Scottish Parliament Region: South of Scotland

Case 200601233: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; Care of the elderly; Clinical treatment/diagnosis

Overview

The complainant (Miss C) had a number of concerns about the care and treatment given to her late mother (Mrs A) at Ayr Hospital (the Hospital). In particular, she felt that the Hospital had not correctly dealt with problems Mrs A had had with her legs and had failed to provide Mrs A with treatment in the days prior to her death. Miss C was also concerned that medical records recorded a conversation between herself and a consultant which she said could not have happened on the date given.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the care and treatment provided to Mrs A was not appropriate (*partially upheld*); and

(b) information recording a conversation in the medical records was inaccurate (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board apologise to Miss C for the failure to appropriately assess Mrs A's needs following the decision to end active treatment and for failing to ensure all relevant notes were made available to the Ombudsman's office during the initial investigation of this complaint.

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

Main Investigation Report

Introduction

1. Mrs A, aged 66, was first admitted to Ayr Hospital (the Hospital) on 4 April 2004. She had been suffering from painful and swollen legs for some weeks and had a weeping ulcer on one leg. Mrs A also had a number of pre-existing conditions including chronic obstructive pulmonary disease (COPD) and had been diagnosed as having a tumour on her right lung in 2002. Mrs A was discharged on 9 April 2004.

2. On 4 May 2004 Mrs A collapsed at home and was again admitted to the Hospital. On 5 May 2004 it was recorded in Mrs A's notes that she should not be resuscitated in the event of cardiac arrest. Mrs A remained in hospital until her death on 10 May 2004.

3. On 2 February 2005 Mrs A's daughter (Miss C) complained about the care and treatment Mrs A had received. Correspondence between Miss C and Ayrshire and Arran NHS Board (the Board) about her concerns continued until 8 February 2006. Miss C also attended a meeting to discuss her complaint on 9 May 2005. Miss C remained unhappy following the final response of the Board in February 2006 and, on 26 July 2006, complained to the Ombudsman.

4. The complaints from Miss C which I have investigated are that:

(a) the care and treatment provided to Mrs A was not appropriate and;

(b) information recording a conversation in the medical records was inaccurate.

Investigation

5. The investigation of this complaint involved obtaining all the background documentation relating to the complaint and Mrs A's medical records. Advice was also obtained from a medical adviser (Adviser 1) and two nursing advisers (Adviser 2 and Adviser 3 respectively) to the Ombudsman. Enquiries were also made of the Board. The abbreviations used in the report are explained in Annex 1 and the medical terms used in the report are explained in Annex 2.

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

(a) The care and treatment provided to Mrs A was not appropriate

7. The medical records relating to both Mrs A's admissions (4 April to 9 April 2004 and 4 May to 10 May 2004) were reviewed by Adviser 1, Adviser 2 and Adviser 3.

8. Adviser 1 said that during her first admission Mrs A was diagnosed as having severe heart failure and a soft tissue infection in both legs.[1] She was appropriately treated for these conditions with oxygen, pain relief and increased diuretics (medication to encourage fluid loss). A Doppler/ultrasound scan showed she was not suffering from a deep vein thrombosis and, when Mrs A was found to have a low potassium level, her diuretic treatment was correctly changed. He noted Mrs A was seen by the tissue viability nurse and that it had been recorded on discharge she should be reviewed by the dressings clinic. He said the actions of staff throughout this admission showed there had been reasonable and appropriate management of Mrs A's care.[2]

9. Adviser 2 said that the nursing records showed that a comprehensive assessment was made of Mrs A on her admission and that, as a result, she was referred to a dietician and weighed daily. Adviser 2 added that she considered the improvement in Mrs A's condition which allowed her to return home was also evidence she had been properly cared for during this stay.

10. In their letter of response to Miss C dated 1 June 2005 the Board apologised for the fact that, although it had been noted in her records Mrs A should be referred to a dressings clinic for review, this appointment was not made. The Board said that this had been discussed with both the staff responsible for making the referral and the dressings clinic and they would ensure improvements took place.

11. On her admission on 4 May 2004, Mrs A was found to be in respiratory failure. On 5 May 2004 Mrs A was reviewed by a consultant (Consultant 1). She noted Mrs A was suffering from septicaemia, COPD and lung cancer. Consultant 1 recorded a conversation with Miss C and that Miss C had explained that her mother had been active (going out for walks) prior to the

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[1] This was in addition to her pre-existing conditions (see paragraph 1).

[2] Reasonable in this report should be taken as mean whether the decisions and actions taken were within the boundaries of what would have been considered to be acceptable practice in terms of knowledge and practice at the time in question.

admission. Given this and, as Consultant 1 felt there were reversible as well as irreversible features to Mrs A's condition, Mrs A was referred to a specialist respiratory unit that day. However, Mrs A was also assessed as not suitable for resuscitation.

12. On 6 May 2004 Mrs A was said to be in distress and began to receive diamorphine (a powerful painkiller) through a syringe pump. An entry in the clinical records on 7 May 2004 states that she was more settled and that she should be kept comfortable. The next entry on 10 May 2004 said 'Looks comfortable. No agitation (as per nursing staff). Keep comfortable'. Mrs A died later on 10 May 2004.

13. In commenting on the notes for Mrs A's second admission, Adviser 1 said that given Mrs A had lung cancer, serious lung impairment and an infection that was not responding to antibiotics, the decision of the consultant to provide her with treatment to relieve symptoms but not to resort to resuscitation in the event of either a heart attack or respiratory arrest was entirely reasonable. Adviser 1 was concerned there was no medical review between 7 and 10 May. In response to a previous draft of this report the Board said that 8 and 9 May 2004 was a weekend period and that they were unable to provide routine medical review over weekends. However, there was an on-call team and a consultant did carry out ward rounds and would see patients admitted over the weekend who had not been seen by a consultant and other patients highlighted by nursing or medical staff.

14. In considering this, Adviser 1 said that the reduction in cover over weekends was understandable and the ward rounds laudable. He continued that the question was, therefore, whether Mrs A required review during this period. He said given the entry on 7 May 2004 which indicated Mrs A was stable and that there was no active treatment occurring it was not unreasonable that no review was required. There was evidence that daily observations were being taken by nursing staff.

15. Adviser 2 noted that nursing staff again undertook and recorded a full assessment of Mrs A at the start of her second admission. As a result, Mrs A was provided with a special mattress. It also appeared that Mrs A was initially given fluids direct into a vein but that later these were delivered under the skin. Fluid intake and drug charts were completed up until Mrs A's death but

Adviser 2 also said that after 6 May 2004 there was very little noted about Mrs A's condition and how nursing care was administered to her.

16. In response to a draft of this report, the Board referred to specific nursing notes which neither I nor the Advisers had seen. I raised this with the Board who provided 25 pages of additional records. These records had originally been created and stored electronically.

17. I asked Adviser 3 to review these and she said that these did provide evidence of care being delivered to Mrs A and of some communication with Miss C. However, she felt there could have been more recognition of the fact that Mrs A was dying and a more specific assessment of her needs in relation to the end of life stage. Adviser 2 also reviewed the full documentation and said that there remained a lack of information about the quality of care given to a dying patient. For example, she was concerned there was no evidence of how her pain levels were assessed.

18. The relevant nursing policy in force in the Board area in 2004 contained only a brief section on palliative and terminal care. This consisted mainly of definitions of those terms. There was a section on family support which stressed the importance of keeping family members informed and supported. The Hospital Palliative Care Service had produced revised guidelines on the management of symptoms in March 2004.

19. The Board confirmed that this policy had been replaced by one based on the Liverpool Care Pathway for the end of life.[3] I received a report dated April 2005 which reviewed the initial implementation project and demonstrated documentation around the end of life had been significantly improved as a result of using this pathway. The Board also provided copies of the documentation itself which showed that these included sections on communication and support, as well as physical care. The Board said that leaflets about the pathway and on dying were also available.

[3] The pathway consists of a linked series of guidance, policies and documentation which was developed to transfer the hospice model of care into the hospital setting. More details can be find on the Liverpool Care Pathway website – www.mcpil.org.uk/frontpage

(a) Conclusion

20. Adviser 1 and Adviser 2 have said that the care and treatment provided on Mrs A's first admission was appropriate. They were also both of the view that, prior to 6 May 2004, the care and treatment provided to Mrs A on her second admission was also appropriate and well-documented. In particular, Adviser 1 has said that the decision to provide active treatment but that Mrs A should not be resuscitated in the event of a cardiac arrest was reasonable.

21. Adviser 1 has said that from the evidence it was likely that a decision had been made on 6 May 2004 to move to end all active treatment and to move to end of life care and that, given the deterioration in Mrs A's condition, this would have been a reasonable clinical decision. There was no evidence Mrs A required additional review over the weekend period and he did not criticise the medical decisions made. However, both Advisers 2 and 3 raised concerns about the quality of care provided to a dying patient. Although it was noted that there was evidence of monitoring and some communication, Advisers 2 and 3 have said there should have been more recognition of the fact that Mrs A was dying and specific assessment made of her needs.

22. I have also noted that the guidance given to staff on the care of the dying in May 2004 was limited. However, it is also clear that since May 2004 the Board have made a substantial effort to review and improve their care for the dying. The documentation now in use is extremely thorough and impressive. The report on the initial implementation showed demonstrable improvement and I would commend the Board for their efforts in this area. Therefore, while I am partially upholding this complaint to the extent that Mrs A's needs as a dying patient were not fully recognised, I make no recommendations on the palliative care currently being provided by the Board.

23. I would also commend the Board for having accepted, in responding to Miss C's complaint, that there was a failure to ensure Mrs A was appropriately referred to the dressings clinic, apologising for this and explaining actions taken to prevent this from recurring to Miss C.

24. I remain concerned that substantial documentation was only made available to this office following the issue of a draft of this report. This led to the need for a full review of all documentation and the issuing of a second draft. The Board have said that at the time of the complaint, a computerised care planning system was in existence and that because of the volume of records

contained in this system they were not kept with the paper files and were not copied with the rest of the medical records. I understand the computerised system is no longer in use and the Board are aware of the importance of ensuring all relevant information is provided during an investigation, I do not intend to comment on this further. However, I have asked the Board to apologise to Miss C for this error.

(a) Recommendation

25. The Ombudsman recommends that the Board apologise to Miss C for the failure to appropriately assess Mrs A's needs following the decision to end active treatment and for failing to ensure all relevant notes were made available to the Ombudsman's office during the initial investigation of this complaint.

(b) Information recording a conversation in the medical records was inaccurate

26. In the course of pursuing her complaint with the Board, Miss C was told that there were notes of a conversation she had had with Consultant 1 on 5 May 2004. The Board said these notes showed that Miss C had been fully informed of the decision not to resuscitate Mrs A but that Mrs A would still receive appropriate treatment.

27. Miss C wrote to the Board about this on 13 September 2005 saying that she was positive she had spoken to Consultant 1 on 4 May 2004 (the day Mrs A was admitted) and that this indicated that the decision not to resuscitate her mother had been made without taking enough time to assess her thoroughly. In their response to this, the Board confirmed that they believed Miss C had spoken to both a consultant and a Senior House Officer following Mrs A's admission on 4 May 2004 but had not been spoken to by Consultant 1 until 5 May 2004. In support of her complaint to the Ombudsman's office, Miss C provided copies of telephone calls from her home around the time she is recorded as having spoken to Consultant 1 at the Hospital on 5 May 2004. This showed three calls were made prior to 12:20 on 5 May 2004, two calls made shortly after 14:00 and two further calls made around 16:15. Miss C also said her son had an exam in the morning and that she had not been able to visit the Hospital until after 17:00.

28. I have reviewed the clinical notes. These were thorough and each entry was dated and often the time of the entry given. There were two entries for 4 May 2004. The first was made at 10:40. The second entry did not include the

time made. The entries related to clinical examinations of Mrs A. Any discussion with Miss C on this day is not noted.

29. There were a number of entries made on 5 May 2004. The first was made at 01:00, the next did not note the time and then there were entries at 10:00 and 12:45. None of these entries were made by Consultant 1. There then followed two entries by Consultant 1. The time given on the first entry was 13:15, this described an examination of Mrs A. The second recorded a detailed conversation with Miss C about this examination and was referred to in part at paragraph 11). There was no time recorded next to this entry, however, the next entry, in another hand, was at 15:30. There were no other entries in the clinical notes by Consultant 1.

30. In Miss C's initial complaint to the Board she referred to the conversation with Consultant 1 and in that letter she stated that later in the evening following this conversation Mrs A was transferred to a specialist respiratory ward. This transfer occurred on the evening of 5 May 2004.

(b) Conclusion

31. The clinical records clearly document a conversation with Miss C and it appears that this occurred between 13:15 and 15:30 on 5 May 2004. Consultant 1 had not examined Mrs A until 5 May 2004 and there was no evidence of her previous active involvement in Mrs A's care. The decision to refer Mrs A to a specialist respiratory ward on 5 May 2004 was made as a direct result of this conversation. Indeed, Miss C's initial recollection of events support this version although I accept she now believes this was mistaken.

32. While I do not doubt Miss C's sincere conviction that she spoke to Consultant 1 on 4 May 2004 and not on the 5 May 2004, there is substantial evidence that this was the case and the telephone records do not make this impossible. In the circumstances, I do not uphold this complaint.

33. 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

Mrs A	Miss C's late mother
The Hospital	Ayr Hospital
COPD	Chronic obstructive pulmonary disease
Miss C	The complainant
The Board	Ayrshire and Arran NHS Board
Adviser 1	Medical adviser to the Ombudsman
Adviser 2	Nursing adviser to the Ombudsman
Adviser 3	Nursing adviser to the Ombudsman
Consultant 1	A consultant at the Hospital

Annex 2

Glossary of terms

Chronic Obstructive Pulmonary Disease	Chronic slowly progressive disease which obstructs the airways and damages the lungs
Deep vein thrombosis	A blood clot (thrombus) that develops in a deep vein, usually in the leg
Diamorphine	A powerful painkiller
Diuretics	A drug used to treat conditions where excessive fluid has accumulated in the body
Doppler/ultrasound scan	A form of ultrasound that can detect and measure blood flow
Septicaemia	A condition where there is an infection in the bloodstream, due to multiplication of bacteria and/or their toxins