Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Western Health and Social Care Trust

NIPSO Reference: 202000196

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

I received a complaint about the Western Health and Social Care Trust (the Trust) regarding the care and treatment of the complainant's father during an admission in Altnagelvin hospital. The complainant believed that the Trust did not properly investigate her father's delirium; that he was discharged prematurely and should have been readmitted immediately. She asked the Trust to carry out a 'serious adverse incident' (SAI) investigation[1] but this was not done.

I obtained all relevant information, including the patient's medical records which were reviewed by an independent professional advisor (IPA). My investigation found that it was a failing in care and treatment that not all appropriate assessments were undertaken to establish the cause of the patient's delirium and treat it to ensure that he was fit to be discharged. On the day of discharge, the complainant and her family expressed concerns about their father's condition. I found that the patient should not have been discharged until a medical review established that he was medically fit. I also found that the ward sister ought to have exercised discretion to readmit the patient to the ward immediately after premature discharge as he was clearly unwell.

It was also a failing that a COVID-19 test was not repeated before discharge to check that the patient remained Covid negative. This was in not in accordance with a Department of Health protocol issued in October 2020, two months earlier. The patient was admitted to another hospital as an emergency on the evening of discharge and passed away with COVID-19 nine days later. My investigation established that this was most likely a case of COVID-19 contracted during the patient's stay in Altnagelvin Hospital.

I found that these were failings which caused the complainant uncertainty and upset about whether the outcome for her father might have been different had he remained in hospital for further assessment and treatment or been readmitted to the ward after discharge when the family expressed concerns. The complaint also suffered the injustice of concern that she and other family members were exposed to the virus.

[1] 'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation' arising during the course of the business of a HSC organisation

The patient suffered considerable distress and inconvenience because he had to be transported by ambulance to the ED of a different hospital shortly after the premature discharge and endure the triage process again.

The Trust belatedly instigated a process to decide whether to carry out a SAI investigation. I was concerned that it took almost a year to reach a provisional decision not to carry out this investigation. I also found that the rationale for this decision was not adequately documented. This delay and failure in record keeping amounts to maladministration which caused the complainant the injustice of frustration that the Trust did not adequately address her complaint.

I recommended that the Trust apologises to the complainant for these failings.
For service improvement and to prevent future recurrence, I recommended that the Trust carries out a review to establish why the DoH protocol advice to retest a patient, who had previously tested negative, between day five and seven, was not followed in this case.

I note that the Trust identified some learning from this case. For further learning and to prevent future recurrence I recommended that the Trust and the treating doctors and nurses reflect again on how on the patient's care and discharge on ward 41 was managed and identify what else might have been done differently in this case.

I also recommended that the Trust discusses the Datix[2]/SAI process with the RRG[3] staff and assistant director who were involved in this investigation to establish whether they were properly informed of the circumstances of the discharge, including the failure to retest for COVID-19 before they made a provisional decision that an SAI was not appropriate in this case. The Trust should proceed with the plan to discuss the case again at a Mortality and Morbidity review (M and M) and make a fully informed decision whether an SAI should proceed.
The Trust and the complainant accepted my findings and recommendations.

[2] The Trust's electronic incident reporting system
[3] Rapid Review Group

THE COMPLAINT

1. I received a complaint about the actions of the Western Health and Social Care Trust (the Trust) regarding the care and treatment the complainant's father (the patient) received at Altnagelvin Hospital. The complainant is the patient's daughter.

Background

2. The patient was aged 72 and had Parkinson's disease (PD) for nearly ten years. He also had a history of osteoarthritis and cardiac issues. He attended the Emergency Department (ED) on 5 December 2020 and was admitted to a Hospital ward on 7 December 2020. He presented with hallucinations and a suspected infection associated with long-term catheter use. A consultant gastroenterologist was responsible for his care on the ward and the Acute Medical Unit (AMU) and Care of the Elderly (COE) team also reviewed him. The hospital discharged him home on Monday 14 December 2020.

3. The complainant said that upon discharge the patient began hallucinating and was unable to stand or get into the car unaided. The complainant immediately contacted the hospital ward from where he was discharged to ask for medical help. A nurse advised the complainant to bring the patient to ED as he could not be readmitted directly to the ward. The complainant said that ED was busy and the patient was distressed, so she took him home. The complainant said that when they arrived at his home, she checked his temperature, which was very high. She called an ambulance to take him to ED at the Causeway Hospital. The complainant believed that an xray showed 'white patches' on the patient's lungs and he also tested positive for COVID - 19. The patient sadly passed away on 23 December 2020.

Issues of complaint

4. The issues of complaint accepted for investigation are:

Issue one

Whether the Trust carried out appropriate and sufficient assessments to establish whether the patient was medically fit for discharge on 14 December?

Issue two

Whether the Trust's investigation of the circumstances of the discharge was adequate?

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, the Investigating Officer obtained independent professional advice from a consultant physician, MB MSc MD FRCP FRCPE FRCPI Dip Card RPMS, with more than 40 years' experience and an accredited geriatrician since 2001.
I enclose the clinical advice received at appendix six to this report.

7. I also obtained an opinion from a Professor of Molecular Virology, Doctor of Philosophy (PhD) focused in Virology/Microbiology, an experienced Professor with a demonstrated history of working in higher education and industry.

8. I included the information and advice that informed the findings and conclusions within the body of this report. The IPA provided 'advice'; however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

9. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those 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[4]:

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

10. I refer to the specific standards and guidance that applied at the time the events occurred. These governed the exercise of the professional judgement of those individuals whose actions are the subject of this complaint. The specific standards and guidance relevant to this complaint are:

- NMC (2015). The Code. Professional standards of practice and behaviour for nurses and midwifes (The NMC code);
- Royal College of Physicians 2017 'National Early Warning Score (NEWS) 2. Standardising the assessment of acute illness severity in the NHS';
- General Medical Council (GMC) Guidance Good Medical Practice (2013) (the GMC Guidance);
- Public Health England. Guidance COVID-19: management of staff and exposed patients or residents in health and social care settings. (2020);
- National Institute for Health and Care Excellence (NICE) Delirium: prevention, diagnosis and management. Clinical guideline [CG103] 28 July 2010;
- NICE guideline [NG71] – Parkinson's Disease (PD) in adults ;
- COVID-19 Infection Prevention & Control Guidance April 2020;
- COVID 19 Interim Protocol for Testing Version 7 issued by the Department of Health (DoH) COVID-19 Directorate (the DoH protocol) in October 2020.
- Safety, tolerability and viral kinetics during SARS-CoV-2 human challenge 1 February 2022 https://www.researchsquare.com/article/rs-1121993/v1

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

11. 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 considered to be relevant and important in reaching my findings.

12. 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 Trust carried out appropriate and sufficient assessments to establish whether the patient was medically fit for discharge on 14 December 2020?

Detail of the Complaint

13. The complainant said that the patient did not have his bloods taken and tested before discharge. Staff took the last set of bloods from the patient on Friday 11 December 2020. Furthermore, medical staff did not take his temperature before discharge. The complainant also said that it is unclear whether the 'National Early Warning Score' was assessed on the day of discharge.

14. The complainant believed there was poor communication between medical staff and the family. She also said there was poor communication between the doctors and the nursing staff internally. When the family arrived to collect the patient as instructed, nursing staff appeared unaware that the patient was to be discharged.

15. The complainant said that the hospital discharged the patient into the family's care on 14 December 2020, despite the family's explaining to the medical staff that he was still unwell. The patient's baseline was that he was independently mobile using a three-wheeled rollator. However the complainant explained that, on discharge, he was unable to weight bear, was hallucinating, drowsy and breathing rapidly.

16. The complainant immediately returned to the ward to seek help from nursing staff, but a nurse informed her that Trust protocol was that a patient could only be readmitted following triage in ED The Trust subsequently apologised that the ward sister did not exercise her discretion on this occasion to readmit the patient directly. For the purposes of this investigation I accept that the ward sister ought to have used her discretion to readmit the patient for further assessment.

Evidence Considered

17. I attach extracts from the letter of complaint to the Trust dated 17 December 2020, at Appendix three and the Trust's response to the complainant dated 8 February 2021, at Appendix four. I also enclose extracts from the Trust's responses of 31 March and 12 October 2021 to NIPSO's investigation enquiries at appendices five and seven.

18. I considered the following policies and guidance which are referenced in the advice from the IPA (appendix six) :
    - The GMC Code (appendix nine)
    - The NMC Code (appendix ten).
    - NICE guideline CG103 (see IPA advice for references)
    - COVID-19 Guidance April 2020.

    '3.2 Incubation and infectious period
    The incubation period is from 1 to 14 days (median 5 days). Assessment of the clinical and epidemiological characteristics of COVID-19 cases suggests that, similar to SARS, most patients will not be infectious until the onset of symptoms. In most cases, individuals are usually considered infectious while they have symptoms; how infectious individuals are, depends on the severity of their symptoms and stage of their illness.'

19. I also considered the DoH protocol)October 2020 which states:
    'During April 2020, testing arrangements were introduced for all acute elective and non-elective patients admitted overnight into hospital, to be tested for

COVID-19. This includes patients who are asymptomatic (that is those who are not showing any symptoms of infection) and also now includes patients who are double vaccinated.
In October 2020, COVID-19 testing requirements in a hospital setting were extended to require all patients who test negative for COVID-19 on admission, to be subject to a further single re-test conducted between 5-7 days after admission to hospital.'

The Trust's response to investigation enquiries

20. The Trust stated:
'The Consultant Gastroenterologist and Senior Manager has reviewed all medical, nursing and laboratory results and confirms that there was no clinical need to have further blood tests taken. Bloods were taken and reviewed on the 7, 8, 9, 10 11 December 2020 with no significant abnormality noted.
National Early Warning Score (NEWS) was recorded at 08:30hrs as O and NEWS had been recorded as O > 72hours prior to discharge. The patient temperature was not taken prior to discharge as they were no clinical indications to do so. Staff are advised to use clinical judgement and seek advice if they have concerns about the patient regardless of the score however it is noted that the patient was sitting out at bedside with no presenting indications to warrant further recording of clinical observations.'

21. In relation to communication the Trust stated:
'It is recorded in the medical notes that the patient's daughter raised concerns around her father's discharge however after speaking with a FY2 doctor she was happy for the discharge to take place.' The Trust also stated '*It is regrettable that the concerns raised during the day and on the evening of the 14 December 2020 were not addressed in a more considered manner to you and your family.'*

Relevant Independent Professional Advice

Virologist IPA

22. The Investigating Officer asked the Virologist IPA to advise which was most likely, that the patient was discharged with the COVID 19 infection from Altnagelvin hospital (A), caught the COVID infection while he was at home, in transit or when he arrived at the Causeway Hospital (B)?

23. The Virologist IPA advised:
'Based on the information you provided, in my opinion the most likely scenario is that the patient picked up the infection in hospital A.
If the patient was infected in the 10 hour period between discharge from hospital A and admission to hospital B, it is extremely unlikely that the virus would be detected even by RT-qPCR[5] in such a short time following exposure/infection.
For all viruses there is a period between initial exposure/infection and the production of new viruses in the host called the eclipse period. Until the virus starts the production of new viruses in the host, i.e., after the eclipse period, it will not be easily detectable by any means. Evidence from a recent Imperial College London human challenge study preprint[6] suggests that the eclipse period in humans lies somewhere between 36 and 40 hours following infection.'

Physician IPA

24. The Investigating Officer asked the IPA to comment on the blood tests results. He advised that the tests on 7 December 2020 identified Acute Kidney Injury (AKI) and urinary tract infection (UTI) which were appropriately treated. In relation to the tests on 11 December 2020, he advised :
'FBC [full blood count] *was largely normal. Urea and electrolytes were within normal limits as were liver function tests… Sodium was unchanged at 140;*

[5] reverse transcription polymerase chain reaction is a molecular test used to detect the presence of COVID 19
[6] Preprints are defined as an author's version of a research manuscript prior to formal peer review at a journal, which they deposit on a public server https://www.researchsquare.com/article/rs-1121993/v1

potassium was 4.7 and 4.4 respectively on the two dates. Urea was marginally raised on 7/12/20, making him biochemically a bit dry on that date. There was no big change overall. This mild AKI improved by 11/12.20 when the blood test was repeated.'

25. The IPA did not consider it was '*crucial to test his bloods again'* on 14 December 2020. However, he advised that the patient's delirium had not resolved and a PD specialist should have assessed him before discharge.
'The delirium itself was attributed to constipation. The approach then should have been to treat the constipation and thus if possible, to resolve the delirium prior to discharge. This did not happen.
The physiotherapy notes from 14/12/20 is telling, "Struggling with Sit to stand". "Not feeling great." said the patient. It is obvious that the patient was not in fit shape to be discharged at that point.'

26. The IPA referred to NICE guideline CG103 and advised:
'If indicators of delirium are identified, it would be necessary to carry out a clinical assessment based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) criteria or short Confusion Assessment Method (short CAM) to confirm the diagnosis. The guideline also requires that a healthcare professional who is trained and competent in the diagnosis of delirium should carry out the assessment'
He noted that a PD specialist was verbally consulted regarding possible changes to drugs.

27. The Investigating Officer asked the IPA to comment on concerns the patient's family raised to nursing staff by telephone on the morning of 14 December 2020 and the subsequent response from the SHO. He advised:
'The SHO should have recorded the details of his conversation with the family in the notes as well as communicated to the nurses the gist of his conversation with the family. "[daughter] happy after I explained this is likely due ongoing delirium due to AKI/ constipation. Discharge with laxatives". His explanation was erroneous because it had not been proven that delirium was consequent on AKI/constipation alone.

This would be an unsatisfactory discharge because it had not been ascertained that constipation relief with laxatives would have cured his delirium and hallucinations.'

28. The IPA advised:
'As he was still hallucinating and delirious, he should not have been discharged without getting to the bottom of the issue. Or else after satisfying themselves and communicating to the family that the hallucinations were part of his Parkinson's syndrome. The latter may well have been the case...Appropriate referral to a geriatrician and/or a PD specialist may have helped obtain a holistic view of delirium in the context of PD and it may have been managed better.'

29. The records indicate that the patient had a COVID-19 test on 6 December 2020 at 01:05. It was reported as negative at 15.16 on 7 December 2020. The Investigating Officer referred the IPA to the COVID-19 Directorate protocol issued in October 2020 and sought his further advice. He advised:

'*The Northern Ireland directive in October 2020 required that COVID-19 testing be extended to ALL patients in the hospital setting who test negative for COVID-19 on admission. Such patients were to have a further single re-test conducted between 5-7 days after admission to hospital. In this case, the patient attended ED on 5/12/20 and was tested the following day, at 0105 hrs on 6/12/20. The result of this test was negative at 1516 hrs on 7/12/20. The patient was then discharged without a further COVID -19 test on 14/12/20. Hence there was failure to comply with the extant protocol in that a COVID-19 test was not performed between 10/12/20 and 12/12/20 as it should have been between days 5 and 7. The obvious impact of this failure was that it was not ascertained that the patient remained Covid negative when discharged on 14/12/20 from Altnagelvin Hospital; and unfortunately, he was sent home despite being still ill and symptomatic. On arrival at the Coleraine/Causeway Hospital, he tested Covid positive.*

The Trust's response to the Physician IPA advice dated 20 June 2021

30. The Investigating Officer provided the Trust with a copy of the IPA advice (see appendix six). The Trust responded as follows (see appendix seven): *'Patient was reviewed and assessed by medical ST7 on 8 December 2020 and medical plan of care was discussed with the consultant. It was felt that Delirium was multiple factorial due to dehydration, catheter associated urinary tract infection and constipation. Given the patient's presentation and diagnosis we agree [with the IPA advice] that it would have been appropriate to manage under the care of a Geriatrician however the patient was not moved due to current bed pressures. Patient was referred and reviewed by a Geriatrician with a view to review the Parkinson treatment and they had no recommended adjustment to treatment at this time.'*

Analysis and Findings

31. The patient's blood test results from Friday 11 December 2020 were reported on Monday 14 December 2020 and were relatively normal. The NEWS scores were noted to be normal at 08.30 on 14 December 2020. The Trust explained *'Staff are advised to use clinical judgement and seek advice if they have concerns about the patient regardless of the score however it is noted that the patient was sitting out at bedside with no presenting indications to warrant further recording of clinical observations.'*

32. The clinicians were treating the patient's constipation and UTI, which they believed may have caused his delirium, which had not resolved by the time of discharge. I note that the Trust agrees with the IPA that it would have been more appropriate to manage the patient under the care of a Geriatrician in view of his underlying Parkinson's disease. The Trust stated that the patient *'was not moved due to bed pressures,'* however a Geriatrician reviewed him and recommended no adjustment to treatment at that time. I accept the advice of the IPA that it was not clear how much involvement the elderly care team had concerning the diagnosis and management of the patient's delirium. In addition there was no record that a short CAM clinical assessment had been carried out

as required by NICE guidelines. A SHO[7] telephoned the complainant on the day of discharge and explained that the likely cause of the ongoing delirium was constipation. I accept the advice of the IPA that the cause of the delirium was not adequately assessed before discharge. This is a failing in care and treatment.

33. The records show that the complainant's brother and sister spoke to the patient on the telephone on the morning of 14 December 2020. The patient complained to them of feeling unwell and they noted that he was confused. The complainant communicated this to nursing staff later that morning when discussing the proposed discharge. I note that the Mortality and Morbidity Review (M and M) states:
'Family expressed concerns throughout the day and were spoken to by nurses & junior medical staff. Patient was not reviewed medically, and these concerns were not shared with senior medical staff.'
It is a failing that nursing and medical staff did not give sufficient weight to the family's genuine concerns.

34. Nursing staff on duty at the time of discharge were unaware that the doctor had told the complainant that the patient was fit for discharge earlier that day. I accept the advice of the IPA that communication between staff fell below the GMC and NMC standards.

35. The IPA advised that '*the patient remained unwell – confused, delirious, hallucinating and unable to stand or mobilise'.* This was how the complainant found the patient when she arrived at the hospital to take him home. She noted that he was far from his baseline of mobilising independently using a three-wheeled rollator. I find these failings in communication between staff and with the complainant that contributed to the patient's premature discharge caused her the injustice of distress that she was not being listened to.

36. I refer to the DoH protocol which was issued to Health and Social Care Trusts in October 2020. According to this protocol the patient ought to have

[7] A junior doctor in training

been tested again for COVID-19 between 5-7 days after admission to hospital. He was admitted to hospital on 5 December via the ED and to a ward on 7 December 2020. Therefore, he ought to have been retested for COVID-19 prior to discharge on 14 December 2020. It is a failing that this did not happen. This resulted in the injustice of uncertainty about whether the outcome may have been different if his COVID19 infection had been detected sooner. This was also an injustice to the complainant of concern that she and other family members were exposed to COVID 19.

37. I am not satisfied that the Trust carried out appropriate and sufficient assessments to establish whether the patient was medically fit for discharge on 14 December 2020. I find a failing that nursing staff did not repeat observations or check the patient's blood pressure before discharge, despite the family's concerns. I also find a failing that the SHO did not examine the patient and order further blood tests or seek an opinion from a more senior clinician.

38. I accept the advice of the IPA that the patient was sent home despite being still ill and symptomatic and should not have been discharged. The patient therefore suffered the injustice of loss of opportunity for more timely care and treatment. The complainant also suffered the injustice of uncertainty whether the outcome may have been different if the patient had not been discharged.

39. It was also a failing that the ward sister did not readmit the patient on the evening of 14 December 2020 when he was clearly unwell. This was a further missed opportunity for the patient to be reassessed by medical staff. This failure caused the injustice of considerable distress to the patient who had to be readmitted by ambulance to another hospital later that evening and endure the triage process again.

40. The complainant also suffered the anxiety of having to return to ED to find it was extremely busy and there was no one to help her lift her father from the car. I welcome that the Trust acknowledged that the senior nurse ought to have used her discretion to readmit the patient in these circumstances.
I uphold this issue of complaint.

Issue two

Whether the Trust's investigation of the circumstances of the discharge was adequate?

INVESTIGATION

Detail of complaint

41. The complainant said the circumstances into her father's death were not fully investigated.

42. She complained that the Trust did not address failures in her father's care in its response to her complaint; for example, standards in nursing care and the lack of clinical observation prior to discharge have not been adequately addressed.

43. The complainant explained that she requested that the situation would be logged as a serious adverse incident and the nurse agreed to this. However, this did not happen.

Evidence considered

44. I attach extracts from the HSCB procedure for the reporting and follow up of serious adverse incidents (SAI), November 2016, at Appendix 11.

45. I include extracts from the M and M which took place on 13 May 2021 in the Ward 41 seminar room at Altnagelvin Hospital at Appendix eight.

46. I attach extracts from the minutes of the subsequent M and M on 16 December 2021 at Appendix 12.

The Trust's response to investigation enquiries

47. The Trust explained:

'The concerns raised were investigated through the Formal Complaints

Procedure and the Trust issued a response to the Complainant on 8 February 2021. I advise that the opportunity to come back to the Western Trust to re-open this complaint was not an option the complainant availed of.'

48. The Investigating Officer asked what lessons the Trust identified from this case. The Trust stated:
'Many lessons were learnt from this incident.
Communication between medical and nursing teams post take - resulting in new process of nurse in charge/nurse presence on all medical round where possible. When nurse not available for example if multiple post take rounds in progress the medical team will actively feedback actual and potential discharges for that day to nurse in charge of shift. Actual and potential discharges clearly marked on ward flow board. 4pm Board rounds re-established to ensure effective communication.'

49. The Trust provided a further response on 8 December 2021 regarding the 'Datix' which was recommended in the M and M of 13 May 2021. The Datix was raised on 5 October 2021. The record shows that the RRG discussed the incident and made a provisional decision not to proceed with a SEA[8] or SAI. The Trust said the status of the Datix was '*awaiting final approval*' and was to be discussed again at the M and M on 16 December 2021.

50. The Trust provided a copy of the Datix. This contained the record of the discussion of the RRG as follows:
'21.10.21 -RRG Action: NIPSO Complaint -It was agreed that this is not reportable as a SAI and may be downgraded to amber. It was agreed that there is a comprehensive summary within the complaint and Assistant Services Manager should review this before downgrading the incident.'
14.10.21 -RRG Action: Assistant Director will discuss with Assistant Services Manager to enquire what has triggered this complaint to be noted on Datix as an incident. Assistant Director will feed back to Risk Management

[8] Significant event audit

13.10.21 -CSH: This was initially reported as complaint ID8219 which is also with NIPSO. Assistant Director is unsure what has triggered an incident to be reported now. He has planned a meeting with Assistant Services Manager tomorrow to discuss.
07.10.21 -The group noted that this was initially a complaint. The group queried why this has been reported as an incident and query SAI'.

51. The minutes of the M and M on 16 December 2021 did not record any discussion about the proposal to downgrade the incident. The minutes record the action point '*Assistant service manager to check covid policy from October 2020*.' The Investigating Officer invited the Trust to comment on the failing that the patient was discharged without a further COVID-19 test on the evening of 14 December 2020. The Trust's Service Manager declined to offer any comment.

Relevant Independent Professional Advice

52. The complainant stated that the ward sister agreed to a SAI. This was not taken forward. The Investigating Officer asked the IPA if the circumstances of the patient's discharge met the criteria for a SAI. He advised:
'At the time of discharge, it was not known that he had Covid-19. Hence that is not why this was a Serious adverse Incident (SAI). The reason for this being deemed a SAI was because the issue at stake was a patient was being discharged when he was clearly unwell and hence not fit for discharge.'

53. In relation to the delayed M and M, the IPA advised:
'Delays do occur for a variety of reasons and need to be accepted as inevitable. The timing is not crucial. There are lessons that need to be learnt. Hence, it is important the case be discussed even if there is a delay in obtaining that learning.'

Analysis and Findings

54. Section five of the Principles of Good Complaint Handling, 'putting it right' includes *'Acknowledging mistakes and apologising where appropriate'*. I note that the Trust responded to the complaint on 8 February 2021. I attach the Trust's response at Appendix four. The Trust apologised that the nurse in charge did not exercise discretion to readmit the patient to the ward. The Trust stated this was *'an opportunity missed where your father could have been reassessed by medical staff'*. I concur with that statement.

55. The Trust also stated '*It is regrettable that the concerns raised during the day and on the evening of the 14 December 2020 were not addressed in a more considered manner to you and your family'.* I welcome the fact that the Trust identified some learning from this complaint (see Appendices seven and twelve also). I also welcome that the Trust offered to meet with the complainant. However, she declined and brought her complaint to my Office.

56. The complainant said that she asked the nursing staff on 14 December 2020 to investigate by way of a SAI investigation. The HSCB procedure states that an incident that meets the criteria should be reported within 72 hours. The HSCB procedure acknowledges that an SAI and a complaint may coexist and states: *'It is therefore important that complaints handling staff and staff who deal with SAIs communicate effectively and regularly when a complaint is linked to a SAI review. This will ensure that all aspects of the complaint are responded to effectively, via the most appropriate means and in a timely manner.'*

57. It is evident that the Trust gave no consideration to the request at that time and that it was the formal complaint that eventually triggered the subsequent action. This resulted in an unacceptable delay in addressing the complainant's concerns.

58. At Appendix eight I attach extracts of a M and M on 13 May 2021 which states that the patient was not reviewed medically, and that family's concerns were not shared with senior medical staff. It recorded evidence of poor

communication between medical and nursing staff in that the nurses were not aware that the patient was to be discharged. I note the recommendation for the submission of an incident report on DATIX. The M and M was on 13 May 2021 yet the incident report on Datix was not raised until 5 October 2021. This is a further unnecessary and unexplained delay.

59. The record shows that the incident report on Datix was raised on 5 October 2021 and referred to the RRG. The information contained on Datix records that the RRG, and indeed the assistant director, were unclear why the incident was being reported at that time. This suggests to me that the RRG and the assistant director were either inadequately briefed about the gravity of the situation or failed to appraise themselves of the facts. This does not instil confidence about the robustness of the decision taken by the group.

60. It is recorded that the RRG agreed on 21 October 2021 that the incident was not reportable as a SAI and referred it to the Assistant Services Manager to review their decision. This was to be discussed again at a M and M on 16 December 2021. There is no record on the minutes of this meeting that the decision was discussed at that meeting. The Trust did not provide an explanation for this or any other evidence to indicate when this decision was ratified. This is a failing in record keeping.

61. I note that neither the M and M meetings, the incident form recorded on Datix nor the RRG records identified that the patient was not retested for COVID-19 between days 5-7, in accordance with the advice in the DoH protocol that was in force from October 2020. I consider this to be a significant omission from the Trust's investigation. The Investigating Officer invited the Trust to comment on the failing that the patient was discharged without a further COVID-19 test on the evening of 14 December 2020. The Trust's Service Manager declined to offer further comment.

62. The complainant considered that the Trust's response to her complaint did not adequately address standards in nursing care and the lack of clinical observation prior to discharge. The minutes of the M and M on 16 December 2021 record *'When the nurse advised the SHO that the family raised concerns*

the doctor did not assess the patient but reinforced to the family that the patient was discharged to go home. There was little documented when the family raised concerns. The team agrees that the patient should have been examined and bloods carried out'. I consider that this statement is an acknowledgement that the patient should not have been discharged without further assessment. I welcome this admission. However, I am critical that it has taken the Trust a year to clearly articulate it.

63. Section six of the Principles of Good Complaints handling is 'Seeking continuous improvement'. This includes 'Using all feedback and the lessons learnt from complaints to improve service design and delivery'. I find that the Trust's investigation of the circumstances of the patient's discharge was inadequate for the reasons set out in paragraphs 54-62. While some lessons were learned from this complaint, opportunities for further learning were missed. I consider that these failings constitute maladministration and I uphold this issue of complaint.

CONCLUSION

64. I recognise the pain that the complainant and her family experienced over the loss of their father in these circumstances and I wish to offer them my sincere condolences.

65. I also wish to acknowledge the challenges the pandemic had at that time, and continues to have, on health and care services, and the unremitting pressure placed on staff to respond to ever changing situations in an adaptive and co-ordinated way.

66. I investigated the complaint and found failings in relation to the adequacy of the assessments undertaken to assess the patient's delirium and to establish whether the patient was medically fit for discharge on 14 December 2020. I found that the patient should not have been discharged. While we cannot say with certainty the effect premature discharge had on the patient, I believe that this failure in care and treatment caused the injustice to the patient of loss

of opportunity for more timely care and treatment and the distress of having to be taken by ambulance to another hospital and be readmitted through another ED.

67. The complainant also suffered the injustice of uncertainty and upset about whether the outcome for her father might have been different had he remained in hospital on 14 December 2020 for further assessment and treatment. I also agree with the IPA's advice that it was an injustice to the patient that medical staff failed to ascertain whether he remained Covid negative when discharged on 14 December 2020. He was discharged despite remaining ill and symptomatic and he subsequently tested Covid positive. This resulted in uncertainty as to when the patient contracted COVID-19.

68. I also found that the failure to readmit the patient to the ward after discharge on the evening of 14 December 2020 was a further missed opportunity for the patient to be reassessed by medical staff. This repercussions of this failure caused considerable distress to the patient, the complainant and her family. I welcome that the Trust accepted that the nurse ought to have used her discretion to readmit the patient on this occasion.

69. I also found maladministration in relation to the Trust's subsequent investigation of the circumstances of the patient's discharge. I considered that the complainant had a legitimate expectation that the Trust would quickly learn from the failings that led to the patient's premature discharge. From the information available it appears to me that the premature discharge of the patient and subsequent admittance to another hospital a few hours later and his subsequent death met the criteria for an SAI and the circumstances should have been investigated. It is unsatisfactory that the Trust has not concluded its investigation and disseminated the learning from it more than a year after the patient's discharge and subsequent death. It is unacceptable that The Trust has not yet communicated its final decision about conducting an SAI. This caused the injustice to the complainant of frustration that the Trust did not adequately address her complaint in a timely way.

Recommendations

70. I recommend that the Trust issues an apology to the complainant for the injustice caused by the failings I identified. This should include explanations to the complainant regarding the outcome of the consideration of the SIA process and the failure to retest the patient for COVID-19 before discharge.

71. I note that the minutes of the M and M of 16 December 2021 recorded that the Assistant Service Manager was tasked to check the COVID-19 policy in force from October 2020. For service improvement and to prevent future recurrence I recommend that the Trust carries out a review to establish why the DoH protocol advice to retest a patient, who had previously tested negative, between day five and seven, was not followed in this case in December 2020. This review should include an investigation of how DoH protocols, and this one in particular, were communicated to all staff within the Trust.

72. For learning and to prevent future recurrence I recommend that the Trust should reflect on how the nursing and medical staff on ward 41 managed the patient's care and what might have been done differently in this case. The Trust should provide clarity to staff regarding the discretion to readmit a gravely ill patient after premature discharge and provide guidance on how this should be exercised. I also recommend that the doctors and nurses involved be asked to reflect and discuss the case as part of their next appraisal.

73. I also recommend that the Trust discusses the Datix/SIA process with the RRG staff and assistant director who were involved in this investigation to establish whether they were properly informed of the circumstances of the discharge, including the absence of a COVID -19 retest before deciding that an SAI was not appropriate in this case. The Trust should proceed with the plan to discuss the case again at a M and M to decide whether an SAI should proceed.

74. I recommend that the Trust implements an action plan to incorporate these recommendations and provides me with an update **within three months** of the date of this 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. The Trust should provide me with a copy of the relevant procedure for the dissemination of DoH protocols to all staff.

Margaret Kelly **22 June 2022**

Ombudsman

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:

1. Getting it right

- Acting in accordance with the law 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 learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure in the right way and at the right time.

2. Being customer focused

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

3. **Being open and accountable**

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

4. **Acting fairly and proportionately**

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

5. **Putting things right**

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

6. **Seeking continuous improvement**

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