Scottish Parliament Region: North East Scotland

Case 200800181: Tayside NHS Board

Summary of Investigation

Category

Health: Clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns regarding the treatment that her father (Mr A) received from staff at Ninewells Hospital (the Hospital). She complained that, for a five day period following admission to the Hospital, her father was neglected by nursing staff, his condition left unmonitored and incorrect assumptions made regarding his mental state. Mrs C felt that inattention and poor record-keeping by staff of Tayside NHS Board (the Board) contributed to a deterioration in Mr A's condition, and to his death.

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) incorrectly assumed that Mr A had dementia (*not upheld*);

(b) failed to treat Mr A appropriately for a five day period following his admission to the Hospital (*upheld*); and

(c) failed to appropriately monitor Mr A's fluid intake (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) review their progress against the action plan and provide an updated version of the document;

(ii) provide details of the steps that they have taken to implement the Scottish Government's new Food, Fluid and Nutrition programme;

(iii) provide details of the steps that they have taken to achieve the Scottish Government's new Clinical Quality Indicators for Food, Fluid and Nutrition; and

(iv) formally apologise to Mrs C and her family for the distress and anxiety caused to them and Mr A during his stay at the Hospital.

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

Main Investigation Report

Introduction

1. The complainant (Mrs C)'s father (Mr A) attended the Accident and Emergency department of Ninewells Hospital (the Hospital) on 28 October 2006, having fallen and injured his shoulder and head. Mr A was treated for a fractured humerus and cut head before being discharged. However, upon returning home, he continued to experience a great deal of pain. Mr A returned to the Hospital, where he was admitted to an orthopaedic ward later the same day. On 29 October 2006, Mr A was relocated to Ward 17 at the Hospital. Mrs C complained that, during a five day period in this ward, Mr A received no treatment from nursing staff, despite being violently ill. She said that his food and fluid intake was not monitored and he was left to become dehydrated to such an extent that he subsequently suffered kidney failure, and dehydration. Mr A was subsequently moved again to Ward 3 on 3 November 2006, however, Mrs C felt that the lack of care that he received during the five days that he spent in Ward 17, caused irreversible damage that ultimately led to Mr A's death on 17 November 2006.

2. Mrs C raised a number of concerns about Mr A's care in a formal complaint which she submitted to Tayside NHS Board (the Board) via her local MSP (the MSP). Whilst some of these concerns were resolved by the Board through correspondence and meetings with Mrs C, she remained dissatisfied with their comments regarding Mr A's treatment in Ward 17. She, therefore, brought her complaint to the Ombudsman in April 2008.

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

(a) incorrectly assumed that Mr A had dementia;

(b) failed to treat Mr A appropriately for a five day period following his admission to the Hospital; and

(c) failed to appropriately monitor Mr A's fluid intake.

4. Although Mrs C raised concerns about a number of aspects of Mr A's care between 28 October and 17 November 2006 I am satisfied that many of the points raised were adequately addressed by the Board. In my report I have, therefore, only considered the details of events that took place between 28 October and 3 November 2006.

Investigation

5. In order to investigate this complaint, I have reviewed all correspondence between Mrs C and the Board. I have also reviewed Mr A's clinical records and notes of meetings that the Board held with Mrs C. Professional advice about the treatment provided to Mr A was obtained from two medical advisers. 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 Board incorrectly assumed that Mr A had dementia; (b) The Board failed to treat Mr A appropriately for a five day period following his admission to the Hospital; and (c) The Board failed to appropriately monitor Mr A's fluid intake

6. Mr A slipped on a kerb on 27 October 2006, falling and injuring his left shoulder and forehead. Mrs C escorted Mr A to the Hospital's Accident and Emergency department the following day and he was found to have no significant head injuries. He was found to have a fracture at the top of his left humerus. In later correspondence with the MSP, the Board commented that Mr A had been noted as being 'alert and orientated'. Mr A's forehead wound was closed with paper stitches and his arm placed in a collar and cuff sling. He was discharged and allowed to return home, however, Mrs C expressed concern over his ability to cope with his injuries whilst at home, as he lived alone and did not wish further support at home.

7. Mrs C took Mr A home and remained with him for the rest of the day. Mr A continued to experience severe pain and was unable to keep food down. Mrs C felt that he would be unable to cope on his own and arranged, via Mr A's GP, for him to be readmitted to the Hospital. After his initial admission to Ward 16, a shortage of beds led to his transfer to Ward 17 on 29 October 2006. A note entered in Mr A's clinical records later that day stated that Mr A appeared 'slightly disorientated?'. The reason given for this is that Mr A was recently relocated from another ward and that he was hard of hearing and had poor eyesight.

8. Mr A's clinical records covering his transfer between Ward 16 and Ward 17 note that he had vomited and was passing only a small amount of urine. He was reviewed by a doctor who changed his medication and ordered conservative management of his shoulder injury and discharge once he was independent. On 30 October 2006, Mr A was seen by a physiotherapist who

noted that he was able to mobilise independently with the aid of a walking stick and that he was suitable for discharge with the support of out-patient physiotherapy.

9. Mr A remained in the Hospital overnight on 30 October 2006. His clinical records for 31 October 2006 note that he became somewhat confused and agitated that morning and that he had low blood pressure. Ward staff had difficulty collecting a urine sample from Mr A.

10. On 1 November 2006, Mr A was again recorded as having been 'mildly confused' during the early part of the previous evening. Mrs C contacted the Hospital on 1 November 2006 and raised concerns about Mr A's fluid intake levels and the fact that ward staff had been unable to obtain a urine sample from him. The staff member that took her call reassured her that ward staff would encourage Mr A to take on fluids, however, it was stressed that they could not force Mr A to eat or drink. Mrs C requested a meeting with medical staff regarding her father's condition.

11. Further clinical records from 1 November 2006 note that Mr A was encouraged to take fluids but that he refused to do so. He later drank half a glass of diluting juice and was further encouraged to drink, however, throughout the day he continued to be noted as having not passed urine. Mr A was examined by a doctor at 21:00 on 1 November 2006 and it was recorded that his bladder was empty. A fluid chart was commenced to monitor the levels of fluid that Mr A took in and passed out. Mr A was catheterised and a urine sample obtained around 23:45 on 1 November 2006. Simple ward testing found no abnormalities with the urine sample. The examining doctor also arranged for Mr A to be put on a drip with gelofusine (a blood volume expander, used to raise the blood pressure).

12. Early on the morning of 2 November 2006, Mr A was recorded as appearing dehydrated, with a dry tongue. He had increased levels of C-Reactive Proteins, which can be indicative of infection and blood tests showed that he had renal impairment. A Medical Registrar reviewed Mr A and found no evidence of infection, but noted his abnormal blood tests and that his urine output was now improved, following introduction of the gelofusine drip. Mr A's behaviour later became aggressive and a second Medical Registrar reduced his medication. An intravenous drip was inserted and empirical antibiotics prescribed (broad-spectrum antibiotics that are prescribed when the

true nature of an infection is unknown). Further blood tests were carried out and Mr A's kidney function was shown to have deteriorated further. An Orthopaedic Registrar examined Mr A and found that his lower left abdominal area was tender with guarding (suggesting a perforated gut with inflammation of the abdomen's membrane). A surgical opinion was sought and the surgeon requested CT scans of Mr A's chest and abdomen. The chest scan showed fluid in Mr A's chest cavity with lung collapse and consolidation (solidification).

13. Mr A's clinical records show that, on the morning of 2 November 2006, Mrs C was contacted by telephone by staff at the Hospital. The corresponding note does not record who made the call, or whether Mrs C was advised of Mr A's deteriorating condition, however, notes that she gave some background information about Mr A's normal level of independence. Mrs C is also recorded as having advised that Mr A was 'usually never confused'. Around 17:00 on the same day, another conversation with Mrs C was recorded. This time, the Orthopaedic Registrar advised that Mr A's condition had improved in terms of his blood pressure and urine output, but that his prognosis was poor. Mrs C is recorded as having expressed concern that Mr A had been 'vegetating' in the ward, not drinking for two days. Mr A had, by now, been diagnosed with a chest infection, which was causing sepsis (a life-threatening inflammation caused by the body reacting to bacterial infection, which can block blood flow to the organs). It was decided that Mr A should be transferred to a respiratory ward for further treatment in light of his sepsis. A nurse recorded that Mrs C remained concerned about Mr A's fluid intake and that she was reassured that nursing staff were making every effort to encourage her father to drink.

14. On the morning of 3 November 2006, Mr A was reviewed by renal specialists, who found that his condition was satisfactory and recorded him as 'clinically better'. His blood tests produced more normal results and he produced a good urine output. He was transferred to the respiratory ward, Ward 3, later the same day.

15. Sadly, Mr A's condition later deteriorated whilst in Ward 3 and he died on 17 November 2006.

16. Following Mr A's death, Mrs C raised with the Board a number of concerns about his care. She met with medical staff at the Hospital to discuss her complaints about the nursing care that Mr A had received. Mrs C complained that she had found it very difficult to obtain any information about her father's

progress during his time in Ward 17. She said that it was clear to her that Mr A's condition was serious and that he was dehydrated, and asked why ward staff had not noticed this. In her subsequent complaint to the Ombudsman, Mrs C explained that she had felt it necessary to take a baby bottle with her when visiting Mr A, to ensure that he drank some fluids.

17. During a meeting with hospital staff on 9 November 2007, Mrs C asked to view the fluid charts that had been used to monitor Mr A's fluid intake whilst in Ward 17. She believed that he had not eaten or taken on any liquids during the five days that he was in Ward 17. Mrs C noted that, during this period, Mr A had been violently sick, and had complained of a burning sensation in his stomach. She said that he was unable to take fluids and medication that ward staff left by his bedside. Mrs C was also concerned that medical staff felt it necessary to contact her on 2 November 2006 to establish Mr A's condition prior to his admission to the Hospital. She felt that, had he been monitored properly from the point of admission, the changes in his condition would have been obvious. Mrs C commented on Mr A's rapid deterioration and noted that he had been admitted to the Hospital with a broken humerus, but had developed a chest infection and kidney failure. She considered that Mr A's lack of food and drink during the early part of his stay in Ward 17 must have been a contributing factor to this. She said that she had asked for Mr A to be put on a drip, but that she had been advised that this was not possible until a urine sample was collected.

18. The Board explained to Mrs C that fluid charts had been started to monitor Mr A's intake and output on 1 November 2006. They conceded that the clinical records were unclear as to the extent of Mr A's vomiting, but noted that fluid charts would not be used routinely for patients admitted with a broken humerus. The Board advised Mrs C that each patient is assessed individually, and a fluid chart commenced where required.

19. The Consultant Orthopaedic Surgeon that was responsible for Mr A's care in Ward 17 (Consultant 1) explained that Mr A's condition had deteriorated rapidly due to a combination of factors, including his fractured humerus, the chest infection that he developed and dehydration. He noted that, normally, a chest infection would cause a gradual deterioration, but that Mr A had experienced a rapid deterioration. He further explained that the chest infection that Mr A developed would have predisposed him to kidney problems. The

infection would have caused his body to work harder, burning energy, which would have led to dehydration and appetite suppression.

20. In response to Mrs C's concerns that the extent of Mr A's illness was not picked up by ward staff, Consultant 1 explained that Mr A had been in Ward 17 for five days. He was very unwell for two of those days and staff were not expecting him to deteriorate as quickly as he did. Consultant 1 acknowledged Mr A's dehydration but said that dehydration alone would not have led to kidney failure of the extent that Mr A encountered. He suggested that Mr A's chest infection may have affected his heart, which in combination with other factors led to deterioration of his kidney function. It was accepted that Mr A's body had to deal with both dehydration and infection and that he was not strong enough to fight the infection. Mr A's kidney function was noted as having improved following his move to Ward 3, but his overall condition deteriorated due to his chest infection.

21. In her complaint to the Ombudsman, Mrs C said that Mr A's treatment in Ward 3 had been good, but that he had been neglected in Ward 17, causing health problems from which he could not recover. She noted that, by 31 October 2006, Mr A had become disorientated and confused and did not recognise her when she visited the Hospital. Mrs C said that there appeared to be a general assumption among clinical staff that Mr A had dementia. She stressed that this was not the case, but she felt that this assumption may have impacted on the approach taken to Mr A's treatment.

22. Having reviewed the clinical records, I could find no evidence of a diagnosis of dementia being recorded for Mr A, although there were numerous episodes of Mr A being described as 'confused' or 'anxious'. There is, however, a letter contained within the complaint correspondence that has a hand-written note on it stating Mr A 'could not consent as he had dementia'. I asked the Board for their comments on Mr A being regarded as having dementia. They clarified that this note was written by their Complaints and Advice Co-ordinator (the Co-ordinator) following a discussion with Mrs C, who was planning to submit her complaint on behalf of Mr A. When asked for Mr A's consent to do so, Mrs C reportedly advised that Mr A was unable to provide consent, as he was too confused and unwell at the time. The Co-ordinator, mistakenly, understood this to mean that he had dementia.

23. When investigating Mrs C's complaint, I asked two professional medical advisers to review Mr A's clinical records and the background to Mrs C's complaint. The first adviser (Adviser 1), a specialist in care of the elderly, commented in detail about the clinical treatment that Mr A had received. He noted that Mr A's observation charts showed a slowed pulse on 30 October 2006 followed by a marked drop in blood pressure on 31 October 2006. Adviser 1 further noted that Mr A was administered oxygen at a rate of four litres per minute. He commented that these observations were noted in the clinical records but did not appear to have been questioned more thoroughly other than to assume that Mr A had lung damage. During this period of low blood pressure and slow heart rate, Mr A's temperature remained normal. Adviser 1 explained that this is not unusual for elderly patients, even where an infection is present. Adviser 1 expressed concern that Mr A's confused state had been recorded on a number of occasions but had not been questioned more thoroughly. He noted that, in a patient who had not been confused before, this was an important change, which was almost certainly related to Mr A's infection and persistently low levels of oxygenation, both of which Adviser 1 considered should have indicated the lungs as a probable source of sepsis.

24. With regard to Mr A's hydration levels, Adviser 1 felt that the fact that he had refused drinks for a period of three days should have alerted nursing staff to the possibility of dehydration. Adviser 1 was critical of the nursing staff's assessment skills, suggesting that they should have noticed that he was drinking inadequately and was developing a dry mouth. He said that maintenance of a fluid chart would have highlighted the poor fluid intake at an earlier stage. Noting that it was the combination of inadequate fluid intake and developing infection that rapidly led to Mr A's renal failure, Adviser 1 considered that recognition of his poor fluid intake was delayed by at least 36 to 48 hours, resulting in Mr A having severe biochemical malfunction by the time treatment was started. Adviser 1 considered this to be a very dangerous situation for Mr A, given his age and a past history of high blood pressure. Adviser 1 stressed that Mr A's treatment from 1 November 2006 onward, once treatment for his infection and dehydration commenced, was reasonable and appropriate, however, by that time reversal of Mr A's situation was less likely to be successful.

25. I asked Adviser 1 whether there was any information within Mr A's clinical records to support a diagnosis or assumption of dementia. He noted that Mr A

was recorded as living alone in sheltered accommodation, with only the support of his two daughters. The clinical records make no mention of confusion or unusual behaviour in the first two days of his admission, only that he was anxious and hard of hearing. Adviser 1 said that the fact that Mr A refused drinks, was unsteady on his feet and anxious in the first 24 to 48 hours, is not untypical of any elderly person admitted to hospital. He observed that Mr A was first recorded as being confused on the afternoon of 31 October 2006, when he was unwell and poorly oxygenated. Adviser 1 considered that a diagnosis of delirium would have been more appropriate than dementia under these circumstances. He defined delirium as confusion with a sudden onset and fluctuating level of impairment but which clears when the precipitating factor is removed. Dementia is a slowly progressive and irreversible cognitive memory impairment. Adviser 1 considered that the evidence of Mr A having any significant degree of dementia on admission to the Hospital was lacking but that his behaviour when ill was typical of delirium.

26. Generally, Adviser 1 considered medical and nursing staff in Ward 17 failed to adequately react to the mental and physical changes that Mr A exhibited between 20 October and 1 November 2006. This meant that his emerging infection and dehydration were left unrecognised and untreated to a point where his biochemical abnormalities and lung infection had deteriorated to life-threatening levels.

27. I asked the second adviser (Adviser 2), a specialist nursing adviser, to comment on the nursing care that Mr A received. She concurred with Adviser 1's view that there were serious failures in the assessment and monitoring of Mr A's condition, particularly with reference to fluid balance and management. She said that, on a number of occasions, observations were made in Mr A's clinical records that required action, but no action was taken. Adviser 2 explained that it is a fundamental nursing skill that, when a patient's vital signs are outwith the normal limits, this is recorded, reported if required and further action taken. She was critical of the nursing staff that cared for Mr A, as she felt that they failed to implement appropriate interventions, such as commencing a fluid balance chart. Adviser 2 further stressed that action should have been taken when Mr A demonstrated signs of new onset confusion, as an underlying infection is one of the most common causes of acute confusion.

28. Before bringing her complaint to the Ombudsman, Mrs C corresponded with the Board and met with senior staff to discuss her concerns. Whilst these

discussions did not entirely resolve her complaints, a number of issues were addressed satisfactorily. The complaints process highlighted a number of operational issues which the Board took steps to rectify. The Board accepted that their staff were slow to recognise the seriousness of Mr A's deterioration and to react appropriately. They introduced further training for staff on the use of the Scottish Early Warning System (SEWS), which helps staff recognise any changes in vital signs and to notify the appropriate clinical staff timeously. The Board also noted that the introduction of the Situation Background Assessment Recommendation (SBAR) tool also provides additional support and guidance to staff to improve communication. This is a system that has been designed to simplify communication between different members of the care team, for example, between nursing staff and consultants. Additionally, in early 2007, the Board began using the Malnutrition Universal Screening Tool (MUST), a tool that is now used across Scotland to effectively monitor patients' food and fluid intake. In addition to the implementation of these tools, the Board advised me that they have introduced 'safety huddles' as a means of improving communication and support for junior staff. The Board provided me with a copy of an action plan, which they created following Mrs C's complaint. They noted that the introduction of safety huddles and ongoing monitoring of the SEWS, SBAR and MUST tools had seen a marked improvement in staff performance in Ward 17. The action plan was initially created in December 2006 and the Board provided me with further copies evidencing reviews in March and November 2007. The action plan describes a series of staff interviews and performance monitoring procedures aimed at improving services in Ward 17.

(a) Conclusion

29. Mrs C raised the specific concern that staff at the Hospital had mistakenly assumed that Mr A had dementia and that they may have made decisions regarding his treatment on this basis. The clinical records do not suggest that medical staff were working on the assumption that Mr A had dementia, however, he is recorded as being confused and anxious.

30. The only reference that I have seen to dementia, made by the Board, is the hand-written note from the Co-ordinator. I accept that this was written as a result of her own assumptions, rather than being based on a clinical opinion. The evidence that I have seen indicates that this note was made solely with reference to the complaints process when it was invoked by Mrs C and I am, therefore, satisfied that it would not have had any impact on Mr A's treatment, or

the decisions made by the medical staff caring for him. With this in mind, I do not uphold this complaint.

(a) Recommendations

31. The Ombudsman has no recommendation to make.

(b) Conclusion

32. The evidence that I have seen clearly indicates that the Board took Mrs C's complaint very seriously and accepted that Mr A's care could have been better managed. I commend them for their efforts to meet with Mrs C to discuss her concerns in person and for the steps that they have taken to improve the service provided by Ward 17 following Mrs C's complaint. Whilst the Board have acknowledged the shortcomings in Mr A's care, they do not appear to have emphasised the seriousness of missing the signs of his deterioration.

33. Mr A was admitted to the Hospital on 28 October 2006 with a fractured humerus. I acknowledge that, at that time, it was not normal practice for the Board to commence fluid charts for patients with fractures who were not displaying other symptoms. Between 29 October and 1 November 2006, Mr A developed new symptoms of confusion accompanied by a refusal to take on fluids. His blood pressure and pulse rate dropped significantly. Whilst I am satisfied that it was not assumed that Mr A had dementia, both Adviser 1 and Adviser 2 highlighted these symptoms as indicative of delirium, suggesting an underlying infection. I was concerned that these recognisable changes in his vital signs were not highlighted by nursing or medical staff between 30 October and 1 November 2006, despite the basic facts of his symptoms being recorded in his clinical records. Furthermore, Mrs C was recorded as having raised specific concerns about Mr A's hydration levels. Again, these were recorded but with no apparent follow-up. Whilst Mr A was eventually put on a drip to address his dehydration, I was extremely disappointed to learn that Mrs C had found it necessary to take it upon herself to provide fluids for Mr A, despite having specifically asked ward staff to address this issue.

34. Both Adviser 1 and Adviser 2 agreed that, had fluid charts been started as a matter of routine following Mr A's admission to the Hospital, treatment for his subsequent infection would have commenced earlier and renal failure avoided.

35. I accept Adviser 1's advice that there was evidence available to nursing and medical staff that could have been used to improve Mr A's treatment. He did not have a history of confusion and his behaviour and symptoms were indicators of an underlying infection. I also accept that, had a record been kept of Mr A's fluid intake from the point of admission, further evidence of his dehydrated state would have been apparent. I consider staff at the Hospital to have failed to react to strong diagnostic indicators that were presented to them. I am satisfied that Mr A's care from 1 November 2006 onward was good, however, consider that his developing condition was managed poorly up to that point. As such, I uphold this complaint.

(b) Recommendations

36. I acknowledge that the Board have already taken steps to improve the performance of Ward 17 at the Hospital. I am satisfied that the action plan implemented to achieve these improvements is appropriate to address the issues highlighted by Mr A's experiences. I acknowledge that parts of the action plan have been completed, however, I recommend that the Board:

(i) review their progress against the action plan and provide an updated version of the document;
(ii) provide details of the steps that they have taken to implement the Scottish Government's new Food, Fluid and Nutrition programme;
(iii) provide details of the steps that they have taken to achieve the Scottish Government's new Clinical Quality Indicators for Food, Fluid and Nutrition; and
(iv) formally apologise to Mrs C and her family for the distress and anxiety caused to them and Mr A during his stay at the Hospital.

(c) Conclusion

37. For the reasons detailed under Conclusion (b) I uphold this complaint.

(c) Recommendations

38. The Ombudsman has no further recommendations to make.

39. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	The complainant's father
The Hospital	Ninewells Hospital, Dundee
The Board	Tayside NHS Board
The MSP	Mrs C's local MSP
Consultant 1	The Consultant Orthopaedic Surgeon that was responsible for Mr A's care
The Co-ordinator	A Complaints and Advice Co-ordinator for the Board
Adviser 1	A professional medical adviser to the Ombudsman
Adviser 2	A professional medical adviser to the Ombudsman
SEWS	The Scottish Early Warning System
SBAR	Situation Background Assessment Recommendation
MUST	Malnutrition Universal Screening Tool