Scottish Parliament Region: North East Scotland

Case 200500951: Grampian NHS Board

Summary of Investigation

Category

Health: Hospitals; Clinical treatment

Overview

Ms C raised a number of concerns on behalf of her mother (Mrs A) that she had not received proper or adequate treatment from Grampian NHS Board (the Board) whilst in Woodend Hospital (Hospital 1) for a knee operation. She was transferred to Aberdeen Royal Infirmary (Hospital 2) on 11 December 2004.

Specific complaints and conclusions

The complaints which have been investigated are that the Board failed to:

(a) provide proper or adequate nursing and medical care to Mrs A (*upheld*);
(b) identify a small bowel obstruction (*upheld*); and
(c) communicate effectively with Mrs A's family (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) review medical and nursing documentation and advise the Ombudsman of the outcome of the review;
(ii) introduce a system for the audit of clinical documentation, for example pulling five files on a monthly basis, and advise the Ombudsman of the proposed action; and
(iii) consider if there are training needs for staff in relation to communication with patients and relatives/friends.

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

Main Investigation Report

Introduction

1. On 25 June 2005, the Ombudsman received a complaint from Ms C on behalf of Mrs A. Ms C complained about the treatment Mrs A had received from Grampian NHS Board (the Board) and that the Board had not communicated effectively with Mrs A's family. Ms C complained to the Board, but was not satisfied that they had provided an adequate response or that they had taken action to ensure that the problems did not recur.

2. The complaints from Ms C which I have investigated are that the Board failed to:

(a) provide proper or adequate nursing and medical care to Mrs A;
(b) identify a small bowel obstruction; and
(c) communicate effectively with Mrs A's family.

Investigation

3. Investigation of the complaint involved reviewing Mrs A's medical records relevant to the events and the Board's complaint file. I also sought the views of a surgical (Adviser 1) and a nursing (Adviser 2) adviser to the Ombudsman. The Board provided me with additional information requested following receipt of Adviser 1 and Adviser 2's views.

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

5. The broad facts of the case are not in dispute. Mrs A was admitted to Woodend Hospital (Hospital 1) for a total knee replacement on 5 December 2004. The operation took place on the following day. After the operation, Mrs A became increasingly unwell. She developed projectile vomiting, dehydration, elevated blood sugars and a bowel obstruction. She was transferred to Aberdeen Royal Infirmary (Hospital 2) on 11 December 2004 and underwent emergency surgery for small bowel obstruction on 12 December 2004.

6. Ms C complained to the Board on 16 December 2004 about the treatment that Mrs A had received. The Board issued a response on 16 March 2005, but Ms C remained unhappy and wrote again on 1 April 2005. The Board issued a

further response on 28 April 2005. Ms C then referred the complaint to the Ombudsman's office on 17 June 2005.

(a) The Board failed to provide proper or adequate nursing and medical care to Mrs A

7. In her complaint to the Board dated 16 December 2004, Ms C made a number of complaints regarding the nursing and medical care provided to Mrs A in Hospital 1. She said that there had been delays in administering medication for diabetes and in removing a surgical drain. She also said that Mrs A's continual heartburn was poorly controlled and there was no reference to whether she was tolerating fluids or managing to cope with food intake. She said that Mrs A was still projectile vomiting after two days and there was no peripheral access for fluid resuscitation. Ms C complained that although Mrs A's sodium level had dropped, the medical staff restricted her fluid intake and delayed in referring her to Hospital 2.

8. In their response, the Board said that Mrs A's sugar levels had been monitored regularly and it was reported to medical staff that they were elevated. On their instructions, blood sugar levels were monitored and it was considered that no further treatment was required. They said that a consultant had told nursing staff to remove her drain. A specific time had not been given for this and staff had removed it at the earliest opportunity. The Board also said that medication was prescribed and administered for heartburn, nausea and vomiting.

9. The Board stated that the amount of fluid was restricted, as sodium levels were low. A consultant explained that this was associated with over hydration. The Board also said that a diabetic consultant was contacted and insulin infusion was commenced because Mrs A's blood sugars remained high. They advised that they had no control over the arrival of an ambulance and that prior to Mrs A being transferred to Hospital 2, an x-ray was performed and intravenous fluids and insulin infusion were commenced.

10. Ms C wrote to the Board again on 1 April 2005. She said that although blood sugar levels were abnormally high, nothing was done and that the surgical drain could have been removed earlier. She complained that there were delays in treating Mrs A's vomiting and that staff did not try to establish the cause of her heartburn. She said that she had been advised that staff did not routinely keep fluid balance sheets as part of documented records. Ms C said

that restricting fluids had compounded the problem and asked if there had been a cover up, as no dates or times were given for intravenous fluids being started or the naso-gastric tube being inserted. She advised that Mrs A had to be fluid resuscitated for 30 hours before being operated on in Hospital 2 and said that in her view, the ward sister obviously had no control over her ward or staff. She also complained about an orthopaedic surgeon's treatment of Mrs A.

11. In their response, the Board said that an opinion from a diabetic consultant had been sought and Mrs A's diabetes had been managed appropriately. They apologised that she had to wait a considerable amount of time to have the surgical drain removed. They said that this was done at the earliest opportunity. The Board said that a staff member had been correct in stating that fluid balance charts are not normally retained in the medical notes when a patient has been discharged, as they take up too much space. Nurses normally evaluate the results of the fluid balance charts in the nursing documentation.

12. The Board also said that Mrs A's urea and electrolytes were not checked immediately after the operation, but were checked on 9 December 2004. At that time, her sodium was noted to be lower and her urea and creatinine mildly elevated. Medical advice was sought and staff were advised to restrict fluids to 1,500mls per day. They stated that Mrs A received symptomatic therapy for her heartburn and that the orthopaedic surgeon had no recollection in behaving in the manner described.

13. Adviser 1 commented that the medical records really only began when Mrs A started to develop abdominal complaints. He also commented that, during a ward round with the consultant orthopaedic surgeon on 10 December 2004, a doctor reported that the patient was still vomiting, having difficulty mobilising, had low sodium and was on restricted fluids. Although there was a plan of action, there was no reasonable history taken and no examination of her abdomen. He also said that it was not clear from the notes what time Mrs A was transferred to Hospital 2.

14. Adviser 2 said that, when reviewing nursing records, she looked for evidence of a coherent structured approach to nursing assessment, care planning and evaluation and that she would expect relevant supporting documentation, such as observation records and risk assessments, to be included in the records. She highlighted some significant issues. She said that the records were inadequate in relation to the ongoing assessment of need,

progress evaluation and timely revision of the care plan. She commented that observation recordings were poorly charted, making it difficult to detect subtle changes in the patient's condition. She also said that the recording and monitoring of fluid balance was poor and, as Mrs A was a diabetic, this was of particular concern.

15. Adviser 2 also noted that records show a small but significant rise in Mrs A's pulse rate from 8 December 2004. The root cause of this may have been her increasing discomfort from nausea, vomiting and upper abdominal pain (described as heartburn), but could equally have been a reflection of her deterioration from that time.

16. In response to Ms C's complaint, the Board told Ms C that Mrs A's fluid intake was monitored on the ward and there was documentation to confirm this. In their subsequent response, the Board stated that fluid balance records are not routinely retained in clinical records as they take up too much space, but that nursing staff normally evaluate the results of the fluid balance charts in the nursing documentation. However, there is no evidence in the nursing records to support this statement. There were no fluid balance charts for 8 December or 9 December and Adviser 2 suspects that they were not completed for these two days. She stated that it would be strange to dispose of only two charts in the middle of a fixed period.

17. Adviser 2 was satisfied with the Board's explanation that the surgical drain was removed at the earliest opportunity. She did not consider that the delay in removing the drain would have had any negative impact on Mrs A's health. She said that there was evidence that nursing staff monitored Mrs A's blood sugar levels regularly. She also commented that she considered that Mrs A received a reasonable standard of care in relation to her orthopaedic surgery.

(a) Conclusion

18. Based on the clinical advice I have received, I am satisfied that Mrs A received a reasonable standard of medical care in relation to her orthopaedic surgery. Although there was a delay in removing a surgical drain, this would not have caused Mrs A any health problems.

19. The Board clearly failed to maintain adequate medical and nursing records for Mrs A and failed to complete some of the necessary documentation. I have concluded that the Board has failed to provide evidence that it gave adequate

nursing and medical care to Mrs A in relation to her diabetes, hydration levels, food intake, projectile vomiting and sodium levels.

20. I note that Mrs A was transferred to Hospital 2 in the early hours of 11 December 2007. Hospital 1 failed to record any observations after 21:00 on 10 December 2007, when her condition deteriorated considerably. I uphold this aspect of Ms C's complaint. The Ombudsman has made recommendations in relation to this at (b) below.

(b) The Board failed to identify a small bowel obstruction

21. The medical records show that Mrs A vomited at breakfast and at 08.00 on 8 December 2004, but that medication was administered to good effect. On the same day, a physiotherapist also recorded that Mrs A vomited whilst he was examining her.

22. On the following day, the physiotherapist who examined Mrs A recorded that she was feeling slightly nauseous. It was recorded on the core care plan that Mrs A had established a bowel pattern. On 10 December 2004, Hospital 1 recorded that Mrs A had suffered projectile vomiting at approximately midnight on the previous night. It was also recorded that she had a loose stool and that medication was given to good effect. It was then recorded that she vomited large amounts several times. She was given medication, which initially helped, but she started vomiting large amounts again at 21:00. At that time, it was recorded that she had not passed a stool for four days.

23. A small bowel obstruction was identified on 10 December 2004 and Mrs A was transferred to Hospital 2 on 11 December 2007. During her admission, she went into fast atrial fibrillation, which was treated with medication. She had abdominal surgery on 12 December 2004.

24. Adviser 1 noted that although there were medical notes regarding the operation, vomiting, abdominal pain and the distension Mrs A suffered, the notes did not make it clear that any sort of abdominal examination was done. He was also critical that there were no dated sheets in the notes showing when exactly Mrs A's abdominal problems started. In the absence of any notes to the contrary, Adviser 1 believes that it is likely that there was a delay in making a diagnosis of Mrs A's small bowel obstruction.

25. Adviser 2 commented that the daily checklist, which indicates a number of key patient assessments that should be carried out on each shift, did not equate with the nursing records. The daily checklist showed that there was a bowel movement on 7 December 2004 and a signature on the core care plan for 9 December indicated that a bowel pattern had been established. However, it was recorded on the medical records on 9 December 2004 that Mrs A had been constipated for four days. The medical records do not make any other references to this matter prior to 9 December 2004.

26. Adviser 2 said that clinical staff did not increase the level of monitoring in respect of fluid management and did not consider other causes of her vomiting and lack of bowel movement, when Mrs A's recovery deviated from what would have been expected. She commented that she would have expected senior nursing staff to have questioned Mrs A's persistent vomiting and the fact that she had not properly opened her bowels. She said that although the fluid balance records were incomplete and the physiological records were poorly plotted and incomplete, they demonstrated some changes that should have alerted staff to a change in Mrs A's condition. However, there is no evidence of any abdominal assessment following the onset of vomiting.

27. Adviser 2 was also concerned at the treatment given to Mrs A after a member of the orthopaedic team noted that her sodium was low and that she had not opened her bowels for four days. A discussion with the duty physicians was held and it was decided to restrict her fluid intake and to prescribe a suppository (followed by an enema) to address what was thought to be constipation. There is no evidence that any intestinal cause was considered for the signs and symptoms displayed. In the event, Mrs A required fluid resuscitation to rectify dehydration when she was transferred to Hospital 2.

28. In their response to Ms C of 16 March 2005, the Board said that medical staff examined Mrs A on 8 December 2004 and found her abdomen soft. They stated that bowel sounds were also present and there was no evidence of an obstruction. However, there is no evidence to suggest that Mrs A's abdomen was checked at any other stage prior to an emergency assessment at 21:00 on 10 December.

(b) Conclusion

29. The multi-disciplinary care of patients, particularly the elderly with many different diagnoses, makes it important that shared care is organised routinely

between physicians and all those involved in a case, in this case the orthopaedic surgeons in particular. Although acute abdominal emergency may be rare in patients in these stand-alone units, clinical staff need to ensure that problems are identified and adequate treatment provided.

30. I have already addressed the Board's failure to provide evidence of proper or adequate nursing and medical care to Mrs A above. Based on this and the views of the Advisers, I conclude that there was an unnecessary delay in identifying the bowel obstruction. I, therefore, uphold this aspect of the complaint.

(b) Recommendations

31. The Ombudsman recommends that the Board:

(i) review medical and nursing documentation and advise the Ombudsman of the outcome of the review; and

(ii) introduce a system for the audit of clinical documentation, for example pulling five files on a monthly basis, and advise the Ombudsman of the proposed action.

(c) The Board failed to communicate effectively with Mrs A's family

32. Guidance from the Royal College of Surgeons advises that members of the surgical team should ensure that a record is made of important events and communications with the patient or supporter (for example, prognosis or potential complication). The Nursing and Midwifery Council's guidance on record-keeping states that good record-keeping is an invaluable way of promoting communication.

33. Adviser 2 commented that the clinical records showed a lack of communication with Mrs A's family regarding her worsening condition. She commented that the Board wrote to Ms C on 16 March 2005 and said that medical and nursing staff:

> '... do not normally approach relatives of patients who are alert, orientated and able to feedback information to their relatives themselves, unless a request is made by the relatives to do so.'

Adviser 2 said that she could understand that this was the case when Mrs A was recovering well after the operation. However, she said that she would expect nurses to ensure that planned care and interventions were clearly understood by both patients and their carers, especially when unexpected

events occurred and changes in treatment were made. She also said that it was not acceptable to say that communication is the responsibility of the patient and relatives should not be expected to have to request information.

(c) Conclusion

34. Effective communication with patients and their carers is an integral part of good healthcare. The Board has stated that clinical staff frequently speak to patient's relatives, but do not routinely record this in the medical records unless it has a direct bearing on a patient's treatment. It would clearly be unreasonable for staff to record every occasion on which they communicated with patients and their families. However, it is good practice for clinical staff to keep patients and their supporters informed and to maintain adequate records of this. I have concluded that the Board has failed to demonstrate that they communicated adequately with Mrs A's family. I uphold this aspect of the complaint.

(c) Recommendation

35. The Ombudsman recommends that the Board consider if there are training needs for staff in relation to communication with patients and relatives/friends.

36. 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.

21 November 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mrs A	The aggrieved – Ms C's mother
The Board	Grampian NHS Board
Adviser 1	Surgical adviser to the Ombudsman
Adviser 2	Nursing adviser to the Ombudsman
Hospital 1	Woodend Hospital
Hospital 2	Aberdeen Royal Infirmary

Annex 2

Glossary of terms

Atrial fibrillation	A condition where there is disorganised electrical conduction in the atria, resulting in ineffective pumping of blood into the ventricle
Creatinine	A waste product of protein metabolism that is found in the urine
Electrolytes	Substances that dissociate into two or more ions, to some extent, in water
Enema	A liquid injected or to be injected into the rectum
Naso-gastric tube	A fine or narrow bore tube passed into the stomach via the nose
Symptomatic therapy	Therapy aimed at relieving symptoms without necessarily affecting the basic underlying cause(s) of the symptoms
Urea	The final nitrogenous excretion product

Annex 3

List of legislation, policies and guidance considered

Royal College of Surgeons of England: Good Surgical Practice 2002 (Endorsed by the Association of Surgeons of Great Britain and Ireland, the Royal College of Surgeons of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow.)

Nursing and Midwifery Council: Guidance on record keeping