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

Report Reference: 202003116

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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.

TABLE OF CONTENTS

Page

SUMMARY ………………………………………………………… 5

THE COMPLAINT ………………………………………………. 6

INVESTIGATION METHODOLOGY …………………………. 7

THE INVESTIGATION ………………………………………….. 9

CONCLUSION …………………………………………………... 37

APPENDICES …………………………………………………… 39

Appendix 1 – The Principles of Good Administration

Case Reference: 202003116

Listed Authority: Northern Health and Social Care Trust

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 husband, (the patient) across two admissions from 12 December 2019 to 17 December 2019 and 27 December to 9 January 2020.

The complaint relates to how clinicians diagnosed and treated the patient across the two admissions as well as the standard of nursing care provided during his second admission.

My investigation found there were no failures in the patient's care and treatment during his first admission. However, I did identify failures in his care and treatment during his second admission. These were:

- Delay in the recognition of the patient's renal impairment;
- Delay in commencing fluid management; and
- Delay in the nutritional assessment and management of the patient.

These failures meant the patient experienced the loss of opportunity to optimise possible treatment options. I also recognised the upset these failings would have caused the complainant and the continuing uncertainty of not knowing what difference any earlier treatment may have made to the patient's clinical pathway.

I recommended that the Trust provides the complainant with a written apology because of the failures in care and treatment I identified. I also made further recommendations to the Trust for service improvement and to prevent future recurrence of the failings identified.

THE COMPLAINT

1. I received a complaint about the care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's late husband, (the patient) from 12 December 2019 to 9 January 2020.

Background

2. On the evening of 12 December 2019, the patient attended Antrim Area Hospital's (AAH) Emergency Department (ED) because of abdominal pain, vomiting and diarrhoea. ED staff completed several clinical tests however, the patient self-discharged due to the length of wait for some of the test results. He returned to the ED the next day with the same symptoms. The patient was subsequently admitted under the care of Dr A, Consultant Gastroenterologist, with jaundice[1], vomiting and diarrhoea and a working diagnosis of alcohol related acute hepatitis[2]. Following various investigations, clinicians discharged the patient on 17 December 2019.

3. On 27 December 2019 clinicians re-admitted the patient to AAH, via the ED, under the care of Dr B, Consultant Gastroenterologist. Dr B considered the patient's presentation was consistent with probable acute alcohol-related hepatitis with decompensated cirrhosis[3]. However, he considered corticosteroid[4] therapy inappropriate at this stage due to patient's infective diarrhoeal symptoms. On 30 December 2019 Dr B recommended the commencement of corticosteroid therapy, as the patient's liver tests were deteriorating, and stool culture tests returned as negative.

4. Over the next number of days, despite the commencement of corticosteroid therapy, the patient's liver tests continued to deteriorate as did his renal function. Clinicians sought advice, on the patient's case, from the Specialised Liver Unit at King's College Hospital, (KCH) London, and a Consultant Hepatologist at the Royal Victoria Hospital (RVH). The specialists' assessments

[1] Yellowing of the eyes/skin usually due to liver dysfunction.
[2] An inflammatory condition of the liver caused by heavy alcohol consumption over an extended period of time.
[3] An acute deterioration in liver function in a patient with cirrhosis (scarring).
[4] Often known as steroids, are an anti-inflammatory medicine

considered the patient would not be suitable for transfer or escalation of care. On 7 January 2020 Dr B recommended, due to the patient's poor prognosis, care should move to that of a palliative nature and referred him to the Palliative Care Team. The patient sadly passed away on 9 January 2020. I enclose a chronology detailing the events leading to the complaint at Appendix five to this report.

Issues of complaint

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

Issue 1: Whether the patient received appropriate care and treatment from the Trust between 12 December 2019 and 17 December 2019.

Issue 2: Whether the patient received appropriate care and treatment from the Trust between 27 December 2019 and 9 January 2020.

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 advisors (IPA):

- A Consultant Gastroenterologist and Hepatologist with over 12 years' experience of providing care to patients with decompensated liver cirrhosis including alcoholic hepatitis (G IPA); and
- A Senior Nurse with 21 years' experience of providing care across primary and secondary care settings (N IPA).

8. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs 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[5]:

   - The Principles of Good Administration

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 Good Medical Practice, updated April 2019 (the GMC Guidance);
   - The Nursing and Midwifery Council’s Code: Professional standards of practice and behaviour for nurses and midwives, October 2018 (the NMC Code);
   - The National Institute for Health and Care excellence (NICE), Clinical guideline [CG100]: Alcohol-use disorders: diagnosis and management of physical complications, updated 12 April 2017; (NICE CG100),

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

- The British Association for the Study of the Liver (BASL) and The British Society of Gastroenterology (BSG.): Decompensated Cirrhosis Care Bundle - First 24 Hours, 2014 (The Care Bundle);
- The Health and Social Care Board's Guiding Principles for Getting Patients on the Right Road for Discharge, 2015 (the Discharge Principles); and
- The Northern Health and Social Care Trust's Coroner, Referral of a Patient's/Client's Death Policy, February 2019 (the Trust's referral of death policy).

Trust records

11. I completed a review of the relevant Trust records. Relevant extracts from the records are included at Appendix four to this report.

12. 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.

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

Complainant's response to draft report

14. The complainant did not agree with everything the IPA had advised. As he had based his decision on the records provided by AAH she felt unable to *'…argue…'* her point.

THE INVESTIGATION

Issue 1: Whether the patient received appropriate care and treatment from the Trust between 12 December 2019 and 17 December 2019.

This considered the diagnosis and treatment of patient and the decision to discharge the patient on 17 December 2019.

Detail of Complaint

Diagnosis and treatment of patient

15. The complainant said, as result of the medical and lifestyle history the patient gave to clinicians, they deemed and treated him as an alcoholic from that point on. She believed clinicians took no other information into consideration when reaching a diagnosis. She also questioned why staff gave an antibiotic drip to the patient, when first admitted, only to take it away five minutes later.

Evidence Considered

Policies/Guidance

16. I considered the following policies/guidance:
    - the GMC Guidance; and
    - NICE CG100.

Trust's response to investigation enquiries

17. The Trust stated: Dr A cared for the patient from 14 to 17 December 2019 and *'…various investigations were performed prior to discharge…the main treatment of liver disease is with supportive therapy and to try and take the stress and burden off other organs so that the liver has potential time to heal. If the liver does not heal itself then deterioration can occur which will eventually impact on other organs' ability to function. If situations when the liver does not demonstrate signs of recovery and improvement then other potential aspects of care need to be considered such as making a referral to a Liver Specialist Unit for second opinion…'*

18. The Trust agreed the documented history of the patient's alcohol history *'...does vary through the notes…'* However, this is due to the answers the patient gave to the question as to what alcohol he was consuming. Even given the varied answers the patient *'...did admit to several years of excessive alcohol intake on a daily basis in previous years. This and the likely underlying*

fatty liver disease of NAFLD[6] *are significant risk factors to the development of liver cirrhosis…*' The clinical assessment and subsequent investigations supported this. A liver screen test undertaken across both admissions *'…excluded numerous other potential liver pathologies…'*

Relevant Independent Professional Advice

19. The G IPA advised: the patient initially presented to the ED with jaundice. Clinicians documented a detailed alcohol history *'… revealing 4-5 beers a day [sic] further 2-5 whiskey drinks for 10 years…'* While the complainant has disputed the exact amounts of alcohol *'…Importantly, it was also documented that the patient gets withdrawal symptoms…*' Assuming the alcohol consumption is accurate *'…then it is certainly excessive equating to around 12-14 units a day so around 80-100 units a week. This would support the suspected diagnosis of alcoholic hepatitis. The patient was also significantly overweight which is a risk factor for fatty liver and chronic liver disease.'* The evidence of certain medications, usually given to patients consuming excess alcohol, prescribed by the patient's General Practitioner (GP) *'…does further corroborate a history of excess alcohol consumption.'*

20. The patient underwent initial management based on the suspicion of alcohol related liver disease. *'…This would appear reasonable based on the available information and in line of accepted practice…Further investigations included ultrasound scan liver which revealed a fatty and scarred liver consistent with cirrhosis. Therefore, it is likely that there had been chronic liver damage over years that was not previously identified or diagnosed…'* In such cases there are no specific direct therapies to *'…improve the liver per se...*' however clinicians gave the patient *'…intravenous vitamins (pabrinex), fluids and chlordiazepoxide (a drug to reduce withdrawal symptoms.)…*' Steroids are sometimes given to reduce liver inflammation when a patient's Maddrey's discriminant function[7] [MDF] score is above a certain threshold however, the threshold was not met in this case and *'…Therefore, steroids were not*

[6] Non-alcoholic fatty liver disease is a term for a range of conditions caused by a build-up of fat in the liver. It's usually seen in people who are overweight or obese.
[7] A blood test which helps determine patients with alcoholic hepatitis that may have a poor prognosis and benefit from steroid administration.

prescribed and this was in line with guidance… the patient appeared to make a gradual recovery based on the ward round entries and also the blood test results.'

21. The IPA advised clinicians did take other factors into consideration, other than the patient's alcohol consumption, and this was evidenced by the liver screen[8] tests undertaken. The results of these tests were negative *'…so excluding alternative significant causes of liver disease, strengthening the case for the liver disease being mainly alcohol related with some contribution from fatty liver due to the raised weight…'* The clinicians working diagnosis *'…was reasonable and appropriate…'* and was based on *'…the available clinical, biochemical and radiological investigations.'*

22. In relation to clinicians seeking more specialist advice the IPA advised: *'…there was no indication for discussion with King's [KCH] as a specialist liver transplant unit…'* This was because the patient was improving and as the MDF indicated there was no evidence of severe alcoholic hepatitis. KCH *'…would not have offered alternative management and in particular could not have offered liver transplant…'* This is because of strict criteria for liver transplant listing in the UK. *'…Alcoholic hepatitis is not yet an accepted indication for liver transplant listing (as opposed to chronic liver disease/cirrhosis) and the severity of liver disease was not at a level for acute listing for transplant…'*

23. In relation to administration of the antibiotic drip the N IPA advised: clinicians prescribed the patient the antibiotic Tazocin and he was administered an IV drip containing the antibiotic. *'…The fluid chart also shows the administration of Tazocin…was diluted to 120ml...When prepared in 120ml's, Tazocin runs over a short period of 30 minutes...The evidence is that Tazocin was given and was not removed at any point during administration. This is because it is signed for on the drug chart and 120ml has been added on to the fluid chart.'*

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[8] A panel of blood tests to assess for alternative causes of liver disease including for example chronic viral hepatitis or autoimmune liver disease.

Analysis and Findings

24. The complainant said clinicians treated the patient as an alcoholic taking no other information into account when reaching a diagnosis. She also complained about the administration of the patient's antibiotic when first admitted.

25. I considered the Trust records and noted following assessments, clinicians working diagnosis for the patient was that of Acute hepatitis. Clinicians requested various investigations including, a liver ultrasound scan and liver screening tests. I note the Trust's comments that clinical assessment of the patient and a liver screen test supported the patient's diagnosis.

26. I considered the G IPA's advice: that the patient's alcohol history (although disputed), presence of withdrawal symptoms, weight and medications prescribed by the patient's GP '…*would support the suspected diagnosis of alcoholic hepatitis...'* This working diagnosis *'…was reasonable and appropriate…'* and based on *'…the available clinical, biochemical and radiological investigations.'* Therefore, '…*excluding alternative significant causes of liver disease*…' I also note the G IPA's advice the management plan put in place for the patient '…*would appear reasonable based on the available information and in line of accepted practice…'* I note this also included no indication to discuss with a specialised centre.

27. The N IPA advised clinicians prescribed the antibiotic, Tazocin and this was administered and the evidence, within the patient's records documented, it '…*was not removed at any point during administration…'*

28. Given the available evidence, including the G IPA's advice, I am satisfied clinicians took all appropriate information into account when reaching a working diagnosis for the patient, as well as putting into place an appropriate management plan to treat him. I acknowledge the complainant's comments staff took away the patient's antibiotic drip after five minutes. However, I accept the N IPA's advice in relation to the administration of the patient's antibiotic drip

which runs over a 30 minute period and I am satisfied nursing staff administered it appropriately.

29. Therefore, I do not uphold this element of complaint.

Detail of Complaint

Decision to discharge

30. The complainant said clinicians discharged the patient on 17 December 2019 while still unfit and this was due to the pending nursing strike the following day.

Evidence Considered

Policies/Guidance

31. I considered the following policies/guidance:
    - the Discharge Principles;

    I enclose the relevant section of the guidance considered at Appendix three to this report.

Trust's response to Investigation enquiries

32. The Trust explained after clinicians performed various investigations the patient's *'…white cell count had returned to normal…'* and liver screening, used to exclude other causes of liver disease, *'…were also normal…'* At the time of discharge, Dr A advised, the patient *'…appeared well…'* with a NEWS[9] score 1. The Trust reassured the complainant in its initial response to her on 16 November 2021 that the *'…nurses' industrial action did not influence or hasten [the patient's] discharge...'*

Relevant Independent Professional Advice

33. The G IPA advised: clinicians first considered discharging the patient on 16 December 2019, but this would be dependent on blood test results. On 17 December 2019 *'…The blood test result confirmed gradual improvement in bilirubin and hence the condition of the liver…the Maddrey's discriminant*

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

function was not significantly elevated to indicate severe liver inflammation…and the decision was made to discharge…' The decision to discharge *'…at that stage appeared reasonable…'*

34. The G IPA was *'…unable to see any evidence that the impending nursing strikes influenced the discharge decision in any way.'*

Analysis and Findings

35. I examined the Trust's records and note on 16 December 2019 clinicians were planning to discharge the patient home if bloods improved. The patient was subsequently discharged home on 17 December 2019. I note the Trust's considered the patient's white cell count and liver screening tests were normal, as well as its reassurance that the pending nursing strike did not influence the patient's discharge.

36. I accept the G IPA's advice that the decision to discharge the patient was reasonable and he was unable to see any evidence the pending nursing strike influenced the clinicians' decision to discharge. I understand the complainant's concerns regarding the pending nursing strike; however, based on the available evidence, I am satisfied it was reasonable for clinicians to discharge the patient on 17 December 2019. Therefore, I do not uphold this element of complaint.

Issue 2: Whether the patient received appropriate care and treatment from the Trust between 27 December 2019 and 9 January 2020. In particular the following issues were considered under this heading:-

- **a. Diagnosis and treatment of patient, to include:-**
  - **Medical review;**
  - **Following-up on considered specialist treatment;**
  - **Administration of medication;**
  - **Fluid management from 5 January 2020**
  - **Consideration to transfer to Intensive Care Unit;**
- **b. Nursing care provided from 26 December 2019 to 9 January 2020;**
- **c. Pain management in final hours of life; and**

d. Non referral of patient's death to the coroner.

Detail of Complaint

Diagnosis and treatment of patient

37. The complainant raised a complaint about the diagnosis of the patient including the follow-up treatment. She said that as result of the medical and lifestyle history the patient gave to clinicians they deemed and treated him as an alcoholic. She believed clinicians took no other information into consideration when reaching a diagnosis and said clinicians discussed specialist treatment but did not follow this up until the option was no longer viable. The complainant also queried if junior doctors reported any signs of deterioration to more senior doctors during the period between Dr B's ward rounds on 30 December 2019 and 3 January 2020.

38. The complainant also said the patient did not get his GP prescribed medication and at one point staff administered an incorrect dose of another medication. The complaint queried the fluid management of the patient and questioned whether the approach taken had any impact on him as she believed his condition deteriorated rapidly following this. She also complained that given the patient was so unwell clinicians should have transferred him to the intensive Care Unit (ICU).

Evidence Considered

Policies/Guidance

39. I considered the following policies/guidance:
    - the GMC Guidance;
    - the NMC Code;
    - NICE CG100; and
    - the Care Bundle

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

Trust's response to investigation enquiries

Diagnosis and treatment of patient

i. Medical review

40. I refer to information the Trust provided at paragraphs 17 and 18 of this report. The Trust also explained Dr B reviewed the patient on 30 December 2019 and again on 3 January 2020. On 31 December 2019 and 2 January 2020 Dr B's medical team reviewed the patient and *'…would have discussed daily progress with [Dr B] typically by telephone…'* As the patient had been stable and, 1 January 2020 was a bank holiday, the patient *'…was not considered to be requiring consultant review on this day…'* Dr B had initiated corticosteroid therapy for the patient on 30 December 2019 *'…in an attempt to control the potential of acute alcohol related hepatitis that was potentially complicating his underline condition of decompensated liver cirrhosis, No immediate alternative action was considered necessary especially as [the patient] remained well in this period…Treatment of such liver conditions is largely supportive with no specific therapy available…'*

ii. Consideration of specialist treatment

41. The Trust explained: clinicians discussed the patient's case with KCH's Specialised Liver Unit for liver transplantation on 5 January 2020. KCH advised AAH to *'…carry out a CT of the liver to assess for potential clots or other pathologies…'* It also felt there was a possibility the patient had developed grade 1 encephalopathy[10] and the advice was *'…if there was further deterioration, then admission to ICU could be considered…'* KCH also recommended *'…the commencement of antibiotics...and consideration for transjugular liver biopsy[11]…'* The KCH team *'…did not consider [the patient] required transfer to London but were happy to be contacted for further advice if required...'*

42. Clinicians also discussed the patient's case with Dr C, Consultant Hepatologist in the RVH on 5 January 2020. Dr C recommended *'… there should be*

[10] Refers to changes in the brain that occur in patients with advanced, acute (sudden) or chronic (long-term) liver disease.

[11] a procedure that involves taking a tiny specimen of the liver for examination. The specimen is obtained by passing the needle through the jugular vein in the neck. This method is normally used in patients who have clotting disorders or ascites, i.e. fluid in the abdomen, which increase the risk of bleeding after a liver biopsy.

completion of the liver screen to assess for causes of liver disease but did not consider that [the patient] reached the criteria for fulminant liver failure[12]…' On 5 January 2020 Dr D, Consultant Nephrologist, at AAH provided an opinion regarding the potential requirements for dialysis due to the patient's deteriorating renal function. Dr D recommended the patient '…*should be referred to the Intensive Care Unit if there was worsening hepatic encephalopathy or if he developed signs of renal decompensation…'*

43. The Trust also explained: *Assessment by the Renal Team was undertaken on 6 January 2020 with the recommendation to continue with hepatorenal syndrome protocol and to discontinue IV fluids. [The patient's] case was discussed with the Liver Unit, RVH again on 6 January 2020 who stated that [the patient] was not considered suitable for escalation of care due to multi-organ dysfunction / failure and should receive best supportive care...'*

44. By 7 January 2020, in discussions with the gastroenterology team of AAH there was agreement the patient's condition had *'…dramatically deteriorated…'* and was likely a *'…culmination of liver cirrhosis due to non-alcohol-related fatty liver disease compounded with prior alcohol misuse leading to decompensated liver failure with complication of hepatorenal syndrome[13], renal failure respiratory failure and hepatic encephalopathy…'*

iii. Medication concerns

45. The Trust explained: when a patient is admitted acutely unwell *'…it is common practice to alter or stop…'* certain GP prescribed medications. When they are recommenced *'…depends on the patient's recovery and the ongoing clinical indication for the medication.'*

iv. Fluid management

46. The Trust explained staff regularly monitored and adjusted the patient's fluid balance accordingly due to the underlying conditions of decompensated liver

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[12] This has traditionally been defined as the presence of acute liver failure including the development of hepatic encephalopathy within 8 weeks after the onset of jaundice in a patient without a prior history of liver disease.

[13] A form of impaired kidney function that occurs in individuals with advanced liver disease.

cirrhosis with hepatorenal syndrome, a combination of conditions *'…with a poor prognosis and high mortality rate.'*

v. Consideration to transfer patient to Intensive Care Unit

47. I refer to information the Trust provided at paragraphs 40 to 43. The Trust also explained Dr B had *'…explained to the patient, his wife and brother that unfortunately his liver failure had led to further failure of other organs and there was a low probability that he would be able to survive this illness…'* Dr B also explained other liver units *'…did not consider that he was a suitable candidate for escalation of care as there would be a low probability he would be able to survive any form of care offered as he was deemed to be too unwell…'*

Relevant Independent Professional Advice

Diagnosis and treatment of patient

i. Medical review

48. The G IPA advised: On the patient's second admission he had repeat blood tests, a liver screen, and repeat imaging/scanning. Clinicians reached a clinical impression the patient had acute decompensation of liver disease however, the liver screen requested was to exclude causes other than alcohol. *'…This management was consistent with recommendations of the BASL/BSG liver bundle for decompensated liver disease…'* Despite queries over the patient's actual alcohol intake levels *'…There is enough evidence to corroborate hazardously high alcohol consumption…'* which on balance were *'…sufficiently high to cause liver disease…'* The liver screen, sent to assess for other cause of liver disease *'…returned negative. Therefore, the clinicians did take into account other potential causes and it was reasonable to continue management as likely alcohol related.'*

49. The G IPA outlined the treatment the patient received during his second admission and advised: this was *'…appropriate and consistent with practice and…guidelines. However, the patient failed to respond and deteriorated. There were delays in recognising the renal impairment and in nutrition assessment and management…'*

50. In relation to the patient's renal failure the G IPA advised: clinicians first identified this through blood tests on 4 January 2020 at which point treatment started. Renal function can be determined by creatinine[14] levels in the blood but the patient's earlier blood samples did not have a creatinine result. This could be related *'…to the severe jaundice which can affect the lab results for creatinine. However an estimate of creatinine can be given or sought from the lab by clinical teams. The urea another marker of kidney function but less useful than creatinine had been steadily rising. On balance, the renal failure/AKI (acute kidney injury) likely due to the liver failure (hepatorenal syndrome or HRS) had started some days earlier but not recognised until 4/Jan...'*

51. In relation to whether clinicians appropriately escalated signs of deterioration in the patient, over the new year period, the G IPA advised: based on clinical observations there *'…does not appear to have been an overt clinical deterioration but the worsening renal function may not become clinically apparent until significantly advanced.'* On 2 January 2020 clinicians documented they planned to discuss the patient with Dr B but there is no documented record that a discussion took place and if it did what the outcome was. *'…Whilst there was a delay in recognising and managing the renal failure, on balance it most probably did not affect the ultimate outcome.'*

52. In relation to nutritional assessment the G IPA advised: dietician input and review did not occur until 6 January 2020. This is of importance as patients with *'…advanced liver disease have higher caloric needs and often very poor appetite and hence much reduced oral intake…'* After reviewing the patient, the dietitian recommended nasogastric feeding[15] but the patient only tolerated this for a short time. *'…It is difficult to determine the impact of the nutritional support delay but likely to have been modest at worst…due to the alcoholic hepatitis was so severe.'*

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[14] A waste product that comes from the digestion of protein in your food and the normal breakdown of muscle tissue. A creatinine test is a measure of how well kidneys are performing their job of filtering waste from your blood.
[15] Process of supplying food and medicine to the stomach through the nose via a special tube.

ii. Consideration of specialist treatment

53. The G IPA advised: the medical team sought advice from KCH on 5 January 2020 due to the patient's *'…ongoing deterioration in the liver condition in addition to the significant deterioration in renal function...The request for advice was largely to ascertain if any different management should be instituted and whether there was any possible benefit to transfer to another centre.'* The advice provided confirmed the management plan in place already and *'…largely centred around providing ongoing supportive management…A transjugular liver biopsy was also suggested as there was slight doubt to the diagnosis, however it was unlikely to change management and it did not take place which had no impact. And as discussed above [paragraphs 20 to 22], the diagnostic uncertainty was not significant… Ultimately, it was agreed that there was no indication to transfer to another hospital…'*

54. He also advised that while the timing of the specialist discussion was *'…late in the course of the hospital stay had no material impact and would not have changed management even if it had been sought at an earlier stage…On balance, the clinicians did follow the advice given, where feasible and of relevance…'*

iii. Medication concerns

55. The G IPA advised he could not identify any *'…relevant omissions...'* relating to clinicians prescribing the patient's GP medication. *'…The thiamine vitamins prescribed were given intravenously as pabrinex...'*

56. The N IPA advised *'…the GP medications that were prescribed by clinicians on both admissions were administered by nursing staff. The exception was vitamin B compound and thiamine and these were not administered on medical advice… because the patient was taking Pabrinex…Nursing staff therefore followed national guidance.'* On review of the medical charts from both admissions the N IPA was *'…unable to see any episode where an incorrect dose of a medication was administered…'*

iv. Fluid management

57. The G IPA outlined the steps clinicians took to manage the patient's fluid once they had identified the patient's renal failure. He advised: clinicians planned to give intravenous (IV) fluids aggressively, 2 litres over 6 hours, with the aim to reverse renal failure. On 4 January 2020 most of the IV fluids were given and then albumin solution (a smaller volume of fluid) given on 5 January 2020. *'…It appears [the patient] tolerated the initial iv fluids but this did not reverse the renal function with ongoing poor urine output and worsening renal failure…Eventually, the patient became overloaded with too much fluid on board including on the lungs which required the fluids to be stopped. The iv fluid given reduced on the 6th and then stopped following review by the renal team…*' The G IPA could *'…not see fast fluids been given on the 6th or afterwards.'*

58. *'…On balance, the fluid management was delayed due to the late recognition of the renal failure. Unfortunately, this did not successfully reverse the renal failure…as the renal failure/AKI or specifically hepatorenal syndrome was advanced due to the severity of the liver disease,…*resulting in low chance of success and may have *'…contributed to the later development of pulmonary oedema…Even if the pulmonary oedema did not develop, it is likely that the outcome and prognosis were the same in view of the severity of the alcoholic hepatitis causing the irreversible renal failure.'*

v. Consideration to transfer patient to Intensive Care Unit

59. The G IPA advised: In such situations, escalation to ICU *'…depends entirely on the situational judgement at the material time…'* Clinicians had discussions with the ICU and renal teams, as well as discussions with King's College London and the RVH. After a review on 6 January 2020, clinicians documented *'… 'dialysis' would need to be guided by prognosis and ICU management. In essence, the severity of the liver disease and low chance of reversibility meant that dialysis would most probably have simply delayed the deterioration and death…'* There *'…is relatively little documented detail regarding the deliberations…'* around transferring the patient to the ICU. However, *'…It appears the main decision not to admit [to the ICU] was based on the fact that*

the only treatment that could be delivered…was dialysis (+/- intubation.) Inferring …the patient was deemed to have too severe disease with multi-organ failure that was irreversible to benefit from ICU admission and dialysis- i.e. futility of further intervention.'

60. Based on the reviews completed *'…Consideration for ICU was considered at an appropriate stage in that there was little that could have been delivered on ICU prior to the stage of needing dialysis. On balance, admission to ICU would not have made a difference to the outcome…'*

Trust's response to draft report

61. Dr B said he appreciated the issues raised by the report and for that he *'…sincerely apologises…'* to the complainant that, her husband's care was *'…not as ideal as could be expected.'* The Trust also offered its sincere apologies to the complainant for *'…any undue distress or worry caused to her as a result of the failures identified...'* in the report.

62. In relation to the IPA's comments about recording Consultant discussions when they are not present on the ward the Trust agreed there should be a *'…formal method of documenting the discussion…'* It said *'…This should be achieved with the introduction of Encompass to the Trust later this year, planned for November 2024.'* The Trust went on to say this issue would also *'…be raised at the gastroenterology governance meeting to discuss the issue for reflection and to seek a process to document any such discussion.'*

63. In relation to the BSG Liver Care Bundle the Trust said that while this would not prevent deaths from decompensated liver disease and associated complications, it could assist the *'…appropriate initiation of care at the appropriate time in the care of such patients…'* The Trust also acknowledged it did not use the care bundle during the patient's admissions but said the use of the care bundles had *'…increased in ad-hoc use by individual consultants…'* and it *'…should seek to institute this bundle at the outset of the admission of such patients...'* To attain this goal in patient care, Dr B *'…would advocate this should be raised at the gastroenterology and acute medicine governance*

meetings to seek its introduction for use by junior medical staff on the acute medical take-in of patients through ED with decompensated liver disease.'

64. In relation to the keeping of food charts and the patient's referral to a dietitian the Trust said that on admission, staff completed a MUST[16] score within 24 hours of admission to Ward C6 and, the patient was eating and drinking independently. The patient's Must score was O. *'…A MUST score of O doesn't automatically warrant a referral to Dietetics however if there was a diagnosis of Alcoholic Liver Disease and/or poor oral intake, a referral should have been made. Food record charts would support evidence of a poor oral intake and enable the Dietitian to monitor this.'*

Analysis and Findings

Diagnosis and treatment of patient

i. Medical review

65. The complainant said clinicians treated the patient as an alcoholic taking no other information into account when reaching a diagnosis. The complainant also queried if junior doctors reported any signs of deterioration to more senior doctors during the period between Br B's ward rounds on 30 December 2019 and 3 January 2020. I wish to acknowledge the complainant's comments that she did not agree with the comments of the IPAs.

66. I examined the Trust's records and noted following assessments, clinicians working diagnosis for the patient was that of decompensated liver disease. Clinicians requested various investigations including, an ultrasound scan and liver screening tests and the patient commenced steroid treatment on 30 December 2019. I note Dr B completed a ward round on 30 December and then again on 3 January 2020. However, the medical team did review the patient during this time. Following a medical review on 2 January 2020 clinicians were to discuss the patient with Dr B.

[16] A five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese.

67. I note the Trust's comments that clinical assessment of the patient and a liver screen test supported the patient's diagnosis. I also note the Trust's comment that the patient remained well during the period 31 December 2019 to 3 January 2020 and, as he was stable did not require consultant review on the bank holiday of 1 January 2020. The medical team would have also discussed daily progress with Dr B. I will refer to this at paragraph 71 below.

68. I considered the G IPA's advice and note, based on the information clinicians had, they reached a clinical impression the patient had acute decompensation of liver disease. They also ruled out other potential causes by means of a liver screen which was in line with guidance. Given the negative liver screen result *'…it was reasonable to continue management as likely alcohol related.'* I further note the G IPA advised the patient's treatment was *'…appropriate and consistent with practice and…guidelines…'* However, there were delays in recognising renal impairment. The clinical team should have sought an estimate of creatinine levels from the lab as urea makers had already been steadily rising in the patient but based on clinical observations there *'…does not appear to have been an overt clinical deterioration but the worsening renal function may not [sic] become clinically apparent until significantly advanced.'* I further note the G IPA's advice that whilst there was a delay in recognising the patient's renal failure *'…on balance it most probably did not affect the ultimate outcome.'*

69. I also considered the G IPA's advice that there were delays in the patient's *'…nutrition assessment and management.'* However, the impact of this delay is *'…difficult to determine…but likely to have been modest at worst…due to the severe nature of the alcoholic hepatitis…'*

70. Given the available evidence I am satisfied clinicians diagnosed and put in place an appropriate management plan for the patient. However, I accept the G IPA's advice that there were delays in both the recognition of the patient's renal impairment and in his nutritional assessment and management. I consider these, failures in the patient's care and treatment. I acknowledge the G IPA's advice that on balance these failures would not have changed the patient's

ultimate outcome. However, it is my view as a consequence of these failures, the patient experienced the loss of opportunity to optimise treatment options. I also consider the complainant sustained the injustice of uncertainty and upset. This is because the complainant will always question what difference any earlier treatment may have made to the patient's clinical pathway.

71. I would like to draw the Trust's attention to the G IPA's comments that he was unable to determine whether clinicians had any discussion with Dr B on 2 January 2020 as planned and, if the discussion took place what the outcome was. I note the Trust said during the holiday period clinicians would have provided daily updates, usually via telephone, to Dr B. I consider these discussions should have been documented and, in particular any outcome recorded, in line with the GMC code which states clinical records should include relevant clinical findings and the decisions made and actions agreed. I consider this a service failure. Although I do not consider this impacted on the patient's overall care and treatment, I would ask that the clinicians involved reflect on the G IPA's comments and welcome the Trust's comments regarding the consideration it is giving to this point.

ii. Consideration of specialist treatment

72. The complainant said clinicians discussed specialist treatment but did not follow this up until the option was no longer viable. I considered the Trust's records and note the discussions with KCH, RVH and other specialities within AAH. I also note the Trust's comments at paragraphs 41 to 43 which also outlines the discussion within the records.

73. I considered the G IPA's advice and note that whilst clinicians could have sought advice an earlier point during the patient's second admission, it *'…had no material impact and would not have changed management even if it had been sought…earlier…'* I also note while KCH suggested a liver biopsy, clinicians did not complete this but, the G IPA advised this did not have an impact as the *'…diagnostic uncertainty was not significant…'* and '*…On balance, the clinicians did follow the advice given, where feasible and of relevance…'*

74. Given the available evidence I am satisfied clinicians did seek specialist advice. While I understand the complainant believed this advice was not sought until specialist treatment was not viable, I accept the G IPA's advice that even if advice had been sought earlier the patient's management plan would not have altered. Therefore, I do not uphold this element of complaint.

iii. Medication concerns

75. The complainant said the patient did not get his GP prescribed medication and at one point staff administered an incorrect dose of another medication. I considered the G IPA's advice that he could not identify *'…relevant omissions...'* relating to clinicians prescribing the patient's GP medication. I also considered the N IPA's advice and noted she could not see '…*any episode where an incorrect dose of a medication was administered…'* and nursing staff administered all medications as prescribed in line with guidance.

76. I accept the G IPA and N IPA's advice and I am satisfied the prescribing and administration of the patient's medication was appropriate. Therefore, I do not uphold this element of complaint.

iv. Fluid management

77. The complaint queried the fluid management of the patient and questioned whether the approach taken had any impact on him as she believed his condition deteriorated rapidly after this. I considered the Trust's records and note on 4 January 2020 the clinical record documents staff were to administer two litres of iv fluids over the next six hours to the patient. The patient was then to get albumin. The renal review on 6 January 2020 recommended IV fluids be stopped. I note the Trust's comments its staff regularly monitored and adjusted the patient's fluid balance accordingly due to the underlying conditions of decompensated liver cirrhosis with hepatorenal syndrome, a combination of conditions.

78. I considered the G IPA's advice and note once clinicians identified the patient's renal failure, they took steps to manage his fluids, and while initially tolerated,

this did not reverse the poor renal function or improve his urine output. The patient however became '…*overloaded with too much fluid on board including on the lungs which required the fluids to be stopped. The iv fluid given reduced on the 6th and then stopped following review by the renal team…'* I further note the G IPA's advice the fluid management was delayed due to the late recognition of the renal failure. However, *'…even if the pulmonary oedema did not develop, it is likely that the outcome and prognosis were the same in view of the severity of the alcoholic hepatitis causing the irreversible renal failure.'*

79. I have already identified, at paragraphs 68 and 70, a delay in the recognition of the patient's renal failure. Given the available evidence and the G IPA's advice I am satisfied there was also a delay in commencing the management of the patient's fluid input/output. This is because of the delay in recognising the patient's renal failure. I consider this a failure in the patient's care and treatment. However, I am satisfied when fluid management commenced, to treat the renal failure, clinicians managed it appropriately given the patient's symptoms. It is my view that as a consequence of this failure the patient experienced the loss of opportunity to optimise treatment options. However, I acknowledge the G IPA's advice that the patient's outcome and prognosis were likely to remain the same. I also consider the complainant sustained the injustice of uncertainty and upset as I note she queried whether the approach taken had resulted in the rapid deterioration of the patient. Therefore, I partially uphold this element of complaint.

v. Consideration to transfer patient to Intensive Care Unit

80. The complainant was concerned clinicians did not transfer the patient to the ICU given he was so unwell. I examined the Trust's records and note clinicians had discussions about transferring the patient should his symptoms deteriorate. I also note the Trust's comments (paragraphs 41 to 43 refer) which also reference to the discussions had with KCH's Specialised Liver Unit and Dr D in AAH about considering transferring the patient to ICU.

81. I considered the G IPA's advice and note that while clinicians did not record their deliberations in detail *'…Consideration for ICU was considered at an*

appropriate stage in that there was little that could have been delivered in ICU prior to the stage of needing dialysis…' I also note his advice that the severity of the patient's liver disease and low chance of reversibility *'…meant that dialysis would most probably have simply delayed the deterioration and death…'*

82. Given the available evidence I am satisfied clinicians did consider the transfer of the patient to ICU with relevant specialities. Therefore, I do not uphold this element of complaint.

Detail of Complaint

Nursing care provided

83. The complainant raised a complaint about the level of nursing care provided to the patient particularly when clinicians moved him to a side room. She said staff ignored the patient, he missed meals, and she had to change bed clothes on three occasions due to blood staining. She was further concerned about the actions of nursing staff following the patient's loss of sight on 6 January 2020 which included the patient's access to his call bell.

Evidence Considered

Policies/Guidance

84. I considered the following policies/guidance:
    - the NMC code;

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

Trust's response to investigation enquiries

85. The Trust explained: The patient had *'…symptoms of infective diarrhoea and required isolation and further investigations to determine the cause and exclude C-Difficile…'* Records document *'…nursing staff attended to [the patient's] personal needs…'* and changing bedsheets is something nursing staff do '*…on a daily basis but also as and when required…'* However, it is not *'…normal procedure…'* to document this. The patient was not on a food chart which

'…on reflection he perhaps should have been…' as this would have given clear information on his nutritional intake. On review of his notes and fluid balance charts *'… there is a clear trend of [the patient] refusing food due to nausea…and his oral intake remained poor…'* Following dietitian assessment *'…an attempt was made to place a nasogastric tube (NG tube) to facilitate nasogastric feeding…'* On 6 January 2020 staff inserted the NG tube at 15:56 but *'…unfortunately [the patient] did not tolerate the NG tune and he removed this himself at 19:30 as 'it did not feel comfortable'…'*

Relevant Independent Professional Advice

i. Staff ignoring patient

86. The N IPA advised: this could be difficult to assess through the documents but on review of *'…the nursing assessments and evaluations, medication charts, fluid balance charts and NEWS (national early warning score); there were no apparent unmet nursing needs over this admission…'*

ii. Missed meals

87. The N IPA advised: at initial assessment the patient was independent with eating and drinking. However, as he had been admitted with a loss of appetite *'…the use of food charts to monitor intake initially should have been considered…It is likely the patient's intake was reasonable initially as on 29/12/2019 it is documented that lunch was refused because he was going off the ward with his mum…'* There are references to the patient refusing meals on the fluid balance charts and within the medical and nursing evaluations. *'…food was refused from 03/01/2020 (lunch refused), on 04/01/2020 breakfast was not given at 08:00 because the patient was asleep and then at 09:00 the patient refused his breakfast. All intake was refused on 5th…On 06/01/2020, it is documented that the patient was refusing all food and complaining of severe nausea…'* Staff tried to manage the patient's nausea so he could eat and be comfortable and a nasogastric tube (NG) *'…was passed to deliver nutrition…but was removed by the patient that same evening as it was uncomfortable…'* Staff also referred the patient to dietitians.

88. Without food charts it is *'…difficult to know exactly what the patient did eat…'* and even though he was at low risk from malnutrition these should have been maintained. *'…The records do show however that the patient refused meals to his deteriorating condition from 03/01/2020 and severe nausea, rather than them being 'missed'*. As a *'…multidisciplinary approach was taken to try to address nutritional intake…there was no impact on the patient…'* despite the absences of food charts.

iii. Changing of bed clothes

89. The N IPA advised: *'…The patient was bleeding from his nose and mouth from 09/01/2020…'* and nurses '*…delivered regular mouthcare and took advice from the Palliative care team on managing this…*' Steady bleeding from the mouth and nose would result in *'…blood staining to bedding despite frequent mouthcare.' '…there is no indication that the patient's hygiene needs were not met*. *Nurses will not document when bedding is changed and thus we will not be able to reconcile this completely…'*

iv. Actions of staff following patient's loss of sight

90. The N IPA advised: on 6 December 2020 at 22:00 nursing staff documented *'…the patient 'was worried because he was having blurred vision'.* They escalated this *'…to HAN (hospital at night) who examined the patient at 00:30 and did not find any obvious cause…This was further escalated to a senior doctor (registrar on call) who provided advice at 04:50...Nurses escalated the patient blurred vision to the medical team and he was reviewed accordingly. This was in line with nursing standards...'*

91. In relation to the patient's access to his call bell the N IPA advised*: '…it is difficult to establish this from the…documentation…'* However, the documentation can show if nursing staff did meet the patient's needs. *'…whilst the records do not prove that the patients call bell was accessible (aside from when family were advised to use it from 8th); the records show very frequent patient contacts, during which time, any outstanding needs could be addressed.'*

Summary

92. The N IPA advised: the patient was initially independent with all his activities of daily living (ALD's). From 30 December 2019 the nurses cared for the patient in a side room *'…as he was a C-Diff[17] carrier. He used the toilet frequently due to loose stools and he was independent in mobilising to the toilet…'* From 6/7 January 2020 the patient's condition changed *'…when his ability to mobilise and provide self-care became severely limited…'* The care given was in line with national standards and the N IPA *'…could not see any unmet nursing needs.'*

Analysis and Findings

i. Staff ignoring patient

93. The complainant raised a complaint about the level of nursing care provided to the patient particularly when clinicians moved him to a side room. She also said staff ignored the patient. I considered both the Trust records and its response. I note and accept the reasoning why staff cared for the patient in isolation. I also considered the N IPA's advice and accept she could not identify *'…any unmet nursing needs.'*

94. While I understand and acknowledge the complainant's concerns, given the available evidence, I am satisfied the patient's nursing needs were met appropriately. Therefore, I do not uphold this element of complaint.

ii. Missed Meals

95. The complainant said the patient missed meals. I examined the Trust records and note initially on admission to the ward, on 28 December 2019, the patient was eating and drinking independently. I also note the dates and times the patient refused meals and staff inserted a NG tube to assist with feeding on 6 January 2020. However, the patient removed this. I considered the Trust's response and note the patient was not on a food chart but on reflection it considered the patient *'…perhaps should have been…'* I also note the Trust

[17] Clostridium difficile is a type of bacteria that can cause diarrhoea and can spread from person to person.

considered the patient's oral intake was poor with a trend of him refusing food due to nausea.

96. I considered the N IPA's advice the *'…patient refused meals to his deteriorating condition…and severe nausea, rather than them being 'missed'*...' but food charts should have been maintained. I am satisfied, there was no impact on the patient despite the absence of food charts as staff took steps to address his nutritional intake. Given the available evidence I am satisfied the patient did not miss meals and therefore I do not hold this element of complaint. However, I accept staff did not maintain food charts for the patient and these would have provided clear information on the patient's nutritional intake. I consider this a service failure. I welcome the Trust have identified this issue already and would ask it to reflect on how it will ensure staff maintain such information in the future.

iii. Changing of bed clothes

97. The complainant said she had to change the patient's bed clothes on three occasions due to blood staining. I considered the Trust's records and note that on 9 December 2020 the patient had steady bleeding from his mouth and nose. I note the Trust comments that bed clothes are changed '*…on a daily basis but also as and when required…'* but that it is not normal procedure to record this.

98. I considered the N IPA's advice there would be blood staining to bedding despite frequent mouth care given and that there was '…*no indication that the patient's hygiene needs were not met*….' I also note the N IPA agrees with the Trust that nursing staff will not document when they change bedding. I have no reason to disbelieve the complainant changed the patient's bedding and acknowledge the distress she would have been experiencing at this time. However, given the changing of bed clothes is not an element of care documented within nursing records, I have been unable to determine if nursing staff failed to change the patient's bedding in a timely manner. Therefore, I cannot make a finding on this element of complaint.

iv. Actions of staff following patient's loss of sight

99. The complainant raised a complaint about the actions of nursing staff following the patient's loss of sight on 6 January 2020 as well as the patient's access to his call bell at this time. I considered the N IPA's advice that nursing staff escalated the patient's blurred vision to the medical team *'…in line with nursing standards...'* I note the N IPA was unable to establish from the records if the patient had access to this call bell but, she was able to determine he had *'…very frequent patient contacts, during which time, any outstanding needs could be addressed.'*

100. I recognise that a change in the patient's vision will have been distressing and disorientating for him and access to a call bell would have provided reassurance to him and the complainant at this time. However, from the available evidence I was unable to identify occasions when staff left the patient without his call bell or that there was any impact to the patient. Therefore, I cannot make a conclusion on this element of complaint. However, I hope the details of the frequent patient contact recorded by nursing staff, as the N IPA advised, provides some reassurance to the complainant.

Detail of Complaint

Pain management in final hours of life.

101. The complainant said staff failed to escalate and respond to concerns about the patient's pain relief in the final days before he passed away.

Evidence Considered

Policies/Guidance

102. I considered the following policies/guidance:
    - the NMC code.

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

Relevant Independent Professional Advice

103. The N IPA advised: On 7 January 2020 the palliative care team provided pain management advice which the palliative care consultant updated the same day.

At 15:00 nursing staff *'…appropriately escalated concerns of increased abdominal pain to medical staff…'* Staff documented later in the day *'…the patient's pain was 'slowly coming under control with opioids...and…the patients spouse reported a 'settled night' on the morning of 8th...'* At 09:00 on 8 January 2020 nursing staff documented the family were to alert staff if they felt the patient was in pain and staff would regularly monitor for pain as well. Later that morning the complainant raised concerns the patient was in pain. *'…Nurses escalated this to medical staff appropriately and morphine was administered…'*

104. In the early hours of 9 January 2020 *'…the patient was unsettled, and nurses administered medication to help with these symptoms. The family remained very concerned and therefore nurses appropriately escalated the HAN,…but when the patient was reviewed, he had already settled...The patient was reviewed regularly throughout the day by medical staff and the palliative care team and the syringe driver doses were amended twice…'* The N IPA advised nursing staff escalated the patient complaints of pain appropriately in the last days of his life.

105. In relation to the administration of pain medication the N IPA advised: analgesia was administered via a syringe driver (delivered continuous over a 24 hour period) and subcutaneously[18] for breakthrough pain. Nurses administered analgesia, including changes requested by the palliative care consultant, *'…as directed…'*

106. Staff were to administer the subcutaneous analgesia as required but, to be given *'…no more than 6 hourly…'* at a dose of one to two mg. Staff administered the analgesia in line with these requirements up until 05:09 on 9 January 2020 *'…when it was given after five hours rather than the prescribed six hours…'* When clinicians increased the doses and frequency of the analgesia on 9 January 2020 nursing staff administered it *'…in line with medical directions.'* While '…*analgesia was administered one hour earlier than prescribed on the morning that the patient died. This did not negatively impact on the patient and indeed would have added to his comfort. This is noted by the*

[18] Under the skin

increased frequency and dose of this medication on that same day…However, nurses should have asked medical staff to amend the prescription to reflect the more increased frequency prior to administration…'

Analysis and Findings

107. The complainant said staff failed to escalate and respond to concerns about the patient's pain relief in the final days before he passed away. I examined the Trust's records, paragraphs 20 to 35 of Appendix four, and note the times nursing staff escalated the patient's pain to the medical team. I also considered the N IPA's advice that *'…nursing staff escalated the patient complaints of pains appropriately in the last days of his life.'* However, there was one occasion when nursing staff administered the patient's 'as required' analgesia '…*after five hours rather than the prescribed six hours…'* but this did not have an impact on the patient '…*and indeed would have added to his comfort…'*

108. Given the available evidence I am satisfied Trust staff did escalate and respond to concerns about the patient's pain relief in the final days of his life. However, I accept nursing staff did administer 'as required' analgesia after five hours rather than six but am satisfied this did not impact the patient's care and treatment. I would ask the Trust to reflect on how the prescriber amends the prescription before staff administer an earlier dose of analgesia if adjustments to 'as required' analgesia are needed.

Detail of Complaint

Referral of patient's death to the coroner

109. The complainant was concerned that a post-mortem did not take place following the patient's death.

Evidence Considered

Policies/Guidance

110. I considered the following policy:
    - the Trust's referral of death policy

I enclose relevant sections of the guidance considered at Appendix three to this

report.

Trust's response to investigation enquiries

111. The Trust stated: it did not consider it necessary to refer the patient's death to the coroner as there was *'…sufficient evidence to support the clinical diagnosis of decompensated liver cirrhosis with multi-organ failure…'* and this was in line with opinions from other centres.

Relevant Independent Professional Advice

112. The G IPA advised: the patient's death was in essence *'…due to natural causes…'* (severe decompensated liver disease due to alcoholic hepatitis) with no unusual circumstances. While there may have been some doubt as to the exact diagnosis, *'…it was not sufficient to warrant a post-mortem by a corner…on balance it was reasonable not to refer to the coroner…'*

Analysis and Findings

113. I considered both the Trust's comments and the requirements of its referral of death policy. I note the G IPA's advice that it was reasonable for the Trust not to refer the patient's death to the coroner. Based on the available evidence, and the G IPA's advice I am satisfied it was reasonable for the Trust not to refer the patient's death to the coroner. Therefore, I do not uphold this element of complaint.

CONCLUSION

114. I received a complaint about the care and treatment the Northern Health and the Trust provided to the complainant's late husband.

115. For reasons outlined in this report the investigation established failures in the care and treatment in relation to the following matters:
    - Delay in the recognition of the patient's renal impairment;
    - Delay in commencing fluid management; and
    - Delay in the nutritional assessment and management of the patient.

116. I recognise the failures caused the patient experienced the loss of opportunity to optimise treatment options. I also consider that the complainant sustained the injustice of uncertainty and upset.

Recommendations

117. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's '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).

118. I further recommend for service improvement and to prevent future recurrence the Trust:

- Discusses the findings of this report with relevant clinicians and other staff members involved in the patient's care;
- Reviews the mechanisms to ensure renal function results, specifically creatinine, are available (or best estimates) in icteric samples to avoid delayed recognition of renal failure in icteric/jaundiced patients; and
- Reviews at what stage in a patient's admission clinicians should make a nutritional referral.

The Trust should provide evidence that it has completed these reviews and updates/improvements made as necessary.

119. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **3 months** of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

120. The Trust accepted the findings of the report.

121. I offer through this report my condolences to the complainant for the loss of her husband and recognise the ongoing distress she experiences as a result of her

husband's death. It is clear from my reading of the records how involved she was in the patient's care. I recognise the complainant does not totally agree with all of my conclusions. However, I wish to assure her I reached them only after my full consideration of the facts of this case. I hope this report goes some way to address the complainant's concerns.

MARGARET KELLY
Ombudsman **27 March 2024**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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.