Scottish Parliament Region: Central Scotland

Case 200601576: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; General medical; Clinical treatment/diagnosis

Overview

The complainant, Mr C, complained that his late mother's (Mrs A) fluid retention had not been treated correctly while she was in Wishaw General Hospital. He was concerned, in particular, about a failure to recommence diurectic medication. He believed that this led to congestion on Mrs A's lungs which he felt was the cause of her death. Mr C was unhappy that the death certificate said the cause of Mrs A's death was Alzheimer's disease.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs A's fluid retention was not treated correctly (*upheld*)[1]; and

(b) Mrs A's death certificate was completed incorrectly (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) pass a copy of this report to the Clinical Nurse Specialist who audited the ward in 2007 to decide whether it should be reflected in the action plan;

(ii) create a structured programme of review of medical records;

(iii) share this report with all clinical staff involved in Mrs A's care;

(iv) ensure that, when clinical staff are asked to review meetings notes they are, where appropriate, reminded of the importance of checking the accuracy of clinical information provided;

(v) apologise to Mrs A's family for the failures in her care;

(vi) take steps to correct the error in Mrs A's death certificate or provide acceptable reasons why this cannot be done;

(vii) consider whether death certification should be included in the continuing

[1] In investigating this complaint it became clear that Mrs A had not died of congestion on the lungs but it was found that the failure to restart her medication may have contributed to her death.

education of medical staff; and

(viii) apologise to Mr C for the failure to respond appropriately to his concerns about the error in the death certificate.

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

Main Investigation Report

Introduction

1. Mrs A (aged 89) was admitted to Wishaw General Hospital (the Hospital) on 6 April 2006 and remained there until her death on 24 April 2006.

2. Mrs A had been admitted because of her doctor's concerns about a chest infection. She also had diabetes and was suffering from dementia. Mrs A's diurectic treatment was stopped on admission.

3. Mr C said that, initially, Mrs A seemed to improve and there was discussion about a possible discharge. However, he said he then noted that there had been a deterioration in the condition of her legs and he brought this to the attention of staff. On 22 April 2006 diuretic medication was restarted. Mrs A suffered a cardiac arrest and, sadly, died on 24 April 2006. The death certificate recorded that Mrs A died as a result of Alzheimer's disease. Mr C believed that Mrs A died as a result of fluid on her lungs, caused by a failure to restart her diurectic medication earlier, and complained to Lanarkshire NHS Board (the Board). In their response to Mr C, the Hospital accepted that the information on the death certificate was wrong and apologised for this. They also said that they could not speculate on what may have caused Mrs A's cardiac arrest but did not consider that the withdrawal of the medication contributed to this.

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

(a) Mrs A's fluid retention was not treated correctly; and

(b) Mrs A's death certificate was completed incorrectly.

Investigation

5. In investigating this complaint, I obtained all the background documentation relating to the complaint and Mrs A's medical records. Advice was also obtained from a clinical adviser to the Ombudsman (the Adviser). 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. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) Mrs A's fluid retention was not treated correctly

7. Mrs A had had a number of medical conditions for some years, including type 2 diabetes, vascular dementia and heart problems. She had been treated by her own GP for two weeks for a chest infection when, on 6 April 2006, she was admitted as an emergency to the Hospital with pneumonia, increasing confusion and dehydration. She underwent a number of tests and, as one of these showed impaired kidney function and dehydration, her diurectic medication was stopped.

8. Mr C said that, initially, Mrs A improved and he was told that she would be able to go home once she had received a Social Work review. On 20 April 2006 Mrs A said she had chest pains and an electrocardiogram (ECG) was taken. This was said to have shown no difference from an ECG taken on admission. At 22.00 on 20 April 2006, a nurse noted Mrs A's feet were swollen and that medical staff would be asked to review this the next day (21 April 2006). A nursing record on 21 April 2006 noted her legs were swollen. On 22 April 2006 Mr C approached staff about Mrs A's leg swelling and, after examination by a doctor, Mrs A's diuretic medication was restarted immediately. The notes show that the doctor had also heard crackles at the bases of both lungs and a slightly elevated venous pressure. Mr C said that, by this stage, Mrs A's breathing was deteriorating but she received no further assistance. Mrs A died in hospital on 24 April 2006.

9. In response to Mr C's complaint, the Hospital sought statements from the two consultants concerned before producing a written response and, following this, a meeting with Mr C was also arranged. Mr C was then sent a note of the meeting by the Hospital. In their responses, the Hospital said that the decisions to stop and to restart the diuretic medication were correct and that Mrs A's fluid retention had improved once this had been restarted. They also said that, while Mrs A's risk of death was high in view of her multiple medical problems, it was not entirely anticipated.

10. The Adviser reviewed the medical notes and the complaint file from the Board. He was critical of the care received by Mrs A during her admission. He said that Mrs A did not receive sufficiently frequent medical reviews during the admission and, in particular, that there were no notes or evidence of an examination of her legs on 21 April 2006 and no review on the morning following the restarting of the diuretic medication. As a result, while Mr C was noted to have said during the meeting with Hospital staff (see paragraph 9) that

Mrs A's legs had improved, there was nothing in the notes which could demonstrate this. On this point the Adviser was concerned that, in the notes of the meeting sent to Mr C, clinical staff present were also said to have referred to an improvement with Mrs A's fluid retention. He said that staff present were not involved in Mrs A's care on the date in question and would not have been able to substantiate this from memory or from the notes.

11. The Adviser added that the symptoms described in the notes on 22 April 2006 indicated that Mrs A was in a degree of heart failure at that time. He said that the symptoms described were unlikely to have developed within 12 hours but there was no mention of these in any previous medical note. There was also no evidence that the doctor who compared the two ECGs on 20 April 2006 examined Mrs A's legs or lungs. The Adviser went on to say:

> 'My criticism is therefore this: a doctor was called late on 22/04 to see [Mrs A] when she was clearly in heart failure and this did not appear to have been noticed before; it is likely that she had been in a degree of failure for some time. This should have instigated re-starting her diuretic some 24-48 hours before it was.'

12. On reviewing the nursing records, the Adviser speculated the time of likely onset of heart failure could be narrowed down further to 17 or 18 April 2006 and that this meant that 'there was a four-day delay before appropriate medical advice was given'. As the ECGs were undated he could not comment on them fully. In reviewing the nursing notes, the Adviser noted Mrs A had fallen out of bed on 23 April 2006, despite cot sides. Although this had not been raised as a complaint, he was concerned that there was no information in a falls prevention chart[2], explaining why cot sides had been placed given Mrs A's dementia, and no sign of a re-assessment for falls being undertaken following this incident.

13. Mr C had been concerned that the failure to restart the medication had contributed to Mrs A's death. The Adviser considered this and said that, given the suddenness of her death, it could be concluded that heart failure and congestion on the lungs were not the specific cause of her death but that Mrs A suffered a fatal coronary occlusion or heart attack. The Adviser added that, while the withdrawal of the diuretic was not a factor in her deterioration, in his opinion, the failure to restart it timeously may have been. The Adviser also

[2] Mrs A's family had raised the question of falls with staff on 14 April 2006, as she had had occasional falls at home.

noted that, in the notes of the meeting with Mr C, clinical staff had said they could not give a view on what had caused the fluid retention with her legs, although it was clear from the notes that Mrs A had all the symptoms of heart failure.

14. In response to the Adviser's comments, I made further enquiries of the Board. The Board had introduced an audit system for nursing care and record-keeping in 2005. We have commended them for this in previous reports (see report 200502688). I asked for the audit records for the ward where Mrs A had been during her stay in the Hospital. The audit taken in May 2006 showed there had been some concern about record-keeping and care being fully documented. There was also a note on the need to improve communication. An overall score of 92/132 had been given.[3] The ward had been re-audited in May 2007. The audit showed significant improvement in all areas and the score had improved to 114.

15. The Board also said similar audits had been carried out for medical records in the past at all acute hospital sites but there had been no ongoing, structured programme.

(a) Conclusion

16. My investigation has established a number of areas of concern. The Adviser has said there was a lack of adequate medical review in general and a four-day delay before appropriate medical advice was given about Mrs A's fluid retention. I am also concerned that the Board's response to Mr C made reference to an improvement which was not documented in the notes (see paragraph 10) and that the Board did not answer his questions about the cause of his mother's fluid retention, when I have been advised this could have been easily ascertained from the notes.

17. Mr C's main concern was that the failure to treat his mother's fluid retention was a direct cause of her death. The Adviser has said that the delay in restarting diuretic medication may have contributed to this. However, it is also clear that Mrs A had a number of conditions which may have also contributed. It is, therefore, not possible to provide Mr C with a definitive

[3] According to the scoring system used, a score above 99 indicates minor adjustments are required and a score between 66 and 99 that some adjustments are required. If the score falls below 32 this indicates significant adjustments are required.

answer to his concern. Although I am unable to do so, given the failures that have been identified in the treatment of Mrs A's fluid retention and in the response to Mr C's concerns about this, I uphold this complaint.

18. As indicated in paragraph 14, the Board have made significant efforts to improve the standards of nursing records. It was reassuring to note that, given the concerns about the documentation surrounding the fall and the lack of nursing notes on the condition of Mrs A's legs, the Board could provide evidence of significant, general improvement in the nursing audit undertaken in the ward since the events detailed in this report occurred. The Ombudsman, therefore, recommends that this report be passed to the Clinical Nurse Specialist responsible for the 2007 audit, to see whether it should be reflected in the current action plan. I was also pleased to note that similar audits have occurred on medical records and, in view of this, the Ombudsman recommends that this be done on a regular, structured basis. However, I remain concerned about the failures to provide adequate medical review and that Mr C was given information by the Board, in response to his concerns, which it has not been possible to substantiate. I have noted that this was given in a meeting with Mr C and, in part, in response to information provided by Mr C. Nevertheless, it is also good practice to hold such meetings and I would commend the Board for doing so. In a response to this draft report, the Board confirmed medical staff had reviewed the note before issue. The Ombudsman recommends, however, that when notes are issued for review to staff, they are reminded of the importance of checking any clinical information provided in them.

(a) Recommendation

19. The Ombudsman recommends that the Board:

(i) pass a copy of this report to the Clinical Nurse Specialist who audited the ward in 2007 to decide whether it should be reflected in the action plan;

(ii) create a structured programme of review of medical records;

(iii) share this report with all clinical staff involved in Mrs A's care;

(iv) ensure that, when clinical staff are asked to review meetings notes they are, where appropriate, reminded of the importance of checking the accuracy of clinical information provided; and

(v) apologise to Mrs A's family for the failures in her care.

(b) Mrs A's death certificate was completed incorrectly

20. In Mrs A's death certificate the cause of death was described as '1a Alzheimer's disease'. In responding to Mr C's complaint, the Board did not

initially comment on his concerns. In the note of the meeting sent to Mr C, it is recorded that they accepted this was not the cause of death but he was told they could not provide him with a definitive cause of Mrs A's cardiac arrest and death and apologised for this.

21. The Adviser has said that studies show there is often uncertainty about the accuracy of the cause of death in death certificates but that, in this case, the cause of death recorded – Alzheimer's disease - was inconsistent with the clinical records.

22. As stated in paragraph 13, the Adviser has said that, given the suddenness of her death, it was likely Mrs A suffered a fatal coronary occlusion or heart attack. The Adviser considered that the true cause of death could have been reasonably described as:

'1a Myocardial Infarction
1b. Ischaemic heart disease
2. Vascular Dementia.'

23. In their original letter of response the Board did not deal with this aspect of Mr C's complaint and made no reference to the death certificate. They did say that Mrs A's death was unexpected and she died as a result of a cardiac arrest following a sudden deterioration. They also said that Mrs A had a number of co-existing medical conditions and that, given this, she was at a higher risk of a 'further event'.

24. The notes of the meeting with Mr C indicated that, when he raised this complaint again, the Board accepted the problems with the death certificate and apologised. Mr C was told again that his mother had had a number of ongoing medical problems which could have been the cause. The Adviser has said this was reasonable.[4] However, Mr C was also told that it was only possible to speculate on the cause of the cardiac arrest. The Adviser considered that if this was the case then Mrs A's death should have been reported to the Procurator Fiscal. However, he added that the certification suggested in paragraph 23 would be unlikely to have been contested and that, given the evidence in the records, that Mrs A's death would be unlikely to have warranted a report to the Procurator Fiscal unless there was much more doubt about the diagnosis.

[4] See paragraph 17 where he has also suggested that the failure to restart medication may have been one of those causes.

25. A previous investigation report by the Ombudsman's office on a complaint against the Board (report number 200503208) dealt with an error in a death certificate. A recommendation in that report was made that steps be taken to avoid a recurrence. In response to my queries, the Board have said that for some time all junior doctors joining hospitals in the Board area were required to complete specific and detailed online training on death certification. The training documentation remained available as a reference source. In addition, the Registers of Births, Deaths and Marriages sent copies to the Medical Education Department of any incorrectly completed certificates which were then followed up with the trainees. Following report number 200503208, the Director of Medical Education reviewed the contents of the induction programme. The Board said that the Director of Medical Education advised that since its introduction there had been a reduction in errors of medical fact but a persistence in errors of haste (spelling). As a result, it was not felt necessary to change the programme but the report (200503208) was widely circulated to staff and discussed at clinical and managerial forums.

(b) Conclusion

26. Although the Board have taken action following the previous report, I remain concerned that this error recurred. While the Board accepted the error in this case and apologised to Mr C before the complaint was raised with this office, it is clear from the advice I have received that the cause of death could reasonably have been determined from Mrs A's medical records.

27. However, when responding to Mr C's concerns on this point the Board, despite there being clear evidence in the notes which could have led to them reassuring Mr C on the cause of Mrs A's death, did not provide any further comment on this point. I am critical of this failing. I was also concerned, on reading the first letter of response, to note that this aspect of Mr C's complaint was not addressed. Having considered the matter carefully, in all the circumstances, I uphold this complaint.

(b) Recommendation

28. The Ombudsman recommends that the Board:

(i) take steps to correct the error in Mrs A's death certificate or provide acceptable reasons why this cannot be done;

(ii) consider whether death certification should be included in the continuing education of medical staff; and

(iii) apologise to Mr C for the failure to respond appropriately to his concerns about the error in the death certificate.

29. 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	Mr C's late mother
The Hospital	Wishaw General Hospital
Mr C	The complainant
The Board	Lanarkshire NHS Board
The Adviser	Clinical adviser to the Ombudsman
ECG	Electrocardiogram

Annex 2

Glossary of terms

Alzheimer's disease	A progressive disease of the brain that is characterised by impairment of memory and a disturbance in at least one other thinking function
Coronary occlusion	A heart attack (also known as a myocardial infarction) is the death of heart muscle from the sudden blockage of a coronary artery by a blood clot
Diuretic	Medication to help reduce the amount of water in the body
Electrocardiogram	A test which measures the electrical activity of the heart
Ischaemic heart disease	Narrowing or blockage of coronary arteries causing chronic shortage of blood supply to the heart muscle
Myocardial infarction	See coronary occlusion
Type 2 diabetes	A type of diabetes in which the body produces insulin but is unable to use it effectively because the cells of the body are resistant to the action of insulin
Vascular dementia	A form of dementia in older people that is due to disease affecting the blood vessels and arteries of the brain, usually with stepwise deterioration from a series of small strokes
Venous pressure	The pressure of blood within a vein