advised that on 25 September 2017 ‘[the] *review shows evidence of taking into account the patient’s preference, which is in line with national recommendations (NICE) to involve patients as much as possible in their nutritional care decisions’.*

The records show that the dietitian discussed the care plan with the patient. She stated that there was no record that the Dietitian discussed the plan with the patient’s family and advised this ‘*does not meet expectations*’.

Haematology IPA (the H IPA)

115. The Investigating Officer asked the H IPA to comment on the standard of communication with the patient and her sons about the rectal bleeding in September 2017. He advised:

‘*The only note about this conversation states “family updated by consultant haematologist remains for full escalation…”* There is also a later note from the consultant haematologist’s ward round that documents ‘…*D/W patient and sons about CT angio – no active bleeding…’*

116. The H IPA said there was not a full transcript in the records of the detail of the discussion about DNACPR with the patient and her sons on 17 October 2017. However, he advised.

‘The entry in the notes seems a good summation of the situation and almost certainly reflects what was said, but it gives no insight into how it was conveyed, how the family reacted, what questions were asked and answered and what

concerns may have been expressed.'

He added

'*I have gained the impression from the clinical notes that [the doctor] is a conscientious doctor who had been involved with the patient's care for some time so I would hope and expect that the discussions were handled well but that is speculation.'*

117. The Investigating Officer asked the H IPA about 'palliative care' and end of life discussions with the patient and her sons. He advised:

'*The first mention of palliative care (PCT – Palliative Care Team) was on 18.10.17 at 1145 when 'PCT referral' is recorded. I can find no record that suggests that she had been seen or assessed by the palliative care team in the following 48 hours before her death. I cannot identify any record that suggests that Palliative Care referral had been discussed with the patient or family.'*

118. The H IPA concluded:

'It is clear to me that The patient deteriorated rapidly during the morning of 20th October 2017 and that this afforded little time to discuss withdrawal of some of the invasive interventions such as NG tube, urinary catheter, intravenous access, or blood tests that might be considered in someone who is approaching end of life. Clinical notes represent a summary of findings, diagnoses and management decisions and may not reflect the many formal and informal discussions between clinical staff and with the patient and their relatives. I consider the clinical notes in this case to be of high standard and they have allowed me to closely follow her progress and the dilemmas faced by the clinical team. I cannot, however, comment on the quality and content of the discussions with patient and relatives.'

119. The Investigating Officer asked the H IPA to identify areas for learning from the complaint. He advised:

- *'More comprehensive record of discussions with patients and / or relatives may have reduced the concerns implied in the questions posed to this report. This may be difficult and time-consuming but should reflect any particular areas of concern or disagreement that arose in discussion.*
- *It may be recorded in notes that I haven't seen, but the potentially fatal outcome of the diagnosis and its treatment may not have been discussed with the patient*

and/or relatives leading to unrealistic expectations. These are difficult conversations but may have prevented some of the concerns that have led to this report. These discussions need to be recorded in the notes.'

Surgery IPA (the S IPA)

120. The Investigating Officer asked the S IPA to identify when surgical reviews took place. He advised:
'There were 3 surgical entries in the medical notes between 30 September 2017 and 3 October. I can find no surgical entry after 3 October [2017]*. After this, there was no need for further surgical opinion, as the bleeding had settled. There is no specific guidance on the quality of communication between specialties, but I can find no evidence of poor communication*'.

Analysis and Findings

Communication and record keeping regarding DNACPR and palliative care

121. GMC guidance requires doctors to '*Respect patients' right to confidentiality'.* It also states:
'You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.'
There is no suggestion that the patient was not competent to understand her medical condition therefore patient confidentiality is an important consideration. However, I am not able to determine from the records to what extent the patient understood how complex and life threatening her condition was.

122. I accept the complainant's belief that the patient wanted her sons to be present at all meetings to be able to understand what was happening and explain to her and to ask questions on her behalf. I note that records clearly state that the patient's sons were present during discussions and that the complainant was contacted directly by telephone by the consultant haematologist on 26 September 2017. I am satisfied that it was appropriate for staff to communicate with the complainant and his brother in order to aid their own and the patient's understanding of her complex and life threatening medical condition and how it was being treated.

123. However, I note that each of the IPAs advises that there are few records of discussions with the patient and her family by nursing, dietitian or clinical staff. This tends to support the complaint that '*complex health issues and treatment options were not properly explained'* to the complainant.

124. It is clear from the records that nursing staff escalated a deterioration in the patient's health on 10 September 2017 appropriately and the patient was referred to ICU. However, I find that inadequate communication with the complainant led him to the conclusion that his concerns were ignored on that occasion.

125. In relation to dietetics, the Trust said that *'Dietitians always discuss nutritional care plans with patients themselves in the first instance, and family if they are present or this is requested specifically by the patient, family members or MDT. No requests were received from the family or MDT to discuss the nutritional plan with the family members'.* The Dietetic records show that the dietitian communicated with the patient frequently with regard to her preferences. The Dietitian IPA described this as '*excellent practice'*. However, there was no record that the Dietitian discussed the nutritional plan with the patient's family. The Dietititan IPA advised that this '*does not meet expectations*'. I consider that it was a failing that neither the dietitian nor nursing staff discussed nutritional plans with the complainant, bearing in mind there was an expectation that family members might assist with feeding when visiting.

126. The complainant has a good recall of the discussion on 26 September 2017 with the consultant haematologist after the patient had suffered several days of rectal bleeding. However, I cannot not locate any record of this conversation in the clinical notes. The H IPA advised *'I cannot, however, comment on the quality and content of the discussions with patient and relatives.'* In the absence of clear records the H IPA could not advise to what extent '*the potentially fatal outcome of the diagnosis and its treatment'* was discussed with the patient and relatives. He advised '*these are difficult conversations but may have prevented some of the concerns that have led to this report'.* The GMC Guidance states: '*You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including their condition, its likely progression and the options for*

treatment including associated risks and uncertainties'. I agree with the H IPA that these difficult discussions must take place and must be recorded in the notes.

127. I note the complainant's observation that estimates of times on the clinical records were often out by several hours, but I am unable to make any determination about this. It may be the case that some records were written retrospectively and timed accordingly. I note that the H IPA commented on several occasions about the high standard of the clinical notes and records which allowed him *'to closely follow* [the patient's] *progress and the dilemmas faced by the clinical team'.* The S IPA did not identify any areas of poor communication. With the exception of the events of 26 September 2017 when the record of the discussion with the consultant haematologist was absent, I consider that the clinical records are satisfactory and meet the GMC standard of record keeping.

128. The complainant stated '*at no stage prior to Friday 20 October 2017 were the patient's sons told that the patient's condition was getting worse and that she was going to die'.* However, on 17 October 2017, the doctor recorded a discussion about DNACPR and ICU and advised that the patient may not survive. I am satisfied that this was a brief but adequate record of the discussion you would expect the doctor to have with the patient and the family at that time.

129. I note that the complainant recalls the discussion about DNACPR on 17 October 2021 but not the message that the patient '*may not survive this episode.'* He also recalls that the doctor told him that DNACPR is a medical decision and not the patient's choice. This conversation is in line with the Trust DNACPR policy which states *'the overall responsibility for decision-making rests with the consultant/general practitioner in charge of the individual patient's care'* and the objective 't*o encourage appropriate and realistic discussion with patients and their relevant others about resuscitation issues.'*

130. The complainant believed that the DNACPR was an excuse to cease treatment for the pneumonia, however I consider that this belief was unfounded. In relation to issue one, the H IPA provided clear advice that the patient's pneumonia was properly treated and there was '*no indication that antibiotic therapy had been withdrawn immediately prior to her demise.'*

131. I am satisfied that the doctor's conversation on 17 October 2017 with the complainant covered the key points about the DNACPR and the possibility that the patient may not survive. I agree with the H IPA that the record '*it gives no insight into how it was conveyed, how the family reacted, what questions were asked and answered and what concerns may have been expressed.'* I acknowledge that time constraints sometimes lead to less detail in records than is optimum when recording such important conversations. I cannot determine whether questions were asked or concerns raised by the patient or her relatives on that occasion. However, I am satisfied that all relevant clinical matters were discussed

132. I note a referral for palliative care was made on 18 October 2017. The H IPA could see no record that the referral was discussed with the complainant. The complainant stated that the consultant haematologist was quite positive on Thursday 19 October 2017, therefore he was unprepared for his mother's death the following day. I consider that the consultant haematologist, as the senior doctor in charge of the patient, should have taken the time to communicate the process of palliative care with the patient's family, respond to any questions they may have had and record the information in the patient's notes and records.

133. I am not satisfied, from my examination of the available records, that the recording of communication with the patient and her family consistently met the GMC standard or the high standard of the recording of the clinical findings. In my view, records should precisely record the dates and times of communication of key issues with patients and family members. This also helps to ensure clarity for those clinicians who will later rely on the information that is recorded in the patient's medical record.

134. I therefore uphold elements of the complaint relating to communication with the complainant about the nutritional plan, the patient's breathing difficulties on 10 September 2017, rectal bleeding on 26 September 2017 and the plan for palliative care on 18 October 2017.

135. I consider the failings in communication with the complainant caused him the injustice of frustration and uncertainty regarding his mother's prognosis and left him inadequately prepared for her death on 20 October 2017.

CONCLUSION

17. I received a complaint about the care and treatment the patient received in the Ulster Hospital following surgery to remove her spleen on 8 September 2017. The patient sadly died of pneumonia due to pulmonary embolism on 20 October 2017.

136. I recognise the pain that the complainant and his brother experienced over the loss of their mother in these circumstances and I wish to offer them my sincere condolences.

Issue one

137. In the first issue of complaint, I considered whether the care and treatment provided to the patient following her Splenectomy were consistent with good medical practice.

138. I did not find failings in relation to:

- Post operative ICU care;
- The care and treatment the consultant haematologist and her team provided to the patient during this admission including treatment of pulmonary embolism and pneumonia;
- The nutrition support part of the Dietitian's plans on 15 and 20 September 2017;
- The quality of dietetic reviews from 25 September 2017 onwards;
- The decision to commence NG feeding;
- The care and treatment the colorectal surgeon and his team provided to the patient during this admission;
- How nursing staff identified and treated the patient's mouth ulcers;
- Maintenance of NEWS charts and escalation of issues arising to medical staff:
- Hygiene management, relating to mouth hygiene and changing of the patient's hospital gowns.

139. The investigation identified the following failings in care and treatment:

- Dietetic referral was unreasonably delayed;
- The dietitians both in ICU on 15 September 2017 and on the ward on 20 September 2017 did not give adequate consideration to the risks of refeeding syndrome during their initial assessments;
- Food charts did not commence until 20 September 2017 and these were incomplete, with some sections blank;
- Must scores were not always calculated correctly;
- The patient's fluid intake was not accurately recorded;
- There is little evidence that staff on the ward assisted the patient with eating;
- There were five occasions when prescribed medicines were not given and nursing staff did not record an explanatory code as required by the NMC standard. However I found that these omitted doses were unlikely to have impacted on the patient; and
- There is no record that the patient's bed was set at the optimum 45 degree tilt.

140. I consider that the failings in nutritional care and record keeping caused the patient the injustice of the risk of harm. The complainant also suffered the injustice of uncertainty and upset that his mother's nutritional needs were not addressed in a timely way.

Issue two

141. In issue two, I considered whether communication with the patient and her family was consistent with good medical practice.

142. The investigation identified several failings in communication. I therefore uphold elements of the complaint relating to communication with the complainant about the patient's deteriorating condition, and in particular, relating to:

- The nutritional plan;
- The patient's breathing difficulties on 10 September 2017;
- The consultant haematologist's conversation with the complainant on 26 September 2017 and
- The commencement of palliative care.

143. The complainant suffered the injustice of frustration and uncertainty regarding his mother's prognosis.

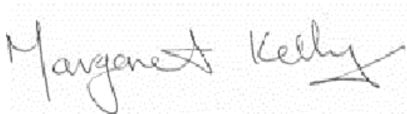
Recommendations

144. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures identified within **one month** of the date of this report.

145. The Trust stated that the team in Ward 6A have undertaken a programme of audit in omitted and delayed medications and I welcome that. I recommend that the Trust shares the findings of the audit with my office.

146. I further recommend for service improvement and to prevent future recurrence that the findings from this complaint are shared with the ward sister, dietitians and haematology team.

147. I recommend that the Trusts implements an action plan to incorporate these recommendations and should provide me with an update within three months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies.



Margaret Kelly **6 SEPTEMBER 2022**

Ombudsman

Appendix 1

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.