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

Report Reference: 202001434

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

The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

TABLE OF CONTENTS

Page

Case Reference: 202001434

Listed Authority: Southern Health & Social Care Trust

SUMMARY

I received a complaint about the actions of the Southern Health & Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to his father (the patient) in Craigavon Area Hospital (CAH) between 30 October 2018 and 7 November 2018. In particular, the complainant was concerned clinicians failed to recognise the deterioration in the patient's condition while he was recuperating on a ward after surgery for bowel cancer, leading to the patient's death the day after his discharge from CAH.

I found failures in care and treatment in relation to the following matters: the failure to adequately examine the patient's wound when his symptoms indicated a deterioration in his clinical condition; the failure of clinicians to communicate effectively in relation to the patient's symptoms; the failure to correctly record the patient's CRP; the failure to adequately assess the patient before discharge. I concluded that these failings amounted to a loss of opportunity for the patient, which ultimately led to his untimely death.

The investigation also found failures in the Trust's handling of the complaint and its reporting of a Serious Adverse Incident[1].

I recommended the Trust provide the complainant with a written apology for the injustice caused as a result of the failures in care and treatment I identified. I also made recommendations for service improvements and to prevent further recurrence. I recognise this report may be distressing to read and I offer my sympathies to the complainant for the loss of his father.

[1] Serious Adverse Incident: any event or circumstance that led or could have led to unintended or unexpected harm, loss or damage.

THE COMPLAINT

1. The complainant raised concerns about the actions of the Southern Health and Social Care Trust (the Trust) in relation to the care and treatment provided to his father (the patient) at Craigavon Area Hospital (CAH) between 30 October 2018 and 7 November 2018.

Background

2. The patient attended CAH on 30 October 2018 for surgery to remove a cancerous sigmoid tumour[2]. The operation involved the removal of the sigmoid colon by open surgery[3]. The patient's surgical wound began to bleed on 4 November and continued to leak fluid on 5 and 6 November.

3. On 7 November the Trust transferred the patient to CAH's discharge lounge after a doctor found him medically fit for discharge. The complainant took the patient home and assisted him to bed at 22.00. Sadly, the complainant's wife found the patient dead at 08.25 the following morning. The patient's death certificate noted the cause of death as 1(a) small bowel obstruction and necrosis[4], aspiration of gastric contents and pneumonia due to (b) small bowel volvulus[5] following recent sigmoidectomy[6] for bowel cancer

Issues of complaint

4. The issues of complaint accepted for investigation were:

Issue 1: Whether the care and treatment provided to the patient by the Trust between 30 October 2018 and 7 November 2018 was reasonable and in accordance with relevant standards? In particular, this will include consideration of:

[2] Sigmoid colon cancer is a fairly common malignant tumour that affects the area of the large intestine located above the rectum (the sigmoid colon).
[3] The most common type of surgery where a surgeon makes an incision, then performs surgery through that large incision. It is characterised by the staples or stiches used to close the incision.
[4] A finding of several different disease processes characterized by cellular death due to reduced blood flow to the gastrointestinal (GI) tract. The condition can be secondary to vascular occlusion, bowel inflammation, obstruction, or infection
[5] Twisted bowel
[6] Removal of the sigmoid colon

- Decision making around the patient's care and treatment in CAH;
- Communication between clinical staff;
- Recording of blood results;
- Discharge from hospital; and
- Record keeping

Issue 2: Whether the complaints handling by the Trust was appropriate and in accordance with relevant standards?

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 the complainant raised. 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 advisor (IPA):

- **Consultant in general and colorectal surgery** MBChB, MSc, MD, FRCS. A general and colorectal surgeon with over 20 years of clinical experience (G IPA).
- **Registered General Nurse (RGN)**: Diploma in Asthma, Diploma in Chronic Obstructive Pulmonary Disease, BSc (Hons) Nurse Practitioner, MA Health Service Management, V300 Non-medical prescriber Association for Respiratory Technology & Physiology. Spirometry. A senior nurse with 21 years nursing and managerial experience across both primary and secondary care. (N IPA)

7. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'; however how this advice was weighed, 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 make reference to relevant regulatory, professional and statutory guidance.

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

   - 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 Department of Health's (DoH) Guidance in relation to the Health and Social Care Complaints Procedure, Revised April 2019 (the DoH's Complaints Procedure);
   - The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
   - Guidelines and Audit Implementation Network (GAIN) Guidelines on Regional Immediate Discharge Documentation for Patients Being Discharged from Secondary into Primary Care, June 2011 (GAIN discharge guidelines);
   - Health and Social Care Board (HSCB)[8] Procedure for the reporting and follow up of Serious Adverse Incidents April 2010 (HSCB SAI procedure);
   - Nursing & Midwifery Council (NMC) The Code – Standards of Conduct, performance and ethics for nurses and midwives, March 2015 (NMC Code); and

[7] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[8] Known as Strategic Planning and Performance Group from 1 April 2022

- Royal College of Physicians (RCP) National Early Warning Score (NEWS[9]) Standardising the assessment of acute-illness severity in the NHS December 2017 (NEWS).

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

11. I shared a draft copy of this report with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The Trust and the complainant made a number of comments in relation to the findings of the draft report. I sought additional independent advice in relation to several of the issues the Trust raised. The Trust also asked for reconsideration of the report's recommendations on the basis of practical achievability. It made a number of suggestions for actions it could take to improve services in areas where the report found a failing. I considered the Trust's suggestions and amended the recommendations where appropriate.

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the patient by the Trust between 30 October 2018 and 7 November 2018 was reasonable and in accordance with relevant standards?

Decision making around the patient's care and treatment in CAH

Detail of complaint

12. The complainant said the patient's wound began to leak five days after his operation. Clinicians did not appreciate the wound was deteriorating and their failure to do so denied the patient '*an opportunity for reassessment*' of his

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

condition prior to discharge. The Trust cleared the patient for discharge between 3 and 4 November and the care it provided from that point '*was based on the assumption he was suitable to go home*'

Evidence Considered

Legislation/Policies/Guidance

13. I considered the following guidance:
    - GMC guidance;
    - NEWS; and
    - NMC Code

The Trust's response to NIPSO

14. The Trust stated the following: fluid leak from the patient's wound was '*not usually an indication of significant underlying complication following bowel surgery*.' Following bowel surgery, patients were '*likely*' to develop wound infection or a '*degree of dehiscence*[10] *of the abdominal wall*' leading to fluid leak. The patient's Consultant reviewed him on 5 November. The Consultant planned to discharge the patient on 6 November if the wound was dry and to keep his wound clips in place for 14 days. Clinicians reviewed the patient again on 6 November and felt the patient '*was fit for discharge*'. Staff kept the patient in hospital an additional day to allow the family to arrange to care for him at his home.

Relevant Independent Professional Advice

G IPA

15. The G IPA advised the following: between 31 October and 3 November the patient's recovery '*was as per expected*'. On the evening of 4 November, the patient's wound began to bleed and a nurse noted the wound looked like '*it could de-hisc* (sic)'[11]. The patient's wound began to ooze haemoserous fluid[12] on 5 November, which changed to a '*significant amount*' of serous fluid[13] on 6

[10] the separation of a wound due to improper wound healing. This scenario usually occurs 5–8 days following surgery when healing is still in the early stages
[11] Dehisce: to rupture or break open
[12] Fluid coloured with small amounts of blood
[13] Clear fluid

November; this was a '*classic feature*' of wound dehiscence. By the morning of 7 November, the patient was hiccupping. The change in wound discharge from haemoserous fluid to increasing amounts of serous fluid followed by hiccups was an *'indicator of something going wrong*'.

16. Following the nurse's observation on 4 November that it appeared his wound could dehisce '*if clips removed*', a doctor '*should have*' escalated the patient to a Consultant for review. The possibility of dehiscence indicated '*healing* (was) *being prevented to a degree'.* Haemoserous discharge at day five post operation was '*typical of a deeper dehiscence*' and the patient's wound '*need[ed] medical attention*'.

17. The Consultant's plan to keep the patient's clips in situ for a minimum of 14 days without establishing why the wound was discharging fluid was '*unwise*'. This ran the risk '*that a deep dehiscence will be missed*' with an additional risk of infection due to fluid accumulation in the wound. Wound dehiscence could have '*serious consequences*'.

18. The patient's symptoms were *'consistent with developing a wound dehiscence*', which the Trust '*fail[ed] to consider*'. Clinicians '*should have*' closely examined the patient's abdomen to establish if this was the case. The Trust '*could have*' removed some of the patient's clips to help drain the wound and establish the cause of the serous discharge. The Trust could have considered a CT scan. The patient's clinical assessments appeared to lack '*frequent senior clinical input (consultant)*'.

19. The patient's post-mortem '*did not actually highlight a partial dehiscence*'. The cause of death was '*bowel ischaemia*[14]', caused by a *'small bowel volvulus*'. It was '*very unusual*' for a small bowel volvulus to occur so soon after surgery. One way in which a volvulus could develop was when a piece of the bowel became trapped '*e.g. in a partial dehisced deep wound*'. While the post-mortem concluded the blockage arising from the volvulus caused the patient's death, the circumstances that caused the volvulus to occur initially '[were] *not*

[14] Small bowel or mesenteric ischemia may be a life-threatening condition, arising from any one of numerous causes of disturbance of the normal blood flow through the small bowel wall

apparently looked for' or '*established*' and '*this needs to be explained'*. The G IPA clarified that whatever the actual cause of death, the patient's symptoms following surgery were '*warning signs*' that clinicians '*should have… acted upon*'.

20. I asked the G IPA if the Trust's actions in relation to this issue caused the patient detriment. He advised that given his symptoms, the Trust should have taken steps to attempt to establish their cause. Failure to do so and to '*rule out any remediable issue would have detrimental effects*.' It was '*unlikely*' that the volvulus was '*unique and unrelated*' to the patient's symptoms after surgery.

N IPA

21. The N IPA advised the following: there were two occasions when nursing staff '*should have*' referred the patient to the medical team. The first occasion was on 4 November when the patient's wound began to bleed and looked like '*it could de-hisc'.* However, as the patient's NEWS was clinically stable there was no indication for an immediate escalation and it would have been timely to escalate him the next day. A doctor examined the patient at 8.30 the following morning.

22. The patient vomited on the evening of 5 November, but that he *settled*' after nurses gave him medication. The patient felt nauseous again early on the morning of 7 November, however that nursing staff made medical staff '*aware*' of this. On this basis the care nursing staff provided '*was in line with national standards*'.

The Trust's records

23. In response to the complainant's original concerns about the patient's death, the Trust carried out a Significant Event Audit (SEA)[15] in relation to the matter. I examined the SEA report which documents the review team considered that treating clinicians did not appear to show '*any appreciation that the patient's*

[15] A method of formally assessing significant events, with a view to improving patient care and services. The process involves seeking contributions from all members of the healthcare team and a subsequent discussion to answer why the occurrence happened and what lessons can be learned. Events triggering a SEA can be diverse, include both adverse and critical events, as well as good practice

wound was deteriorating'. The review team concluded that had clinicians recognised the deterioration '*it may have provided an opportunity for reassessment of [the patient's] clinical condition including examination of his abdomen*'.

Analysis and Findings

24. The complainant was concerned clinicians treating the patient at CAH did not appreciate the deterioration of his wound. The complainant believed this was due in part to the Trust's assumption that the patient was fit for discharge from 4 November. I note the Trust's response that fluid leaking from a wound following bowel surgery was '*not usually an indication of significant underlying complication*'.

25. I examined the Trust's records which document that on 4 November the patient's wound began to bleed '*after an episode of coughing*'. A nurse noted part of the patient's wound '*looks like it could de-hisc* (sic) *when clips are removed*'. When a consultant reviewed him on 5 November, the patient's wound was *'oozing'.* The wound continued to leak fluid, changing from haemoserous on 6 November to '*straw*' (serous) on 7 November. The notes also document the patient was '*hiccuping* (sic) *this am, slightly nauseated*'. I note nursing staff advised doctors that the patient's wound was leaking as his medical notes from 7 November document '*wound leaking overnight – Eakin dressing*[16] *applied*'.

26. The NMC Code states nurses should '*make a timely referral to another practitioner when any action, care or treatment is required'* The N IPA advised that nursing care in relation to escalation to medical staff '*was in line with national standards*'. I accept this advice. Having considered the clinical notes, the relevant guidance and the N IPA's advice I am satisfied that nursing staff escalated the patient to medical staff in accordance with the guidance.

27. The G IPA advised the change from haemoserous to serous fluid leaking from

[16] A dressing used to contain fluid drainage from wounds

a wound was a '*classic feature*' of wound dehiscence. I note his advice that in addition to the wound leaking, the patient hiccupping was an indication of '*something going wrong*'. The G IPA advised that considering the patient's symptoms, the consultant's plan to keep his wound clips in for 14 days was '*unwise*'. He advised the medical team risked missing a possible '*deep dehiscence*', which could have had '*serious consequences*' for the patient.

28. The G IPA advised that the Trust '*fail[ed] to consider*' a possible wound dehiscence. I note the SEA review team reached a similar conclusion when it found that clinicians did not seem to appreciate '*that the* (patient's) *wound was deteriorating*'. I note the G IPA's advice that the post-mortem did not appear to fully address the origin of the small bowel volvulus that caused the patient's death. However, irrespective of this, the patient's symptoms were '*warning signs*' that should have prompted clinicians to act. In light of this I accept the G IPA's advice that doctors should have carried out a detailed examination of the patient's abdomen '*to rule out any remediable issues*.'

29. In its response to the draft report the Trust stated it did not believe it was '*unwise*' to leave the patient's wound clips in situ for 14 days. The Trust noted the G IPA's '*emphasis*' on wound dehiscence and the '*extensive*' references to it in the draft report. It stated that an examination of the wound showed only a superficial dehiscence. It also noted the coroner did not '*mention*' deep wound dehiscence following the post-mortem.

30. The Trust also stated it was '*well known*' that small bowel obstruction was a '*common*' post-operative complication. It stated the evidence suggested the patient experienced a '*fast and significant deterioration over a period of a few hours'* after discharge. I sought additional advice in relation to this; the G IPA disagreed. He advised the development of the bowel obstruction '*likely*' happened over a '*period of days*' and the patient's symptoms on the ward pointed towards this.

31. I acknowledge the Trust's comments, however I reiterate that both the SEA review and the G IPA independently concluded the Trust failed to appreciate the warning signs that the patient's clinical condition was deteriorating. I note

the Trust did not dispute this in its response.

32. I refer to the GMC Guidance which states '*if you assess, diagnose or treat patients, you must: a**)** adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient; b**)** promptly provide or arrange suitable advice, investigations or treatment where necessary*'.

33. Having considered the clinical notes, the guidance and the IPA's advice, I am satisfied that the failure of clinicians to adequately assess and examine the patient's wound when his symptoms indicated his clinical condition was deteriorating was a failure in care and treatment. I therefore uphold this element of the complaint. I am satisfied that as result of this failure the patient sustained the injustice of the loss of opportunity to have his symptoms adequately considered, to have his wound re-examined and receive additional treatment. The lack of wound management by clinicians is a matter of serious concern and in this case is supported by clear, clinical evidence. I cannot conclude from the evidence available that this failure resulted from the Trust's assumption that the patient was fit for discharge from 3 or 4 November, however I acknowledge the complainant's concern in this regard.

Communication between clinical staff.

Detail of Complaint

34. The complainant was concerned about the number of doctors and nurses responsible for the patient's care during his stay in CAH. He questioned if this allowed for effective communication between clinical staff.

Evidence Considered

Legislation/Policies/Guidance

35. I considered the following guidance:
    - GMC Guidance; and
    - NMC Code

The Trust's response

36. The Trust stated the following: due to '*shift patterns, working hours and other clinical commitments*' it was impossible for nursing and medical staff to provide one on one treatment to patients in the General Surgical Department and Ward. Therefore, clinicians work in teams. At the end of each shift the nursing team on duty provided the incoming team with a verbal and written handover containing '*the salient information*' on each patient on the ward. Each surgical team consisted of four tiers of doctors working at any time. Due to different rotas and shift patterns, it was not unusual for '*at least six to eight doctors*' to be involved in the care of someone who was an inpatient for five days. The Trust emphasised it was ultimately the Consultant leading the team who was responsible for the patient.

Relevant Independent Professional Advice

N IPA

37. The N IPA advised the following: from a nursing point of view the communication between doctors and nurses was '*adequate*'. This was because '*nurses made doctors aware of any concerns*', such as nausea and wound leakage. In relation to communication between nursing staff, as communication between nurses '*is rarely documented within the patient records*' it was difficult to gauge its adequacy. Nurses update each other on patient care during the handover at shift change. The patient's records did not indicate any lapses in nursing care '*which can indicate poor handover*'.

G IPA

38. The G IPA advised the following: several different doctors reviewing a patient during an extended stay in hospital was '*a relatively common event*' across the NHS; therefore '*good documentation and systematic approach*' were important in ensuring continuity of care. The documentation in the patient's medical records '*was not consistent*'. An example of this was fact the patient's medical notes only contain a record of the blood results on 31 October and 2 November, despite clinicians taking the patient's bloods daily. This '*inadequate documentation*' appeared to have led to a breakdown in communication between doctors. This '*very possibly led to the omission of review of bloods'* on

6 November, when a doctor based his assessment of the patient on the incorrect set of blood results.

39. Communication between nursing and medical staff appeared to be '*suboptimal*'. There was a general '*mismatch*' between nursing observations and '*ward round reflections.*' '*Significant events*' recorded by nurses were not reflected in the medical notes. These included '*nausea, vomiting, very distended abdomen, coughing causing wound to bleed* (and) *persistent intermittent oozing of wound*'. These symptoms were '*probable causes of concern'*. A '*failure to recognise the significant* (sic) *of events*' by nursing staff may have caused the communication breakdown. However, it was equally possible the cause was a '*failure of medical staff to be proactive in enquiry on progress*' with nurses and the patient.

Analysis and Findings

40. The complainant was concerned the numbers of doctors and nurses involved in the patient's care led to a breakdown in effective communication between staff. The G IPA advised it was '*relatively common*' for several staff to care for a patient during an extended stay in hospital. I accept the advice of this experienced clinician and I do not consider that the actual number of staff involved in the patient's care was a cause for concern.

41. However, I note the G IPA's advice that effective communication between multiple doctors responsible for a patient's care involves '*good documentation'.* The documentation in the patient's medical notes was '*inadequate*' and '*not consistent*'. The G IPA highlighted doctors' inconsistent recording of the patient's bloods. I accept his advice that this '*inadequate documentation*' appeared to have caused a communication breakdown between doctors.

42. The G IPA advised there was a mismatch between the patient's nursing and medical notes. I examined the patient's records. I note that medical notes did not refer to the patient's distended abdomen, the extent of the fluid loss from his wound, or his nausea, vomiting, or hiccups documented in the nursing notes. The G IPA described these symptoms as '*significant*' and as '*probable*

causes of concern'. I am concerned that the patient's medical notes do not record or refer to these symptoms.

43. The N IPA advised that from a nursing perspective, communication between nursing and medical teams was '*adequate*' because nurses informed doctors of '*any concerns.* I acknowledge the N IPA's advice. However, I also note the G IPA advised that communication between nursing and medical staff appeared to be '*suboptimal*'. He advised the breakdown in communication between nursing and medical staff may have been the nursing team's '*failure to recognise the significant* (sic) *of events*' or the medical team's failure '*to be proactive in enquiry on progress'* with nursing staff and the patient. While it is not possible to be definitive about where the breakdown in communication occurred, I accept the G IPA's advice that it was '*suboptimal*'.

44. I refer to the GMC Guidance which requires doctors to '*share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty'*. In addition, the NMC Code requires nurses to '*maintain effective communication with colleagues*' and to '*share information to identify and reduce risk*'.

45. In summary, having considered the clinical notes, the guidance and both IPAs' advice, I am satisfied communication between individual doctors on the General Surgery Team and between nurses and doctors on the ward was inadequate and not of a reasonable standard. I consider that the failure of clinicians to communicate effectively in relation to the patient's symptoms was a failure in care and treatment. I therefore uphold this element of the complaint. I am satisfied that as result of this failure the patient sustained the injustice of the loss of opportunity to have his condition adequately and appropriately assessed.

Recording of blood results.

Detail of Complaint

46. The complainant said the Trust '*failed to follow hospital procedures*' when recording the patient's blood results. He said clinicians recorded the *'wrong result*' on his father's hospital notes prior to his discharge on 7 November.

Evidence Considered

Legislation/Policies/Guidance

47. I considered the following guidance:

    - GMC Guidance;

The Trust's response to NIPSO

48. The Trust acknowledged clinicians inaccurately recorded the patient's blood results on the day of his discharge. This was '*simply down to human error*'. It clarified that a '*Junior Doctor*' transcribed the results from an electronic system into the patient's paper records. It *'sincerely apologise[d] for the distress this may have caused to the family*'.

The Trust's records

49. The patient's medical records document that on the ward round of 7 November a doctor recorded the patient's C-reactive protein (CRP)[17] level from the previous day as 26. I examined the SEA report which documented the review team found that the doctor had recorded the CRP level from 5 November instead of 6 November. The review team found the patient's CRP had increased from 26 to 104 on 6 November. The review team stated '*it would appear that computerised laboratory records were not checked and the wrong result was documented in [the patient's] written notes*'. It concluded that had medical staff reviewed the correct blood results '*it should have prompted a full assessment*'.

Relevant Independent Professional Advice

50. The G IPA advised the following: the rise in the patient's CRP level on 6 November was '*significant*'. In addition to the rise in the CRP level, the patient's urea level had increased to '*9.8 from a normal level*'. It was '*likely*' the patient's bloods '*were not consistently reviewed and written in the notes*' during ward rounds and that this contributed to the '*error*' in the patient's notes. Another

[17] protein made by the liver. CRP levels in the blood increase when there is a condition causing inflammation somewhere in the body. A CRP test measures the amount of CRP in the blood to detect inflammation due to acute conditions.

contributary factor was clinicians' '*inconsistent recording*' of when they took the patient's bloods.

51. The rise in CRP and urea in addition to persistent serous fluid leak overnight were indicators that '*there would likely need to be further investigation and treatment*', including a repeat of the blood tests and a '*reassessment of the patient*'. The inaccurate blood results were '*likely to cause inappropriate clinical decision making with consequent risk to the patient***.'**

Analysis and findings

52. The Trust's admitted a '*Junior doctor*' recorded the incorrect blood results in the patient's medical notes on 7 November. The patient's notes document the patient's CRP level for 6 November was 26 when it was actually 104. The G IPA advised that this was a '*significant*' rise in the CRP levels.

53. The G IPA advised that the rise in the patient's CRP and urea levels in combination with his existing symptoms should have prompted clinicians to '*reassess…the patient'*. I note the SEA review team reached a similar conclusion. Unfortunately, as doctors based their assessment on an incorrect entry in the medical notes, it is likely this led to what the G IPA advised was '*inappropriate decision making with consequent risk to the patient*'. I accept the G IPA's advice.

54. I acknowledge the Trust's admission that clinicians inaccurately recorded the patient's blood results on the day of his discharge. It subsequently apologised to the complainant and his family. However, I note the Trust's explanation that the mistake was '*simply down to human error'.* The G IPA advised that the patient's bloods '*were not consistently reviewed and written in the notes*' during ward rounds and that this contributed to the doctor's mistake. I accept the G IPA's advice and I am satisfied that while it may have been a junior doctor's '*human error*', that led to the incorrect entry in the patient's notes, clinicians' inconsistent review and recording of the patient's bloods was certainly a contributary factor.

55. I refer to the GMC Guidance which states '*Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards*' and doctors who assess, diagnose or treat patients must: '*adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient'.*

56. I considered the clinical records, the guidance and the G IPA's advice and I am satisfied the failure of clinicians to correctly record the patient's CRP was a failure in care and treatment. I therefore uphold this element of the complaint. I am satisfied that as result of this failure the patient sustained the injustice of the loss of opportunity to have an accurate assessment of his condition which put the patient at risk.

Discharge from hospital

Detail of Complaint

57. The complainant believed the Trust did not follow '*safe discharge procedures'* when it discharged the patient on 7 November. He said the patient was not at his bedside during the ward round of 7 November when clinicians decided he was fit for discharge.

Evidence Considered

Legislation/Policies/Guidance

58. I considered the following guidance
    - GMC Guidance.

The Trust's response to NIPSO.

59. The Trust stated it accepted that the patient's discharge on 7 November 2018 '*should not have taken place*'.

The Trust's records

60. The patient's records document the following: the doctor who reviewed the patient on the ward round of 6 November planned to discharge him that day. The Trust subsequently delayed discharge for one day to allow his family to make the necessary arrangements to care for him at his home.

61. On 7 November, the patient was '*not at bedside*' during the morning ward round. The patient's NEWS was 1 and his CRP was 26. The patient's wound was '*leaking overnight*' and nurses applied an Eakin dressing. The plan was for '*home today*'. The Trust completed the patient's discharge notification at 10.36 and transferred the patient to the discharge lounge later that morning. On 15 November a registrar[18] noted retrospectively that he '*assessed*' the patient in the discharge lounge on 7 November and considered him '*medically fit*' for discharge.

62. The SEA Review team found that had clinicians reviewed the correct set of blood results on 7 November '*it would have likely resulted in an extended stay*' for the patient. It also found clinicians failed to appreciate the deterioration of the patient's wound. The review team concluded that the patient's discharge on 7 December was '*inappropriate*'.

Relevant Independent Professional Advice

63. The G IPA advised the following: the note in the patient's records on 7 November which documented his wound was oozing overnight '*demanded*' that clinicians re-examine the wound. The consultant's plan on 5 November was to discharge the patient '*if wound dry';* overnight '*persistent*' oozing meant '*this was not the case*'.

64. In respect of the Trust's plan to discharge the patient on 7 November, the '*emphasis appears to be on NEWS and bloods*.' These are *'very useful but not always adequate'* as changes can occur which are not always '*in synchrony*' with these readings. There were '*several other indicators*' something was wrong

[18] a doctor in the middle of their training. This is the last stage of training, after being a junior doctor.

with the patient. It was '*a concern*' that clinicians decided to discharge him **'***without a visible review and examination*'.

65. Considering the patient's '*progress and symptoms*', the missed increase in his CRP and urea levels and the '*failure*' of clinicians to '*adequate[ly] examine*' him on 7 November; it was '*unreasonable*' to discharge him on 7 November. The patient died at home the following day and the '*course of events and short time to demise after discharge lead to a conclusion that the events are related to the consequence***'.**

Analysis and Findings

66. The Consultant planned to send the patient home on 5 November if his wound remained dry, but this was not the case. I note the G IPA's strongly expressed view that the persistent serous discharge from the patient's wound overnight on 6 November '*demanded*' that clinicians re-examine him before discharge.

67. The Trust's records document the patient was not at his bedside during the morning ward round of 7 November. The G IPA advised that in his absence, the Trust's plan to send him home placed an '*emphasis*' on his NEWS and (incorrect) blood results. In addition, given the patient's other symptoms, 'it was '*a concern*' that clinicians decided to discharge him '*without a visible review and examination*'. I accept the G IPA's advice. I am extremely concerned the Trust would discharge a patient without carrying out such a review.

68. In summary, the G IPA advised it was '*unreasonable*' for clinicians to consider discharging the patient on 7 November, given his existing symptoms, the '*failure*' to examine him and the incorrect blood results. I accept the G IPA's advice. I note with great concern the patient died shortly after discharge and the G IPA's conclusion '*that the events are related to the consequence*'.

69. The complainant said the Trust did not follow '*safe discharge procedures'* when it discharged the patient on 7 November. I agree with the complainant. I note the Trust, the SEA review team and the G IPA agreed clinicians should not have discharged the patient on 7 November.

70. I refer to the GMC Guidance which states that those clinicians assessing, diagnosing, or treating patients must '*adequately assess the patient's conditions, taking account of their history*'. Having considered the clinical records, the relevant guidance and the G IPA's advice, I am satisfied the Trust's decision to discharge the patient without carrying out an adequate assessment on the ward, or considering his existing symptoms was a failure in care and treatment. I am satisfied as a result of this failure the patient experienced the loss of opportunity to have his condition adequately assessed before discharge and to receive further appropriate care and treatment. I therefore uphold this element of the complaint.

71. I will address the matter of the doctor's retrospective note from 15 November in the section on record keeping.

Record keeping

Detail of complaint

72. A doctor reviewed the patient in the discharge lounge on the afternoon of 7 November and confirmed he was well and fit for discharge. The doctor made a note of the review in the complainant's medical records on 15 November, eight days after his discharge and a week after he died. The complainant asked if this was acceptable practice and questioned the accuracy of the note.

The Trust's response to NIPSO

73. The Trust stated it was '*not uncommon*' for doctors to add retrospective notes to patients' records. The note was '*only*' the individual doctor's recollection of the event and it was '*difficult*' to prove its accuracy.

The Trust's records

74. The records document the Trust transferred the patient to the discharge lounge at 10.50 and the complainant picked him up at 16.00. The final entry in the patient's medical records is a retrospective note dated 15 November 2018. The doctor who completed the note stated he '*assessed*' the patient on 7 November '*in the afternoon*'. He noted the patient was '*clinically well*' and '*medically fit for discharge*'.

Relevant Independent Professional Advice

75. The G IPA raised concerns about the doctor's retrospective note of 15 November which recorded that he examined the patient in the discharge lounge on 7 November. He advised the following: it was '*uncertain*' why the doctor did not make a contemporaneous note of the review. It was '*a concern*' that the doctor made the note '*over a week*' after the patient's discharge and questioned if it was correct. It was '*inappropriate*' and '*inexplicable*' to write a clinical note eight days after the patient's discharge. The contemporaneous nursing records made no reference to a medical examination in the discharge lounge.

76. Even though the patient was not at his bedside during the ward round of 7 November, there was no indication in the medical records a doctor should see him before discharge. Clinicians expressed '*no clinical anxiety*' which would indicate the need to examine the patient in the discharge lounge. A doctor signed the patient's discharge notice prior to his transfer to the discharge lounge. It was '*difficult to ascertain*' if the review took place because the entry '*lacks consistency*' with the notes from the morning ward round and the nursing notes in the discharge lounge. It was '*difficult to reconcile the week-old retrospective documentation with the evidenced documentation'*

Analysis and Findings

77. The complainant was concerned if it was appropriate for the doctor who reviewed the patient in the discharge lounge to record the event eight days after the patient's discharge. The Trust responded that it was '*not uncommon*' for doctors to write retrospective notes in patient records and that it was '*difficult*' to verify the note's accuracy.

78. The G IPA advised it was '*inappropriate*' and '*inexplicable*' for the doctor to write a clinical note eight days after the patient's discharge. I note the GMC Guidance requires doctors to '*make records at the same time as the events you are recording or as soon as possible afterwards'.* The G IPA advised doctors expressed '*no clinical anxiety*' during the ward round with no indication for another patient review before discharge. The nursing records from the

discharge lounge made no reference to the review. Considering these circumstances, the G IPA concluded it was '*difficult to ascertain*' if the doctor reviewed the patient in the discharge lounge. The Investigating Officer contacted the doctor concerned to seek clarity on this issue. He explained he examined the patient on the ward in the morning at the request of a nurse. He stated that previously he '*mistakenly*' referred to the review as occurring in the afternoon which may have caused some '*confusion*'. Irrespective of this, having considered the relevant guidance, I accept the G IPA's advice that it was '*inappropriate*' for a doctor to make the note eight days after the patient's discharge.

79. I consider a failure in maintaining accurate and contemporaneous records impedes the thorough, independent assessment of care provided to patients. I also consider that maintaining accurate and appropriate records affords protection to staff involved in providing patient care by providing a clear record of their actions and the treatment provided. The patient had unfortunately passed away before the doctor made the note, therefore I do not consider this caused him to experience an injustice. However, I am satisfied the Trust's failure to make contemporaneous and accurate records constitutes a service failure.

Residual matters

SEA

Detail of complaint

80. In his response to the draft report, the complainant asked if the Trust could clarify why it initially decided an SEA was not required to investigate the patient's care and '*his unsafe discharge'.* While this question was not originally raised as an issue of complaint, I consider the Trust's actions in this matter and its responses to the complainant and this office to be concerning. I have therefore used my discretion under Section 24 of the 2016 Act to address the issue here.

Evidence Considered

Legislation/Policies/Guidance

81. I considered the following guidance:

- HSCB SAI Procedure.

The Trust's response

82. The Trust stated the following: an initial screening of the patient's death found '*it did not meet the criteria*' of an SEA. It did not commission an SEA until it received the complaint. As the Clinical Governance Team was '*unaware*' of the patient's death until 9 May 2019 there was '*no discussion*' about whether the case met the threshold for an SEA/SAI[19]. The delay '*did not deter from the case being tabled for review*'. In his original complaint the complainant asked the Trust what the '*standard timeframe*' was to '*instigate*' an SEA after the death of patient. The Trust stated there was '*no set timeframe*'.

Analysis and Findings

83. I note the Trust stated it did not commission an SEA until it received a complaint, as prior to this the Clinical Governance Team was unaware of the patient's death. However, it also stated that an initial screening found the patient's death did not meet the criteria for an SEA. This is clearly contradictory. I examined the Trust's complaint file which documents that the General Surgery Team discussed the patient's death following the post-mortem and concluded there were '*no learning points*'.

84. It is evident the Trust was aware of the patient's unexpected death months before the complainant submitted his complaint. The HSCB SAI procedure states '*SAI to be reported within 72 hours of the incident being discovered or in the case of an unexpected/unexplained death'.* I considered the Trust's response that the delay in commissioning an SEA '*did not deter from the case being tabled for review*'. The response does not address the fact that had the complainant not submitted his complaint, the failures in the patient's care would not have come to light. I find this extremely concerning.

[19] Serious Adverse Incident: any event or circumstance that led or could have led to unintended or unexpected harm, loss or damage

85. The First Principle of Good Administration 'Getting it right' requires public bodies to act '*in accordance with the public body's policy and guidance (published or internal)*'. In its failure to report an SAI within 72 hours of the patient's death I consider that the Trust did not meet this standard. I consider this failure to act in accordance with the relevant guidance constitutes maladministration. I will address the Trust's statement that there was *no set timeframe*' to instigate an SEA under the issue of complaint handling.

86. Consequently, I am satisfied the maladministration identified caused the complainant to sustain the injustice of uncertainty and frustration. Therefore, I uphold this additional element of complaint.

Frequency of consultant input

87. I note the G IPA's advice that the patient's clinical assessments on the ward appeared to lack '*frequent senior clinical input'*. Although the frequency of the consultant's input in the patient's care is not a matter the complainant raised in bringing his complaint to me, it is important that I highlight it in this report, particularly considering the lack of adequate assessment of the patient's wound during his stay in CAH.

88. The G IPA recommended that senior clinicians should have more frequent involvement in reviews and assessment as less experienced clinicians may not appreciate the signs of clinical deterioration. I note the Trust's statement that it is the Consultant leading the team who is ultimately responsible for the patient's care. It is my expectation that the Trust will give careful consideration to this matter. In its response to the draft report the Trust stated the '*Surgical Department has recognised the need of ongoing presence and input from Consultant Surgeons in the postoperative care of the patients. A team-based approach in the management of the patients and daily ward rounds has been adopted'.* I welcome the Trust's response and I look forward to the Trust demonstrating how it has implemented this approach and how postoperative care has improved as a result.

Injustice

89. In summary I identified that the patient experienced the loss of opportunity to have his symptoms adequately considered and his wound re-examined; to have an accurate assessment of his condition, to be adequately assessed before discharge and to receive further treatment if necessary. In attempting to determine how these failures affected the patient's outcome, I considered the G IPA's advice. In relation to the Trust's failure to consider the patient's symptoms from 4 November, I note the G IPA advised this '*would have detrimental effects'.* He advised it was '*unlikely*' the small bowel volvulus, identified as the cause of death was '*unique and unrelated*' to the patient's symptoms after surgery. In relation to the patient's discharge the G IPA advised the '*course of events and short time to demise after discharge lead to a conclusion that the events are related to the consequence*'. I accept the G IPA's advice. Therefore, on the balance of probabilities I am satisfied that the losses of opportunity identified led directly to the patient's premature death. As a result of this I am satisfied that the complainant experienced the injustice of distress and uncertainty about the appropriateness of the care and treatment provided to his father up until his death.

Issue 2: **Whether the complaints handling by the Trust was appropriate and in accordance with relevant standards?**

Detail of complaint

90. The complainant said the SEA report the Trust commissioned to investigate the patient's treatment in CAH did not deal with his complaint '*in a satisfactory manner*' and lacked '*empathy*'. The SEA left questions '*unanswered*' and raised additional questions '*that need to be dealt with*'. The review only provided the factual details of the patient's care and treatment and '*fail[ed] to take responsibility*' for the patient's '*unsafe*' discharge and death. The complainant was dissatisfied with the Trust's explanation that the SEA was the end of the complaint process. He also wanted proof the Trust had included the patient's death in 2018 mortality numbers for CAH.

Evidence Considered

Legislation/Policies/Guidance

91. I considered the following guidance:
    - The DoH's Complaints Procedure; and
    - HSCB SAI procedure.

The Trust's response

92. The Trust agreed the SEA review contained '*only factual information*' and did not display the '*compassion required in serious cases.*' It had recently appointed a Family Liaison Team to '*support…families throughout the process*' of SEA investigations, including signposting to bereavement support.

93. In response to the complainant's view that the Trust had not answered his original complaints to his satisfaction and there were additional questions '*that need to be dealt with*', the Trust explained the complaints process at the time the complainant raised his concerns. A complaint would either be dealt with through '*complaints*' or SEA/SAI review. As it was reviewing the patient's care via the SEA process, the initial complaint '*was to be addressed through this investigation process*'. The Trust *'sincerely apologised*' it '*did not respond…*' to the complainant's initial concerns.

94. In its initial response to the complainant the Trust stated it discussed the patient's death '*as if it was an in-hospital death*' so it '*would have*' been included in the 2018 mortality numbers. In its response to this office the Trust explained '*only inpatient deaths are recorded*'. As such the patient's death was '*not recorded*' as part of 2018 mortality numbers.

95. In its response to the complainant's question of what the '*standard timeframe*' was to '*instigate*' an SEA after the death of patient. The Trust stated there was '*no set timeframe*'

Trust records

96. The SEA report documented the patient's medical history from August 2018 and the care and treatment the Trust provided to him in CAH between 30 October 2018 to 7 November. It documented his discharge from CAH on 7 November and his death on 8 November.

97. The report's Learning Summary section found clinicians involved in the patient's care lacked '*appreciation that* (the patient's) *wound was deteriorating*'. It noted doctors '*inaccurately recorded*' the patient's CRP levels on the day of his discharge. It concluded had clinicians recognised these factors, it was '*likely*' they would have extended the patient's stay in hospital. It also concluded the patient's discharge was '*inappropriate*'. The report made a number of recommendations in relation to its findings. The report contained an appendix that answered questions and concerns raised by the family on 8 May 2019 and 5 September 2019.

98. The complainant and his wife attended a meeting with Trust staff on 10 December 2019 to discuss the findings of the SEA report and other concerns raised by the complainant. The minutes of the meeting record that the Trust informed the complainant that the SEA report was '*the final report*'.

Analysis and Findings

99. I note the complainant's concern the Trust had not answered his original complaints to his satisfaction and there were additional questions '*that need to be dealt with*'. I consider that the Trust's response to this office in relation to this matter was incoherent and failed to address the issue in any meaningful way. However, I consider that it was the Trust's response to the complainant that is significant.

100. I examined the Trust's records. In response to the complainant's concerns the Trust commissioned a review of the patient's treatment. The review identified several concerns in respect of the treatment clinicians provided to the patient in CAH during his stay there. It made recommendations in relation to the failures it identified. The complainant asked the Trust a number of questions about the patient's care and treatment in emails he sent on 8 May 2019 and 5 September 2019. I note that in the appendices, the SEA report answered all of the complainant's questions. Following this, the Trust met with the complainant on 10 December 2019 to discuss the findings of the SEA report. I examined the minutes of the meeting and it is evident that the Trust attempted to address the

issues the complainant raised there.

101. However, while the findings of the SEA report and those of the G IPA were broadly similar, there were several significant differences between them. The SEA report did not make any reference to the consultant's plan to keep the patient's clips in for 14 days; a decision the G IPA advised was '*unwise*'. The report did not make any reference to the '*mismatch*' between nursing and medical records, or to the '*inadequate documentation*' in the medical notes. The G IPA advised these issues led to a breakdown in communication between clinicians involved in the patient's care. The report made no reference to the unexplained presence of the small bowel volvulus or offered an explanation as to why it might have occurred. I am surprised and concerned the SEA did not address these points which are central to the concerns about the patient's care and treatment.

102. In relation to the registrar's retrospective note from 15 November, the report states the patient's notes '*document Doctor 10 did assess the patient*' in the discharge lounge on the afternoon of 7 November. The report does not question the accuracy, or appropriateness of the length of time between the patient's date of discharge and the addition of the note and appears to have accepted it was correct without further investigation. I find this extremely concerning.

103. I am further surprised the report makes no attempt to address the question of the patient's death only hours after his discharge from CAH. This is especially concerning as the report previously identified that the patient's wound was deteriorating, his condition required re-assessment and his discharge was inappropriate. The question of why the patient died so soon after discharge from CAH was the complainant's fundamental concern. I agree with the complainant that for this issue at least, the SEA left his question '*unanswered*'.

104. The Fourth Principle of Good Complaint Handling 'Acting fairly and proportionately' requires public bodies to ensure '*that complaints are investigated thoroughly and fairly to establish the facts of the case*'. In its response to the complainant through the SEA report, I do not consider the Trust

meets these standards for the reasons outlined above. I consider this failure to conduct a thorough and accurate investigation constitutes maladministration.

105. In relation to the issue of whether the Trust recorded the patient's death in the 2018 mortality numbers, the Trust told the complainant the patient's death was included in the numbers '*as if it was an in-hospital death*'. I note the Trust's response to this office directly contradicts this. I consider that the response the Trust provided to the complainant in respect of this matter was misleading and untrue. In conversations with my office, the complainant expressed a lack of confidence in the honesty of the Trust's response to his complaint and it is evident from its response to this issue at least that his concerns are justified.

106. In relation to the Trust's response to the complainant that there was '*no set timeframe*' for it to instigate an SAI following the unexpected death of a patient, this is also clearly incorrect. The HSCB guidance specifies that a Trust should report an SAI '*within 72 hours of the incident being discovered or in the case of an unexpected/unexplained death'.* I would expect the Trust to have been aware of this guidance and I consider its response to the complainant is misleading.

107. The Third Principle of Good Complaint Handling 'Being open and accountable' requires public bodies to provide '*honest evidence-based explanations'.* I do not consider the Trust meets these standards for the reasons outlined above. I consider that this failure to provide honest evidence-based answers to the complainant's questions constitutes maladministration.

108. Consequently, I am satisfied the maladministration identified caused the complainant to experience the injustice of upset, frustration, uncertainty and the time and trouble of bringing a complaint to this office. Therefore, I uphold this element of the complaint. I am pleased to note that the Trust agreed to meet with the complainant to discuss his outstanding concerns over the patient's care and treatment in CAH.

CONCLUSION

109. I received a complaint about the actions of the Trust. The complainant raised concerns about the care and treatment the Trust provided to patient in CAH between 30 October 2018 and 7 November 2018. The complaint also concerned the Trust's handling of the complaint.

Issue One

110. The investigation established failures in the care and treatment in relation to the following matters:

- The failure to adequately examine the patient's wound when his symptoms indicated possible deep wound dehiscence;
- The failure of clinicians to communicate effectively in relation to the patient's symptoms;
- The failure to correctly record the patient's CRP;
- The failure to adequately assess the patient before discharge.

111. I am satisfied that the failures in care and treatment identified caused the patient to experience the injustice of the loss of opportunity to have his symptoms adequately considered and his wound re-examined, an accurate assessment of his condition, to be adequately assessed before discharge and to receive further treatment if necessary. It is my view that unfortunately these losses of opportunity led ultimately to the patient's untimely death. I consider that as a result of this the complainant and his wife experienced the injustice of distress. I note that the complainant repeatedly described his father's death as '*traumatic*'. I consider that the experience of finding the patient unresponsive the morning after his discharge must have been extremely distressing for the complainant and his wife and I extend my deepest sympathies to them.

Issue Two

112. The investigation established maladministration in relation to the following matters:

- The failure to conduct a thorough and accurate investigation; and

- The failure to provide honest evidence-based explanations.

Residual matters

113. The investigation established maladministration in relation to the following matters:
    - The failure to follow relevant guidance when reporting an SAI.

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

Recommendations

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

116. I further recommend for service improvement and to prevent future recurrence, the Trust

    - The Trust brings the failures identified in this report regarding the assessment and treatment of post-surgical wounds to the attention of the clinical relevant staff, emphasising the importance of adequate review, consideration of symptoms and escalation to senior staff where necessary;
    - The Trust discusses the findings of the report at senior governance level;
    - The Trust discusses the patient's treatment and outcome at the next General Surgery Morbidity and Mortality meeting;
    - The Trust undertakes a review of SAIs and complaints completed over the previous three years in relation to the General Surgery Ward to identify if poor communication has been a common theme in these areas. Take action to address any identified trends or shortcomings. The

Trust ought to include any recommendations identified in its update to this office. The Trust should report its findings to my office;

- In its response to the draft report the Trust stated it was working on ways to increase availability of electronic results on ward rounds with increasing compliance on electronic sign-off. The Trust should demonstrate the ways in which it has tried to achieve this and provide evidence where possible that ward staff have adopted this approach.
- The Trust brings the failures identified in this report to the relevant medical staff regarding the need for adequate, in-person assessment of patients prior to discharge within three months of the date of my final report;
- The Trust provides staff with training in keeping relevant and accurate records in particular identifying good practice and legislative requirements; Trust staff involved in this case should evidence a reasonable level of reflection of findings in the complaint including discussion of the matter in their next appraisal; and
- The Trust provides evidence that it has reviewed why its own investigation of the complainant's concerns did not identify or acknowledge all the failings highlighted here.

117. I recommend that the Trust implement 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).

118. I am conscious the loss of his father in such circumstances is still extremely painful for the complainant. I can only hope the detail in this report answers some of the many questions he had about the care and treatment his father received in CAH.

MARGARET KELLY
Ombudsman **October 2023**

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.