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PUBLIC SERVICES OMBUDSMAN FOR WALES

The investigation of a complaint against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202101000

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Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs A.

Summary

Mrs A complained about the care her sister, Ms B, received at Ysbyty Glan Clwyd ("the Hospital") between May 2019 and May 2020. Ms B sadly died on 6 May 2020.

Complaint 1

Mrs A was concerned that delays in placing stents (drains) into Ms B's kidneys led to later complications with her condition. The Ombudsman was satisfied that Ms B's kidney treatment was reasonable and did not uphold this part of the complaint.

Complaint 2

Mrs A complained about inadequate bowel care for her sister when she was in hospital in April and May 2020.

Ms B was in hospital mainly because she had breathing problems. But while in hospital, she needed a specific type of bowel care. This did not take place as no skilled staff were available to do it. Nurses did not update doctors that it had not been done.

Ms B developed some new symptoms. These new symptoms may have meant that Ms B had a bowel blockage, but this was not considered. She was discharged from hospital on 5 May. The Ombudsman was concerned that Ms B went home without being seen by a doctor but decided it was not possible to say that the failure to carry out the bowel care, or the lack of communication about this, contributed to Ms B's death as she was very unwell with other problems.

The Ombudsman's view was that the failure in bowel care meant that there was a loss of dignity for Ms B. Mrs A said her sister was embarrassed by her bowel symptoms. Dignified care is a principle in the professional framework for nurses from the Nursing & Midwifery Council. The Ombudsman also identified that Ms B and Mrs A's rights under the Human Rights Act – Article 8, the right to respect for private and family life – should have been considered.

The Ombudsman's investigation saw examples of poor record keeping by staff. The record keeping fell short of the requirements expected for both doctors and nurses. The Ombudsman has identified similar problems of failings in basic nursing care, in record keeping, and in communication in previous cases she has investigated about this Hospital.

The Ombudsman noted that Ms B was in hospital during the early days of the COVID-19 pandemic. They were difficult and uncertain times with stretched NHS resources. Despite that, Ms B's care should have been of an acceptable standard.

The Ombudsman upheld Mrs A's complaint.

Complaint 3

Mrs A was unhappy with the Health Board's replies to her complaints.

In its replies to Mrs A's complaints, the Health Board did not fully identify the failings that have now come to light. The Health Board's own investigations were not thorough or open enough. The Ombudsman upheld Mrs A's complaint about this.

Ombudsman's recommendations

The Ombudsman made many **recommendations** which the Health Board accepted. These included:

- an apology to Mrs A, and payments to her totalling £4,500 for distress and having to pursue her complaint
- to share the report with staff involved in Ms B's care for them to reflect on their actions
- to remind nursing staff at the Hospital about proper record-keeping
- to complete a Bowel Care Protocol, and to ensure that enough nursing and medical staff at the Hospital are trained to carry out manual bowel evacuation

- to review its complaint handling and responses in light of the NHS Wales Duty of Candour which will be introduced in April 2023.

The Complaint

1. Mrs A complained about the care and management of her sister, Ms B, between May 2019 and 6 May 2020 at Ysbyty Glan Clwyd ("the Hospital"). Her concerns centred around the following:

a) whether delays in the fitting of stents into Ms B's kidney led to post operative complications

b) Ms B's inpatient management and care at the Hospital following her admission in April 2020, which included inadequate bowel care

c) the adequacy and the robustness of the Health Board's complaint response.

Investigation

2. My investigator obtained comments and copies of relevant documents from Betsi Cadwaladr University Health Board ("the Health Board") and considered those in conjunction with the evidence provided by Mrs A. Clinical advice was sought from my Professional Advisers, Mr David Almond, a Consultant Urologist, Dr Diane Parry, a Consultant in Respiratory Medicine, and Mr Andy Jones, a Director of Nursing. The Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. It is my role as the Ombudsman to determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. In relation to events which occurred at the height of the COVID-19 pandemic, I carefully consider whether the care delivered was appropriate within this context. I take into account the severe pressure on public bodies at the time and the impact on the organisation's ability to balance the demands on its resources and capacity to provide treatment, when reaching a decision about whether the care and treatment was

appropriate. In doing so, I will consider the explanations of the organisations complained about and whether its approach to care and treatment was appropriate at the time.

4. My office has investigated other complaints[1] against the Health Board in the last 18 months which identified shortcomings in basic nursing care and record keeping at the Hospital. Given this pattern of concerns as well as the serious issues I have identified in Mrs A's complaints, I consider it appropriate to publish this report in the public interest.

5. Both Mrs A and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant legislation, guidance and policies

6. Reference is made within this report to the following legislation, clinical guidance and policies:

a) The Human Rights Act 1998 ("the HRA") and the European Convention on Human Rights ("the ECHR"). Article 8 of the ECHR is enshrined in UK law by the HRA and deals with the right to respect for one's private and family life which encompasses issues of dignity. All public bodies are required to comply with the HRA. It is not my function to make definitive findings about whether a public body has breached an individual's human rights by its actions or inaction. However, I will identify where human rights matters are engaged and comment on a public body's regard for them.

b) The FREDA Principles: a set of guiding principles (Fairness, Respect, Equality, Dignity and Autonomy) which were developed to help NHS organisations and clinicians treat patients and their loved ones in a way that protects and respects their human rights.

c) The Royal College of Nursing - Management of Lower Bowel Dysfunction, including Digital Rectal Examination and Digital Removal of Faeces (2019).

[1] Case references 202101446 and 202104669.

d) Guidelines for the Management of Neurogenic Bowel Dysfunction in individuals with Central Neurological Conditions – initiated by the Multidisciplinary Associations of Spinal Cord Injury Professionals.

e) The General Medical Council's "Good Medical Practice" guidance ("the GMC Guidance") updated in 2019 sets out what is expected of doctors when it comes to patient care and record keeping.

f) The Nursing & Midwifery Council ("NMC") "The Code: professional standards of practice and behaviour for nurses and midwives" (2018) ("the NMC Guidance"). Principle 1 of the NMC Guidance states that "people should be treated as individuals and their dignity should be upheld. To achieve this, nurses must make sure that fundamentals of care are delivered effectively; fundamentals of care include bowel care".

g) Welsh Government guidance on Coronavirus: Ethical values and principles for health care and delivery framework (12 April 2020).

h) My predecessor issued a thematic report "Ending Groundhog Day: Lessons from Poor Complaint Handling" (2017) which was focused on driving improvement in public services using learning derived from complaints.

i) My predecessor issued guidance "Principles of Good Administration and Good Records Management" (2016 - an updated version of which was issued in 2022) ("the Guidance") which bodies within my jurisdiction are also expected to have regard to, in order to deliver good administration and customer service. The Guidance sets out the good administration principles that public service providers are expected to adopt when it comes to service delivery and dealing with service users. These principles include, for example, the need to be open and accountable.

j) The Health and Social Care (Quality and Engagement) (Wales) Act 2020 will come into force in April 2023. It will establish an organisational duty of candour on providers of NHS services requiring them to be open and honest with patients and service users when things go wrong.

The background events

7. Ms B, who was aged 60 at the time of her death, was born with spina bifida and used a wheelchair. Nerve damage to her bladder meant her bladder function was affected and she also suffered with kidney problems. At age 11, Ms B had her bladder removed and an ileal conduit (where a new passageway is made for the urine) created. She was under the care of the Urology Team at the Hospital. Ms B's condition meant she needed regular manual bowel evacuations (a procedure used for people with a non-reflex bowel, where stool is emptied by gently inserting a finger into the rectum and removing it) and this was carried out at her home by the District Nursing Team.

8. Ms B's clinic records show that over the years she had repeated episodes of chronic urinary tract infections due to narrowing of the ileal conduit. By November **2018** investigations had shown she had impaired kidney function, together with a suspected obstruction of the urinary flow from both kidneys.

9. In **2019** Ms B's care was transferred to a consultant urologist ("the Urologist"). On 14 May Ms B had stents (nephrostomies) inserted in her kidneys to improve drainage from the ileal conduit. Ms B suffered post-surgical complications which led to a stay in hospital. Ms B was told that she would need reconstructive surgery to the ileal conduit, and she would be referred to a reconstructive urological surgeon. Subsequently, the nephrostomies not draining led to further hospital admissions for Ms B.

10. In **2020** Ms B had 4 inpatient hospital admissions. Her admission on 21 February was again related to her nephrostomies not flushing. Ms B was treated with antibiotics for 4 days.

11. Ms B was re-admitted on 16 March with breathing difficulties and type 2 respiratory failure (where the respiratory system is unable to adequately remove carbon dioxide from the body).

12. Ms B was admitted again on 30 March due to her ongoing respiratory problems. She had a low level of oxygen in her blood which was attributed to pneumonia. She was discharged 5 days later when her oxygen levels had improved.

13. On Thursday 30 April Ms B attended the Hospital's outpatient clinic to have the nephrostomies replaced. She became unwell and was admitted as an inpatient under the care of a consultant in Respiratory Medicine ("the Respiratory Physician").

14. The records show that on 2 May Mrs A informed nursing staff that Ms B needed a bowel evacuation 3 times a week and which days they needed to be performed. The nursing entry on 3 May documented that a nurse asked 2 doctors about bowel evacuation for Ms B but as the doctors had not done a bowel evacuation before she had contacted another ward. However, none of the nurses there were able to do a bowel evacuation. The nurse noted that she would contact the doctor again. There is no record that this happened.

15. At 06:45 on 5 May nursing documentation noted that Ms B had opened her bowels. There is no further description available, but at 12:45 it was documented that Ms B had complained of loose stools and being in severe pain. It was not stated where the pain was located. It was reported to a doctor on the ward who discussed the matter with the Respiratory Physician. The latter attributed Ms B's symptoms to the antibiotics (flucloxacillin) she had started the previous day. The Respiratory Physician advised Ms B that she could go home but should stop flucloxacillin and re-start prophylactic antibiotics (where antibiotics are given to prevent an infection), and a stool sample would be sent for testing. Ms B was told to contact the Respiratory Team if she had any concerns. There is no evidence from the records that Ms B was examined again by the Medical Team before she was discharged. It was documented that Ms B was happy with the plan and she was discharged home.

16. On 6 May Ms B was re-admitted to the Hospital as her carers had found her unwell. She was assessed and possible sepsis (when the body overreacts to an infection and damages the organs and tissue) identified together with heart-related issues and type 2 respiratory failure. Sadly, despite treatment, her condition deteriorated rapidly, and she died at 14:25. Her cause of death was noted to be acute and chronic respiratory failure, restrictive air capacity in the lungs (respiratory restrictive disease) due to Ms B's disability, fluid build-up in the brain (hydrocephalus) and kidney disease (hydronephrosis).

17. Mrs A complained to the Health Board on 21 May about Ms B's care and management. The Health Board responded on 30 July. It concluded that Ms B's care was reasonable and that the treatment she received was appropriate. As Mrs A remained unhappy with the complaint response, a Local Resolution Meeting was held in December.

18. Given Mrs A's continued dissatisfaction, a further complaint response was sent in March **2021**. This noted that the failure to carry out a bowel evacuation might have caused Ms B's body extra stress with the additional pressure on the diaphragm affecting her ability to breathe. The Health Board accepted that its care of Ms B fell below a reasonable standard to the extent that there was a failure to carry out bowel evacuation during the admission between 30 April and 5 May 2020. It also considered that Ms B should not have been discharged home on 5 May. However, the Health Board did not feel that these failings contributed to Ms B's death. The Health Board said that its investigation had found that the cause of Ms B's death was respiratory failure, rather than as a result of bowel complications from a lack of bowel evacuation.

Mrs A's evidence

19. Mrs A said that her sister required hospital admissions as her nephrostomies had stopped draining. She said that following the procedure her sister again became ill and required admission to the Hospital due to breathlessness (see paragraph 13). Mrs A said that she believed the Urologist's delays in carrying out surgery contributed to her sister's death.

20. Mrs A referred to her conversation on 2 May with nurses about why her sister needed to have bowel evacuation. Mrs A added that over the weekend her sister's mood was low and she expressed concerns that she had not had a bowel evacuation. Her sister complained that she felt "really sick". Mrs A said she contacted the ward again and was told that someone would be coming to do the bowel evacuation at 17:00 that day.

21. Mrs A referred to the update she had received from the Respiratory Physician on the day her sister was discharged in which he noted the improvement in Ms B's respiratory condition that morning. Mrs A said that her sister telephoned her later that afternoon and said that she felt really poorly, was being sick, and was leaking from the back passage. Her sister had spoken about how embarrassed she felt as staff kept having to change her. Mrs A said she was worried and called the ward but was unable to get through. Mrs A said that she later received a telephone call from the Hospital saying that her sister had a "stomach bug" and that samples had been taken. It had also been confirmed that her sister was to be discharged home.

22. Mrs A said she was shocked at the state her sister was in when she returned home. Mrs A referred to her sister's distress, and the bed sores she had developed on her knees and elbows from lying face down the whole time she had been on the ward. Mrs A said that her sister had vomited, and it had looked and smelt "disgusting…like diarrhoea".

23. On 6 May the District Nurses saw her sister at home but they were unable to carry out a bowel evacuation as she was leaking liquid. Mrs A noted the deterioration in her sister's breathing. She said she became very unwell and was taken to the Emergency Department ("ED") by ambulance. Mrs A said that her sister "died in her arms" an hour later.

The Health Board's evidence

24. The Health Board was invited to provide comments but did not add anything further to its original complaint responses. However, 2 of the clinicians who were involved in Ms B's respiratory and nursing care did comment. Their summarised responses are set out below.

The Respiratory Physician

25. The Respiratory Physician, in referring to his respiratory outpatient consultation with Ms B on 30 April, said that Ms B had been extremely disappointed that he wanted to admit her to carry out further tests due to her respiratory failure. The Respiratory Physician said that by the time the equipment was available, the tests could not be arranged until Monday, 4 May. The Respiratory Physician said that Ms B was extremely keen to leave hospital, and given her level of disability, and the risks of contracting COVID-19 in hospital, he had "relented" and agreed to her returning home on 5 May. In the meantime, he intended to refer Ms B urgently to a colleague at another hospital site for urgent provision of domiciliary ventilator support.

26. The Respiratory Physician extended his sincere regret and condolences to Mrs A.

27. In commenting on the draft version of this report, the Respiratory Physician said that he would reflect on Ms B's care and outcome for some time to come. The Respiratory Physician said that at the time of the pandemic, he was seeing "high risk" patients earlier in the day before he entered a COVID-19 ward for ward rounds. The Respiratory Physician said that he avoided face-to-face reviews of non-COVID patients after his COVID-19 ward round to avoid inadvertent cross-infection. The Respiratory Physician added that if he had been made aware of the significant changes to Ms B's condition, he would have reviewed her.

28. The Respiratory Physician said that, due to the strain on hospitals caused by the first wave of the pandemic, Ms B was on a ward that was not usually a medical ward; senior nursing professionals were less familiar with how to escalate changes in circumstances to consultant colleagues. He added that the changes to wards and staffing meant that the usual communication channels were disrupted due to the first wave of COVID-19.

The Head of Nursing

29. The Head of Nursing at the Hospital, in commenting on the lack of bowel evacuation provision for Ms B, noted that ordinarily, to ensure the comfort of the patient, the Hospital would invite community nurses (District Nurses) to do the bowel evacuation. She added that the Health Board had trained nurses on site but that they were re-allocated due to COVID-19 and so were not available. The Head of Nursing, in noting that nursing staff had not escalated concerns beyond the ward, said the bowel care protocol had been shared with all areas and a training needs analysis was being carried out. She noted that since these events, the team on the ward concerned had changed, and there was a new ward manager in post.

Professional Advice

The Urology Adviser

30. The Adviser said it was doubtful whether an earlier nephrostomy insertion would have led to a different outcome in Ms B's case.

31. The Adviser said that a surgical reconstruction of the ileal conduit would have been associated with a significant risk, due to Ms B's likely poor respiratory condition, her spina bifida shape, and abdominal adhesions (scar-like tissue) from a previous surgery. The Adviser said that it was understandable therefore, that there was a delay while efforts were being made for reconstructive surgery to be carried out by experienced and skilled surgeons under optimal conditions. The Adviser noted that while awaiting reconstructive surgery, Ms B's kidneys were drained with nephrostomies. These would have protected her kidneys from infection and further deterioration in function. He added that long-term nephrostomy drainage without formation of a new conduit would have been a credible option for Ms B. The Adviser noted that requests were made to several larger Urology departments for help in undertaking Ms B's reconstructive surgery, without success. The Adviser said that Ms B's clinical notes suggested that her main problem was respiratory, rather than urinary.

The Respiratory Medicine Adviser

32. The Adviser noted that Ms B had previously been admitted with hypercapnic respiratory failure (where there is too much carbon dioxide in the blood, and near normal or not enough oxygen in the blood) and had required non-invasive ventilation ("NIV") in March 2020. She noted that on Ms B's admission on 30 April it appeared that she had established chronic hypercapnic respiratory failure. The Adviser said that the standard management in such cases would be to maintain oxygen levels between 88 and 92%.

33. The Adviser said that it was not standard practice to allow oxygen levels to fall as low as 75% before considering intervention. NIV would have been another way of managing Ms B's respiratory failure, although she might not have met the clinical criteria for this. The Adviser noted that consideration was given to a long-term NIV being set up during Ms B's admission, but this was switched to an outpatient plan due, it seems, to Ms B's desire to go home, her improved oxygen levels and ability to maintain satisfactory oxygen levels on air. The Adviser added that, given this improvement, it was reasonable to consider community NIV, provided it could be delivered quickly.

34. The Adviser said had there been clear communication with nursing staff about the inability to perform a bowel evacuation, an alternative assessment of Ms B and her bowel symptoms might have been undertaken. The Adviser added that, while Ms B was pressing to be discharged, had this information been available to the Medical Team, it might have led them to re-consider the discharge plan and undertake further inpatient assessments and treatment. That said, the Adviser added it was possible that Ms B's condition would have deteriorated had she remained an inpatient and that this might not have been reversible. The Adviser was clear that it was not possible to state that Ms B's death would have been avoided had she not been discharged.

35. The Adviser said that on the day of discharge, Ms B's new symptoms included loose stools, but the volume and appearance of the bowel action was not stated. There was no documentation of a clinical examination of Ms B's abdomen prior to discharge. There was also no mention of her

vomiting while on the ward, and this appeared to have developed after her discharge. The Adviser said that the description given by Mrs A suggested that this was feculent vomiting (where the material vomited is of faecal origin).

36. The Adviser added that despite nursing staff knowing that there had been no bowel evacuation over the first weekend of May, there was no documentation to suggest that this was raised with the Respiratory Physician on the Monday or Tuesday or when Ms B had the loose stools. The Adviser added that the possibility of Ms B's bowel symptoms being overflow diarrhoea secondary to constipation, or an impacted bowel, were not considered and were attributed to the antibiotics started the day before. The Adviser commented that it was not possible to draw definite conclusions about the cause of Ms B's loose stools and her bowel status at discharge. However, the description of feculent vomiting was suggestive of an element of bowel obstruction which would have been a contributory factor in the deterioration of her respiratory status.

37. The Adviser, based on the medical records, was critical of the lack of medical and nursing intervention and appropriate escalation of Ms B's bowel evacuation.

38. In terms of record keeping, the Adviser said that the clinical documentation relating to the weekend period (covering 2 and 3 May) was poor. She noted that Ms B had been commenced on antibiotics but there was no entry documented by the on-call team, who had presumably been called to see her, concerning an assessment, or why it had not been done. The Adviser was critical of what appeared to be poor communication overall between nursing and medical staff regarding Ms B's bowel and bowel evacuation situation which, had better communication happened, might have resulted in different decisions.

The Nursing Adviser

39. The Adviser said Ms B's nursing records note that on 30 April she was seen in the ED at 15:46 and transferred to a ward at 18:30 the same evening. The nursing documentation and defined risk assessments were not undertaken until approximately 08:30 onwards on 2 May. He noted that

the very limited assessments undertaken (for falls, pressure sores and nutrition for example) were poor and the information on which they were based showed a lack of accuracy and detail.

40. The Adviser noted that a toileting needs assessment document was not completed for Ms B, but a toileting risk assessment was recorded as being undertaken at 08:33. He said that both in terms of accuracy and detail the completed risk assessment was poor. For example, the response to the question “have constipation/diarrhoea” was “no”, while “normally uses any equipment to help with toileting” was answered in the affirmative by way of a tick but no note was made as to whether this referred to Ms B’s ileal conduit or not. There was also no recording of Ms B’s requirement for bowel evacuation 3 times a week.

41. The Adviser noted the Health Board’s risk assessment document clearly stated that there should be an individualised care plan developed (referred to as an “intentional rounding” document) to include toileting regime and incorporating the patient’s continence status needs and preferences at each nursing handover. The Adviser noted that the intentional rounding documents did not record any clear care plan to address Ms B’s specific toileting requirements and were regularly incomplete and inaccurate. The Adviser also found no evidence of a completed care protocol assessment of Ms B’s bladder and bowel dysfunction.

42. The Adviser said that a distended bowel caused by constipation or impaction can have serious, potentially fatal medical consequences, so it is very important that an effective bowel management programme is established and maintained in individuals who are at risk of constipation.

43. The Adviser said that the nursing documents record that Ms B had bowel movements on 4 May at 14:30 and 5 May at 06:45, however, the accuracy of this information was unclear, given the lack of clarity as to whether Ms B passed any faecal matter independently or was entirely reliant upon bowel evacuation. The Adviser said that the Health Board’s urinary catheter nursing care plan was also poorly completed and only completed on 1 and 5 May instead of daily, as expected, and again fell short of the expected standards of care.

44. The Adviser said that there was a clear breakdown in communication and a failure to escalate, in order to find trained and competent staff to undertake Ms B's bowel evacuation. The Adviser said that the Health Board was right to note the pressures on staffing due to the COVID-19 pandemic. The Adviser said that the notes of the Health Board's meeting with the family held on 2 December referred to restrictions on staff moving around as a result of COVID-19. The Adviser did not agree with the Health Board's position. He considered there was sufficiently clear opportunity to locate staff to conduct this procedure, especially given the reminder from Ms B's family regarding its importance, and that staff could be deployed to areas of need.

45. The Adviser was critical of Ms B's pressure sore management. He said there was a clear lack of documentation and evidence of action being taken in relation to maintaining Ms B's tissue integrity. The Adviser noted that while Ms B's high risk of sustaining pressure sore damage was identified, there was no record of a suitable mattress being selected or of Ms B undergoing a daily re-assessment. The Adviser noted that on 3 May at 13:45 the nursing records noted "tear to groin left side and circular wound seen to sacral area with black substance cleaned and minimal white stuff seen". He said that this should have prompted staff to get medical photography input, a tissue viability nursing review, and an update of the pressure ulcer risk assessment document, but none of these actions appeared to have been done.

46. The Adviser noted that on 4 May at 17:00 the intentional rounding log recorded a blister to Ms B's left leg, and that a doctor had seen it. However, there was no further reference to this blister in the notes. There was also no evidence of any communication with the District Nurses regarding Ms B's pressure damage care following her discharge.

47. Finally, the Adviser was concerned about the appropriateness of Ms B's discharge given her high National Early Warning Score of 6 ("NEWS" - a tool used to assess a patient and alert the Clinical Team to any medical deterioration and triggering a timely clinical response) due to her increased respiratory rate, reduced oxygen saturation and raised heart rate, especially given that her faecal fluid bypass had not been sufficiently considered. This was also coupled with pressure care being lacking.

48. In conclusion, the Adviser was critical of failings in basic nursing care, where the care provided was sub-optimal and completed documentation often poor and inaccurate. He also expressed concerns that the Health Board was only operating with a draft bowel evacuation policy at the time of Ms B's admission.

Analysis and conclusions

49. I would firstly like to offer Mrs A and her family my sincere condolences. It is clear from Mrs A's correspondence, and my Investigator's conversations with her, how deeply these events have affected her and her family. I recognise that they will find much of the detail in this report distressing. That said, I am conscious that the family have been left with uncertainty surrounding the quality of Ms B's care and I hope that this report will help to provide them with answers.

50. I am mindful that Ms B was an inpatient during the early days of the COVID-19 pandemic. I accept that staff were navigating through uncertain and unprecedented times with stretched resources. Welsh Government had issued clear guidance, however, that despite the pressures, health service delivery was to continue to follow the principles set out in equality and human rights legislation in terms of providing patient-centred care.

51. The advice I have received is very clear, which is why I have set it out in some detail above. This enables me to be relatively brief in what I have to say here. While accepting that advice in full, the findings set out below are my own. I will address each of Mrs A's concerns in turn.

a) Surgical delays in the fitting of stents into Ms B's kidney led to post operative complications.

52. The Urology Adviser has highlighted the significant risk that reconstructive surgery to Ms B's ileal conduit posed for her. The Adviser has highlighted that in both the immediate and longer-term, the nephrostomies would have helped prevent infection and further deterioration in Ms B's kidney function. I am satisfied that the care and management Ms B received from the Urologist was reasonable and that the nephrostomy delays did not lead to Ms B's deterioration after 30 April 2020. I have therefore **not upheld** this aspect of Mrs A's complaint.

b) Ms B's inpatient management and care at the Hospital following her admission in April, which included inadequate bowel care.

53. My investigation has highlighted shortcomings in medical and nursing care. I will address these in turn.

54. During Ms B's final admission, she had established chronic respiratory failure and was very unwell, although her respiratory condition subsequently showed some improvement. Whilst I note the Respiratory Physician's reasons for Ms B's discharge and that it was well intended, given that Ms B had new symptoms of pain and loose stools in the hours before her discharge, I am concerned her discharge took place without at the very least a medical review.

55. It was clearly documented that Mrs A had told nursing staff from 2 May 2020 about Ms B's need for bowel evacuation, and the frequency that this should take place. Despite that information being passed on to nursing staff, Ms B did not have the bowel evacuation she required and although it appears some attempts were made to identify staff who could carry out a bowel evacuation for her, this was not escalated when it should have been when those initial enquiries proved fruitless. It is concerning that despite Mrs A's contact with the nursing staff reminding them of the need for Ms B's bowel evacuation, this was not given the attention that it should have had, particularly given the possible serious medical consequences of not doing bowel evacuation.

56. Further, nursing staff did not inform medical colleagues of the lack of bowel evacuation. Had this happened, it might have resulted in different decisions being made about Ms B's care and management. She was discharged with new bowel symptoms when doctors did not have a full clinical picture. The possibility of Ms B's bowel symptoms being overflow diarrhoea secondary to constipation, or an impacted bowel, might have been considered at that point.

57. Mrs A has referred to the considerable distress that her sister experienced as a result of her last admission. Whilst it is not possible to say that the failure to carry out a bowel evacuation contributed to Ms B's death given her significant respiratory problems, I have no doubt that the

deficiency in Ms B's care and subsequent discharge-related failings caused her avoidable and unnecessary pain and discomfort as well as compromising her dignity.

58. The situation was compounded by the fact that Ms B's risk of pressure sores was not adequately addressed. Even when Ms B did develop a pressure sore blister this did not seem to have prompted the care and attention that was needed.

59. Mrs A has referred to her shock at her sister's condition when she saw her and witnessed her sister's distress. It seems to me that Mrs A's memories of her sister will be marred by the events following her discharge which culminated in her sister dying in her arms while in the ED. The episodes of poor care endemic in Ms B's last admission caused her an injustice.

60. As Ombudsman, I am not able to make definitive findings of breach when it comes to human rights. However, I can comment on the Health Board's regard for these rights, and I am satisfied that both Ms B and Mrs A's Article 8 rights were engaged. The failure to address Ms B's bowel evacuation meant that her dignity was compromised. Dignity is one of the FREDA principles and dignified care is a principle outlined in the NMC Code. Mrs A has spoken of her sister's embarrassment that she was leaking from her back passage and was being placed in a position of repeatedly having to ask nurses to change her. The failure to provide basic care regarding Ms B's bowel evacuation reinforced Ms B's dependency and lack of autonomy (engaging another FREDA principle). I am mindful that Ms B and her sister would have felt they were not being listened to, despite stressing how important bowel evacuation was to Ms B.

61. This investigation has identified several examples of poor record keeping by the clinical/nursing staff and this extended to basic elements of Ms B's care such as her need for bowel evacuation. Clinical records are a tool to enable clinicians to help explain and justify their actions post-event, but most importantly, to inform care. Such failings seriously undermine the confidence of patients and their families in the quality of their care and

treatment. I consider the record keeping in this case fell short of the requirements expected as outlined in both the GMC guidance and the NMC Code and this constitutes maladministration.

62. I have identified service failings in the decision to discharge Ms B on 5 May 2020, and the failure to provide her with the bowel evacuation she needed between 30 April and 5 May 2020. There was also maladministration in the poor standard of record keeping. The importance of Ms B having a bowel evacuation 3 times a week was not documented. There was a lack of care and attention when it came to documenting and addressing other aspects of Ms B's toileting needs. As a result, there was no effective clinical/nursing oversight and monitoring of Ms B's care. This prevented a holistic person-centred approach to her care. Further failings in documenting and assessing Ms B's pressure sore management also contributed to Ms B's basic care needs not being met. These failings caused Ms B an injustice as her dignity was compromised by her bowel care needs not being met and this must have been a significant cause of discomfort for her. This is also an injustice for Mrs A, who had to witness her sister's suffering and for whom this will be an enduring source of distress. There is also uncertainty about whether Ms B's clinical management might have been different. I have therefore **upheld** this aspect of Mrs A's complaint.

c) the adequacy and the robustness of the Health Board's complaint response.

63. The Health Board's second response to Mrs A's complaint in March 2021, following a meeting with her in December 2020, acknowledged that bowel evacuation had not been carried out and that Ms B should not have been discharged on 5 May 2020. However, its initial response to the complaint in July 2020 had supported the decision to discharge Ms B, and whilst it did acknowledge deficiencies in relation to bowel evacuation, it did not do so to the extent of the second response. I am concerned that the Health Board did not initially identify the extent of the failings that have now come to light, or indeed fully in its second response. This demonstrates that the initial review of Ms B's care lacked depth, rigour, openness and transparency and this contributed to a lack of candour on the part of the Health Board. It should not have taken a second response, following a

meeting with Mrs A, for these issues to be identified by the Health Board. This put Mrs A to unnecessary additional time and trouble in pursuing her concerns, at a time of bereavement, which could have been responded to following the initial investigation of her complaint. That was an injustice to her. In view of the shortcomings in complaint handling identified by my investigation, I **uphold** this aspect of Mrs A's complaint.

64. To reflect the significant injustice caused to Mrs A and her family, I am recommending financial redress. I stress that this is in no way to be seen as compensation for the family's loss, but rather to reflect the injustice caused. I consider that the level of financial redress I am recommending in paragraph 63 (b) appropriately reflects the distressing impact that the failings identified in this report will have on Mrs A and the family.

Recommendations

65. I **recommend** that the Health Board should within **1 month**:

a) Provide Mrs A with a fulsome written apology for the failings identified in this report.

b) Make a payment to Mrs A of £4,000 in recognition of the distress caused by the failings in care.

c) Make a payment of £500 in recognition of the inconvenience and trouble to which Mrs A was put in pursuing a complaint about these matters to me.

66. I further **recommend** that, within **6 months** of this report being issued, the Health Board should:

d) Share my report with the Clinical and Nursing Directorate and all relevant medical and nursing staff involved in Ms B's care, and ask them to reflect on my findings - which include the need to ensure that the FREDA principles are implemented and observed when providing patient care.

e) Remind nursing staff at the Hospital of the timeframes for the completion of core risk assessments with specific attention to timely and full completion of the documentation.

f) Remind nursing staff that when skin integrity and risk assessments are undertaken, they should focus on identifying and recording of actions as a result of the risk assessment.

g) Ensure that it has in place a programme of regular audits of nursing documentation on its wards at the Hospital to assess compliance with core documentation/risk assessment completion, legibility and action.

h) If not already completed, finalise its draft Bowel Care Protocol and formally issue it. This should be accompanied by a suitable communication strategy, which draws attention to the use of the forms in its appendices.

i) Ensure that sufficient nursing and medical staff at the Hospital are trained to carry out manual bowel evacuation procedure.

j) Ensure the new ward manager's objectives include improvement of bowel care knowledge and skills, documentation and escalation of any care constraints.

k) Ensure that dignified care audits are undertaken by corporate/independent staff.

l) As part of quality assurance, review its complaint handling and responses in light of the forthcoming Duty of Candour and report its findings to its Patient Safety committee.

67. I am pleased to note that in commenting on the draft of this report **Health Board** has agreed to implement these recommendations.

MM. Morris.

Michelle Morris 31 March 2023
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