Scottish Parliament Region: South of Scotland

Case 200503633: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C) raised a number of concerns about the treatment her husband (Mr C) received at Crosshouse Hospital, Kilmarnock in February 2005. In particular she was concerned that there was a delay by staff in reaching a diagnosis and that medication which was administered was not written in the medical records. Mrs C also complained about the way her complaint was handled.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was a delay in reaching a diagnosis (not upheld);

(b) staff failed to record when medication was administered to Mr C (not upheld); and

(c) there was inadequate complaints handling (upheld).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) bring to the attention of staff the comments made by Adviser 1 in regard to the failure to recognise the decrease in Mr C's kidney function from 17 February 2005 and the monitoring of his Gentamicin levels;

(ii) conduct an audit of the nursing records for Ward 3A to ascertain if they are in accordance with the standards as set out by the Nursing and Midwifery Council; and

(iii) conduct a review of their complaints procedure to ensure that staff are acting in accordance with the National Guidance.

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

Main Investigation Report

Introduction

1. On 24 March 2006 the Ombudsman received a complaint from Mrs C about the treatment Mr C received at Crosshouse Hospital, Kilmarnock (the Hospital) in February 2005. Mrs C complained that there was a delay by staff in reaching a diagnosis and she was concerned that medication which was administered was not written in the medical records. Mrs C also complained about the way her complaint was handled. Mrs C was dissatisfied with the responses provided by Ayrshire and Arran NHS Board (the Board) and complained to the Ombudsman.

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

(a) there was a delay in reaching a diagnosis;

(b) staff failed to record when medication was administered to Mr C; and

(c) there was inadequate complaints handling.

Investigation

3. In writing this report I have had access to Mr C's clinical records and the complaints correspondence from the Board. I obtained advice from the Ombudsman's professional medical and nursing advisers (Adviser 1 and Adviser 2) regarding the clinical aspects of the complaint.

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 can be found at Annex 1. A glossary of the medical terms can be found at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Medical history

5. Mr C became unwell at the end of 2004 and his GP referred him to the Hospital on 7 January 2005 as a chest x-ray had shown shadowing in the left upper zone. The reported concerns were also of a three month history of lethargy, muscle pains and night sweats. Mr C was seen in the respiratory clinic on 18 January 2005 and investigations the following week proved inconclusive. The decision was taken to admit Mr C for a lung biopsy. However, before this could take place, Mr C was admitted as an emergency on 5 February 2005 as he had developed facial paralysis. Investigations for a malignancy proved negative and the probable cause of Mr C's chest problem

was thought to be an infection. While investigations were continuing Mr C deteriorated suddenly and dramatically and developed acute respiratory and renal failure. Further tests indicated he was almost certainly suffering from Wegener's Granulomatosis (see Annex 2). Mr C was seen by the renal team who commenced haemodialysis for the renal failure and plasma exchange. Mr C was transferred to the ITU at another hospital where, with continued treatment, he recovered from both lung and kidney problems.

(a) There was a delay in reaching a diagnosis

6. Mrs C complained about the delayed diagnosis of Wegener's Granulomatosis. She believed that such a condition is only confirmed by a biopsy and ANCA blood test. As Mr C had had two lung biopsies she wondered why staff had not reached the diagnosis earlier.

7. The Board's Nurse Director (the Director) responded that Wegener's Granulomatosis is a multi system disease and can affect many parts of the body. Initially it was felt that a malignancy could be Mr C's problem. A lung biopsy was ordered and this revealed no evidence of malignancy but was consistent with the presence of inflammation or infection. As the investigations continued, advice was sought from a clinician in Glasgow who agreed to the continuing treatment with antibiotics and that an ANCA blood test be performed. Even at that time it was thought Wegener's Granulomatosis was unlikely and a confirmed diagnosis was only made when the result of the ANCA blood test was known.

8. Adviser 1 said that in general he was satisfied with the standard of care Mr C received. Wegener's Granulomatosis is a rare condition and is often difficult to diagnose. Mr C's original diagnosis was understandably thought to be cancer of the lung. Once the malignancy had been excluded, infection in the lungs and ears was then the favoured diagnosis. When these tests proved negative, advice was sought from an Ear Nose and Throat Specialist and the diagnosis of Wegener's Granulomatosis was suggested as an outside possibility. It was then that the ANCA test was carried out. Mr C deteriorated suddenly on 20 February 2005. The previous day it was reported he had improved but a rash had developed at his ears. Adviser 1 recognised from the records that there had been a significant drop in Mr C's kidney function between 17 February 2005 and 19 February 2005. This was not spotted by the medical team until 20 February 2005 when the renal failure was more pronounced. The nephrotoxic drugs which had been prescribed (Gentamicin and Diclofenac)

were stopped on 20 February 2005. Adviser 1 was critical of the fact that staff did not act on the results of blood tests taken on 19 February 2005 as they indicated renal failure and, as a result, the nephrotoxic drugs were continued for 24 hours longer that they should have been.

9. Adviser 1 also had concerns about the staff's failure to monitor Mr C's Gentamicin levels adequately as they were recorded on 14 February 2005 and not again until 20 February 2005. He explained that although the Gentamicin toxicity could have contributed to Mr C's renal failure he felt that the acute renal failure was predominantly due to an acute flare up of the Wegener's Granulomatosis. Although the Gentamicin levels were toxic, the rapid change of Mr C's creatinine level from normal to at least twice normal between 17 and 19 February 2005 was not caused by Gentamicin toxicity. Adviser 1 said that Mr C was treated rapidly and appropriately when his condition deteriorated. The ANCA blood test was expedited and up-to-date management for Wegener's Granulomatosis was instituted and this contributed to saving Mr C's life. It was not unexpected that Mr C would then require artificial ventilation and care in an ITU environment and the treatment was successful in a short space of time.

(a) Conclusion

10. Mrs C believes that staff should have reached a diagnosis of Wegener's Granulomatosis at an earlier stage of Mr C's treatment. However, the advice which I have received and accept is that the clinicians involved in Mr C's care and treatment acted appropriately and followed recognised procedures in an effort to reach a definitive diagnosis. Wegener's Granulomatosis is a rare disease and it was only after the provisional diagnoses had been discounted that staff were able to concentrate on the correct diagnosis. The fact that staff did not initially diagnose the condition is not an indication of failure in treatment provided that the action which had been taken was reasonable. Accordingly, I do not uphold this aspect of the complaint.

(a) Recommendation

11. Although I have not upheld this complaint, I have noted the failings identified by Adviser 1 (paragraphs 8 and 9). The Ombudsman, therefore, recommends that the Board brings to the attention of staff the comments made by Adviser 1 in regard to the failure to recognise the decrease in Mr C's kidney function from 17 February 2005 and the monitoring of his Gentamicin levels.

(b) Staff failed to record when medication was administered to Mr C

12. Mrs C complained that she felt the medication which was administered to Mr C in the Hospital contributed to his renal failure. She was aware there could be serious side effects from the medication and that Mr C had not been tested to see if he was allergic to the drugs. Mrs C was particularly concerned that Furosemide had been administered on 20 February 2005 yet there was nothing written in the notes to confirm this. Mrs C said when she had asked the nurse what the tablets were for she was told it was something to start Mr C's kidneys as they were not working.

13. Adviser 1 said that the case notes clearly documented that Furosemide was prescribed and given on 20 February 2005 and 21 February 2005. Initially it was prescribed as cover for the blood transfusion (counteract the effects of increased fluid input) and increased the following day as Mr C had become short of breath and clinically because a chest x-ray had shown that fluid had developed in the lungs. Adviser 1 said that Furosemide was fully justified and did not contribute to Mr C's renal failure which was already established.

14. Adviser 2 commented that the nursing records (Ward 3A) confirm that Furosemide was administered on 20 February 2005 and is recorded in the medication administration chart. Adviser 2 thought that Mr C received a good standard of nursing care but had some concerns about the quality of the nursing documentation which did not accord with the standards published by the Nursing & Midwifery Council. These standards set out that record-keeping should be factual, consistent and accurate; written as soon as possible after the event; accurately dated, timed and signed, with signature printed alongside the first entry; not include abbreviations; and identify problems that have arisen and action taken to rectify them. Adviser 2 found records from 16 February 2005 which were not timed; illegible signatures; no printed signatures after the first entry; and fluid balance charts which were not completed accurately. Adviser 2 also found that although some of the nursing entries were descriptive they did not identify the action taken when a problem had been identified.

(b) Conclusion

15. Mrs C had concerns that Furosemide was administered to Mr C without being written in the records and that this contributed to his renal failure and in addition, allergy testing had not been carried out. Again, the advice which I have received and accept is that it was clinically appropriate for staff to prescribe Furosemide to Mr C and there is evidence that it was administered on

20 February 2005. It has also been explained that Furosemide did not contribute to Mr C's renal failure. Therefore, I do not uphold this complaint.

(b) Recommendation

16. While this complaint has not been upheld Adviser 2 had concerns about the nursing records. The Ombudsman, therefore, recommends that the Board conduct an audit of the nursing records for Ward 3A to ascertain if they are in accordance with the standards as set out by the Nursing and Midwifery Council.

(c) There was inadequate complaints handling

National Guidance

17. The NHS Complaints Procedure which was revised on 1 April 2005 states that on completion of local resolution a letter must be sent by the authority to the complainant which should address all the issues raised and show that each element has been fully and fairly investigated. Normally local resolution should be completed within 20 working days but where this cannot be achieved the complainant must be informed of the reason for the delay and the investigation can be extended up to a further 20 working days. If the investigation is extended beyond 40 working days the complainant should be asked to agree an extension or advised that they could formally complain to the Ombudsman.

18. Mrs C said she was dissatisfied with the responses she received from the Board regarding her complaint. The responses were inaccurate in that it was said a doctor had spoken to Mr and Mrs C on 18 February 2005 when in fact it was only Mr C who had seen the doctor that day. Mrs C attended a meeting at the Board on 12 October 2005. She was not satisfied that her concerns had been addressed and she was told further investigations would be made. Mrs C heard nothing further and sent a letter to the Board on 12 January 2006. She received a response dated 26 January 2006 from the Director which apologised for the delay in sending the letter reporting the outcome of the meeting which had been overlooked. The letter mentioned that 'From memory … has recalled that it was agreed that a number of quality improvement actions would be instigated following the meeting'. Mrs C was dissatisfied with the length of time taken for the Board to follow-up on the resolution meeting and that the final letter referred to 'from memory' and did not address the question of the inaccurate comments from the doctor.

(c) Conclusion

19. It is clear that there has been a failure by the Board to act in accordance with the NHS Complaints Procedure in regard to Mrs C's complaint. Mrs C first raised her detailed complaint on 12 July 2005 and this prompted an eight page response from the Director on 15 August 2005 which was followed by a meeting on 12 October 2005 as Mrs C was dissatisfied with the initial response. It was from there that the procedure broke down. The letter which was supposed to have been sent to Mrs C following the meeting was overlooked and it was only discovered when Mrs C sent a further letter on 12 January 2006 asking for an update. In summary, the Board failed to address all the issues which Mrs C raised and the time taken to consider the complaint was far outwith the National Guidance. As a result, staff would have had to rely on memory for certain issues and due to the passage of time accurate recollection of events could be difficult to achieve. I note that the Board have apologised to Mrs C for the failure to send a letter following the meeting. In all the circumstances I uphold this complaint.

(c) Recommendation

20. The Ombudsman recommends that the Board conducts a review of their complaints procedure to ensure that staff are acting in accordance with the National Guidance.

21. 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.

20 June 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	Mrs C's husband
The Hospital	Crosshouse Hospital
The Board	Ayrshire and Arran NHS Board
Adviser 1	The Ombudsman's professional Medical Adviser
Adviser 2	The Ombudsman's professional Nursing Adviser
The Director	The Nurse Director
ITU	Intensive Therapy Unit
Nursing and Midwifery Council	Regulatory Body for Nurses and Midwives

Annex 2

Glossary of terms

ANCA blood test	Blood test which would aid a diagnosis of Wegener's Granulomatosis
Creatinine	A substance in the blood which if levels rise could indicate a problem with kidney function
Diclofenac	Non-steroidal anti-inflammatory drug taken to reduce inflammation
Furosemide	Diuretic medication
Gentamicin	Antibiotic
Haemodialysis	Dialysis where the blood is cleaned outside the body by a machine
Malignancy	Cancer
Nephrotoxic medication	Poisonous or damaging to the kidney
Wegener's Granulomatosis	Rare disease associated with inflammation of the small arteries. Many tissues of the body can be affected but most commonly seen is involvement of the respiratory tract and kidneys.