Scottish Parliament Region: South of Scotland

Case 200603455: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospitals; General Medical; Clinical treatment

Overview

The complainant, Mrs C, raised a number of concerns about the care and treatment provided to her late mother, Mrs A, while she had been a patient at Ayr Hospital (Hospital 1). She said she felt Mrs A had been wrongly given Diazepam and that the nursing care was inadequate. She believed that the care had led to a significant deterioration in Mrs A's condition.

Specific complaint and conclusion

The complaints which have been investigated are that:

(a) the nursing care provided to Mrs A was inadequate (*not upheld*);

(b) Mrs A did not receive appropriate treatment and was wrongly prescribed Diazepam (*upheld*);

(c) Mrs A's family was not given sufficient time to consider a proposed move of hospital (*not upheld*);

(d) Mrs A's transfer to another hospital was carried out inappropriately (*no finding*); and

(e) a conversation about Mrs A's treatment was inappropriately held in a public place (*no finding*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mrs C for the failures in record-keeping, which have made it difficult for the Ombudsman's advisers to fully evaluate Mrs A's care, and for the error in their letter to Mrs C of 5 December 2006 concerning the use of Diazepam in Mrs A's care;

(ii) provide clinical staff involved in Mrs A's care and the Board's relevant clinical director with a copy of this report; and

(iii) provide evidence of the systems in place to monitor and audit medical and nursing records.

Main Investigation Report

Introduction

1. Mrs A was admitted to Ayr Hospital (Hospital 1) on 10 May 2006, following an emergency referral from her GP. She stayed there until 25 July 2006, when she was transferred to Ailsa Hospital (Hospital 2). Mrs A was transferred back to Hospital 1 on 17 August 2006 and, sadly, died there on 30 August 2006. Mrs A was aged 68 at the time of her death.

2. Mrs C complained to Ayrshire and Arran NHS Board (the Board) in detail in September/October 2006, about the care and treatment provided during Mrs A's first period of admission in Hospital 1. In her letter to the Ombudsman, Mrs C said she had no concerns about treatment received at Hospital 2 or during Mrs A's second admission. The Board replied on 5 December 2006. They did not uphold any aspect of Mrs C's complaint but did say that her concerns about nursing care had been brought to the attention of the nursing team, who would reflect on the comments and take any appropriate action. Mrs C remained unhappy with the response received and complained to the Ombudsman in February 2007. She repeated the concerns raised with the Board and, in particular, said she was concerned about the medication given to her late mother; felt the nursing care she had received was inadequate; that the family was given very little time to respond to the decision to move Mrs A; and that the move was not carried out appropriately. Mrs C added that she felt the failures in the care contributed to Mrs A's decline. Mrs C also said that she considered staff did not respond appropriately to the family's concerns and that, on one occasion, she had a conversation in a public area with a member of the medical staff (the Consultant) about Mrs A's condition.

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

(a) the nursing care provided to Mrs A was inadequate;

(b) Mrs A did not receive appropriate treatment and was wrongly prescribed Diazepam;

(c) Mrs A's family was not given sufficient time to consider a proposed move of hospital;

(d) Mrs A's transfer to another hospital was carried out inappropriately; and

(e) a conversation about Mrs A's treatment was inappropriately held in a public place.

Investigation

4. In investigating this complaint, I have obtained the background documentation relating to the complaint and Mrs A's medical records from Hospital 1. Advice was also obtained from clinical advisers to the Ombudsman, a medical adviser and nursing adviser (Advisers 1 and Adviser 2 respectively).[1] The abbreviations used in the report are explained in Annex 1 and the medical terms used in the report are explained in Annex 2.

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

(a) The nursing care provided to Mrs A was inadequate; and (b) Mrs A did not receive appropriate treatment and was wrongly prescribed Diazepam

6. Mrs A was 67 when she was admitted as an emergency to Hospital 1 on 10 May 2006. The letter from her GP referring her to hospital said she had presented with non-specific symptoms and was deteriorating rapidly. The GP questioned whether she might have cirrhosis (scarring and hardening of the liver), given the results of liver function tests, but it was also noted that there was no history of excess alcohol use. On admission, Mrs A was noted to have suspected autoimmune hepatitis (a disease in which the body's own immune system attacks liver cells).

7. While in Hospital 1, Mrs A's condition deteriorated further. She was diagnosed as having a urinary tract infection and was noted as becoming increasingly confused and distressed. She was also diagnosed with hepatic encephalopathy.

8. Adviser 1 provided some detailed background on the effect of hepatic encephalopathy. This condition occurs when the liver is damaged to the point of liver failure. As the liver can no longer process various toxins from the blood, these can reach the brain. In the early stages, the effect of this on the brain functioning can disturb sleep patterns and cause personality changes; as the

[1] The standard used in this report for assessing the actions of medical staff is whether the actions were reasonable. By reasonable, I mean the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical profession in terms of knowledge and practice at the time.

disease progresses, the patient may become confused and distressed. In the later stages, the patient tends to become noisy, aggressive and disorientated. Adviser 1 noted that the later stages can be very difficult to treat.

9. While in Hospital 1, Mrs A did become increasingly confused, distressed and noisy. On 25 July 2006, she was transferred to Hospital 2 for specialist care. In his letter to Mrs A's GP following her transfer (dated 2 September 2006 but dictated 15 August 2006), the Consultant said that he had thought Mrs A's symptoms were a result of DTs (delirium tremens) and had treated her accordingly. He said that her condition did not improve and a range of disorders were considered, treated and rejected. They had eventually considered that she had encephalopathy, related to infection and underlying cirrhosis.

10. Mrs A made an initial good recovery but then deteriorated and was readmitted to Hospital 1 on 17 August 2006. Following Mrs A's death in Hospital 1 on 30 August 2006, a post mortem was conducted and the primary cause of death given was adult respiratory distress syndrome. Cirrhosis of the liver and hypothyroidism were given as secondary causes.

11. In their response to Mrs C's complaint, the Board said that Mrs A had been admitted with a number of symptoms, including hallucinations, which indicated an organic brain disease. They said the hepatic encephalopathy had been induced by the urinary tract infection and this caused a sudden deterioration in Mrs A's condition around 25 May 2006. The infection was successfully treated but her underlying condition remained undiagnosed and there was a second marked deterioration noted on 18 July 2006. A specialist at Hospital 2 was consulted and suggested she be transferred there immediately. The Board said that Mrs A had not, as Mrs C believed, been sent by herself in a taxi to Hospital 2 but had been accompanied by a member of staff.

12. Mrs C had specifically questioned the prescription of Diazepam to her late mother and whether this had contributed to Mrs A's deterioration. In their response to Mrs C, the Board said Mrs A had been prescribed a small amount of Diazepam, two milligrams three times daily for the four day period between 17 May and 20 May 2006. This had been done in response to the confusion and anxiety being experienced by Mrs A.

13. Adviser 1 reviewed the medical records in detail. In general, he said he was concerned about the quality of these and, in particular, found the early entries poor. He said the hand written record was often illegible and used non-standard, ambiguous abbreviations. While the quality improved throughout Mrs A's admission, there was generally a lack of factual clinical data, such as physical signs, in the record.

14. Adviser 1 said that, on the basis of the evidence available in the notes, he considered that Mrs A was, as suspected by clinical staff, suffering from cirrhosis with evidence of liver failure on admission. As stated in paragraph 8, hepatic encephalopathy is a recognised feature of chronic liver disease but Adviser 1 said that there is often also a precipitating factor which contributes to its onset such as an undiagnosed infection, intestinal bleeding or the use of diuretic or sedative drugs. He noted that Mrs A had been prescribed with Diazepam, a sedative drug, during her admission. Adviser 1 said that while this drug was relatively safe, it could exacerbate hepatic encephalopathy. He, therefore, reviewed its use in Mrs A's care in detail.

15. From the records, it appeared that Mrs A was prescribed two milligrams of Diazepam three times daily from 15 May to 20 May 2006. The drug was withheld on 21 May and 22 May with only a single dose being given on 23 May. No dose was given on 24 May. The Consultant stopped all use of Diazepam on 25 May. One dose of Diazepam was administered on 9 July 2006 and Mrs A generally received two milligrams three times daily from 12 July to 21 July 2006 (she only received two doses on 13 July and 20 July). She received two doses on 22 July and 23 July and a single dose on 24 July 2006.

16. The Board have said Diazepam was prescribed to help with Mrs A's confusion and distress (see paragraph 12). However, Adviser 1's interpretation of the record, and in particular an entry dated 15 May 2006, was that it had been prescribed for the treatment of suspected alcohol withdrawal. In their response to a draft of this report, the Board have confirmed this was the case. A reference made in the notes of 15 May 2006 to the hallucinations Mrs A was experiencing referred to mild DTs and a raised corpuscular volume (the volume of blood cells) and a raised level of a specific enzyme in blood tests was noted next to the phrase 'likely alcohol'.

17. Adviser 1 said that, while these are common findings in alcohol withdrawal and Diazepam is an appropriate drug to use for the management of this, there

were other possible causes for Mrs A's symptoms and that, in his view, the evidence Mrs A was suffering from alcohol withdrawal on admission was weak. Adviser 1 said:

> 'The records indicate that Mrs A and her family denied recent alcohol use and there is no objective data in the record such as serum alcohol measurement, alcoholic foetor or intoxication to indicate recent alcohol abuse and the referral letter from her GP specifically indicates there was 'no history of alcohol excess'. I remain of the view that the documented evidence for ongoing alcohol use is weak. In the absence of recent evidence of alcohol use, there would be no indication for the use of Diazepam to prevent local withdrawal symptoms.'

18. In conclusion, given he felt there was no clear evidence of active alcohol use on admission, and the risk of inducing/exacerbating hepatic encephalopathy, it was his opinion that the use of Diazepam was ill-advised.

19. Adviser 1 noted that Mrs A's confusion continued until 25 May 2006 when she became unrousable. He said that this was compatible with drug-induced exacerbation of hepatic encephalopathy. However, in his view, it could not be said that this was the definitive cause of her deterioration. Mrs A's condition had some atypical features which suggested a possible dementia or psychiatric disease, although the recorded investigations did not reveal any possible cause other than the liver disease. He also noted that the length of time of Mrs A's deterioration, which was ten days, was atypically long. During this time Mrs A developed a urinary tract infection which could also have precipitated hepatic encephalopathy.

20. Diazepam was prescribed again on 9 July 2006 (see paragraph 15). Adviser 1 said that this was clear from the nursing records but that there were no medical records for that date. By 12 July 2006 Mrs A's condition had deteriorated further and she was often noisy and aggressive. Adviser 1 said this was a very difficult stage of hepatic encephalopathy, as it was desirable to sedate a patient in order to treat them appropriately and this could also be difficult to manage in a general medical ward. He noted that a trial of treatment with an intramuscular haloperidol (an antipsychotic administered by an injection into muscle), which was less sedative than Diazepam, was prescribed. He said that, in his view, this was appropriate but there was no factual data in the record which would allow him to form an objective opinion on the reason for prescribing Diazepam on 9 July and then from 12 July to 24 July 2006 (see paragraph 15).

Adviser 1 noted that the decision to use Diazepam appeared to have been made by junior members of the clinical team.

21. Adviser 2 reviewed the clinical records in the light of Mrs C's concerns about the nursing care provided. He said the document from Mrs A's initial stay at Hospital 1 provided evidence of an initial nursing assessment; detailed care planning based on this assessment; regular evaluation of the care plans; general nursing communication records; and appropriate risk assessments. He said that, in his view, the documentation demonstrated Mrs A was afforded an appropriate standard of care, although her family had been clearly distressed by her deterioration. It was not possible to determine from the notes whether, as Mrs C had said, Mrs A had been left unkempt and in a state of undress. Adviser 2 also considered that, from the documentation, there was no discernable difference from the care provided to Mrs A between her first and second admission at Hospital 1. Adviser 2 did note some shortfalls in the note-keeping. On occasions, a student nurse's documentation was not appropriately authorised and at times recorded entries were untimed and unsigned. However, these did not raise concerns about the care provided.

(a) Conclusion

22. Mrs A's family were understandably concerned and upset following the deterioration in Mrs A's condition while in Hospital 1. The effects of Mrs A's hepatic encephalopathy caused her considerable distress. I have considerable sympathy for both her and her family.

23. Nevertheless, the advice I have received from Adviser 2 is that the nursing care provided to Mrs A was, in general, adequate. He has seen evidence of initial assessment, care planning and appropriate reassessment. He has concluded that there was no discernible difference in the documented care between separate admissions. On the basis of this advice, I do not uphold this complaint. However, I have noted Adviser 2's concerns that some of the documentation was not completed appropriately (see paragraph 21). I comment on this further under heading (b).

(b) Conclusion

24. The issue relating to the prescription of Diazepam is not about the underlying cause of the cirrhosis but whether there was evidence that Mrs C was suffering from the symptoms of active alcohol withdrawal at the time of admission. The advice I have received is that, given the lack of evidence that

Mrs C was suffering from alcohol withdrawal, the use of Diazepam was ill-advised. In this regard, I have noted that the Board indicated to Mrs C that the use of Diazepam was to help with Mrs A's confusion and distress and that Mrs C's underlying condition remained undiagnosed. However, the first time Diazepam was prescribed there was clear reference in the medical notes to alcohol withdrawal and this was also referred to by the Consultant in his letter to Mrs A's GP (see paragraph 9). It is likely that this was the reason for the initial prescription of Diazepam and the Board have confirmed this in their response to a draft of this report. Adviser 1 has also said that failures in the record-keeping made it difficult for him to comment fully on the second period of Diazepam use in July 2006. In responding to a draft of this report, the Board said they had reviewed the records and found them to be legible. They also provided evidence of the audit programme in line with the recommendation in paragraph 26. However, Adviser 1's concerns relating directly to the content of these specific records (see paragraphs 13, 17 and 20). In all the circumstances, I uphold this complaint.

25. The use of Diazepam relates to questions of clinical judgement. The Ombudsman is, therefore, recommending that clinical staff involved in Mrs A's care and the Board's relevant clinical director receive a copy of this report. I was concerned to note that Mrs C was wrongly told in response to her complaint that Diazepam was only prescribed for four days in May 2006 and I have asked for an explanation and a specific apology relating to this. I understand Mrs C's concerns that the use of Diazepam caused Mrs A to deteriorate. However, in the presence of other possible explanations for her deterioration, for example Mrs A's urinary tract infection (see paragraph 14), Adviser 1 has also not been able to say definitively that this was the cause. Given this, I, therefore, make no further comment on whether the Diazepam contributed to the deterioration in Mrs A's condition.

26. On the failures in record-keeping, it is important to keep good and accurate records so that any other healthcare professional who sees the patient later can see what has been happening and – importantly – why. This is essential to help healthcare professionals make appropriate decisions on the future care and treatment of the patient. Given concerns also raised by Adviser 2, the Ombudsman is asking the Board to provide evidence of their systems for auditing records (The Board completed this recommendation in response to the draft report see paragraph 24).

(b) Recommendations

27. The Ombudsman recommends that the Board:

(i) apologise to Mrs C for the failures in record-keeping, which have made it difficult for the Ombudsman's advisers to fully evaluate Mrs A's care, and for the error in their letter to her of 5 December 2006 concerning the use of Diazepam in Mrs A's care;

(ii) provide clinical staff involved in Mrs A's care and the Board's relevant clinical director with a copy of this report; and

(iii) provide evidence of the systems in place to monitor and audit medical and nursing records.

(c) Mrs A's family was not given sufficient time to consider a proposed move of hospital; (d) Mrs A's transfer to another hospital was carried out inappropriately; and (e) a conversation about Mrs A's treatment was inappropriately held in a public place

28. With regard to the transfer, Adviser 1 said that given the deterioration in Mrs A's condition she could not have been managed in a general medical ward without potentially dangerous sedation. The decision to transfer to a unit where she could receive specialist support was, therefore, entirely reasonable and appropriate. As a result of her condition, Mrs A had not been competent at the time to give informed consent to this transfer. Adviser 1 said that, in these circumstances, the law did not given the next-of-kin the right to give or withhold consent on behalf of an incompetent adult. The Consultant was, therefore, required to act in the best interests of the patient. While it was normal practice to discuss any such decision with the next of kin, the decision ultimately rested with the Consultant. Adviser 1 noted that the transfer had been delayed some days to allow Mrs A's family to discuss this with a second consultant from Hospital 2 involved in the decision. He felt that, in all the circumstances, the Consultant's actions were reasonable and in line with good practice.

29. In considering the complaint that the Consultant inappropriately discussed this in a public place, Adviser 1 noted that Mrs C said this had taken place outside the lifts. He said that it was good practice to ensure sensitive discussions took place in a private place. However, the pressure of space in many NHS institutions was such that appropriate accommodation was sometimes unavailable and discussions, therefore, took place on wards. Adviser 1 said that corridors or lift areas were clearly inappropriate venues for such discussions. Adviser 1 considered the description of the discussion in a log of events from Mrs C and also the response to the complaint from the

Consultant (this response had not been communicated to Mrs C, as it was not dealt with in the Board's letter of response of 5 December 2006). No contemporary note had been taken. While the Consultant had recorded telephone conversations of the day before with Mrs A's family, which made clear his concerns about her care and the reluctance of the family to accept a transfer, there was no note of this conversation in the medical notes.

30. In the log of events, Mrs C had described the Consultant as aggressive and said she had been upset by this meeting. The Consultant, in his comments, said that he was also upset. He felt he was being criticised for not managing a patient who needed specialist care but was being prevented from providing that care. He denied being aggressive but recalled saying he was very disappointed.

31. In reviewing the accounts of the meeting, Adviser 1 said from Mrs C's description it was clear this was an unexpected encounter rather than a planned meeting. It was not clear from either account who initiated the discussion but both parties did participate in the conversation. On the evidence available, it was not possible to comment further.

32. In response to the specific comments made by Mrs C about the transfer, Adviser 2 said that, from the notes, it was not possible to address the issue of the name of the nurse who the Board had said accompanied Mrs A that day. He was also unable to comment on specific issues about the apparent attitude of staff to Mrs A's family.

(c) Conclusion

33. Mrs A improved following her transfer to Hospital 2 and there is no reason to doubt that the decision to move her was the correct one. Mrs C has said she felt they were rushed into this decision but, as Adviser 1 has pointed out, they did not, in fact, require to be consulted. It was good practice for the Consultant to do so and to take their views into account. I, therefore, do not uphold this complaint.

(d) Conclusion

34. Mrs C has also said she believes Mrs A was sent in a taxi on her own. Hospital 1 and Hospital 2 share a campus. There is no direct evidence that she was accompanied but, given the notes made prior to transfer about her extremely confused state, it would have been normal practice for Mrs A to have

been accompanied. However, in the absence of any notes on the record to confirm that she was escorted, I have decided to make no finding under heading (d).

(e) Conclusion

35. I have seen two versions of the conversation on 21 July 2006. Adviser 1 has said it appears that this was a chance meeting and both parties participated in the discussion. While the Consultant has denied being aggressive, I have noted that both the Consultant and Mrs A admit to having been upset and, with hindsight, it does appear that it would have been more appropriate for the Consultant to have made an arrangement to discuss Mrs A's concerns later in an appropriate setting. However, I accept it is not possible now to say how long the conversation was, who initiated it and whether arranging to discuss this later would in itself have been interpreted at the time as overly defensive. I am also well aware that medical staff may well feel frustrated if they feel unable to provide the care they feel is appropriate. There is no independent evidence surrounding this conversation and, in order to be fair to both Mrs A and the Consultant, I have decided to make no finding on this complaint. While I make no finding, I would like to draw to the Board's attention that, in circumstances such as these, where medical or nursing staff are aware that a meeting has been upsetting, it would be good practice to ensure a proper venue and that a record of the meeting is taken at the time.

Annex 1

Explanation of abbreviations used

Mrs A	The complainant's late mother
Hospital 1	Ayr Hospital
Hospital 2	Ailsa Hospital
Mrs C	The complainant
The Board	Ayrshire and Arran NHS Board
The Consultant	Consultant responsible for Mrs A's care during her first period of admission at Ayr Hospital
Adviser 1	Medical Adviser to the Ombudsman
Adviser 2	Nursing Adviser to the Ombudsman

Annex 2

Glossary of terms

Adult respiratory distress syndrome	A sudden respiratory failure caused by rapid accumulation of fluid in the lungs. It is a response to damage in the lungs and can have a number of causes
Alcoholic foetor	The smell of alcohol usually from the breath of a patient
Autoimmune hepatitis	A disease in which the body's own immune system attacks liver cells
Cirrhosis	Scarring and hardening of the liver
Diazepam	Diazepam is a member of the benzodiazepine family. Benzodiazepines are sedatives which cause dose-related depression of the central nervous system. They are useful in treating anxiety, insomnia, seizures, and muscle spasms
DTs	Common abbreviation for Delirium Tremens: hallucinations accompanying alcohol withdrawal
Hepatic encephalopathy	A condition that occurs when the liver is damaged to the point of liver failure. As a result of the failure of the liver to process toxins from the blood, the patient suffers from a deterioration in brain function
Hypothyroidism	A lower than normal level of production of the hormone thyroid

Intramuscular haloperidol	Halperidol is an antipsychotic medication. Intramuscular refers to the method of delivery, through the muscles
Serum alcohol measurement	A measure of the concentration of alcohol in the blood