Scottish Parliament Region: South of Scotland

Case 200503215: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; Cardiology and Nursing Care and Treatment

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment provided to her late husband (Mr C) by Ayrshire and Arran Health Board (the Board) in the months immediately prior to his death in June 2005 and in particular an alleged failure to properly diagnose and treat his cardiomyopathy in a timely manner which led to his dying before arrangements could be made for a heart transplant.

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) failed to provide Mr C with timely or adequate medical treatment *(partially upheld)*; and

(b) failed to provide Mr C with timely or adequate nursing treatment *(partially upheld).*

Redress and recommendations

The Ombudsman recommends that the Board:

(i) give consideration to more urgent treatment being prescribed through the hospital pharmacy to prevent the administrative delays associated with prescribing through general practice and;

(ii) audit and review the existing procedures for monitoring possible cannula site infections and staff awareness of these procedures.

The Board have accepted these recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 20 February 2006, the Ombudsman received a complaint from Mrs C (the complainant) that NHS Ayrshire and Arran Health Board (the Board) had failed to provide her late husband (Mr C) with timely or appropriate care and treatment for his cardiomyopathy from February 2005 until his death on 12 June 2005 and that this failure had caused Mr C considerable distress and prevented his being assessed for eligibility for a heart transplant. Mrs C complained to the Board on 30 June 2005. The Board provided written responses and arranged meetings with Mrs C to try and address her concerns but Mrs C remained dissatisfied and approached the Ombudsman's office with her concerns.

2. The complaints from Mrs C which I have investigated are that the Board:
(a) failed to provide Mr C with timely or adequate medical treatment; and
(b) failed to provide Mr C with timely or adequate nursing treatment.

Investigation

3. Investigation of this complaint involved reviewing Mr C's medical records relevant to the events and the Board's complaint file. I have also spoken with Mrs C and Mr C's sister who supported Mrs C in making this complaint. I have sought the views of a medical adviser (Adviser 1) and a nursing adviser (Adviser 2) to the Ombudsman.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Medical Background

5. Adviser 1 provided an overview of cardiomyopathy and its management. Cardiomyopathy is the name given to any chronic disorder affecting the muscle of the heart. The muscle may be damaged by many conditions including virus diseases, specific diseases and diseases causing inflammation of heart muscle. These, are known as the specific cardiomyopathies. Another group of cardiomyopathies is known as the idiopathic cardiomyopathies (weakness of the heart muscle of unknown cause). The idiopathic group is classified as three main types: hypertrophic cardiomyopathy (commonly with a strong family history); restrictive cardiomyopathy (uncommon in UK); and dilated

cardiomyopathy, by far the commonest of the idiopathic group (and that suffered by Mr C). There are a large number of causes of dilated cardiomyopathy including coronary artery disease but it is occasionally associated with a family history. In this condition, the muscle of the heart is severely and progressively weakened so that eventually the contractions of the heart fail to eject all of the blood, this is known as 'heart failure'. The symptoms of heart failure are shortness of breath which is more pronounced when lying down and on exercise, plus progressive swelling of the lower limbs caused by the accumulation of fluid. Death may occur due to accumulation of fluid in the tissue of the lungs or, quite commonly, the sudden onset of disordered rhythm of the heart.

6. The only possible curative treatment is heart transplantation, however, symptoms can be improved by relieving the heart of some of its workload. This can be achieved by reducing the volume of blood or by dilating the blood vessels to reduce the force of contraction needed to move the blood. This is done with a group of medications called 'ACE inhibitors'. An entirely different group of drugs called 'beta-blockers' is used to reduce the risk of serious rhythm disorders developing.

7. Mrs C raised a number of concerns which I have subdivided into medical and nursing concerns. Mrs C complained about the medical diagnosis and subsequent treatment and also about the quality and quantity of nursing interventions.

(a) The Board failed to provide Mr C with timely or adequate medical treatment

Medical History of the Complaint

8. Mr C first became aware of the family history of dilated cardiomyopathy in February 2005 following the death of his young niece from the condition. Mr C's GP (the GP) became aware of the family history following a report from the out-of-hours doctor who visited Mr C at home on 20 February 2005 and diagnosed left ventricular failure which was treated with frusemide. Mr C was also undergoing testing at this time for recurrent chest infections. The GP made an urgent referral to Cardiology at Crosshouse Hospital, Kilmarnock (Hospital 1) noting Mr C's family history of cardiomyopathy. Mr C was seen by Consultant 1 on 11 March 2005. An echocardiogram and an ECG were performed. Consultant 1 wrote to the GP on 11 March 2005 (but this was not typed until 16 March 2005) recommending treatment with an ACE inhibitor, beta blocker

and increased diuretics. Consultant 1 noted the family history of cardiomyopathy and that the tests had confirmed the diagnosis of cardiomyopathy. Consultant 1 also noted that it was likely Mr C had had pneumonia but that this was now settling. His letter also stated that the prognosis was not particularly good.

9. Mr C commenced his new medications on or around 21 March 2005 but remained unwell and was admitted to Hospital 1 on 26 March by ambulance following a call to NHS 24. Mr C was treated for shortness of breath and a panic attack and discharged the next day. The medical record makes a number of references to Mr C's dilated cardiomyopathy.

10. Mr C was reviewed by the GP on 7 April 2005 and visited by the heart failure nurse on 8 April 2005 who recorded that Mr C had a good understanding of his cardiomyopathy. On 2 May 2005 Mr C was admitted to Hospital 1 by ambulance with shortness of breath. Mr C was transferred to a medical ward for further observation and treatment. Mr C's condition did not improve and he was referred to Hospital 2 on 16 May 2005 for assessment for suitability for heart transplant. Mr C was transferred to Hospital 2 (a hospital operated by another health board) on 17 May 2006. Mr C was too ill to be assessed for transplant immediately but his condition improved and he was later assessed as suitable for inclusion on the transplant list. Unfortunately Mr C then became ill with an infection secondary to a cannula site wound which prevented any further action at that time and he died on 12 June 2005 before a transplant was possible.

Medical Diagnosis and Treatment

11. Mrs C complained that Consultant 1 should have admitted Mr C for active treatment and monitoring following his diagnosis on 11 March 2005 and that Mr C was not well enough to be discharged on 27 March 2005. Mrs C complained that Consultant 1 had failed to see Mr C's cardiomyopathy on the ECG on 11 March 2005 and that he and other members of staff did not listen to Mr C repeatedly telling them that he had cardiomyopathy. Mrs C stated that, following Mr C's admission on 3 May 2005, they were repeatedly told that there was nothing wrong with Mr C's heart and were, therefore, very shocked when Consultant 2 told them on 9 May 2005 that Mr C had heart failure. Mrs C further complained that Consultant 2 did not review Mr C for several days after his admission and was too slow to refer Mr C for assessment for transplant.

12. In response the Board told Mrs C that Consultant 1 had confirmed the diagnosis of cardiomyopathy following the ECG and echocardiogram on 11 March 2005 and had written to the GP with an appropriate treatment plan which involved medication to manage Mr C's symptoms. The Board stated that it would not have been necessary to monitor Mr C continually at that stage. The Board also said that on his admission on 26 March 2005 it was thought that Mr C's symptoms were being caused by his chest infection rather than his heart condition and that a chest infection was confirmed by x-ray. This was also the case initially on his admission on 3 May 2005 although Consultant 2 considered that, as Mr C's condition was not responding to treatment, his symptoms were due to heart failure. The Board noted that it was necessary for some time to elapse in order to evaluate the success or otherwise of the medical treatment for Mr C's condition but that when it was clear Mr C was not responding to treatment Consultant 1 and Consultant 2 discussed Mr C's progress on 12 May 2005 and agreed that a referral to the Advanced Heart Failure Unit at Hospital 2 was now appropriate. Consultant 1 faxed a referral to Hospital 2 on 16 May 2005 and the transfer was arranged for 17 May 2005. The Board commented that this was unusually swift as it was normal for referrals to take several days to arrange.

13. Adviser 1 stated that an echocardiogram performed on 11 March 2005 showed marked dilation of the heart and that the recommended treatment by Consultant 1 included an ACE inhibitor, a beta blocker and two diuretics. Adviser 1 told me that this was consistent with good practice in treating the symptoms of heart failure.

14. Adviser 1 reviewed the medical records for Mr C's admission on 26 March 2005 and noted that examination and investigations revealed some evidence of a right sided chest infection in addition to the heart failure which was already being treated. This infection was treated appropriately prior to Mr C's discharge on 27 March 2005 although Adviser 1 expressed concern that Mr C may have been discharged rather too soon to allow staff to observe the efficacy of this treatment.

15. Adviser 1 noted that on Mr C's readmission on 3 May 2005 his condition was deteriorating due to increasing pre-renal failure (kidney failure due to poor blood flow to the kidneys) and that this turn of events suggested a poor prognosis.

16. Adviser 1 concluded that, based on his review of all the relevant clinical records and correspondence, Mr C suffered from an unusually aggressive form of familial dilated cardiomyopathy which had already reached the stage of causing heart failure by 20 February 2005 but was not yet detectable on the chest x-rays taken to investigate Mr C's recurrent chest infections. Adviser 1's view is that the correct diagnosis was confirmed by Consultant 1 on 11 March 2005 and appropriate treatment recommended. Adviser 1 noted that there was an apparent two week delay in providing the treatment which could have been prescribed on the day of his out-patient consultation. Adviser 1 considers that this would have been particularly useful in light of Mr C's previous episode of left ventricular failure on 20 February 2005 as an earlier prescription would have helped prevent any possible re-occurrence. Adviser 1 further concluded that the subsequent admission on 3 May 2005 was appropriately clinically managed.

(a) Conclusion

17. In reviewing the medical aspects of this complaint it is apparent that medical staff correctly recognised Mr C's condition, cardiomyopathy, and his related symptoms of heart failure. However, it was not fully appreciated by Mr and Mrs C that it was Mr C's symptoms that were being treated while his underlying condition could only be managed by medication and not cured. I am of the view that this confusion gave rise to Mrs C's concerns that staff were not taking Mr C's condition seriously as they were not made aware that Mr C had heart failure until advised of this by Consultant 2 on 9 May 2005. The confusion was further compounded by Mr C's recurrent chest infections which caused staff to describe Mr C's initial presenting symptoms as being not related to his heart problem. I note that Mr C had a visit from the heart failure nurse in April 2005 but that this does not appear to have clarified the position. I am conscious that Adviser 1's view is that Mr C suffered a particularly aggressive form of cardiomyopathy which caused his condition to deteriorate more rapidly than could have been reasonably predicted by his medical team and that this would have, unintentionally, added to Mrs C's anxiety and sense of being ignored. I also note Adviser 1's view that the correct treatment was recommended by Consultant 1. Based on the view of Adviser 1, I conclude that Mr C was offered appropriate treatment but that, despite efforts on the part of staff, Mr and Mrs C were given the impression that staff were not being sufficiently proactive in treating Mr C. I do not consider that there is any specific action that staff could have taken which would have avoided this confusion.

18. Based on the views of Adviser 1, I conclude that the majority of Mr C's treatment was timely and appropriate but that there were areas which could have been better and more appropriately managed. I, therefore, partially uphold this complaint.

(a) Recommendations

Based on the medical advice received the Ombudsman recommends that the Board ask clinicians to give consideration to the urgency of the treatment being prescribed and whether it might be more appropriately prescribed through the hospital pharmacy to prevent the administrative delays associated with prescribing through general practice.

(b) The Board failed to provide Mr C with timely or adequate nursing treatment

19. Mrs C raised a number of concerns about the general care provided to Mr C throughout his admissions. Mrs C complained that Mr C was not initially provided with porter assistance when he was discharged on 27 March 2005 but that staff had expected Mr C to be able to walk out or Mrs C to push him in a wheelchair. Mrs C further complained that Mr C was not offered sufficient nursing assistance to attend to personal hygiene and that it was only because of her own interventions that Mr C was able to keep warm and had an electric bed provided. Mrs C raised a particular concern about the treatment of an infection which occurred at a cannula site.

20. In response to Mrs C's concerns the Board acknowledged that the availability of a porter to assist Mr C on 27 March 2005 had not been well handled and apologised for this, although they noted that it was the view of the nursing staff that Mr C was mobilising well enough on the ward and did not require porter assistance. The Board noted that Mr C was reluctant to allow nursing staff to assist him with his personal hygiene and often preferred to wait until Mrs C arrived to assist him. The Board also noted that Mr C had been asked to return to bed because his showering during the night (to keep warm) was causing a disturbance to other patients, but there was no note in the record of Mr C complaining of cold. The Board commented that Mrs C had provided Mr C with a duvet and pillows and staff were aware she often changed these but that bedding should have been changed daily and apologised if this had not happened. The response noted that electric beds are allocated only according to clinical need and that Mrs C's intervention was purely co-incidental as a bed had already been allocated to Mr C that day.

21. The Board noted that there was very little documentation relating to the infection at the cannula site and that nurses could not recall details of the events. The Board acknowledged Mrs C's concerns and apologised for the anxiety caused. It was also noted that Mr C was extremely anxious and that this anxiety often made his symptoms of breathlessness worse.

22. Adviser 2 noted that a number of apologies had been made by the Board and that there were a number of areas where staff had a different view of events to Mrs C (such as the need for a porter and the provision of the electric bed) which cannot be reconciled from the available evidence. Adviser 2 noted that Mr C was very anxious and very ill and this was difficult for staff to manage as Mr C was often unwilling to allow staff to assist him or to co-operate with monitoring his fluid levels. The nursing notes record that independence was very important to Mr C.

23. Adviser 2 told me that there was no entry in the records she reviewed of a swab being taken from the infected site and accordingly no microbiology result. The record on 14 May 2005 notes that the cannula site might be infected and that a dressing was applied. The record also states 'monitor please'. Adviser 2 commented that there is no further reference to the wound being attended to or monitored before Mr C was transferred to Hospital 2 on 17 May 2005. Adviser 2 has told me that it is her view that a swab should have been taken and the wound monitored as instructed. Adviser 2 expressed particular concern at this failure because a consultant at Hospital 2 had later advised Consultant 1 by letter that Mr C had become septic as a result of the infected cannula site and this may have affected Mr C's being well enough to be considered for transplant.

(b) Conclusions

24. Adviser 2 has told me that the overall nursing care was reasonable but that there were a number of difficulties which sometimes meant nursing care was not delivered as well as it might otherwise have been. Adviser 2 did raise a specific concern about the care provided to Mr C in respect of his cannula site infection.

25. Based on the views of Adviser 2, I conclude that the majority of Mr C's treatment was timely and appropriate but that there were a small number of

areas which could have been better and more appropriately managed, in particular wound management. I, therefore, partially uphold this complaint.

(b) Recommendations

26. Based on the nursing advice received the Ombudsman recommends that the Board audit and review the existing procedures for monitoring possible cannula site infections and staff awareness of these procedures.

27. The Board have accepted these recommendations and will act on them accordingly.

27 March 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	Mrs C's husband
The Board	NHS Ayrshire and Arran Health Board
Adviser 1	Medical adviser to the Ombudsman
Adviser 2	Nursing adviser to the Ombudsman
The GP	Mr C's GP
Hospital 1	Crosshouse Hospital, Kilmarnock
Hospital 2	The hospital in another health board area which assessed Mr C's suitability for heart transplant
Consultant 1	The Consultant who diagnosed Mr C's cardiomyopathy on 11 March 2005
Consultant 2	The Consultant who met with Mr and Mrs C on 9 May 2005

Annex 2

Glossary of terms

Ace inhibitors	A group of drugs which dilate blood vessels to reduce the force of contraction needed to move the blood around the heart
Beta-blockers	A group of drugs used to reduce the risk of serious rhythm disorders developing
Caridomyopathy (dilated)	A chronic disorder affecting the muscles of the heart (which are weakened and eventually fail to eject all the blood from the heart causing heart failure)
Diuretics	A substance that removes water from the body by promoting urine loss
ECG	Electrocardiogram - a test that measures the rate and regularity of heartbeats as well as the size and position of the chambers
Echocardiogram	A test that uses sound waves to create a moving picture of the heart
Frusemide	One of a group of medications called loop diuretics. Loop diuretics act in the kidney to remove excess water from the blood.
Left ventricular failure	The left ventricle (one of the heart's four chambers) becomes less efficient at pumping blood around the body