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

Report Reference: 202001015

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.

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SUMMARY

I received a complaint about the care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's late brother (the patient) from 13 June 2018 to 16 June 2018.

The patient attended the Trust on 13 June 2018 for planned surgery to remove his gall bladder the next day. The patient had a history of hypertension[1], ischemic heart disease[2] and COPD[3]. The patient was admitted a day prior to his surgery in order to perform pre-operative assessments. During the post-operative period the patient developed complications and went into multi-organ failure. The patient sadly passed away on 16 June 2018.

The complainant said the Trust did not carry out the recommended pre-operative assessments, treat the patient as a high-risk patient, and consider a bleed during the post-operative period.

The investigation examined the details of the complaint, the Trust's response, clinical records and relevant guidance. I also sought advice from three independent advisors: Consultant Anaesthetist, Consultant in Intensive Care, and Intensive Care Nurse.

The investigation established a number of serious failures in the care and treatment provided to the patient by the Trust in both pre but more significantly post-operative care.

In particular the investigation found that the Trust did not provide the patient with appropriate post-operative Care.

[1] High blood pressure.
[2] Heart problems caused by narrowed heart arteries.
[3] Chronic Obstructive Pulmonary Disease – a condition that affects respiratory functions and systems.

The Trust failed to monitor the patient appropriately and to recognise quickly enough a significant deterioration in the patient's blood pressure and haemoglobin. As this deterioration continued the Trust failed to consider the diagnostic implications of this and consider that it was potentially a bleed and therefore the need to take further action. I accepted the IPA advice that this failure meant the patient was not provided with the optimal opportunity to recover. I consider the Trust did not avail of the opportunity to perform tests and scans on the patient when he was fit to undergo tests earlier on 15 June 2018. I accept the ICU IPA's advice that if he had received the CT angiogram at 14.00 it would *'have identified bleeding'*, and *'ruled in/out a pulmonary embolism'*. I refer to the GMC Guidance which requires Doctors to *'promptly provide or arrange suitable advice, investigations or treatment where necessary'*.

As a result, I concluded this failure in care and treatment caused the patient to experience an injustice of a loss of opportunity. I also concluded this failure in care and treatment caused the complainant to experience the injustice of distress and uncertainty in the Trust's ability to provide appropriate care and treatment.

The investigation also found failings in the patient's pre-operative care and it was unclear why the patient did not receive physiotherapy and nebulisers on the day prior to surgery as was part of his plan. It was also unclear how the patient's recent chest infection was taken account of in the decision to proceed with surgery. I considered this a failure in the patient's care and treatment.

My investigation also established the Trust's record keeping fell far below the appropriate standard.

I recommended the Trust provide the complainant with a written apology for the injustice caused as a result of the failure in care and treatment. I made further recommendations for the Trust to address under an evidence-supported action plan to instigate service improvement and to prevent further reoccurrence of the failings identified.

THE COMPLAINT

1. I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust). The complaint relates to the care and treatment the Trust provided to the complainant's late brother (the patient) from 13 June 2018 to 16 June 2018 for the removal of his gall bladder.

Background

2. The patient was admitted on 13 June 2018 for elective surgical removal of his gall bladder. The Trust's Consultant Anaesthetist (Anaesthetist A) performed assessments of the patient from 15 January 2018 to 6 February 2018 to decide if the patient was fit for surgery. The results of these assessments included recommendations that the patient may need physiotherapy and potentially nebulisers[4] in both the pre and postoperative period. The patient had a history of hypertension[5], ischemic heart disease[6] and COPD[7]. Anaesthetist A recommended the patient should contact the Trust to reschedule his surgery should he develop a chest infection in the weeks prior to his surgery.

3. A FY1[8] Doctor performed the patient's pre-operative assessments on 13 June 2018 before his scheduled surgery on 14 June 2018. The patient informed the Trust he had a recent chest infection but felt this had improved and was keen to proceed. The FY1 Doctor documented the patient's chest was clear with good air entry. On the following day, the Consultant Anaesthetist (Anaesthetist B) and the Consultant Surgeon (Surgeon A) reviewed the patient and performed a preoperative assessment. The Trust performed surgery to remove the patient's gall bladder on 14 June 2018.

4. Following the surgery, the patient was transferred to the Recovery Ward. During his time within the Recovery Ward, the patient's oxygen levels were low, and required frequent monitoring. At 23.10 on 14 June 2018 the patient was transferred to the Intensive Care Unit (ICU) for respiratory support. Due to the

[4] A nebuliser is a machine that helps you to breathe in medicine as a fine mist through a mask or a mouthpiece.
[5] High blood pressure.
[6] Heart problems caused by narrowed heart arteries.
[7] Chronic Obstructive Pulmonary Disease – a condition that affects respiratory functions and systems.
[8] Foundation Year One Doctor

patient's low oxygen levels and ECG[9] changes, the Trust treated the patient for a Pulmonary Embolism[10] and administered blood thinners. The patient had difficulty recovering in ICU. The patient continued to deteriorate on 15 and 16 June, and sadly passed away on 16 June 2018.

5. The complainant said there was no closure around the patient's death, and the grieving process for their family has been heightened by the anxiety of having to search and fight for answers.

6. The Coroner's Report on 24 June 2022 concluded the patient's cause of death as: bronchopneumonia[11] and multi organ failure in association with COPD, hypertensive heart disease, an intra-abdominal haemorrhage[12] and anti-coagulation[13] therapy following a laparoscopic cholecystectomy[14].

Issue of complaint

7. The issue of complaint accepted for investigation was:

Issue 1: Whether the care and treatment provided by the Trust to the patient from 13 June 2018 to 16 June 2018 was appropriate and in accordance to relevant procedures and guidance.

INVESTIGATION METHODOLOGY

8. 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

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

[9] Electrocardiogram measures electrical activity of the heart to detect cardiac problems.
[10] A condition in which one of the pulmonary arteries in the lungs gets blocked by a blood clot.
[11] Inflammation of the lungs arising in the bronchi or bronchioles.
[12] Bleeding within the abdomen.
[13] Anticoagulants work by interrupting the process involved in the formulation of blood clots.
[14] Surgery to remove a patient's gallbladder.

- Consultant Anaesthetist since 1986 (A IPA). Clinically still practicing including anaesthesia for general surgery. Intensive care consultant 1986 – 2009, but no current ICU activity.
- Consultant in intensive care medicine (ICU IPA), MD MRCP, FRCSEd, FRCEM, FFICM. The IPA looks after elective and emergency patients at high risk of poor outcomes. The IPA has held this role for two decades, and has held roles with responsibility for clinical quality, outcomes and governance. The IPA has also held roles with responsibility for medical services in acute hospitals.
- Registered Nurse, RN DipHE (N PA). The IPA has 18 years' experience in Critical Care Nursing and regularly nurses patients with multi-organ failure.

10. 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 is a matter for my discretion.

Relevant Standards and Guidance

11. 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[15]:

    - The Principles of Good Administration.

12. 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:

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

- The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
- National Institute of Clinical Excellence (NICE), Acutely ill adults in hospital: recognising and responding to deterioration, Clinical guideline CG0 25 July 2007 (NICE Guidance);
- Intensive Care Society Levels of Adult Critical Care Second Edition 2009 (ICS Guidance);
- The Royal Marsden Manual of Clinical Nursing Procedures, 9th Edition, Professional Edition March 2015 (RMM Guidance); and
- Nursing and Midwifery Council (NMC) Code of Conduct 2018 (NMC Code).

13. 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.

14. I shared a draft of this report with the complainant, the Northern Trust and the clinicians whose actions are the subject of the complaint to enable them to comment on its factual accuracy and the reasonableness of my proposed findings and recommendations. The complainant and the Northern Trust submitted comments in response. I considered all the comments I received before finalising this report.

THE INVESTIGATION

Issue 1: Whether the care and treatment provided by the Trust to the patient from 13 June 2018 to 16 June 2018 was appropriate and in accordance to relevant procedures and guidance.

In particular I considered:

- Pre-Operative Assessments;
- Treatment as a High Risk Patient; and
- Post Operation management.

Detail of Complaint

15. The issue of complaint is about the care and treatment the Trust provided to the patient from 13 June 2018 to 16 June 2018. The complainant raised the following concerns:
    - The complainant believed the Trust did not give the patient the best possible chance to come through his surgery successfully;
    - The complainant believed the Trust did not treat the patient as a high-risk patient; and
    - The complainant said the Trust did not treat the patient for a post-operative bleed during the post-operative period. The complainant believed this contributed to the patient's rapid deterioration.

Evidence Considered

Legislation/Policies/Guidance

16. I considered the following policies and guidance:
    - GMC Guidance;
    - NICE Guidance;
    - ICS Guidance;
    - RMM Guidance; and
    - NMC Code.

The Trust's response to investigation enquiries

Pre-Operative Assessments

17. The Trust stated, *'[the patient] had a thorough pre-assessment carried out and whilst it did state on the pre-assessment letter that nebulisers and physiotherapy should be carried out, his chest was documented as clear with good air entry'*. The Trust also stated, *'although the physiotherapy and nebulisers were not given, they may not have changed the outcome'*.

Treatment as a high-risk patient

18. The Trust stated, *'[the patient] was considered a high-risk patient from the outset'*. The Trust also stated, *'[the patient] had a thorough pre-operative assessment and the risks v benefits were discussed and documented; it was [the patient's] preferred choice to proceed with surgery'*.

Post Operation

19. In response to the draft Investigation Report the Trust informed this Office all patients within an ICU/high dependency unit are continuously monitored via a bedside monitoring system and a central monitor with the appropriate alarms and vitals displayed. The Trust explained these electronic observations are pulled across electronically and verified by the nursing staff every two hours as a high dependency patient and hourly as an intensive care patient. The Trust stated the patient was initially a high dependency unit patient, and the documentation of observations was in line with this. The Trust stated the patient received verified observations *'more frequently during his initial stay*[16] *in the critical care unit (ICU)'*.

20. The Trust further stated in response to the draft Investigation Report the patient's haemoglobin level at 17.00 on 15 June *'did not represent a significant fall'*. The Trust stated the drop in blood pressure *'could have signified a change in cardiovascular status or represent the patient sitting up or getting out of bed'*.

21. The Trust stated the patient's deterioration *'was likely multifunctional due to his comorbidities, at the time of consideration of differential diagnosis the emphasis was on a pulmonary embolus, due to the hypoxia*[17]*, tachycardia*[18]*, ECG changes and changes on Echo showing right heart strain'*. The Trust stated the medical staff would have considered a pulmonary embolus to be *'immediately life threatening due to the levels of organ support required and warranted treatment'*. The Trust also stated, *'the anaesthetic and surgical teams reviewed the patient frequently and considered a return to theatre to rule out bleeding or other causes of deterioration. However the patient was not returned to theatre as it was considered as too high of a risk'*.

22. In response to the draft Investigation Report, the Trust stated given the knowledge the staff had at the time, they had a working knowledge of Pulmonary Embolism and all of the patient's observations *'were in keeping with that'*. The medical staff gave the patient the appropriate treatment for the

[16] The patient was admitted to ICU at 23.10 on 14 June 2018.
[17] Hypoxemia is a below-normal level of oxygen in your blood, specifically in the arteries.
[18] A heart rhythm disorder with heartbeats faster than usual.

working diagnosis and there was no indication to undertake *'the high-risk intervention of intubation and transfer for imagining'*.

Relevant Trust records

23. The Trust provided the patient's medical records as well as an explanation of the care and treatment the patient received.

Relevant Independent Professional Advice

Pre-Operative Assessments

IPA – Anaesthetist (A IPA)

24. The A IPA advised the assessments the Trust carried out on 13 and 14 June *'were appropriate and show no obvious signs of active infection/inflammation'*.

25. The A IPA advised the receipt of a physiotherapy assessment and nebulisers may have provided the Trust with information to help determine whether or not to proceed with the patient's surgery. However, *'it is unlikely that physio and nebuliser treatment on one occasion [during the pre-op] stage would have markedly altered the postoperative course'*.
26. The A IPA advised the patient's residual cough and lower oxygen saturation values recorded on the night before his surgery might reflect some residual lung changes from the patient's recent chest infection. The A IPA advised, *'these factors should have been considered by the Anaesthetist on day of operation'*. The A IPA advised the Anaesthetist B may have considered these factors, but the Anaesthetist B did not document this consideration within the patient's medical records. The A IPA advised, *'the patient was seen on the day of operation by the Anaesthetist. There is no documentation of this assessment'*.

Treatment as a high-risk patient

A IPA – Anaesthetist

27. The A IPA advised the patient *'had clearly been identified as a higher risk patient preoperatively'*. The A IPA advised the Trust utilised standard techniques for the patient's surgery and anaesthesia, and closely observed the patient post operatively to support as required.

Post Operation - Recovery Ward

A IPA – Anaesthetist

28. The A IPA advised, *'all appropriate care seems to have been given in recovery'*, and the patient *'was always under close observation'*. The A IPA advised the Trust's *'decision to move from recovery to critical care*[19] *was entirely appropriate'*.

ICU IPA - Intensive Care

29. The ICU IPA advised he could see no issues with the care and treatment the Trust provided to the patient in the Recovery Ward. The ICU IPA advised, *'there was plenty of patient contact and staff response to his symptoms (mainly pain) with the appropriate administration of analgesia.'* The ICU IPA advised there was appropriate staff attendance and note keeping and advised, *'the patient was correctly identified as at risk and moved from the recovery phase to the ward-based care* [level 2 critical care]*'*. The ICU IPA advised the patient received the *'appropriate management plan'* upon checking into the ICU.

30. The ICU IPA advised, *'the patient underwent appropriate post-operative physiotherapy. The patient received nebulised ipratropium*[20] *and salbutamol*[21] *during his post-operative period'*. The ICU IPA advised the impact of this medication to the patient, is unclear and unmeasurable.

Post Operation - Intensive Care Unit

ICU IPA – Intensive Care

31. The ICU IPA advised the Consultant admitted the patient on 14 June 2018 at 23.10 to the ICU for respiratory failure, and he believed the patient could have had a chest infection. The ICU IPA advised he did not see documentation about the risk balance between a chest infection and Pulmonary Embolism, or the risk balance of their treatments.

32. The ICU IPA advised, when the patient was moved to ICU on 14 June 2018, *'the patient was then seen by medical staff including consultants in intensive*

[19] Critical care is provided within an Intensive Care Unit (ICU)
[20] Medication used to open up the patient's medium and large airways in the lungs.
[21] Medication used to treat asthma and other airways-related problems.

care and surgery at approximately 0900, 1200 and 1300 hours [on 15 June 2018]*. No further medical notes were documented until 01.00 hours on 16 June 2018'*. The ICU IPA advised, *'overnight from the 14 June to 15 June 2018 the patient had physiological observations documented hourly as is the usual standard. This was then stepped down to two hourly from 10.00 hours so that for the next 12 hours the patient had a reduction in documented monitoring'*. The ICU IPA advised, *'there was no documentation I could find in the medical or nursing notes that say why this was done'*. The ICU IPA also advised *'it should not matter how frequently patients have their observations verified by a nurse. The continuous monitoring should alert the [staff] to an abnormality'*. The ICU IPA also advised the medical records do not document an evening consultant ward round on 15 June 2018.

33. The ICU IPA advised the patient's blood pressure was recorded at 113/62 mmHg at 14.00 on 15 June 2018. At approximately 16.00 on the same day, the patient's blood pressure was recorded at 106/59 mmHg. On the same day at approximately 18.00 the patient's blood pressure was recorded at 90/53 mmHg. The ICU IPA advised, *'the patient's blood pressure continued to fall in the subsequent hours and remained significantly low (the lowest recorded at 63/42 mmHg). I can find no documented recognition of this or any response between the first fall* [at approximately 16.00] *[…] and the subsequent 9 hours*'.

34. In response to the draft Investigation Report the Trust stated this drop in the patient's blood pressure could have *'signified a change in cardiovascular status or represent the patient sitting up or getting out of bed'*. In response to further enquiries about this matter the ICU IPA advised *'a patient with an unconvincing primary diagnosis with a drop in blood pressure and haemoglobin in the same hour is a patient with a bleed until proven otherwise…to suggest that this was a patient getting out of bed is unsupported by the data provided'*.

35. The ICU IPA advised, *'the next response was a fluid challenge*[22] *at approximately 0100 hours'*. The ICU IPA advised, *'the response to the blood pressure fall was a very modest fluid challenge and initiation of vasopressor'*[23].

[22] A fluid challenge increases cardia output and therefore oxygen delivery.
[23] Medication which causes the constriction of blood vessels.

The ICU IPA advised *'the patient was under resuscitated in terms of fluid volume. The patient was under resuscitated in terms of blood products to correct the clotting dysfunction'*. The ICU IPA also advised, *'no further diagnostic reasoning, or adjustment, was documented at the point of the recognition of the blood pressure drop'*.

36. The ICU IPA advised the patient's time of deterioration was approximately 14.00 on 15 June 2018. The IPA advised at 14.00, *'I believe the patient should have received fluid resuscitation, been intubated and ventilated and undergone a CT pulmonary and abdominal angiogram[24]'*. The ICU IPA advised, at 14.00 the patient was fit to receive the scan if *'sedated and ventilated'*. The ICU IPA advised, *'this would have ruled in/out both a pulmonary embolism and an acute peri-hepatic bleed. This in turn would have altered the approach to anticoagulation and allowed a discussion and decision about an interventional radiology approach to stopping the bleeding and/or a laparotomy[25]'*.

37. The ICU IPA advised, *'unfortunately, by the time action was taken* [by the Trust at 01.00] *to correct the sudden period of hypotension[26] it was too little, too late. I believe that on balance the patient's premorbid state was so poor that he was unable to recover from insult and proceeded to develop multiorgan failure from which he was unable to recover'*. The ICU IPA advised *'I believe that at 0100 on 16th June the patient was likely already too unwell'* to receive tests and scans. The ICU IPA advised if the medical staff preformed these tests on the patient at 14.00, *'it would have altered the process and likely the outcome for the patient'*.

38. Following receipt of the draft Investigation Report the complainant raised concerns about the differences in my report and the SAI[27] report[28]. These differences included: the timing of observations on 15 June 2018, the timing of drops in the patient's haemoglobin levels, and the timing of when the Trust conducted a fluid challenge on 16 June 2018. In response to these concerns

[24] Common test for people with possible heart symptoms.
[25] A type of open surgery of the abdomen to examine the abdomen organs.
[26] Abnormally low blood pressure.
[27] SAI – Serious Adverse Incident is defined as any event or circumstance that led or could have led to unintended or unexpected harm, loss or damage.
[28] A report prepared by the Trust following a Serious Adverse Incident.

the ICU IPA advised the timings in his advice are based on the IntelliVue system[29]. He advised this system *'provides the most precise information and creates time records to the hour to simplify the presentation of data'*.

Nursing ICU (N IPA) – Intensive Care

39. The N IPA advised the patient *'mainly received the appropriate nursing care and actions within the ICU environment'*.

40. The N IPA advised during the evening of 15 June 2018, at 17.33 the patient's haemoglobin level was 121 g/l, and at 22.33 this as 100 g/L. The N IPA advised that during this five hour space the documents record that the patient's blood pressure was dropping *'indicating a deterioration in his condition'*. The N IPA advised there was *'a missed opportunity to increase the frequency of arterial blood gases[30] to monitor many aspects of [the patient's] condition including his haemoglobin levels'*.

41. The N IPA advised the records document the nursing staff assessed the patient's previous arterial blood gases 2-4 hourly, *'this means when [the patient] was deteriorating the frequency of arterial blood gases reduced not increased as recommended'*. The N IPA advised, *'there is no evidence of the deterioration in blood pressure in the nursing documentation'*. The N IPA advised, a *'possible failing is the lack of documentation regarding escalating to a doctor the drop in blood pressure and haemoglobin from 14.00hrs onwards. There is no documentation in the nursing notes evaluating the haemoglobin dropping significantly overnight* [15 June 2018] *and this could indicate a post-operative bleed'*.

Analysis and Findings

Pre-operative assessments

42. The complainant believed the Trust did not follow the patient's recommended pre-operative assessments. In response to the draft Investigation Report the

[29] IntelliVue system is used by clinicians within Trusts in Northern Ireland. This system offers advanced clinical decisions to support a patient's care.
[30] Arterial blood gases is a test to measure a blood's acidity, or pH, and the levels of oxygen and carbon dioxide from an artery.

complainant raised concerns the patient did not receive physiotherapy and nebulisers in the pre-operative period.

43. The Trust stated, *'[the patient] had had a thorough pre-assessment carried out and whilst it did state on the pre-assessment letter that nebulisers and physiotherapy should be carried out, his chest was documented as clear with good air entry* [on 13 June 2018]*'*. The Trust also stated, *'although the* physiotherapy *and nebulisers were not given, they may not have changed the outcome'*. The Trust stated if the patient had not been offered the procedure for the removal of his gall bladder, he would have required emergency surgery for this removal, which would have been higher risk.

44. From 15 January 2018 to 6 February 2018 Anaesthetist A conducted pre-operative assessments of the patient. The results of these assessments included recommendations that the patient may require physiotherapy and potentially nebulisers in both the pre and postoperative period. The medical records document Anaesthetist A recommended the patient should contact the Trust to reschedule his surgery if he had a chest infection in the weeks prior to his surgery.

45. On 13 June 2018 the patient was admitted to hospital a day prior to his elective surgery to enable the Trust to perform pre-operative assessments. The Trust performed temperature, blood pressure, heart rate and respiratory rate assessments and recorded these as normal. The Trust stated the patient informed it of his history of a recent chest infection, but he felt this had improved and was keen to proceed with the surgery. The Trust stated its staff took a blood sample from the patient, which did not show an elevated white cell count, which would indicate infection. The Trust staff assessed the patient's charted oxygen levels as 96% and *'clear with good air entry'*. The medical records do not document the patient receiving physiotherapy and nebulisers prior to his surgery.

46. The medical records document Anaesthetist B reviewed the patient on 14 June 2022, the day of his operation. However, there is no documentation within the

Trust's medical records of this assessment. I note A IPA advised *'there is unfortunately no documentation of further clinical examination or the decision making on the day of the surgery'*.

47. The A IPA advised the Trust's assessments, *'were appropriate and show no obvious signs of active infection/inflammation'*. The A IPA also advised *'the preoperative assessments* [on 13 June 2018] *correctly identified respiratory complications as the most likely overall issue postoperatively'*. The A IPA advised that despite the patient having had a recent chest infection, the assessments did not suggest the patient had a current infection at that time. I accept this advice.

48. I considered all the available evidence, and I am satisfied the Trust carried out the appropriate preoperative tests on the patient. I have considered the concerns the complainant raised in response to the draft Investigation Report, I agree the lack of physio and nebuliser treatment in the absence of a recorded rationale is a failure in the care and treatment of the patient. I do however note the A IPA's advice, *'it is unlikely that physio and nebuliser treatment on one occasion at this stage would have markedly altered the postoperative course'*.

49. I must record my concern about the quality of the patient's medical records. Although this is not a matter the complainant raised in her complaint to me, it is important that I highlight it in this report. I refer to the GMC Guidance which requires all Doctors to include decisions made, and actions agreed, within a patient's medical records. This guidance also requires all Doctors to keep clear and accurate records.

50. I note the medical records do not document Anaesthetist B's decision not to provide physiotherapy and nebulisers to the patient prior to his surgery. There is also no record Anaesthetist B considered the patient's recent chest infection and oxygen saturation levels during his preoperative assessment on 13 June and 14 June 2018. It is, however, clear that the patient consented to proceeding with surgery, and considering the balancing of risks in delaying surgery, I do not question the decision to proceed. I would, however, have

expected to see a record of how Anaesthetist B considered various factors in arriving at the decision to proceed.

51. I am satisfied the Trust's failure in record keeping referred to in paragraphs 49 and 50 above constitutes a failure in the patient's care and treatment. It is my expectation that the Trust will give careful consideration to this matter. It should also carefully consider the need to remind relevant staff of the specific requirement to record assessments and decisions made in relation to a patient's care and treatment. I will refer to this further in the conclusion of the report.

52. In response to the draft Investigation Report, the Trust provided this Office with evidence the Anaesthetic department's record keeping was the subject of the M&M[31] review of the case and was shared with clinicians for learning. I welcome this approach and subsequent learning. The Trust also stated the Anaesthetic Department's record keeping also formed part of the SAI report.

53. Overall, I accept the A IPA's advice that the Trust's preoperative assessments were appropriate; however I am concerned with the lack of records documenting Anaesthetist B's decisions. This is because a patient's medical records are used to ensure clarity for those clinicians who later rely on this information. I partially uphold this element of the complaint in relation to the pre-operative care of the patient.

54. I note the A IPA did not raise any concern the lack of documentation impacted on the standard of care the patient received pre-operatively.

Treatment as a high-risk patient

55. The complainant said the Trust did not treat the patient as a high risk patient.

56. The Trust stated, *'[the patient] was considered a high-risk patient from the outset'*. The Trust explained the patient's medical records document his medical history, and the patient experienced breathing difficulties. Anaesthetist A reviewed the patient on 15 January and 6 February 2018 to conduct pre-

[31] Morbidity and mortality conference which reviews the medical files of a patient whose outcome has been marked by an adverse event such as death or the occurrence of a complication.

operative assessments. During these assessments, Anaesthetist A documented the patient's medical history. The Trust admitted the patient one day prior to his surgery in June to preform further pre-operative assessments. During these pre-operative assessments on 13 June, the patient's oxygen saturations were documented, and it was recorded the patient had a recent chest infection.

57. The A IPA advised the Trust *'had clearly identified [the patient] as a higher risk patient preoperatively'*. The A IPA also advised the Trust identified the patient's risk of respiratory complications at an early stage.

58. I considered all of the available evidence including the advice of the A IPA and I accept the A IPA's advice the Trust *'had clearly identified [the patient] as a higher risk patient preoperatively'*. I also accept the A IPA's advice the Trust's plan to treat the patient as high risk was to *'utilise standard techniques for surgery and anaesthesia and closely observe postoperatively to support as required'*. While I fully understand the complainant's concerns I am satisfied that the Trust did identify the patient as at higher risk and I do not uphold this element of the complaint.

Post Operation

59. The complainant said during the post operative period the patient was treated for a Pulmonary Embolism, and the Trust did not consider the patient had a post-operative bleed. In response to the draft Investigation Report, the complainant did not consider the Trust treated the patient as a high risk patient during the post operative period.

60. The Trust stated the patient's deterioration *'was likely multifunctional due to his comorbidities'*, and the Trust stated, *'emphasis was on a pulmonary embolus, due to the hypoxia, tachycardia, ECG changes and changes on Echo showing right heart strain'*. The Trust stated, *'the anaesthetic and surgical teams reviewed the patient frequently and considered a return to theatre to rule out bleeding or other causes of deterioration. However the patient was not returned to theatre as it was considered as too high of a risk'*.

61. I addressed this element of complaint under Recovery Ward and Intensive Care Unit.

Recovery Ward

62. The Trust's medical records document, following the patient's surgery, the Trust moved the patient to the Recovery Ward. The patient began deteriorating while in the Recovery Ward and required oxygen and monitoring. The patient was admitted to the ICU for critical care at 23.10 on 14 June 2018.

63. The ICU IPA advised, *'the immediate postoperative care in this case was an appropriate standard'*, and the early admission to ICU was *'of an appropriate standard'*.

64. After considering all of the available evidence, I accept the ICU IPA's advice the Trust's immediate postoperative care in the Recovery Ward and admission to ICU was of the *'appropriate standard'*.

Intensive Care Unit

65. The medical records document on 14 June 2018, the Registrar[32] performed an echocardiogram[33], and reviewed the patient's blood results when he was admitted to ICU. The medical records document the Trust observed the patient physiologically overnight on 14 and during 15 June 2018. The medical records also document the Trust stepped this down to two hourly observations from 10.00 on 15 June 2018 for the next twelve hours.

66. The nursing records document the nursing care the patient received in the ICU. This care included: continuous monitoring of his heart rate and rhythm, continuous monitoring of blood pressure, continuous monitoring of body temperature and oxygen saturations.

67. At approximately 14.00 on 15 June 2018, the records document the patient's blood pressure as 113/62 mmHg[34]. The Trust preformed an arterial blood gas

[32] A middle ranking hospital doctor undergoing training as a specialist
[33] An imaging test that uses ultrasound to monitor the heart function.
[34] A blood pressure less than 120/80 mmHg is normal. A blood pressure of 140/90 mmHg or more is too high.

in that hour and it recorded the patient's haemoglobin level as 132g/dL[35]. The medical records document the patient's blood pressure fell to 106/59 mmHg at approximately 16.00, and his haemoglobin level as 121g/dL.

68. The medical records document the patient's blood pressure and haemoglobin levels continued to fall. The patient's blood pressure was recorded as 90/53 mmHg at 18.00, and 65/48 mmHg at 22.00. The medical records document the next recording of the patient's haemoglobin levels taken at 22.33 at 110g/dL. The medicals records evidence ICU Consultant A recorded the fall in the patient's blood pressure at approximately 01.00 on 16 June 2018.

69. At 01.00 on 16 June 2018 the Trust conducted a fluid challenge in response to these falls in blood pressure and haemoglobin, and the patient received treatment for a Pulmonary Embolism. The patient's haemoglobin level was recorded as 82.9 g/L at 05.00. The medical records document the patient's continued deterioration during the day of 16 June 2018, and the nursing documentation reflects this deterioration and treatment given.

70. The patient's medical records document at 10.05 on 16 June 2018 Anaesthetist C reviewed the patient. They further document at 13.00 the patient's organs began to fail and he continued to receive treatment for Pulmonary Embolism. The medical records document the patient passed away at 14.20.

71. Having presented the context above I will now address the medical care and nursing care that was provided to the patient separately below.

(i) Medical Care

72. The NICE guidance states patients in acute hospital setting should have a monitoring plan including physiological observations, presence of comorbidities and agreed treatment plan. The guidelines state the frequency of monitoring should increase if abnormal physiology is detected. The GMC Guidance requires Doctors to record the decisions made and actions agreed within a patient's medical records.

[35] Haemoglobin level in grams per decilitre.

73. Following receipt of the draft Investigation Report the complainant raised concerns about the differences in my report and the SAI report[36]. These differences included: the timing of observations on 15 June 2018, the timing of drops in the patient's haemoglobin levels, and the timing of when the Trust conducted a fluid challenge on 16 June 2018. I sought further ICU IPA advice about this matter. The ICU IPA advised the timings in his advice are based on the IntelliVue system. He advised this system *'provides the most precise information and creates time records to the hour to simplify the presentation of data'*. On this basis I accepted the timings the ICU IPA referred to in relation to the observations.

74. The ICU IPA advised from approximately 14.00 on 15 June 2018, *'there was an unrecognised period of low blood pressure associated with a high heart rate that lasted until approximately 0100 hours on 16 June'*. In response to the draft Investigation Report the Trust stated the drop in the patient's blood pressure to 106/59 mmHg *'did not represent a significant fall'*. The Trust stated this drop in blood pressure *'could have signified a change in cardiovascular status or represent the patient sitting up or getting out of bed'*. In response to further enquiries the ICU IPA advised *'a patient with an unconvincing primary diagnosis with a drop in blood pressure and haemoglobin in the same hour is a patient with a bleed until proven otherwise…to suggest that this was a patient getting out of bed is unsupported by the data provided'*.

75. In response to the draft Investigation Report the Trust stated all patients are monitored via a bedside monitoring system and a central monitor with the appropriate alarms and vitals clearly displayed. The Trust stated the nursing staff verify these observations every two hours in the high dependency unit, and hourly in ICU. The Trust stated the patient's documented observations were in line with the two hourly minimum monitoring, during his high dependency unit stay, and observations occurred more frequently during his initial stay in the ICU. The ICU IPA advised *'it should not matter how frequently patients have their observations verified by a nurse. The continuous monitoring should alert the [staff] to an abnormality'*.

[36] I will refer to this later in the report.

76. The clinical records document the patient was admitted to the ICU on 14 June at 23.10. I also note the clinical records document the patient's verified observations at 10.00, 14.00, 16.00, 18.00 and 22.00 on 15 June 2018. I am not satisfied the medical staff verified the patient's observations hourly after 10.00 on 15 June 2018. I consider this a failure in the patient's care and treatment.

77. The ICU IPA advised at 14.00 on 15 June 2018, the patient *'should have received fluid resuscitation, been intubated and ventilated and undergone a CT pulmonary and abdominal angiogram'*. He also advised the patient would have been fit to receive these tests if sedated and ventilated at 14.00 and, *'it would have ruled in/out both a pulmonary embolism and an acute peri-hepatic*[37] *bleed'*. The ICU IPA advised the patient was not well enough to receive these tests at 01.00 on 16 June 2018.

78. In response to further enquires I acknowledge the ICU IPA advised *'whilst I agree that the whole picture could have been a post operative pulmonary embolus, no consideration is documented as to an alternative diagnosis or work up'*. Given there is no documentation I am satisfied in this circumstance this consideration did not take place and does not change my findings outlined below.

79. In response to the draft Investigation Report the Trust also stated, given the knowledge at the time (14.00) the medical staff felt the patient's symptoms were in line with a Pulmonary Embolism. There was no indication to undertake the high-risk intervention of intubation and transfer for imagining. The Trust explained *'whilst intubation and transfer for imagining at 14.00 may have been possible it was a high-risk intervention that would have only ruled out/in a PE at that time'*. The Trust stated the patient was already receiving treatment for a Pulmonary Embolism and at this time there was no reason for medical staff to be concerned about active bleeding.

[37] Area around the liver.

80. The ICU IPA advised when Consultant A recognised the patient's deterioration at 01.00 on 16 June 2018, the patient was *'under resuscitated in terms of fluid volume and blood products to correct the clotting dysfunction'*. The ICU IPA advised *'by the time action was taken to correct the sudden period of hypotension it was too little, too late'*. The ICU IPA further advised, *'the patient's premorbid state was so poor he was unable to recover from insult and proceeded to develop multi organ failure from which he was unable to recover'*.

81. I am concerned staff failed to react to the patient's fall in blood pressure, and haemoglobin levels, and did not perform the tests the ICU IPA referred to at a time when the patient first started to deteriorate. The ICU IPA identified the patient began to deteriorate at 14.00 on 15 June 2018. I consider these failings a failure in the patient's care and treatment.

82. I must note my concern regarding the quality of the patient's medical records during his time in the ICU. I note the ICU IPA advised the patient's medical records document the medical staff's monitoring frequency was reduced to two hourly on 15 June 2018 without a documented order and a rationale stating why this was done. The ICU IPA also advised the medical staff also did not document a consideration of a Pulmonary Embolus and the patient remained on a two *'hourly vital sign recording despite the next observation set showing a tachycardia and further drop in blood pressure'*. I accept the ICU IPA's advice *'as a minimum, observation frequency ought to have been increased to hourly from 14.00 on 15 June and around 16.00 hour that day'*. I also accept the ICU IPA's advice the Trust ought to have documented a *'review and re-consideration of whether the diagnosis was correct'*.

83. The ICU IPA also advised there is no record within the medical records of an evening consultant ward round on the evening of 15 June 2018. I note the ICU IPA advised there is a lack records documenting the risk balance between the two different diagnoses, and/or the risk balance of their treatments.

84. I refer to the GMC guidance which requires doctors to maintain full and accurate records. I consider the lack of these records referred to above a failure in the patient's care and treatment.

85. I considered all of the available evidence, including the advice of the ICU IPA. I consider the Trust did not avail of the opportunity to perform tests and scans on the patient when he was fit to undergo tests earlier on 15 June 2018. I accept the ICU IPA's advice that if he had received the CT angiogram at 14.00 it would *'have identified bleeding'*, and *'ruled in/out a pulmonary embolism'*. I refer to the GMC Guidance which requires Doctors to *'promptly provide or arrange suitable advice, investigations or treatment where necessary'*. I do not consider the post operative care of the patient in the ICU was appropriate. I also consider the patient's ICU medical records fell below the expected standard. I uphold this element of the complaint.

(ii) Nursing Care

86. The NMC code requires nursing staff to keep clear and accurate records. The NMC code also requires nursing staff to *'accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care'*.

87. I considered all the available evidence, including the advice of the N IPA. I accept the N IPA's advice that, *'failings in the lack of monitoring of arterial blood gases at a critical moment in [the patient's] condition is evident*'. I am critical that nursing staff did not follow national standards in relation to monitoring and escalation of the patient's condition. Based on this I am satisfied the nursing staff did not escalate the patient's condition to a Doctor. I consider this a failing in the patient's care and treatment.

88. I am concerned about the absence of some of the documentation within the Trust's records. The N IPA advised the lack of documentation regarding the escalation of the drop in blood pressure and haemoglobin was a possible failing. The N IPA advised there is no documentation within the nursing notes of the evaluation of the patient's haemoglobin, nor is there documentation of a discussion held between the Doctors and the nursing staff of whether the administration of an anticoagulant remained appropriate. I refer to the NMC code which requires medical staff to maintain full and accurate records. I consider the lack of these records within the Trust's medical documentation a

failure in the patient's care and treatment. I uphold this element of the complaint.

89. In relation to both the medical and nursing care failings the Trust stated *'we appreciate the independent reviewer's comments and understand that there can be difference in clinical opinion and risk assessment…the Trust has previously acknowledged the need for improved documentation in the clinical notes including consideration of differential diagnoses (particularly haemorrhage in setting of post-surgical patient with a falling haemoglobin and change in cardiovascular status)'*. I welcome this commitment.

Injustice

90. I acknowledge the advice of the N IPA that it is difficult to comment on whether the failings identified would have ultimately changed the outcome for the patient. I consider the failings in care and treatment identified caused the patient to sustain the injustice of a loss of opportunity to receive earlier treatment which the ICU IPA advised *'would have altered the process and likely the outcome for the patient'*.

91. I consider the failings in care and treatment caused the complainant to suffer distress and uncertainty. This is because the complainant will always question if the patient had received the appropriate care and treatment at the right time, the outcome may have been different.

92. I would have expected the SAI investigation to highlight the failings identified within this report. I remain concerned these failures in care and treatment and the poor standard of records were not highlighted within the SAI report. In response to the draft Investigation Report the Trust stated it reviewed its SAI report and whilst it identified learning it also referenced several areas of *'suboptimal documentation'*; it acknowledged increased emphasis could have been placed on these deficits in documentation within the report's conclusion and recommendations.

CONCLUSION

93. I received a complaint about the care and treatment provided to the patient in June 2018, following the removal of his gallbladder. I upheld elements of the complaint for the reasons outlined in this report. I considered the failures identified constituted a failure in the patient's care and treatment. I also found the record keeping for this case of a poor standard. It is clear from my investigation that the patient presented as at higher risk and this was understood. While it is not clear why physio and nebuliser treatment did not take place it was reasonable to proceed with surgery despite the recent chest infection. The decision on whether to proceed with surgery or delay involved a balancing of risks and I consider the decision to proceed with surgery was reasonable. The initial post operative care of the patient was reasonable. However when the patients condition began to deteriorate at 14.00 hours on the 15 June 2018 this deterioration was not identified and the treatment given was 'too little too late' with no evidence of a differential diagnosis of a bleed being consider. The patient therefore did not receive the optimal level of treatment and based on the advice received on the balance of probabilities this affected the outcome.

94. In response to the draft Investigation Report the Trust advised this Office that since the patient was in the critical care unit/ICU, it made several improvements to the service which go in some way to address my recommendations. The Trust advised this Office that some of these improvements include:

- *'Medical staffing levels have improved with 24/7 junior medical cover in ICU, previously they would have covered theatres, resus, ICU and delivery suite. This provides easier access to medical advice and for escalation when a patient's condition changes.*
- *The ICU consultants are providing late evening ward rounds as part of their job plans.*
- *The importance of considering acute haemorrhage in this setting as a differential diagnosis has been shared with the surgical, anaesthetic and ICU teams'*.

95. I recognise the impact of the failures identified had on both the patient and the complainant. I especially recognise the distressing situation for the patient and his family during the post-operative period. The patient sadly passed away on 16 June 2018. I offer my condolences to the complainant for the loss of her brother.

Recommendations

96. I recommend the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failures identified within **one month** of the date of this report.

97. I further recommend for service improvement and to prevent future recurrence that:

i) All clinicians involved in the patient's care and treatment should evidence a reasonable level of reflection upon the issues raised in this complaint, with particular reference to the themes set out in the Analysis section of the report, including a discussion of the matter at their next appraisal.

ii) The Trust ensures that all clinicians involved in the patient's care are reminded of the importance of frequently monitoring a patient's blood pressure and haemoglobin levels in an ICU setting and advising staff to increase the frequency of observations/interventions when caring for a patient that is displaying signs of deterioration.

iii) The Trust's Medical Director should review the report and consider whether any of the issues raised warrant a referral of any relevant clinician to the GMC.

iv) The Trust should reflect on the ICU IPA's advice about the standard response to alerts in a patient's blood pressure drop and the escalation pathways and conduct a review of the current approach. The Trust should report back to me on the outcome of the review.

v) All nursing staff involved in the patient's care and treatment have the opportunity to consider the findings in this report and demonstrate

how they have reflected on how they can improve their practice in the future.

vi) The Trust should reflect on the N IPA's advice about the importance of record keeping, and education in the frequency of observations and interventions.

vii) The Trust undertakes an audit using a random sampling of ICU records. The audit should assess if the records contain the following: appropriate monitoring of a patient's haemoglobin and blood pressure levels, observations/interventions of the fall in a patient's haemoglobin and blood pressure levels, full and accurate medical records which include discussions amongst medical staff regarding the patient's care and treatment and justification for decisions taken. The Trust should take action to address any identified trends or shortcomings and include any recommendations identified in its update to this office.

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

Margaret Kelly
Ombudsman **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.