Scottish Parliament Region: Central Scotland

Case 200502302: Lanarkshire NHS Board

Summary of Investigation

Category:

Health: Hospital; Clinical Treatment (cancer diagnosis and pain management)

Overview:

The central aspect of this complaint is about the care and treatment received by a patient at Monklands Hospital, Airdrie between 14 May 2005 and the patient's unexpected death on 17 May 2005. A concern was also raised about the procedures for arranging a post-mortem and the actions of an out-of-hours doctor.

Specific complaints and conclusions:

The complaints which have been investigated are:

(a) the care provided by the Accident and Emergency doctor was inadequate (*upheld);*

(b) the care provided by the out-of-hours doctor was inadequate *(not upheld);*

(c) pain relief provided to Mrs A during her hospital admission was inadequate *(upheld);*

(d) communication between health professionals and Mrs A's family was inadequate *(not upheld);* and

(e) procedures for arranging the post-mortem were inadequate *(upheld).*

Redress and recommendations:

The Ombudsman recognises that action has already been taken by the Board and is satisfied that the failures identified were attributable to individual errors and do not indicate a wider problem. The Ombudsman has no specific recommendation to make.

Main Investigation Report

Introduction

1. On 18 November 2005 the Ombudsman received a complaint from MSP 1 on behalf of his constituent (referred to in this report as Mrs C). Mrs C complained about the care and treatment her mother (referred to in this report as Mrs A) received from NHS Lanarkshire Health Board (the Board). In particular she complained about the care at Monklands Hospital (the Hospital), Airdrie. These events occurred between 14 May 2005 and Mrs A's death on 17 May 2005. Mrs C also raised a concern about the procedures for release of Mrs A's body to the undertaker and the arranging of a post-mortem and the actions of an out-of-hours doctor. Mrs C raised a complaint with the Board on 25 May 2005. The Board provided a written response on 22 June 2005 and a meeting was held with staff on 19 September 2005. The Board apologised to Mrs C for failures by medical staff in examining Mrs A in Accident and Emergency (A & E) and providing Mrs A with adequate pain relief. The Board further apologised for failing to conduct a post-mortem as agreed. Mrs C remained dissatisfied with the Board's overall response and approached her MSP (MSP 1) to assist her in progressing her complaint to this office.

2. The complaints from Mrs C which I have investigated are that:

(a) the care provided by the Accident and Emergency doctor was inadequate;
(b) the care provided by the out-of-hours doctor was inadequate*;*
(c) pain relief provided to Mrs A during her hospital admission was inadequate*;*
(d) communication between health professionals and Mrs A's family was inadequate; and
(e) procedures for arranging the hospital post-mortem were inadequate.

Investigation

3. Investigation of this complaint involved reviewing Mrs A's relevant hospital records, obtaining the opinion of a medical adviser (referred to in this report as the adviser), reading the documentation provided by Mrs C and the Board and meeting with Mrs C and MSP 1*.* Mrs C, MSP 1 and the Board have all had an opportunity to comment on the draft report*.* A summary of terms used is contained in Annex 1. A glossary of medical terms is contained in Annex 2. I have not included in this report every detail investigated but I am satisfied that no matter of

significance has been overlooked.

(a) The care provided by the Accident and Emergency doctor was inadequate

4. Mrs C told me that she attended the A & E department with Mrs A on the morning of the 14 May 2005. Mrs C said Mrs A had back pain, difficulty walking and diarrhoea. Mrs C told me that Mrs A had slurred speech and was staggering, and Mrs C was concerned that Mrs A might have had another stroke (this had occurred two years previously).

5. Mrs C was present when Doctor 1 examined Mrs A and told me that Doctor 1 had not physically examined Mrs A in any way and told her that it wasn't a stroke but old age and arthritis and that Mrs A would have to put up with it. Doctor 1 wouldn't prescribe stronger painkillers (than ibuprofen) as she said this would 'knacker her kidneys'.

6. The triage sheet for the NHS 24 call on 15 May 2005 indicates (amongst other things) that Mrs A had had a recent weight loss, increased lethargy and thirst. None of this detail was noted by Doctor 1 on 14 May 2005.

7. The adviser commented that the examination notes from the A & E doctor were sparse and inadequate for a patient seen in A & E. In particular he noted that although there was a statement saying 'no neurological abnormality' there was no evidence of any neurological examination. The adviser also noted a lack of any other system examination such as chest, heart and abdomen which he considered to be unacceptable. The adviser noted that the presenting condition noted was 'lower backpain' and as such he would have expected to see an examination of the abdomen for common diagnoses of this such as faecal impaction or dissecting aneurysm. The adviser noted that had such an examination been carried out then it was likely that Doctor 1 would have discovered the lower abdominal mass felt by Consultant 1 the following day. The adviser noted that there was no record of Doctor 1 enquiring about Mrs A's current medication. He commented that while advising ibuprofen for what was assumed to be musculoskeletal pain was not unreasonable, it did not take account of the fact she was on two non-steroidal tablets already. The adviser concluded that Doctor 1's examination was inadequate, and carried out properly might have allowed Mrs A to be admitted and

diagnosed earlier. However, the adviser noted that any surgical treatment of a tumour would have been palliative only and would not have significantly lengthened Mrs A's life.

8. At the meeting with Mrs C during local resolution of this complaint, Mrs C was advised by Consultant 3 that he had discussed the consultation with Doctor 1, that Doctor 1 should have examined Mrs A and that he felt she should have been admitted that day.

9. Subsequent to this meeting Consultant 3 wrote to Doctor 1 noting that she had failed to record all the symptoms given by Mrs C and stressing the importance of listening to the information given by relatives where elderly patients are involved.

10. In response to my enquiries the Board provided me with part of the triage system used in A & E by nursing staff. This document colour codes a patient's symptoms to indicate the priority for assessment by medical staff. The Board also provided a copy of the A & E card used by the doctors as part of their assessment of the patient. This document is an A4 form which is added to, according to the information supplied by the doctor in response to prompts. The Board told me that regrettably Doctor 1 did not use the full documentation on this occasion and the additional information and prompts were not utilised.

11. The failure of Doctor 1 to use the appropriate documentation raised further questions about the oversight of junior doctors. I discussed this issue with the Board and they have provided me with general information about the assessment process for Senior House Officers (SHOs) and the assessment of this doctor in particular in relation to her record keeping. This assessment indicates that the doctor's records were considered to be very good.

(a) Conclusion

12. The medical record for the A & E admission was not properly followed by Doctor 1. Formal steps have been taken by the Board to address Doctor 1's failure to note and react to the information provided by relatives. Based on the medical advice I have received I conclude that Doctor 1 failed to properly or appropriately examine and assess Mrs A. I, therefore, uphold this aspect of the complaint.

13. In light of this conclusion and recognising the steps already taken by the Board in respect of Doctor 1 and the evidence of general assessment of SHOs the Ombudsman accepts that this was an individual error by an individual doctor and has no recommendation to make.

(b) The care provided by the out-of-hours doctor was inadequate

14. Mrs C told me that Mrs A continued to be extremely unwell following her discharge from A & E and the family called out-of-hours services (NHS 24) on the morning of 15 May 2005. The family again advised the symptoms as recent low backpain and diarrhoea with slurred speech. The NHS 24 adviser arranged for a doctor to make a home visit. Mrs C told me that the doctor who attended Mrs A, Doctor 2, noted that she was 'a funny colour' and asked what the family wanted to do about it. The family advised him that they wanted her to be admitted so she could be looked after and treated. Doctor 2 arranged for Mrs A to be admitted to the Hospital by ambulance. Mrs C felt that Doctor 2 should not have asked the family what they wanted but, as the medically qualified person, should have made that decision himself.

15. The only entry in the out-of-hours medical record relating to Doctor 2's examination is 'CVA ?'. His referral for admission letter summarises his findings and gives the reason for admission as 'for assessment'. From information supplied to me by the Board during my enquiries I understand that Doctor 2 did not complete the on-line information himself but that this was added later by the next duty doctor thus explaining the brevity of the entry.

16. The adviser commented that the records for the out-of-hours visit were very sparse, however, Doctor 2 clearly took appropriate action in arranging for Mrs A to be admitted to hospital and his admission note contained all the necessary detail.

(b) Conclusion

17. Mrs A was admitted to hospital by Doctor 2 for further examination. This was the appropriate course of action. Doctor 2 acted appropriately in seeking the views of the family prior to admitting Mrs A. The family's concern at being asked to make apparently medical decisions is understandable. I do not consider that this was Doctor 2's intention but rather he sought to understand their preferences at a time when they were, again understandably, very anxious. The limited quantity of

examination notes available preclude any detailed comment on the care provided by Doctor 2. However, I conclude that this was a failure to follow the process in terms of completion of records rather than a failure in the quality of care provided. I do not uphold this aspect of the complaint although I note that the record keeping was inadequate.

(c) Pain relief provided to Mrs A during her hospital admission was inadequate

18. Mrs C told me that Mrs A was transferred to Ward 20 on 16 May 2005 and at this time was in good spirits, although the family were concerned that she was not eating. At that point a surgical referral had been made by the doctor in the Emergency Admission Unit but had not yet happened. On the afternoon of the 17 May 2005, Mrs C's sister visited and found Mrs A distressed and in considerable pain. When this was reported to the nurses the family were advised that this pain was caused by the enema given the previous evening. Mrs C told me that the nurse did not come to see her mother at this stage.

19. Mrs C told me that when she visited Mrs A on the evening of the 17 May 2005 she found her to be in great pain and asked the nurse to give her some stronger pain relief. She was advised that Mrs A had already had some paracetamol but as the pain continued Mrs C repeated her request and the nurse then gave further pain medication. Shortly after this a doctor (Doctor 3) arrived and examined Mrs A and sent her for an x-ray. It was while Mrs A was returning from this x-ray that she went into cardiac arrest and sadly died.

20. Mrs C told me that Mrs A was a very uncomplaining individual and would have been reluctant to make a fuss. Mrs C accepted that this might have meant Mrs A did not draw attention to her pain but the family felt that the Hospital had been too slow to react when Mrs A was obviously in pain.

21. During local resolution the Board commented that Mrs A had not been complaining of pain until the afternoon of 16 May 2005 when her condition changed but that this was initially attributed by the nurses to the effects of the bowel preparation Mrs A had received prior to her sigmoidoscopy. In fact Mrs A's condition changed on 17 May not 16 May as erroneously stated in the Board's response.

22. The Board advised that Mrs A had been given paracetamol at 18:45 but as this had no effect the duty doctor was contacted. The duty doctor examined Mrs A and prescribed Kapake which was administered at 20:45. The Board stated that Consultant 2 had reviewed Mrs A's notes and spoken with the duty doctor. Consultant 2 considered that a stronger painkilling injection should have been given and apologised that the duty medical staff had failed to achieve appropriate pain relief.

23. The adviser has commented that while the Hospital record indicates Mrs A was clearly unwell she is not noted to be complaining of pain until 14:00 on 17 May 2005. At this time the nurses note Mrs A was complaining of abdominal pain but the adviser found no record of any medication being given for this pain until 18:45 when she was given paracetamol, nor is there evidence of any reassessment of Mrs A by nursing staff between 14:00 and 18:45. The adviser commented that the decision of the duty doctor to prescribe Kapake was reasonable given the circumstances and he considered this an appropriate escalation. The adviser considered that there was a failure to react to Mrs A's pain noted at 14:00 and this time delay had direct consequences for the pain relief options open to the duty doctor later that day. The adviser noted that there was also a discrepancy in the perception of the degree of pain between the family and that in the nursing record for that afternoon. He noted that there was no record of any pain scale measurement as he would have expected.

24. In response to my enquiries the Board provided me with the junior doctors' guidelines on the medication and general medical management for older people. The adviser commented that these are exemplary and include instructions to make pain assessments and record these in the medical and nursing notes.

25. The adviser commented that there is no reference to Mrs A being in pain in the admission letter from Doctor 2 or in Consultant 1's ward round notes for the afternoon of 15 May 2005. The admission record for 15 May 2005 notes Mrs A's view that she had no pain at that time or normally. The nursing notes do not contain any references to pain assessments before or after Mrs A is noted to be complaining of back pain at 14:00 on 17 May 2005.

26. In discussions following sight of the draft report the Board explained the training and information provided to nursing staff with respect to assessment of pain and the involvement of Pain Clinical Nurse Specialists throughout the Hospital. The Board provided me with a copy of a typical training programme and the relevant parts of the Nursing Documentation – including a method for recording the scale of pain. The Board also advised me that the events of this complaint have already been discussed at ward level to ensure all nursing staff had an opportunity to reflect on their practice.

(c) Conclusion

27. Based on the medical advice I have received I cannot comment on the medical response to any pain Mrs A was experiencing prior to the afternoon of 17 May 2005 as I have no medical evidence of such pain. Mrs A is clearly noted to be complaining of pain at 14:00 on 17 May 2005 but no action is taken to alleviate this pain until 18:45 with no review by a doctor until 20:15. I acknowledge the action taken by Consultant 2 to address this issue with the junior medical staff but remain concerned at the apparent failure by nursing staff to make a timely referral to the medical staff for assessment of analgesia. I recognise that there is an active, comprehensive education system in place to inform nurses' practice and encourage learning from complaints. However, based on the medical advice I have received, I consider the response of the nurse on this occasion to be inadequate both in degree and timeliness and I uphold this aspect of the complaint.

28. The Ombudsman recognises that again this is an individual rather than a systematic error and has no recommendation to make.

(d) Communication between health professionals and Mrs A's family was inadequate

29. Mrs C told me that although Consultant 1 knew that Mrs A had bowel cancer on the day she was admitted to the hospital she did not advise the family or Mrs A of this and that there was a failure to obtain the surgical referral when requested and to provide appropriate pain relief.

30. During local resolution of this complaint the Board commented that Consultant 1 had examined Mrs A following her admission on 15 May 2005 and felt that her condition was very suggestive of bowel cancer, and had made a referral

for her to be reviewed by the surgical team and for an ultrasound scan and sigmoidoscopy. Mrs A was then reviewed by Consultant 2, from the Medicine for the Elderly Team. At the local resolution meeting Consultant 2 told Mrs C that it was not clear on admission what the exact cause of Mrs A's illness was and the further tests were necessary to give a clear diagnosis. Consultant 2 said she assessed Mrs A on the morning of 16 May 2006 following her ultrasound, and that she repeated Consultant 1's request for surgical review and a sigmoidoscopy. Consultant 2 had not expected Mrs A to be transferred to her ward before being surgically reviewed but this occurred on the evening of 16 May 2005. Consultant 2 said she spoke with Mrs A on the ward on the morning of 17 May 2005 and told her that the scan had indicated there could be something serious wrong but further tests were needed.

31. The adviser commented that at the time of the surgical referrals by Consultant 1 and Consultant 2, the priority was urgent but not an emergency. He noted that the original plan for a sigmoidoscopy on the morning of 17 May 2005 failed because the bowel preparation given on the evening of 16 May 2005 was unsuccessful and the procedure was rearranged for later that week. The adviser did not consider that the delay in obtaining a surgical opinion was significant.

32. The adviser noted that there is no reference in the medical or nursing record to Consultant 2's discussion with Mrs A. However, the adviser considered that Consultant 2 acted sensibly in not informing the family of her suspected diagnosis until she had more information. The adviser did express concern that staff did not appear to have discussed Mrs A's change in condition on the afternoon of 17 May 2005 with her family who were present. He considered that staff should have notified the family of the potentially serious situation when the duty doctor requested an emergency x-ray for a possible bowel obstruction. The adviser considered that this might have gone some way to preparing the family for Mrs A's subsequent death, although he did not consider that this could have been foreseen by staff at that stage.

(d) Conclusion

33. I acknowledge the distress of Mrs C and her family. I conclude, however, that it is appropriate for medical staff to take reasonable steps to confirm a suspected diagnosis before taking any action to inform a patient (and family as appropriate).

Mrs A's condition deteriorated suddenly and unpredictably. I accept the adviser's view that it might have been beneficial to inform the family of the change in Mrs A's condition on 17 May 2005 but acknowledge that, by the time Mrs A's deterioration was recognised, the immediate priority was treating the patient. I do not uphold this aspect of the complaint but note that earlier recognition of, and reaction to the change of Mrs A's condition might have permitted staff an opportunity to communicate the deteriorating situation to Mrs A's family.

(e) Procedures for arranging the hospital post-mortem were inadequate

34. Mrs C complained that when Consultant 2 met with the family on 18 May 2005 to discuss Mrs A's death he suggested a post-mortem to determine the exact cause of death and the family had agreed. On 20 May 2005 Consultant 2 spoke with Mrs C's brother and advised him that the post-mortem would take place as soon as possible. In fact, but unknown to Consultant 2 at this point, the undertaker had already collected Mrs A's body. The family spoke with Consultant 2 later that day and were advised that there would be an investigation into why the post-mortem had not been carried out.

35. During Local Resolution of this complaint the Board advised Mrs C that there had been an error on the part of a Senior House Officer (SHO) who failed to contact the pathology department to arrange the post-mortem. Consultant 2 discussed the matter with the SHO and forwarded the profound apologies of the SHO to Mrs C. Consultant 2 advised that she had worked with this SHO for two years and there had never been any other problems. The Board also advised that the incident had been reported to the Clinical Director who had requested a review of the hospital's procedures regarding release of a body where a post-mortem might be involved.

36. In response to my enquiries the Board supplied me with a copy of the revised procedures brought in following this incident. The adviser has reviewed these and told me that they are clear and comprehensive.

(e) Conclusion

37. The Board took all reasonable and practical steps to apologise to Mrs C and to review the system which had allowed the error to happen. The individual doctor responsible was involved in the discussions and made a full apology. The revised

process is sufficiently robust to help avoid a repeat of these problems. However, procedures were not followed on this occasion and while commending the Board for all the action taken to resolve matters, I uphold this aspect of the complaint.

38. The Ombudsman recognises the comprehensive action taken by the Board to address the problems caused by this error and to prevent a reoccurrence. This error clearly caused additional distress to Mrs C and her family. The Ombudsman considers that the action taken by the Board is appropriate and has no further action to recommend.

26 September 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mrs A	The aggrieved (Mrs C's mother)
Consultant 1	The Consultant who reviewed Mrs A following her admission on 15 May 2005
Consultant 2	The Care of the Elderly Consultant who reviewed Mrs A
Consultant 3	The A & E Consultant who reviewed Mrs A's records after Mrs C complained
Doctor 1	The doctor who reviewed Mrs A in A & E on 14 May 2005
Doctor 2	The out-of-hours doctor who admitted Mrs A to hospital on 15 May 2005
Doctor 3	The A & E doctor who examined Mrs A following her admission to hospital on 15 May 2005
The adviser	Medical adviser to the Ombudsman
MSP 1	Mrs C's Member of the Scottish Parliament
SHO	Senior House Officer – a qualified doctor with two years post-qualification

	experience.
The Board	NHS Lanarkshire Health Board
The Hospital	Monklands Hospital
A & E	Accident and Emergency

Annex 2

Glossary of terms

Kapake	A pain relieving drug containing paracetamol and codeine
Sigmoidoscopy	Examination of the large intestine from the rectum through the last part of the colon.