Investigation Report

Investigation of a complaint against Northern Health & Social Care Trust

NIPSO Reference: 202000844

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Case Reference: 202000844

Listed Authority: Northern Health & Social Care Trust

SUMMARY

This complaint was about care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's late father (the patient) from October to December 2019. It also related to medical staff's communication with the complainant.

The investigation considered evidence obtained from the complainant and the Trust. It also considered independent medical advice from a consultant of haematology and a senior nurse. The investigation found the care and treatment provided to the patient appropriate.

In relation to communication, the complainant was concerned staff spoke to the patient about his prognosis and end of life care without her present. I found that in doing so, staff acted in accordance with relevant guidance. However, the investigation found medical staff did not appropriately consider or respond to the complainant's request for information for a period of six days. I considered this maladministration. I was satisfied the failure caused the complainant frustration and uncertainty.

I recommended the Trust apologise to the complainant for the failure identified and made recommendations to prevent it recurring. I recognised the grief and loss the complainant experienced during this time. I also offered my sincere condolences to the complainant for the sad loss of her father.

THE COMPLAINT

1. I received a complaint about care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's father (the patient) between October and December 2019. It was also about its communication with the complainant as the patient's next of kin.

Background

2. The patient had a diagnosis of myelodysplasia[1] (MDS) and regularly attended a haematologist[2] in Antrim Area Hospital (AAH). On 24 October 2019, the patient told the Trust's chemotherapy helpline he was experiencing severe abdominal pain. He attended AAH and staff diagnosed him with neutropenic sepsis[3] and admitted him to ward C7[4]. The patient remained in hospital until 4 November 2019 when he discharged himself. The medical team did not diagnose the cause of his abdominal pain prior to his discharge.

3. The patient returned to hospital by ambulance on 18 November 2019, again complaining of abdominal pain. Following a computed tomography[5] (CT) scan of the patient's abdomen, the Trust diagnosed him with diverticulitis[6] and neutropenic sepsis. Staff admitted the patient to ward C6[7] of AAH.

4. The patient remained on ward C6 receiving care and treatment from a surgical consultant with input from the haematology team. The Haematology Consultant transferred the patient to his care on 9 December 2019 and moved him to ward C7 later that evening. The patient's condition deteriorated during his admission and he sadly died on 13 December 2019.

Issues of complaint

5. I accepted the following issues of complaint for investigation:

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[1] A type of rare blood cancer where the patient does not have enough healthy blood cells.
[2] Haematologists diagnose and clinically manage disorders of the blood and bone marrow.
[3] A reaction to an infection, which can happen in patients with neutropenia (low level of neutrophils in the blood). Neutrophils are a type of white blood cell.
[4] A haematology ward.
[5] A medical imaging technique used in radiology to get detailed images of the body non-invasively for diagnostic purposes.
[6] A digestive condition that affects the large intestine (bowel). Diverticula are small bulges or pockets that can develop in the lining of the intestine.
[7] A non-haematology ward.

Issue 1: Whether staff of Antrim Area Hospital provided appropriate care and treatment to the patient from October to December 2019.

Issue 2: Whether medical staff of Antrim Area Hospital appropriately communicated with the complainant between October to December 2019.

INVESTIGATION METHODOLOGY

6. 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 complaints process.

Independent Professional Advice Sought

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

    - A Consultant Haematologist, MB BS FRCP FRCPath MBA; with over 30 years' experience in the field of haematology (H IPA); and
    - A senior nurse BSc, MSc, MA, RGN; with 21 years nursing and managerial experience across both primary and secondary care (N IPA).

    The clinical advice received is enclosed at Appendix two to this report.

8. The information and advice which informed the findings and conclusions are included within the body of this report and its appendices. The IPA(s) provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

9. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those 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[8]:

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

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

    The specific standards and guidance relevant to this complaint are:

    - The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
    - The General Medical Council's (GMC) Confidentiality: Good practice in handling patient information, updated May 2018 (the GMC Guidance for Confidentiality);
    - The Nursing and Midwifery Council's The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, updated October 2018 (NMC Code);
    - The National Institute of Health and Care Excellence's Care of dying adults in the last days of life, NICE Guideline 31, December 2015 (NICE NG31); and
    - The Northern Health and Social Care Trust's Palliative Care Services (Specialist) Operational Policy, April 2019 (the Trust's Palliative Care policy).

    Relevant sections of the guidance considered are enclosed at Appendix three to this report.

11. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

12. A draft copy of this report was shared with the complainant and the Trust for

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

comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether staff of Antrim Area Hospital provided appropriate care and treatment to the patient from October to December 2019.

Detail of Complaint

Diagnosis of diverticulitis

13. The complainant raised concerns that the Trust did not diagnose the patient's diverticulitis disease until more than three weeks after the patient first reported abdominal pain. She said the Trust failed to undertake appropriate tests during that period to diagnose the cause of the patient's abdominal pain.

Delay in transfer to ward C7

14. In relation to the patient's second admission to AAH, the complainant said the decision to admit him to ward C6 was not appropriate. She described it as '*noisy*' and said it did not provide the care the patient required. She said nursing staff '*lacked professionalism*' and made Christmas decorations instead of providing care and treatment. The complainant explained she first asked the Trust to transfer the patient to ward C7 on 23 November 2019. However, it did not do so until 9 December 2019.

End of life care

15. The complainant raised further concerns about the end of life care provided to the patient. She explained that on one occasion the patient had to *'urinate into a cup*', as staff were not available to assist him to the toilet. The complainant said when the Trust considered discharging the patient, she asked if it could discharge him to a hospice. However, the Trust informed her the patient did not meet the criteria for a hospice bed.

Evidence Considered

Legislation/Policies/Guidance

16. I considered the following policy and guidance:

- GMC Guidance;
- NMC Code;
- NICE NG31; and
- The Trust's Palliative Care policy.

The Trust's response to investigation enquiries

Diagnosis of diverticulitis

17. The Trust explained that an abdominal x-ray and ultrasound scan performed on the patient following his first admission did not show anything *'significant*'. It said the patient's infection markers improved with antibiotics and he reported his symptoms had settled. He also told staff he wanted to return home.

18. The Trust explained it diagnosed diverticulitis following a CT scan performed on 18 November 2019. It said '*there was no delay in reaching this diagnosi*s'.

Delay in transfer to ward C7

19. The Trust explained it admitted the patient to ward C6 on 18 November 2019 under the care of the surgical team based on its diagnosis of diverticulitis. It said that due to the patient's underlying haematology condition, the haematology team had input into his care.

20. Regarding the complainant's concern about the nursing staff's conduct on ward C6, the Trust referred to its meeting with the complainant. It explained that during the meeting it apologised that '*the standard of care was not of the high standard we expect*'. The Trust explained ward C6 is a *'busy acute surgical ward*' and acknowledged the ward can be '*very noisy*'.

21. The Trust explained the Haematology Consultant took over the patient's care '*when his symptoms settled and it was clear [he] did not need surgery*'. It said it arranged transfer to Ward C7 as soon as a suitable bed became available. It considered '*there was no delay*' in transferring the patient to ward C7.

22. The Trust said its bed availability records show there was one bed available on the ward on 5 December 2019. However, it explained there may have been another patient who was more in need of the bed. It also said that it runs the

bed availability reports at midnight. Therefore, while a bed shows as being available, staff may have been preparing it for a patient.

End of life care

23. The Trust said it '*disputed*' the complainant's view that staff did not provide appropriate end of life care to the patient. It said staff have undergone end of life care training for '*many years*'.

24. In relation to the concern about hospice care, the Trust explained '*it is not practice to simply send patients to a Hospice to wait for them to die*'. It further explained it is not always possible to determine when death will occur. Therefore, '*occupying a hospice bed may not be the most appropriate course of action*'. The Trust said the palliative care team require '*a specific reason*' to take over the care of a patient. It explained '*an expectation that someone is dying is not an adequate reason due to their limited bed capacity*'. The Trust explained nursing staff are trained to care for patients with palliative needs. It said those *'patients who have complex, unresolved needs, may continue on to a specialist care ward such as the Macmillan Unit or hospice*'.

25. The Trust explained staff referred the patient for palliative care on 5 November 2019. It said the Specialist Palliative Care Nurse (SPCN) discussed the referral with the team at that time. However, they did not consider the patient required specialist palliative care. I also referred the Trust to the second referral on 25 November 2019, which led to the SPCN's attendance on 27 November 2019. The Trust explained the haematology team agreed the patient did not require specialist palliative care at that specific time. However, they would consider a bed in the Macmillan Unit when required. The Trust said the haematology team referred the patient for palliative care on 10 December 2019. It explained it commenced palliative care treatment for the patient prior to SPCN involvement. It said the patient *'passed away peacefully*'.

Relevant Trust records

26. A summary of the relevant records is enclosed at Appendix 4 to this report.

Relevant Independent Professional Advice

H IPA – Diagnosis of diverticulitis

27. The H IPA advised staff performed '*routine and appropriate investigations*' for the patient. These included an abdominal x-ray on 1 November 2019 and an abdominal ultrasound on 3 November 2019. The H IPA advised the tests indicated the patient was at risk of neutropenic sepsis. He advised the chest x-ray showed that a chest infection may have been the source of the neutropenic sepsis. The H IPA advised the patient's symptoms '*would not specifically point towards a bowel origin for infection*'. However, the treatment provided would have covered bowel infection.

28. The H IPA advised the patient's GP queried diverticulitis prior to his admission to hospital. He said staff formally diagnosed the condition following the patient undergoing a CT scan on 18 November 2019. He advised an earlier CT scan (and diagnosis) would not have changed staff's management of the patient's symptoms, as the treatment already covered symptoms of diverticulitis. He further advised that surgery was not an option for the patient due to his existing MDS diagnosis.

H IPA – Delay in transfer to Ward C7

29. The H IPA advised that diverticulitis is generally managed on a surgical ward. Therefore, the decision to admit the patient to a surgical ward (C6) with input from the haematology team was '*acceptable*'.

30. The H IPA advised the Trust could have decided to transfer the patient to ward C7 earlier. However, he did not consider there was a '*need*' to do so. He advised the Trust expected to discharge the patient up until 28 November 2019. However, it decided to keep him in hospital. He advised '*there was no clear reason to think that his medical care would be improved by a move'*.

31. The H IPA further advised that once the patient completed his treatment for diverticulitis, he was '*no longer a predominantly surgical case'*. He said the haematology team made the decision to transfer the patient to ward C7 from 3 December 2019. However, the availability of a bed prevented the team from doing so until 9 December 2019. He advised the haematology team undertook

regular senior reviews of the patient up until his transfer, which he considered a '*satisfactory situation*'.

H IPA – End of life care

32. The H IPA advised the patient required end of life care rather than specialist palliative care. He said the patient did not meet the '*urgent*' criterion outlined in the Trust's Palliative Care policy. Therefore, it was appropriate not to transfer him to the MacMillan Unit or a hospice earlier. He advised an earlier transfer would not have '*materially affected the quality of end of life care that he received*'. The H IPA advised that based on the records, the '*symptom control was excellent and that his end-of-life care was optimal*'.

N IPA - Delay in transfer to Ward C7

33. The N IPA advised the records did not document that staff asked the patient to use a cup to collect his urine or that staff were aware of an incident where he had to do so.

34. I referred the N IPA to the records which document that nursing staff kept the patient's door open to monitor him. I asked if there were any additional actions staff could have taken. She said the patient required a side room due to his high risk of infection. She advised '*it was therefore appropriate to leave the door open so that he was more visible to nursing staff*'. The N IPA advised other actions staff could have taken included *'increasing the frequency of comfort rounds and allowing open visiting of family*'. She said staff encouraged open visiting from 6 December 2021. However, this was due to the patient's end of life status. The N IPA also advised staff ordered one to one supervision if the patient is a risk to themselves or others. She advised that in summary, she had '*no concerns regarding the actions taken by nursing staff in assisting the patient with his toileting needs*'.

35. I referred the N IPA to the complainant's concerns about the professionalism of the nursing staff. She outlined the care provided to the patient and advised she could see '*no lapses in nursing care over this timeframe*'. The N IPA further advised the records did not document '*any concerns regarding the noise levels affecting him [the patient] during his admission to C6*'. She advised the nursing

staff's actions '*were appropriate and due to the nature of the ward…it would not be practical to implement other interventions*'.

36. The N IPA advised nursing staff received instruction from the medical team on 3 December 2019 to transfer the patient to ward C7 when a bed became available. She further advised the bed availability records document there was one bed available on 5 December 2019. However, '*there is no way of knowing which patient had the greatest need for that bed…at that time*'. The N IPA advised a bed became available on 9 December 2019, which was the date staff transferred the patient.

37. I asked the N IPA if nursing staff checked bed availability on ward C7 daily. She advised the records document staff regularly checked the possibility of transfer from 4 December 2019. The N IPA further advised a nurse practitioner also contacted the bed manager in an attempt to source a bed. She advised the staff's actions were in accordance with the NMC Code.

N IPA – End of life care

38. I asked the N IPA about end of life care nursing staff provided to the patient. She advised staff referred the patient to the palliative care team on 25 November 2019. The N IPA referred to the Trust's guidance and advised the patient's consultant must agree with the referral, which he did not.

39. I asked the N IPA about the complainant's request to transfer the patient to a hospice upon discharge. She advised the patient informed staff on 30 November 2019 that he did not want them to refer him to a social worker or to Macmillan, but requested a discharge home. She further advised that on 2 December 2019, the patient informing staff '*he did not want to go to a Hospice*'. The N IPA advised the patient's wishes '*take priority*'. Therefore, the only required action at that time was '*to document the discussion*'. She added, *'the patient cannot be discharged to a hospice without consenting*'. The N IPA advised nursing staff referred the matter to the palliative care team, which she considered '*appropriate*'.

The complainant's response to the draft report

Delay in transfer to Ward C7

40. The complainant said staff used urine receptacles to make Christmas decorations. She explained that one of the receptacles would have been useful in the patient's room so that he did not have to urinate into a drinking glass/plastic cup. The complainant referred to the N IPA advice and said staff did not '*ask*' the patient to use a cup to urinate in. She said he had to do so because it was urgent and there were no appropriate provisions in the room.

41. The complainant referred to the N IPA's advice that there were no '*lapses of care'* evident with the patient's records. She considered it unlikely that nursing staff would have documented that noise levels affected the patient or that staff's actions were inappropriate. She said this did not mean it happened that way. The complainant said she would be willing to '*swear an oath'* that the patient '*cried*' and '*begged*' her to '*find him peace from the noise'*. She explained that two nurses agreed with her and were present for a similar conversation with the patient. However, staff did not document this.

42. The complainant said the N IPA's advice did not bring her '*any comfort nor faith that things will change'*. She said she understands that findings can only be based on hard evidence. However, she said if it was happening to someone else's family, they would also be '*distraught, disgusted and disillusioned*'. The complainant said she found it frustrating that without evidence she cannot properly express how '*horrible*' the situation was and that nothing can be done to make a difference. The complainant said the Trust should undertake a '*detailed review on ALL wards in Antrim Area Hospital'*. She also added that staff should be mindful of their '*attitudes*'.

43. The complainant said that as an outpatient for MDS, doctors previously told her that should the patient require admission for any reason, he should be admitted to ward C7 and kept in a sterile environment for his safety. The complainant said she accepted staff in ward C6 had her father in a single side room. However, she considered the provision of care '*less than satisfactory'*. The complainant explained that after her father had a fall, staff propped the door

open. She did not consider this promoted a '*sterile environment'* nor a '*quiet peaceful place for a man nearing the end of his life'*. The complainant explained that if ward C6 was '*fit for purpose'* and had staff who had '*some consideration for the variety of patients they had'*, then remaining on the ward '*maybe…would have been acceptable'*.

44. The complainant referred to the H IPA's advice that there was no '*need*' for the Trust to transfer the patient to ward C7 earlier than it did. She explained she appreciated the advice. However, it would be difficult for the H IPA to '*accurately comment'* as he did not see the state the patient was in. The complainant also said she accepted the Trust made efforts to transfer the patient to ward C7. However, she believed it could have done more earlier.

45. The complainant said she appreciated the Trust's apology on behalf of her late father. However, she did not consider the explanation of the ward being a '*very noisy'* acute ward '*good enough'*. She said the noise was not just the '*hustle and bustle'* of a busy place; it was '*screeching and laughing and unprofessional conduct from the staff*'.

46. The complainant maintained there was a delay in the length of time it took to transfer the patient to ward C7. She explained he should not have been in ward C6 given the condition he was in. She said that in her opinion his time spent there contributed to his '*mental decline'*.

End of life care

47. The complainant said that at her meeting with the Trust, the Haematology Consultant '*held his hands up'* and apologised that he possibly '*misunderstood*' her request to transfer the patient to a hospice. She said she appreciated the apology. However, her father needed 24-hour care and she asked for his transfer to a facility where this could happen. The complainant said her requests '*fell on deaf ears'*.

48. The complainant said the patient agreed to go to a hospice. She explained that if staff spoke to the patient while she was present, it may have benefitted him. The complainant said her father was '*not in his right mind'*. She considered that

a discussion with an end of life specialist in conjunction with a social worker and psychiatry may have been more useful in finding him the '*right place to be'*.

49. The complainant said she accepted the patient did not meet the criteria for a hospice. However, she explained staff caused her '*anxiety*' by stating several times they wanted to discharge him without an '*adequate discussion'* about where to discharge him to. The complainant said staff did not consider what care the patient would have had if they did discharge him. She felt the '*lack of consideration'* for patients and their family members was '*bad practice'* when the Trust suggested discharging '*a dying man'*.

50. The complainant referred to the Trust's comment that the palliative care team require '*a specific reason'* to take over the care of a patient. She said the Trust did not explain this reason to her and she was not given a '*proper chance'* to explain the situation.

51. The complainant referred to the Trust's comment that the medical team did not consider the patient required specialist palliative care on 27 November 2019. She explained that her father was '*not eating, barely drinking, in pain constantly and unable to get out of bed'*. She believed this would have qualified him for '*peaceful and compassionate care'*. The complainant added that palliative care should include '*peace and quiet, and aid a peaceful transition to death'*.

52. The complainant said she disputed the H IPA advice that the end of life care the patient received was '*optimal*' as the Trust should have transferred him to ward C7 earlier. The complainant described the situation as '*chaotic'* and said there was '*no peace'* for her or her father in the last two weeks of his life; only '*confusion, distress and fear'*.

Analysis and Findings

Diagnosis of diverticulitis

53. The complainant was concerned the Trust failed to perform appropriate tests to diagnose the patient's diverticulitis until three weeks after his first admission in October 2019. The records document the Trust performed an abdominal x-ray,

an abdominal ultrasound scan, and a chest x-ray for the patient in early November 2019.

54. Standard 15 (b) of the GMC Guidance requires doctors to '*promptly provide or arrange suitable advice, investigations or treatment where necessary'*. I note the H IPA's advice that the tests the Trust performed during the patient's first admission were '*routine and appropriate'*. I also note the H IPA's advice that only the chest x-ray raised concern as it showed '*shadowing*[9]' in the patient's lung. The H IPA advised this indicated the infection likely came from the patient's chest rather than his bowel, and the Trust treated the patient with antibiotics.

55. I consider it unfortunate that the Trust did not diagnose the patient's illness before his readmission to hospital on 18 November 2019. However, I accept the H IPA's advice that the Trust carried out appropriate investigations for the patient based on his symptoms at that time. Therefore, I consider in performing these tests, medical staff acted in accordance with Standard 15 of the GMC Guidance. Based on the evidence available, I do not uphold this element of the complaint.

56. I note the H IPA's advice that even in the absence of this diagnosis, the treatment the Trust provided to the patient for his infection would also have treated the symptoms of diverticulitis. I hope this brings the complainant some reassurance regarding the patient's treatment during this period.

Delay in transfer to ward C7

57. The Trust admitted the patient to ward C6 (a surgical ward) following his readmission on 18 November 2019. It explained it did so based on the patient's diagnosis of diverticulitis. I note the haematology team had input into the patient's care and treatment while he remained on ward C6. The H IPA advised this action was '*acceptable*'. I accept his advice.

58. The complainant said she did not consider the ward appropriate for the patient as it was '*noisy*' and nursing staff '*lacked professionalism'*. I note the Trust

[9] A description of an abnormal appearance that can be seen on a chest X-ray.

acknowledged the ward can be '*noisy*' given it is a busy surgical ward. I appreciate the complainant's concerns given the nature of the ward. However, given the patient's diagnosis of diverticulitis, I consider the decision to admit the patient to ward C6 appropriate. I note the Trust previously apologised to the complainant that '*the standard of care was not of the high standard we expect*'. However, I also note the N IPA advised that the records did not provide any evidence of '*lapses*' in nursing staff's care of the patient during his time on the ward. I hope this brings the complainant some comfort.

59. The Haematology Consultant took over the patient's care from 3 December 2019 as he no longer required treatment for diverticulitis. The H IPA advised there was no '*need*' to transfer the patient earlier, as '*there was no clear reason to think that his medical care would be improved by a move'*.

60. The records evidence that despite making this decision on 3 December 2019, the Trust did not transfer the patient to ward C7 until 9 December 2019. Therefore, I consider the transfer process did experience a delay.

61. The Trust explained the delay was due to bed availability on ward C7. I note the efforts of nursing staff to secure a bed for the patient between these dates. The N IPA advised the records show one bed available on the ward on 5 December 2019. However, she also advised there is '*no way of knowing which patient had the greatest need for that bed, on that ward, at that time'*. I note the N IPA advised that nursing staff acted appropriately and in accordance with the NMC Code in their attempts to facilitate the move. I accept her advice.

62. I consider the delay unfortunate and I appreciate why it caused the complainant concern. However, I consider that nursing staff acted appropriately in trying to source a bed for the patient. I also note the H IPA's advice that the patient continued to receive care from senior haematology staff during this time, which he considered a '*satisfactory situation'*. Based on the evidence available, I do not uphold this element of the complaint.

End of life care

63. The complainant raised concerns regarding end of life care the Trust provided to the patient. In relation to nursing, she explained that on one occasion the patient had to urinate into a cup as a nurse was not available to assist him to the toilet. I note this incident is not documented in the patient's records. Therefore, there is no evidence to suggest that nursing staff were aware of it. However, I have no reason to doubt it occurred.

64. While this particular incident is not documented, the N IPA identified additional instances where the patient experienced toileting difficulties. To assist the situation, the records evidence that nursing staff kept the door to the patient's side room open so they could monitor him more closely. The N IPA considered this action '*appropriate*'. I also note the N IPA did not identify any '*lapses*' in the care nursing staff provided.

65. While the N IPA did not identify any failings in care, she advised that to assist the patient further, nursing staff could have increased their comfort rounds and allowed open visiting earlier. I would ask the Trust to remind nursing staff to consider these actions for future similar situations.

66. The complainant was also concerned that she asked staff to discharge the patient to a hospice. However, they told her he did not meet the criteria for hospice care. I refer to the Trust's Palliative Care policy. It states that only those patients (or carers) who have '*unresolved complex issues'* which require expertise of the Community Specialist Palliative Care team[10] (CSPCT) should be referred for hospice care. I note the H IPA did not consider the patient met this criterion. Therefore, I consider the decision not to discharge the patient to hospice care appropriate and in accordance with this guidance.

67. The records evidence that nursing staff referred the patient to the Hospital Specialist Palliative Care team (HSPCT) in late November 2019. However, the team did not provide the patient palliative care at that time. I note this was because the medical team did not agree to input from the HSPCT at that time. I

[10] Specialist palliative care in the community is provided by the Northern Ireland Hospice. Specialist nurses with specialist qualifications and experience in palliative care work across local areas providing care through outpatient clinics or visiting the patient at home.

consider this in accordance with the Trust's Palliative Care policy, which states that the patient's consultant must agree to the referral before it progresses.

68. The records evidence the medical team did not agree to a referral until 9 December 2019. I note the H IPA advised the medical team's decision was appropriate. I also note he described the end of life care provided as '*optimal*'. I accept his advice and consider the Trust provided the patient appropriate end of life care. Therefore, I do not uphold this element of the complaint.

69. I fully appreciate why the complainant fought so hard to address the care provided to her father in the last few weeks of his life. However, there is no evidence to indicate the Trust failed in its care and treatment of the patient. Therefore, I do not uphold this issue of complaint. I hope the findings outlined in this report brings the complainant some reassurance and comfort.

Issue 2: Whether medical staff of Antrim Area Hospital appropriately communicated with the complainant between October to December 2019.

Detail of Complaint

70. The complainant said the patient had difficulty understanding and retaining information. She explained that despite informing medical staff of this, they only spoke to the patient when she was not present. The complainant also said staff failed to inform her of the patient's condition and care plan. This was despite emailing requests to speak to the Haematology Consultant.

Evidence Considered

Legislation/Policies/Guidance

71. I considered the following guidance:
    - GMC Guidance;
    - GMC Guidance on Confidentiality; and
    - NICE NG31.

The Trust's response to investigation enquiries

Communication with the patient without the complainant present

72. The Trust explained the patient told the Haematology Consultant to not '*make his daughter worry*' and at times he withheld information from his daughter. It said the patient was only content for the Consultant to speak with the complainant *'towards the end of his life*'.

Communication of the patient's condition and care plan

73. The Trust said the Social Worker documented in the clinical records on 2 December 2019 that the complainant '*was eager to speak with the Consultant*'. It explained the Haematology Consultant met with the complainant on 5 December 2019. The Trust said the Consultant explained the severity of the patient's condition, his poor prognosis and they discussed resuscitation.

74. The Trust explained its staff spoke with the complainant '*on a number of occasions*'. It also said they made every effort '*to accommodate her requests*'. The Trust said the Haematology Consultant provided to the complainant his email address, '*as he was aware of the stress she was under'*. It explained therefore that the Haematology Consultant '*went above and beyond the call of duty to facilitate communication*' with the complainant.

Relevant Trust records

75. A summary of the relevant records is enclosed at Appendix 4 to this report.

Relevant Independent Professional Advice

Communication with the patient without the complainant present

76. The H IPA advised there is no evidence in the records to suggest the patient refused consent for the Trust to share information with the complainant. He advised it was therefore appropriate for staff to do so.

77. The H IPA referred to the complainant's concern that medical staff informed him of his prognosis when she was not with him. He advised '*the first duty of the medical team is to the patient'*. He said that on 3 December 2019, the patient asked questions of the Haematology Consultant about his prognosis when the complainant was not present. The H IPA advised this *'implies that the*

patient was seeking a conversation without the complainant being present'. He advised in this situation medical staff '*are bound to answer the patient's questions honestly and when asked*'. This is regardless of whether or not another person is present.

Communication of the patient's condition and care plan

78. The H IPA said he recognised there was a mismatch between the complainant's expectations and what was delivered. However, he did not consider that medical staff's communication with the complainant '*deprived [her] of information she needed to understand the situation and support her father*'. The H IPA advised the Consultant responded to the complainant's questions she emailed to him. He also advised the Consultant spoke with the complainant on 5 and 9 December 2019 about the patient's prognosis.

79. The H IPA advised there were occasions where the '*ability of the staff to respond was constrained by pressure of work, lack of familiarity with the patient or being simply unable to answer the question'*. He recognised this led to the complainant experiencing '*frustration*'. He further advised that the Haematology Consultant (and other staff) met with the complainant and was '*not deliberately excluded from discussions'*.

The complainant's response to the draft report

Communication of the patient's condition and care plan

80. The complainant referred to the Trust's comment that the Consultant spoke to her about *'resuscitation'*. She said did not recall this. However, she accepted this may be due to the '*stress at the time'*.

The Trust's response to the draft report

81. The Trust said there were a '*number of entries'* in the records to evidence that staff regularly updated the complainant. The Trust considered it appropriate given the patient's capacity and wishes. It further explained that it may not have documented all conversations. The Trust also explained that the H IPA advised that doctors were obligated to respond to the patient's direct questions (which they did), and his care was not compromised.

Analysis and Findings

Communication with the patient without the complainant present

82. In considering the issue of confidentiality, I note the records do not evidence that the patient refused consent for doctors to share information with the complainant. However, they do evidence an initial reluctance on his part, as he was concerned that doing so may cause the complainant upset. I note this changed as the patient's condition worsened. Therefore, I accept the H IPA's advice that it was appropriate for staff to share information with the complainant about the patient's prognosis in December 2019.

83. The complainant was concerned about the patient's understanding of his prognosis, and asked staff to only speak to the patient about it when she was present. I refer to NICE NG31, which states that staff should '*discuss the dying person's prognosis with them (unless they do not wish to be informed) as soon as it is recognised that they may be entering the last days of life and include those important to them in the discussion if the dying person wishes'*. I note there was no evidence within the records to suggest the patient asked doctors not to share information about his prognosis with him. There is also no evidence to suggest that he asked doctors to only speak with him with the complainant present.

84. I note from the records that the Haematology Consultant spoke with the patient on 3 December 2019 about his prognosis and end of life care. I appreciate the complainant's concern that the patient had difficulty understanding information about his prognosis. However, the records evidence that the patient asked the Haematology Consultant specific questions at that time. The H IPA said this implied that he sought a conversation with medical staff without the complainant present.

85. Standard 31 of the GMC Guidance requires doctors to listen to patients and respond honestly to their questions. Therefore, I accept the H IPA's advice that the Haematology Consultant was '*bound*' to answer the patient's questions rather than wait until the complainant was with him. I consider in doing so, the

Haematology Consultant acted appropriately and in accordance with NICE NG31 and GMC Guidance. I do not uphold this element of the complaint.

Communication of the patient's condition and care plan

86. The complainant raised concern with medical staff's communication with her during the patient's second admission. She said they failed to inform her of the patient's condition and care plan. I have already established it was appropriate for staff to share information about the patient with the complainant.

87. The records evidence that the complainant spoke to an FY1[11] doctor on 29 November 2019. The doctor documented in the notes that the complainant wished to discuss her concerns about '*how [the patient] will be able to cope at home and is keen for POC [plan of care]*'. I note the complainant made similar requests to nursing and social work staff on 30 November, and on 2 December 2019 she specifically asked to speak to a consultant. However, there is no evidence in the records to suggest that the Haematology Consultant or the Surgical Consultant considered or responded to these requests. This was until she emailed the Haematology Consultant directly on 2 December 2019, and he met with her on 5 December 2019.

88. GMC Guidance requires doctors to be '*considerate to those close to the patient and be sensitive and responsive in giving them information and support'*. In accordance with the guidance, I consider it was reasonable for either the Haematology Consultant or the Surgical Consultant, as the persons in charge of the patient's care, to speak to the complainant following her specific request. If they were unable to speak with the complainant, I consider they should have informed her as such, or tasked a colleague to speak to her on their behalf. However, they did not do so.

89. I note the Trust's view that the records evidence it regularly updated the complainant on the patient's condition. I agree with its view. However, in making my finding, I specifically considered the complainant's concern

[11] A doctor in their first year of foundation training.

regarding her request to speak with a consultant about the patient's plan of care and discharge plan as outlined previously.

90. The First Principle of Good Administration, Getting it Right, requires bodies to act in accordance with relevant guidance. The Second Principle of Good Administration, Being Customer Focused, requires bodies to deal with people helpfully, promptly and sensitively, bearing in mind their individual circumstances. I consider that in failing to consider or respond to the complainant's requests, the Trust failed to act in accordance with these principles. I consider this constitutes maladministration. I note that following an email from the complainant on 2 December 2019, the Haematology Consultant met with her on 5 December 2019. However, I consider the absence of an appropriate update for those six days caused the complainant frustration and uncertainty. I uphold this element of the complaint.

91. I note the H IPA advised the staff's communication did not '*deprive [the complainant] of information she needed to understand the situation and support her father*'. I hope this provides some reassurance to the complainant. I also wish to acknowledge that while I established medical staff did not appropriately respond to this particular request, the Haematology Consultant later corresponded with the complainant over email. I recognise this is over and above normal practice.

CONCLUSION

92. This complaint is about care and treatment the Trust provided to the patient in November and December 2019. It also relates to staff's communication with the complainant. I uphold one element of the complaint for the reasons outlined in this report. I consider this failure constitutes maladministration. I recognise the impact the failure had on the complainant.

Recommendations

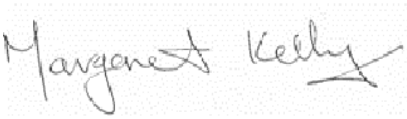
93. I recommend within **one month** of the date of this report:

    i. The Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June

2016), for the injustice caused to her as a result of the failure identified; and

ii. The Trust shares this report with staff involved in the patient's care. It should also discuss the case and my findings with relevant staff at their next appraisal and ask them to reflect on the failure identified. In doing so, the Trust should remind staff of the importance of sharing information with those close to the patient in accordance with Standard 33 of the GMC Guidance (and after they obtain relevant consent).

94. It is evident from my reading of the records how involved the complainant was in the patient's care. Her grief and loss is very evident in her correspondence with both my office and the Trust. I hope this report goes some way to address the complainant's concerns about the care her father received in 2019. I also wish to offer my sincere condolences to the complainant for the sad loss of her father.



MARGARET KELLY
NI Public Services Ombudsman **December 2022**

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.