Scottish Parliament Region: Glasgow

Case 200503669: Greater Glasgow and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C) raised a number of concerns about the treatment her late father (Mr A) received at the Royal Alexandra Hospital, Paisley (the Hospital) from 2 July 2005 to 11 July 2005. This included whether it was appropriate for staff to prescribe oral rather than intravenous antibiotics and whether account was taken of Mr A's pre-existing medical condition prior to the hospital admission.

Specific complaint and conclusion

The complaint which has been investigated is that Mr A was provided with inadequate treatment and staff failed to take into account his pre-existing medical condition *(partially upheld)*.

Redress and recommendation

The Ombudsman recommends that the Board consider the development of Board-wide bereavement guidance and inform her of the outcome of the audit of nursing records.

The Board have accepted the recommendations and will act on them accordingly

[1] On 1 April 2006 the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by Argyll and Clyde Health Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of Argyll and Clyde Health Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to Greater Glasgow and Clyde Health Board as its successor

Main Investigation Report

Introduction

1. On 28 March 2006 the Ombudsman received a complaint from Mrs C about the treatment her late father (Mr A) received at the Royal Alexandria Hospital, Paisley (the Hospital) from 2 July 2005 to 11 July 2005. This included whether it was appropriate for staff to prescribe oral rather than intravenous antibiotics and whether account was taken of Mr A's pre-existing medical condition prior to the hospital admission. Mrs C complained to the Board but remained dissatisfied with their response and complained to the Ombudsman.

2. The complaint which has been investigated is that Mr A was provided with inadequate treatment and staff failed to take into account his pre-existing medical condition.

Investigation

3. In writing this report I have had access to Mr A's clinical records and the complaints correspondence from Greater Glasgow and Clyde NHS Board (the Board). I obtained clinical advice from one of the Ombudsman's professional medical advisers (Adviser 1) and one of the Ombudsman's professional nursing advisers (Adviser 2). I also made a written enquiry of the Board.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in the report is contained at Annex 1 with a glossary of the medical terms at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Complaint: Mr A was provided with inadequate treatment and staff failed to take into account his pre-existing medical condition

Clinical background

5. Mr A had a previous history of chronic obstructive pulmonary disease (COPD). The admission notes record a five year history of emphysema; that he was currently taking 40mg prednisolone; clarithromycin; three different inhalers for his chest; Uniphyllin (a bronchodilator) and Diltiazem. He was aged 78 at the time of his transfer from another hospital to the Hospital on 2 July 2005. He had been admitted to the previous hospital with a heart attack but was transferred because of complete heart block. A temporary pacing wire was

inserted and this was followed by a permanent pacemaker on 7 July 2005. Mr A developed signs of possible infection and antibiotics were administered. He was transferred from the Coronary Care Unit (CCU) to Ward 8 on 9 July 2005. Mr A deteriorated on 11 July 2005 with increasing breathlessness and reduced consciousness and died shortly after his transfer back to CCU with a heart attack.

6. Mrs C complained to the Board on 15 November 2005 about the lack of treatment afforded to Mr A. She said despite Mr A's obvious respiratory deterioration, staff continued to rely on oral administration of antibiotics to an obviously nauseated and vomiting patient who was suffering from increasing breathlessness and was no longer able to speak far less swallow medication. Mrs C felt that a more efficient method of administration of antibiotics would have been intravenously and asked why this method was not used until 10 July 2005 when the nursing staff informed the family it was because of Mr A's continued nausea and vomiting.

7. The Board's Director of Service Delivery (the Director) wrote to Mrs C on 8 February 2006. The letter set out the treatment which Mr A had received. It was explained that as Mr A had shown signs of improvement and was able to take antibiotics orally, a combination of two new oral antibiotics was felt to be the most appropriate initial therapy. On 10 July 2005 it was noted that Mr A's blood levels had grossly increased yet there was no sign of an elevated temperature, therefore, it was decided to change the antibiotic therapy from oral to broad spectrum intravenous antibiotics.

8. Mrs A wrote a further letter to the Board on 23 February 2006 and said that, although the records may have stated that oral medication was received, on one occasion the family found pills in a paper cup, therefore, they felt the administration of the actual drug was not monitored. She also raised concerns about communication issues.

9. Mrs C attended a meeting with Board staff on 16 May 2006 (which was after she had submitted her complaint to the Ombudsman). It was explained that a member of staff had left the Board, therefore, the issue about communications and his attitude and whether he had had a meeting with the family could not be pursued. In view of the explanations offered by the Board and the apology given it was decided not to investigate this specific issue. Adviser 2 has, however, commented and raised various concerns on

communication issues in the context of the nursing records at paragraph 12. It was also explained that it would be normal practice for staff to witness oral medication being taken and an apology was made that on an occasion the medication was left in a cup. It was also acknowledged that Mr A would not have been able to self administer his inhalers. It was stated that the medication issues would be raised with staff in the ward and also with the Drugs and Therapeutics Committee for wider learning. An apology was made for the failures in communication and record-keeping and a commitment given that an action plan would be implemented in due course.

10. Adviser 1 said that Mr A was a man with COPD who developed cardiac rhythm problems following a heart attack. The pacemaker prevented episodes of his heart slowing but he continued to have an unstable heart rhythm. In addition Mr A developed anaemia, the cause of which was not established. Early on in his admission Mr A's white blood count (WBC) was raised. Adviser 1 said the degree of elevation was unusual because such a high level would usually result in an infection being identified. However, Mr A's temperature was not elevated and a x-ray proved negative for infection. Later in the admission Mr A started to produce purulent sputum and this would be an indication of infection. Adviser 1 commented that the staff's assumption of infection based on the WBC was reasonable as was the decision to prescribe oral antibiotics. Adviser 1 explained that intravenous antibiotics would only be prescribed if there was a very severe infection or persistent vomiting which would prevent absorption. Mr A was not showing signs of severe infection and although there was some vomiting on 3 July 2005 which might have benefited from intravenous antibiotics for the duration it lasted, Adviser 1 felt there was no indication of persistent vomiting which would have warranted a permanent change to intravenous antibiotics. He also felt that intravenous antibiotics were not indicated by the degree of illness.

11. Adviser 1 noted that the Board had apologised that the oral medication was not witnessed by staff. He also noted the Board had apologised that Mr A had to administer his own inhalers but that they had been quickly superseded by alternative medication. Adviser 1 continued that the combination of COPD, the heart attack, heart rhythm disturbance, mild renal failure, anaemia and possible infection meant that clinically Mr A's management was not straightforward, and explanation of his symptoms was sometimes difficult. Adviser 1 said that for instance it was difficult to determine whether the episodes of breathlessness were due to Mr A's heart alone or to a combination

of heart and lung problems. Mr A was a very ill man and overall Adviser 1 thought that his management was reasonable. The medical team were aware of and took into account his previous medical condition and except for some of the medication administration as above, Adviser 1 thought the decisions which were made were appropriate.

12. Adviser 2 reviewed Mr A's nursing records and said that while they were detailed in relation to Mr A's medical status they were almost entirely lacking in any reference to, or planning for, emotional support and communication for either Mr A or his family. The care plan and one risk assessment appear not to have been completed until the day Mr A died and there was no evidence that other key risk assessments were undertaken. The records do not meet the standards as set out in the Nursing and Midwifery Council Guidelines for Records and Record-Keeping (2005), which state that 'record-keeping is an integral part of nursing … practice. It is a tool of professional practice and one which should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow'.

13. An enquiry was made of the Board in relation to Adviser 2's concerns about the nursing documentation. Adviser 2 reviewed the Board's response and said that she was encouraged that, in respect of communication issues, a planned observational audit/patient satisfaction survey was to be conducted by the end of 2006. This is a powerful means of assessing the quality of clinical care in clinical areas. Adviser 2 acknowledged that there was evidence of care delivery within the general nursing records but it was essential that meaningful care plans are written within 48 hours of the patient's admission. Equally, risk assessments must be completed at the same time in order for appropriate interventions to be implemented to minimise those risks.

14. Adviser 2 was pleased to note that a pilot audit of nursing records is to be completed by the end of 2006, which will be followed by a full audit. She was also pleased to note there were a number of educational opportunities available to nursing staff relating to issues of bereavement care. Adviser 2 felt that the Board should consider the development of Board-wide bereavement guidelines which should cover grieving and its presentation, communication, care of carers, available supporting agencies, relevant documentation etc. Some hospitals identify specific link nurses to act as a resource for other staff in dealing with bereavement issues and this can be particularly helpful.

Conclusion

15. Mrs C had concerns that staff had failed to take into account Mr A's pre-existing medical condition and that his care and treatment were compromised with the failure to alter his antibiotic medication from oral to intravenous. However, the advice which I have received and accept from Adviser 1 is that Mr A received appropriate clinical treatment which took into account his previous medical history. Adviser 1 has explained that Mr A was a very ill man and that clinically his management was not straightforward. The explanation provided on the use of oral rather than intravenous antibiotics was reasonable in that although Mr A did suffer from vomiting it was not persistent and would not have affected the absorption of the antibiotics. I have also noted that the severity of Mr A's illness in the early stages of his admission would not have warranted intravenous antibiotics and that initially his condition improved.

16. Adviser 2 has reviewed the nursing records and although there was evidence of care delivery within the general nursing records there were failings in the completion of care plans and risk assessments. Adviser 2 has commented that there was little documentation around the time of Mr A's actual death. However, it is noted that the Board have taken action to address these issues with audits planned for the future. Accordingly, although I have no concerns about the actual treatment that Mr A received I am concerned about the standard of nursing documentation. Poor documentation can have an adverse impact on the diagnosis, care and treatment delivered to a patient. In all the circumstances I have decided to partially uphold the complaint.

Recommendation

17. The Ombudsman recommends that the Board consider the development of Board-wide bereavement guidance and inform her of the outcome of the audit of nursing records.

18. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

27 March 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	Mrs C's father
The Hospital	Royal Alexandria Hospital, Paisley
The Board	Greater Glasgow and Clyde NHS Board
Adviser 1	The Ombudsman's professional medical adviser
Adviser 2	The Ombudsman's professional nursing adviser
COPD	Chronic Obstructive Pulmonary Disease
CCU	Coronary Care Unit
The Director	The Board's Director of Service Delivery
WBC	White Blood Count

Annex 2

Glossary of terms

Anaemia	Lack of red blood cells in the bloodstream
Complete Heart Block	Delay in the normal flow of electrical impulses that cause the heart to beat
Clarithromycin	Antibiotic medication
Chronic Obstructive Pulmonary Disease	Progressive lung disease
Diltiazem	Medication to treat hypertension, angina or heart failure
Emphysema	Chronic obstructive lung disease
Prednisolone	Oral Steroid medication
Uniphyllin	Oral Medication for COPD
White Blood Count	The number of white blood cells in the blood