Scottish Parliament Region: North East Scotland

Case 200701333: Tayside NHS Board

Summary of Investigation

Category
Health: Hospital

Overview
The complainant (Miss C) raised a number of concerns about the medical and nursing care and treatment of her 74-year-old mother (Mrs A) at Ninewells Hospital in the few months up to her death in a hospice in August 2006.

Specific complaint and conclusion
The complaint which has been investigated is that Mrs A's care from May to August 2006 was below a reasonable standard (*partially upheld - only in respect of record-keeping*).

Redress and recommendations
The Ombudsman recommends that Tayside NHS Board (the Board) provide the Ombudsman's office with evidence of appropriate monitoring of the guidelines about long-term feeding lines for diabetic patients.

The Board have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. The complaint from Miss C which I have investigated is that her mother (Mrs A)'s care from May to August 2006 was below a reasonable standard.

2. Miss C's complaint to the Board had included many nursing concerns. From the evidence in the Board's complaint file, the Ombudsman's Advisers (the Advisers - see next paragraph) and I consider that the Board took those complaints seriously and took appropriate action, for example, acknowledging shortcomings and taking action to change things. In fact, the Advisers applauded the Board for the extent of this – for example, in conducting a root cause analysis. Where, in our opinion, a health board have taken appropriate action on a complaint before our involvement, we would not generally uphold such a complaint or investigate it. My investigation has, therefore, focussed on the main aspects which I considered remained outstanding at the end of the Board's investigation. As my investigation progressed, some poor record-keeping was identified and this was, therefore, added to the investigation.

Investigation

3. I was assisted in the investigation by the Advisers, whose role as medical and nursing professionals was to explain to me, and comment on, the medical and nursing aspects of the complaint. I accept their advice. We considered the complaint correspondence and comments provided by Miss C. Information which we considered from the Board included responses to my enquiries, internal complaint correspondence and Mrs A's clinical records. In line with the practice of the Ombudsman's office, the standard by which the events were judged was whether they were reasonable. By that, I 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. The purpose of the investigation was to use the information from Miss C and the Board to establish the relevant facts about Mrs A's care and treatment and then to consider whether the facts fell within this range of reasonable practice.

4. 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.

Complaint: Mrs A's care from May to August 2006 was below a reasonable standard

5. Mrs A was admitted, aged 74, to the Hospital on 6 May 2006, with general deterioration and a feeling of unwellness, together with tiredness and some shortness of breath. Because of Crohn's disease, she had previously had bowel surgery. (Crohn's disease is a condition of the bowel, in which the gut wall becomes inflamed, thickened and weakened, resulting in, for example, ulceration or perforation, with faeces leaking either inside or outside the body. A patient may have periods of relative freedom from symptoms. Abdominal surgery should be avoided if possible because of the severity of possible complications.) Amongst other things, Mrs A also had stroke disease and a condition which reduced her lung volume, and she had been taking corticosteroid medication long term.

6. In this paragraph, and at paragraphs 7 to 8, I give a brief overview of Mrs A's time in the Hospital. On admission, she was discovered to have diabetes and was noted to have a mild fever, and there was evidence of infection, which was thought to be related to a chest infection or possibly to a sore that had developed before admission in her lower spine area. A scan suggested the infection was an abdominal abscess due to bowel perforation.

7. Diabetes treatment was started, by insulin injections, but Mrs A's nutrition was very poor. This was not because of any shortfall in care but because of a number of other issues, for example, Mrs A's breathlessness because of lung fibrosis, mouth thrush (which made eating uncomfortable), low mood and infection. Infection generally causes a higher nutritional demand, which was never going to be achievable for Mrs A because of her Crohn's disease, despite her being treated for that disease. It was decided to start feeding Mrs A through a long-term line into the veins. This was to improve her nutritional intake by getting nutrients into the large body vein. Because, in Mrs A's case, access into her veins was difficult, it was decided to use ultrasound to guide the line into position. The line was inserted with the help of ultrasound equipment in early June, following a delay caused by a waiting list for the line. Although that list was three weeks, the wait turned out to be nine days. The Advisers consider that there would always have been several days' delay because inserting these lines is a specialist procedure, needing preparatory tests and the obtaining of special advice beforehand (dietician, blood tests etc). However, the Advisers do not consider that either nine days or three weeks are acceptable delays – although they do not believe that the nine days' delay made any significant

difference to the eventual outcome and they are conscious that the resource implications of this procedure are considerable and, therefore, cannot be overlooked.

8. The clinical records show difficulty in controlling the diabetes, and Mrs A had several hypoglycaemic attacks. (Hypoglycaemia is explained at paragraph 13, and the difficulties of control in this case are explained at paragraph 15.) Tiredness and shortness of breath are increasingly referred to in the records. And the records indicate that Mrs A started passing faeces from the wrong area. Rectal examination showed that she had a fistula (a perforation of the wall of the rectum, which was, therefore, leaking faeces). Biopsies confirmed Crohn's inflammation and ulceration. A note in the records for mid-July said that a change of direction was agreed with Mrs A, with the aim simply to make her comfortable, rather than actively treat her. Deterioration continued, and, on Mrs A's wishes, she was moved to a palliative care unit on 3 August 2006, where, sadly, she died on 16 August 2006.

9. Turning now to the complaint, I note that Miss C was concerned that it took almost a fortnight for doctors to realise that Mrs A was seriously ill and that she said she had been told each day that there was nothing wrong with Mrs A, who would soon be able to go home. When replying to her complaint, the Board told Miss C that the doctors were not acting under the impression that there was nothing wrong with Mrs A and that it was, in fact, concern over her lack of progress which prompted further investigation, including a scan, from which a diagnosis was made. They also said that it was not always possible to reach a firm diagnosis immediately after a patient's admission to hospital.

10. The Advisers have commented that several factors contributed to the time taken for doctors to be clearer about Mrs A's condition, ie any significant physical signs and results of tests were masked by:

- Mrs A's long-term use of steroids, which partly suppress signs and symptoms of infection;
- markers of infection which were misleading: raised C-reactive protein, which could have been caused by infection or other conditions, and raised white blood cell count, which could have indicated infection or steroid use;
- contradictory evidence about a chest infection; and
- an initial apparent improvement in Mrs A's condition.

The Advisers consider, therefore, that it was not unreasonable for these factors to delay diagnosis.

11. Bearing in mind Miss C's concerns about what she was told (see paragraph 9), I turn now to what information she was given in the first fortnight of her mother's admission. I note that the medical notes for that time make no mention of discussions with Miss C. The nursing notes refer to an attempt to reach Miss C by telephone about a ward transfer, to a conversation about another ward transfer and to a request by the family on 16 May 2006 to speak to a doctor, which, although followed up twice by nursing staff, does not appear to have been actioned by a doctor. Possible discharge is mentioned on 7 May ('Aim home 48 hours') and on 15 May, when there is reference to involvement by the Early Supported Discharge Scheme and to the need for advice from the local social work department about help which Mrs A might need at home. In other words, it is not possible to know from the records what Miss C was told about her mother's condition or possible discharge. I return to this in my conclusion.

12. Miss C also felt that there were drug errors, for example, the use simultaneously of two, rather than one, prescribing and administration forms, which I shall refer to as prescription charts. These are charts which set out the medications prescribed for a patient and the dates/times when they were actually given to that patient. I summarise here the Board's explanations to me and, earlier, to Miss C:

> 'Prescription charts have to be rewritten when there is no more space for nurses to signify that a medication has been given. In this case, a doctor rewrote Mrs A's prescription chart for that reason but put it in the wrong patient's folder. Therefore, when the nurses next gave medication to Mrs A, a duplicate prescription chart was written so that they could sign the appropriate box to show it had been given. When the misplaced prescription chart was found, the duplicate was destroyed. At no time was medication actually dispensed from two prescription charts. The matter was brought to the attention of all members of the medical team to avoid any repetition. We acknowledge that start dates for some of the prescriptions are missing and should have been inserted. However, as part of our current approach to the management of medicines on the wards generally, a pharmacist and pharmacy technician are involved in a general improvement to ward practice. Nursing staff have also been

reminded of the standards for administration of medicines – ie local standards and those published by the Nursing and Midwifery Council'.

The Advisers have confirmed that the clinical records support the Board's explanations as far as possible. They are satisfied that, in the circumstances described, it was acceptable to destroy one of the prescription charts because it had never been active.

13. Despite the Board's explanation to me (see previous paragraph), the Advisers were surprised by the number of times the prescription charts had been rewritten. They also considered that the events regarding the diabetic control from 21 to 23 June 2006 were confusing because the entries on the charts were in direct conflict or confusion with the entries in the medical and nursing notes. For example, the medical records for 21 June record a hypoglycaemic episode at 08:30, for which an injection was given; however, there is no record of this in the fluid or diabetic charts for that date. The Advisers, therefore, are critical of the record-keeping about Mrs A's diabetic management. Another example related to a possible drug error of 23 June 2006 – one which Miss C herself said she had raised with a nurse at the time and to which she said that the reply had been that it was not a drug error but a 'misinterpretation of information'. Miss C said that, on the morning of 23 June, insulin was given to her mother, despite a written instruction to withhold insulin, and that her mother was suffering from hypoglycaemia most of the morning. (Hypoglycaemia occurs when the sugar level in the blood falls below normal, and the brain becomes starved of blood sugar, which is the brain's only source of energy. The symptoms of a hypoglycaemic attack range from feeling weak and slurring one's speech to confusion, unconsciousness and death.) The nursing notes for 22 June 2006 do state that insulin was to be withheld the following morning. The insulin record for 23 June 2006 states that insulin was given that morning, but the clinical records do not give any reason. The Advisers note that the insulin record at that time shows Mrs A's blood sugar level as normal, and it may, therefore, have been the case that there was no longer any reason to withhold insulin. It is not possible, therefore, to say whether this was a drug error. It is, however, another example of inadequate record-keeping because the reason for acting against a written intention should have been recorded.

14. On another drugs-related matter, Miss C was concerned that Mrs A was being given continuous (and, therefore, unnecessary) insulin for the newly-

discovered diabetes, which she felt resulted in several avoidable episodes of hypoglycaemia. Miss C said that Mrs A was given insulin at times when she was receiving no food at all because of the time taken to start feeding through the long-term line into the veins (see paragraph 7). I summarise here the Board's explanations to me and, earlier, to Miss C:

> 'Insulin was not given inappropriately. The decision to give insulin despite the blood sugar being low was taken on the advice of our diabetes specialist nursing staff. It is recognised as not necessarily being best practice to avoid giving insulin simply on the basis of a one-off blood sugar reading. The trend of either low or high blood sugar has to be monitored, with alterations made accordingly. The diabetic liaison nurse had done teaching sessions with the staff to ensure they followed current good practice. For example, it is considered good practice to monitor blood sugar levels in patients receiving insulin, so that changes in the blood sugar level can be quickly identified and dealt with. This allows the blood sugar levels to be stabilised much more quickly. The Board's guidelines for the use of long-term feeding lines into the veins have been amended to reflect this information for the feeding of diabetic patients.'

15. As indicated at paragraph 7 and paragraph 8, the records show very poor nutrition, difficulty in controlling the diabetes and several hypoglycaemic attacks. The Advisers have examined the clinical records to see when insulin was given, the apparent reasons and the overall control of the diabetes. They have concluded that insulin was not given continuously, that control was difficult for several reasons (poor nutrition intake, infections, instability of the diabetes and, overall, a complex situation), that, overall, the control was reasonable and that, when the diabetes ran out of control, the Hospital's response was prompt and appropriate. When Mrs A's blood sugar level was too low, insulin was omitted or she was given a drug to raise it and, despite her feeding difficulties, was always able to take this drug, so she was never so hypoglycaemic that she lost consciousness. In other words, the Advisers consider that the control of the diabetes was within the bounds of reasonableness, in the difficult circumstances of Mrs A's case.

16. I turn now to concerns Miss C had about her mother's boarding out. This is the practice of moving a patient to another ward within the same hospital because of pressure on available beds. A typical scenario would be that a patient newly admitted to a ward from a hospital's Accident and Emergency department would be given the bed of a patient whose condition was

considered stable enough for him or her to be moved temporarily to another ward; the aim would be for that earlier patient to be given a bed back in their own ward as soon as possible. Whilst not ideal, it is a recognised and acceptable way to manage bed resources efficiently. I summarise here what the Board told me and, earlier, Miss C, in relation to Mrs A's case:

> 'There is clear guidance for staff should it be necessary for any patient to be boarded to another ward. The guidance does not require patients to be capable of looking after themselves [which Miss C had understood to be the case], although it does require consideration to be given to the patient's dependency level, for example, the level of nursing needed and the balance between the patient's need for general and more specialised nursing care (general nursing care can be delivered by nurses in any of our wards and departments). The guidance also indicates that patients who are expected to be discharged soon will be considered for boarding'.

17. When I asked the Board for a copy of the guidance, I was told there was nothing in writing and that staff 'just know' what conditions would merit boarding out or otherwise. There is no indication in the clinical records that, whenever Mrs A was boarded out, she was medically too unstable for boarding out. I also note that at various times, it was felt that Mrs A could be discharged soon. For example, in relation to her first boarding out, I note that the 7 May 2006 records said that, at that point, the aim was for Mrs A to be discharged within 48 hours. And, in relation to the second boarding out, discharge was again expected soon as the records for 15 May 2006 refer to the involvement of the Early Supported Discharge Scheme. The Advisers consider that, although not ideal, there is no evidence that the boarding out was inappropriate. I accept that, as a frequent visitor, Miss C was familiar with her mother's condition and so may disagree. However, the Advisers and I can only draw conclusions based on the evidence available.

Conclusion

18. In part of my overview of Mrs A's time in the Hospital, I referred (see paragraph 7) to the nine-day delay, and the three-week waiting list, for Mrs A's long-term feeding line. I gave the Advisers' opinions that neither of these were acceptable waiting times, that the nine-day delay did not appear to have made any significant difference to the outcome in Mrs A's case and that the resource implications of this type of feeding procedure were considerable. The Board have assured me that they will try to keep such waits to a minimum. Taking all

this into account, the Ombudsman has decided, on balance, to make no recommendation for action by the Board.

19. Miss C complained (see paragraph 9) that it took almost a fortnight for doctors to realise that Mrs A was seriously ill, during which time they kept telling Miss C that there was nothing wrong with her mother. The Advisers considered (see paragraph 10) that, in the circumstances of this case, it was not unreasonable that the diagnosis was missed initially, as its presence was masked by misleading factors. I also note the doctors' prompt discovery that Mrs A had diabetes. I explained (see paragraph 11) that the clinical records did not indicate what Miss C was told about Mrs A's condition during the first fortnight of her mother's admission. I cannot, therefore, determine what Miss C was told. In other words, the records about the discussions with her are not detailed enough. The Ombudsman considers good record-keeping to be important, and, generally, we would expect a certain level of detail about examinations, decisions taken, treatment given, the patient's progress and discussions with the patient. Where, with the patient's consent, there has been discussion with the patient's close relatives, we would also expect discussions with them to be recorded. We would not generally view time pressure on a doctor or nurse as a good reason for poor records. Although Mrs A's care was not affected by this aspect of the record-keeping, I uphold this aspect of the complaint because, taken in conjunction with the other record-keeping conclusions which I draw below, it is clear that inadequate record-keeping is a significant feature in this case. The Board's complaint response of February 2007 to Miss C assured her that clinical record-keeping would be reviewed and audited regularly to ensure best practice in relation to nursing records. The Board have now provided detailed evidence that this is, and has been, taking place. The Ombudsman welcomes this and has, therefore, decided to make no recommendations for further action by the Board. In a response to me in January 2008, the Board said that the Hospital's guidelines regarding long-line feeding had been amended to include diabetic patients. However, there is no evidence that these guidelines are to be evaluated at intervals to monitor staff practice, and the Ombudsman has decided to make a recommendation in this respect.

20. Moving to the possible drug errors (see paragraph 12 and paragraph 13), I see no possibility of being able to establish the facts any further about the duplicate prescription chart. That is not to say that I do not believe Miss C's account or the Board's. It is simply that I cannot reach a conclusion on an issue

where I have only the parties' accounts, rather than corroborative evidence. I also note that the prescription charts were more difficult to follow than the Advisers would have expected and that the Advisers were surprised by the number of times they had been rewritten. And I note that various records and charts were so confusing and conflicting that it was not possible to be clear whether there had been any drug errors. Clearly, different parts of a patient's clinical records should corroborate each other and, together, paint a clear picture as to what was happening with the patient. On balance, I have had to conclude that there is no evidence of drug errors but that the record-keeping represents significant shortcomings.

21. Regarding the insulin aspect (see paragraph 14), I gave the Advisers' views at paragraph 15. It is difficult to establish all the detail from a paper account, ie the clinical records - and staff's memories could not be relied on as so much time has passed, so I did not approach staff themselves. However, as far as possible, the Advisers are satisfied that there is no evidence of avoidable, unacceptable, error in the giving of the insulin, which means there are no grounds to uphold this aspect of the complaint.

22. Regarding the boarding out (see paragraph 16), I gave the Advisers' views at paragraph 17. I also note references in the nursing records to Mrs A as being 'settled' in the new wards. The Board gave me the impression (see paragraph 16) that the guidance which they had referred to was in writing. Closer scrutiny revealed that not to be the case. However, the Board are not obliged to have written guidance on boarding out, and the Advisers could find no evidence that Mrs A's boarding out had been unacceptable. Therefore, I have no grounds to uphold this aspect of the complaint.

23. To summarise, I have taken the main issues which I considered were outstanding from Miss C's complaint to the Board and have concluded that, in the difficult circumstances of this case, Mrs A's care and treatment were not unreasonable. I have, therefore, not upheld Miss C's complaint. However, poor record-keeping emerged during the investigation, to the extent that it was not possible to reach a conclusion about whether Miss C was told that there was nothing wrong with her mother, nor about whether there had been drug errors; some of the records were also found to conflict with each other and to be highly confusing. Because of the record-keeping element, I have partially upheld the complaint. Paragraph 19 explains why the Ombudsman has made no recommendations in this respect.

Recommendation

24. The Ombudsman recommends that the Board provide the Ombudsman's office with evidence of appropriate monitoring of the guidelines about long-term feeding lines for diabetic patients.

25. The Board have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the Board notify her when the recommendation has been implemented.

Annex 1

Explanation of abbreviations used

Miss C	The complainant
Mrs A	The complainant's mother
The Hospital	Ninewells Hospital
The Board	Tayside NHS Board
The Advisers	The Ombudsman's clinical advisers