Scottish Parliament Region: North East Scotland

Case 200500861: Tayside NHS Board

Introduction

1. On 25 June 2005 the Ombudsman received a complaint from a man (referred to in this report as Mr C) about the death of his wife, Mrs C, in a hospital of Tayside NHS Board's (the Board) Acute Services Division (the Division) in March 2005.

2. The complaints from Mr C which I have investigated concerned:

(a) clinical treatment;

(b) nursing care;

(c) communication, within the hospital and with Mr C.

3. Following the investigation of all aspects of this complaint I did not uphold it, see paragraphs 30 to 36, because I found that the care, treatment and communication were appropriate.

Investigation and findings of fact

4. I was assisted in the investigation by one of the Ombudsman's clinical advisers, a consultant geriatrician. His role was to explain, and give an opinion on, the clinical aspects of the complaint. We examined the papers provided by Mr C, the Board's complaint file and the hospital's clinical records for Mrs C's admission. To identify any gaps and discrepancies in the evidence, the content of some of these papers was checked against information elsewhere on file and also considered against my own and the adviser's knowledge of the issues concerned. I am, therefore, satisfied that the evidence has been robustly tested. Finally, in line with the practice of this office, the standard by which the complaint was judged was whether the events were reasonable, in the circumstances, at the time in question.

5. Mr C and the Board have had the opportunity to comment on a draft of this report.

6. A reminder of the abbreviations used in this report is at Annex 1.

7. I should explain that the Board's Acute Services Division (the Division) partially upheld the complaint about communication; this was in relation to a ward round on 16 February 2005, when Mr C felt that a consultant (whom I refer to in this report as Consultant 1) had given him serious and unexpected news about his wife's condition in an inappropriate way. In their response to the complaint, the Division passed on to Mr C Consultant 1's full apologies and his assurance that he had not intended to appear anything other than sympathetic and that he felt it would have been helpful if he had been able to make time to discuss Mrs C's condition with Mr C in a more private area than her hospital bedside. The Division also said that this would be a learning opportunity for other staff who could in the future be involved in similar discussions with relatives. This aspect has not been part of my investigation as no further value could have been added by me to what the Division have already done.

(a) Clinical treatment

8. Mrs C was aged 74, and had various health problems, including long-standing, worsening, dementia. Mr C cared for her at home. She was admitted to hospital on 16 February 2005 because of swallowing difficulties and a sudden weakness in her face.

9. Later that day Mrs C was seen by the consultant on call, a consultant respiratory physician (Consultant 1) during his ward round. (Paragraph 7 of this report refers to this ward round and to Mr C's complaint about it.) Mrs C was at high risk of developing, and dying from, aspiration pneumonia. Because of this and her poor quality of life, Consultant 1 told Mr C of this risk and asked him to consider (if she did develop pneumonia) whether he would want her simply to be made comfortable or to be treated with drugs.

10. The next day (17 February) Mrs C was seen by the consultant in charge of her care at the hospital, a consultant physician (Consultant 2). The specialist registrar's clinical notes for that day show that, although the aim was for Mrs C to return home some time, this might not be possible. A scan and input from the speech and language therapist (SALT) were arranged.

11. The major part of Mr C's complaint was that Mrs C had no food for many days, contributing to her death on 13 March 2005. He also said that no-one told him that although she later had a PEG inserted, the SALT and the physiotherapist had been against the PEG operation. PEG means percutaneous endoscopic gastrostomy feeding: this is done by way of a semi-permanent tube inserted through the wall of the abdomen to provide liquid food.

12. The clinical records indicate that because of her swallowing difficulties, it was considered unsafe to give Mrs C food by mouth while SALT assessments were carried out and feeding plans discussed. It was decided to insert a naso-gastric tube. This is a feeding tube inserted through the nose. The adviser has explained that decisions about whether to do this, and, if so, when, were difficult because of the conflicting clinical opinions for and against it. On the one hand, it is technically difficult to insert a naso-gastric tube in a patient like Mrs C (for example, someone in a confused state) and it is common for a patient to resist its insertion or, later, to pull it out. On the other hand, a naso-gastric tube can be a useful way to give food. The adviser considers that staff were faced with a genuine dilemma in considering the best option for Mrs C.

13. The initial SALT assessment was to give Mrs C a soft but solid diet by mouth (she could not swallow liquids safely). The SALT's clinical notes advise that Mrs C could safely only be fed when she was fully alert, actively moving food to the back of her mouth and able to sit upright for at least 15 minutes after being fed. The adviser considers that this was an appropriate plan. However, it was unsuccessful, and by 21 February, it had been decided to give Mrs C nothing by mouth (clinically described as nil by mouth) until a decision about how best to feed her could be made. The clinical notes for 21 February and the following days discuss the possibility of naso-gastric or PEG feeding. Consultant 2 thought that Mrs C would be unable to tolerate a naso-gastric tube, which left the possibility of PEG. SALT planned to assess the feeding possibilities again on 21 February but found Mrs C too drowsy for this assessment to be done. The clinical notes for 24 February describe the insertion of a PEG tube as a difficult decision because Mrs C's general condition was poor and she might be unable to tolerate the sedation which would be needed to insert the PEG tube.

14. It was felt that Mr C should have the chance to say whether he wanted artificial feeding or whether Mrs C should simply be kept comfortable. It was also felt that if Mr C opted for feeding, a naso-gastric tube should be tried first as its insertion would not require sedation. The specialist nurse for PEG feeding spoke to Mr C. The clinical notes say that he wanted feeding to be given and that the nurse told Mr C of the death rate which was linked to PEG tube insertion, saying that PEG should be considered only as a last option. The notes also say that Mr C agreed that if Mrs C continued to be unable to swallow, naso-gastric feeding should be tried. Mr C's complaint letter to the Division gave his own account of this conversation, saying that he was told that a PEG tube would be better than a naso-gastric tube and that PEG was a routine operation with high success rates.

15. Whether Mrs C would tolerate a naso-gastric tube continued to be questioned, but a decision was made to attempt it and, with some difficulty, one was successfully passed on 25 February. Mrs C's biochemistry was now being monitored because of the possibility of re-feeding syndrome. The adviser has explained that this is a state in which the introduction of nutrients after a time without food can cause serious disturbance of the body salts. The adviser also considers that the length of time that Mrs C had been without food was understandable and had not been particularly prolonged. As a SALT assessment on 28 February advised a continuation of nil by mouth, the naso-gastric feeding continued, and the clinical notes for the following days show this as remaining successful.

16. However, the question of long-term feeding options was now being discussed because Mrs C's return home would be unlikely if a naso-gastric tube was still being used. Discussion of a PEG tube, therefore, appears in various clinical notes, with various concerns being recorded about the idea. For example, the notes for 3 March say that naso-gastric feeding was still going well and that PEG insertion should not be considered yet. The senior house officer's notes for that day say that the situation had been discussed with Mr C in person. Mr C is recorded as being told that the naso-gastric feeding was going well but that Mrs C would be unlikely to return home with it in place. The clinical notes also say that Mr C wanted a PEG to be considered, to increase her chances of returning home, and that he was aware of the risks of PEG tube insertion and the death rate after insertion. (As indicated at paragraph 14, Mr C told the Division that he had been told that a PEG

tube would be better than a naso-gastric tube and that it was a routine operation with high success rates.)

17. The adviser has confirmed that, although PEG insertion is a commonly-undertaken procedure in patients with long-term swallowing problems, it has complications which should not be under-estimated. I give his comments in detail here. He has said that it is not a routine procedure. Rather, it is one which requires careful assessment of the patient and which is usually performed after all other feeding alternatives have been considered. When the PEG tube is properly inserted and an appropriate regime is put in place, PEG feeding can be very successful. Complications, however, include technical difficulties in the insertion, recognised associated morbidity and even death; also, it does not prevent the possibility of some damaging acid from the stomach getting into the lungs; the abdominal wound may become infected; and the tube may become displaced or fall out. The adviser has also said that it is, therefore, not surprising that opinions were divided and carefully discussed before the PEG was inserted. As it turned out, Mrs C suffered the complication of local gastric bleeding, and the tube fixation possibly became loosened. It is not possible to know whether these two events were the cause or the effect of Mrs C's being able to pull the PEG tube out (as she did on 12 March 2005).

18. Other clinical notes for 3 March advise that Mrs C was still to remain nil by mouth. The clinical notes for the 4 March ward round show continuing questions about whether a PEG tube was the best option, but in view of Mr C's hope for his wife's return home, it was decided that the tube would be inserted on 8 March and that if Mrs C became well enough to go home, Mr C would be trained in using it to feed his wife.

19. The PEG tube operation went ahead and PEG feeding was started immediately. However, Mrs C's blood pressure dropped slightly. The adviser thinks this might have been because of some gastric bleeding. From 9 March, there was clear evidence of gastric bleeding. The adviser says that appropriate monitoring, planning and treatment continued, and the PEG was working well. One of the doctors is recorded as telling the family on 10 March about the bleeding and the poor outlook for Mrs C's recovery.

20. The bleeding continued, and on 12 March the nursing notes also record that the PEG insertion area was leaking. At paragraph 17 I have said that Mrs C pulled out the PEG tube on 12 March; Mr C may find it helpful to know that the adviser is clear that this definitely did not cause Mrs C's deterioration or death in any way.

21. Mrs C's sad death was recorded on 13 March 2005. The clinical notes say that the likely cause of death was related to her heart and that the PEG tube insertion was unlikely to have been the cause because of the stability of the results of the various observations (of blood, for example) that were done in the days following its insertion.

22. The adviser has said that the combination of a urine infection and Mrs C's other conditions may have weakened her. He feels it is unlikely that the period without nutrition contributed directly to her death, although it may have weakened her. He considers that when she was admitted to hospital, the prospect of any meaningful recovery was very slight and the risk of aspiration pneumonia (with or without any type of tube feeding) was very high. He has said that pneumonia would probably have been fatal. In other words, Mrs C's condition was such that any additional health burdens, such as the urine infection and blood loss, would have made it increasingly difficult for her to overcome those burdens, and that one small change for the worse would have been enough to cause her death.

23. The adviser considers Mrs C's overall medical treatment to have been appropriate, with appropriate decisions, suitable discussions and relevant, frequently updated, care plans.

(b) Nursing care

24. Mr C also complained about Mrs C's nursing care. The adviser considers that the nursing records indicate well-run wards, with good assessments on admission and throughout the admission, and good care plans, which were then followed properly. Observation and fluid charts were well completed, which in itself suggests a good level of nursing care.

25. Mr C was concerned that when his wife was moved to another ward, the nurses there did not have her records. It is clear from the records that that delay did not cause any problem and that Mrs C's care continued in the way that had

been planned. I also note that, despite the delay causing no problem, the Division apologised for it in their reply to Mr C's complaint and said they had raised the issue with staff to try to avoid its recurrence.

26. Mr C was also concerned that Mrs C was placed in a side ward on her own, without stimulation. The Division told Mr C that that was the only bed available. The adviser feels that staff could have done little, if anything, about that. The nursing records show that appropriate observations and checks were carried out, and Mrs C would obviously have been seen at those times. However, the adviser feels that, because the dementia meant that Mrs C could not summon help, it would have been better if her care plans had included a brief look through her door every half hour or so. He also considers it would have been unrealistic to expect nursing staff to provide stimulation to a cognitively impaired patient who was often drowsy.

(c) Communication, within the hospital and with Mr C

27. Finally, Mr C complained that communication within the hospital and with him was poor. There is no evidence in the clinical records of communication within the hospital as being below standard. The medical and nursing notes are of a high standard, being clear and detailed, with signed and dated entries. That made it easy for each health professional to see the history of Mrs C's admission and the opinions and actions in relation to it. The medical notes contain many statements by different doctors that they have read the previous entries.

28. The records show a good level of communication with the family. They indicate that this was frequent, in some cases, daily. For example: after the ward round of 16 February (the date of Mrs C's admission), the occupational therapist is noted as having a discussion with Mr C on the 17th; a nurse spoke to him on the 18th about Mrs C's swallowing difficulties; on the 24th a senior house officer discussed the PEG and resuscitation issues and, in a separate conversation, a specialist PEG nurse discussed the PEG. The records also give a number of other examples, and the adviser considers that the communication was all that a relative could reasonably have expected.

29. Mr C also said that he was not informed that nurses and the physiotherapist were against the idea of a PEG tube. The adviser has said that any important clinical decision is often the result of differing opinions being given by team members, with a decision being reached which takes into account such views. The fact that some team members were against the PEG is, therefore, a perfectly proper part of the process and is not evidence that the PEG idea should have been abandoned. The adviser would not expect a hospital to inform a patient or relative of individual team members' views.

Conclusions

Clinical treatment

30. One of Mr C's concerns was that the hospital had decided simply to let his wife die. The above account only gives an outline of the care and treatment described in the clinical records, but I hope it is enough to reassure Mr C that this was not the case. Turning to the decisions to insert a naso-gastric and, later, a PEG tube, I am satisfied with the adviser's advice that these were appropriate. The records clearly show an ongoing evaluation of the arguments for and against these difficult decisions and a care to avoid taking the decisions too quickly.

31. I note (see paragraphs 14 and 16) that Mr C said he had been told that a PEG tube would be better than a naso-gastric tube and that it was a routine operation with high success rates. This is clearly his recollection. However, given the many serious concerns and discussions about the PEG which a number of health professionals noted in detail in the records, I consider it very unlikely that anyone would have described it in such a way. For example, in relation to a PEG tube being better than a naso-gastric tube, I consider that this was probably said in the context of Mrs C's ability to return home, as her chances of doing so were better with a PEG tube. In other words, it seems far more likely to me that Mr C was told this than that he was given a bald statement that PEG was better than naso-gastric feeding. As I have explained in the previous paragraph and elsewhere, the decision to insert a PEG tube was taken after much thought. It is not possible for anyone to know whether Mrs C's death was caused by it. And the adviser has explained (see paragraph 22) that any small additional health burden would have been enough (both before and after the PEG operation) to cause her death.

32. To summarise, taking into account these points and the other advice reported throughout this report, I am satisfied that Mrs C's clinical care and treatment were appropriate.

Nursing care

33. I am concerned (because of their inability to obtain help) to think of any patient with communication difficulties being placed in a single room. I note the Division's comment that no other beds were available. And I note the adviser's view that a better plan would have included a brief look-in every half hour or so. Because this is a minor criticism and because I do not wish to undervalue the good level of nursing care which was given to Mrs C, I make no recommendation here. But I invite the Division to consider whether in future such a suggestion should be considered when drawing up nursing care plans.

34. I share the adviser's views of the overall nursing care as being of a good standard. And I am pleased that the Board addressed the delay in sending Mrs C's records to her new ward (see paragraph 25).

Communication

35. The evidence (that is, the clinical records) demonstrates clearly a good level of communication between the health professionals. In respect of communication with Mr C and the family, I would say that this is almost always a difficult area. On the one hand, patients and their relatives understandably may want a great deal of information. On the other hand, health professionals may spend time than speaking to families, only to find that it still does not match the family's expectations. In this case, there is good evidence in the clinical records that staff took time and trouble to communicate with the family, and I share the adviser's view that the standard of communication, both within the hospital and with the family, was acceptable.

36. To summarise, therefore, I have made one small criticism (see paragraph 33) but, overall, I conclude that care, treatment and communication were good and that Mrs C's condition on admission to the hospital was such that it would have taken very little to bring about her death. It is clear from the information on file that Mr C wanted his wife to return home and to continue as her carer there. It is very sad that this was not to be, and I would not expect any words from this office to comfort

Mr C in his loss. But I hope that the explanations and assurances in this report help him to understand that his wife received appropriate care and treatment from the hospital.

27 June 2006

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	Mr C's wife
The Board	Tayside NHS Board
The Division	The Board's Acute Services Division
Consultant 1	A consultant respiratory physician, who saw Mrs C in his ward round of 16 February 2005
Consultant 2	The consultant physician in charge of Mrs C's care in the hospital
SALT	Speech and language therapy/therapist
PEG	Percutaneous endoscopic gastrostomy (a method of feeding a patient through their abdomen wall)
Nil by mouth	A situation where a patient is fed nothing through the mouth.