Scottish Parliament Region: Central Scotland

Case 200802381: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mr C) raised a number of concerns regarding the care and treatment received by his late wife (Mrs C) at Wishaw General Hospital (the Hospital), in the area of Lanarkshire NHS Board (the Board). Mrs C was admitted to the Hospital on the evening of 14 January 2008 with a perforated ulcer, having been sent home from Accident and Emergency (A&E) earlier that day with an incorrect diagnosis of gallstones. Thereafter, Mrs C remained in the Hospital where she passed away on 25 April 2008.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the recorded primary cause of Mrs C's death was inaccurate (*upheld*);

(b) Mrs C's Alzheimer's was managed inappropriately and she was not treated with respect (*upheld*);

(c) Mrs C's nutrition and oral care were managed inappropriately (*upheld*); and

(d) Mrs C's perforated ulcer should have been diagnosed earlier and her initial discharge from A&E was inappropriate (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) review Mrs C's death certificate in light of the discrepancy with the discharge letter and give the family a definitive answer;	17 September 2010

(ii)	undertake an external review of nursing care in the wards on which Mrs C was treated following her release from intensive care. The review should consider the following: treatment of Adults with Incapacity, including the assessment of ability to consent and administration of medication; and the use of bank and agency staff;	17 September 2010
(iii)	clarify how their papers/standards 'Caring and Compassionate Practice' and 'Top Tips in caring for People with Dementia' are being monitored and measured, and how the education and training is being rolled out;	17 September 2010
(iv)	provide evidence regarding the implementation of the national policy for Senior Charge Nurses ('Leading Better Care');	17 September 2010
(v)	ensure that there are systems in place for assisting patients with feeding, as outlined in the NHS Quality Improvement Scotland 'Food Fluid and Nutritional Care in Hospitals' standards;	17 September 2010
(vi)	ensure that there are systems in place for the provision of oral hygiene, including policies and procedures; education and training and audits;	17 September 2010
(vii)	remind staff of the importance of detailed record-keeping, particularly in relation to doctors' recognition and appreciation of any abnormalities;	17 September 2010
(viii)	remind complaint handling staff of the importance of providing an accurate response to complaints and, where possible, a detailed explanation of events; and	17 September 2010
(ix)	apologise to Mr C for the failings identified in this report.	17 September 2010

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

Main Investigation Report

Introduction

1. On 8 December 2008 the Ombudsman received a complaint from a Member of the Scottish Parliament (the MSP) on behalf of the complainant (Mr C). The complaint related to the care and treatment received by Mr C's late wife (Mrs C) at Wishaw General Hospital (the Hospital), in the area of Lanarkshire NHS Board (the Board). Mrs C, who was 66 years old and suffered from Alzheimer's disease, was admitted to the Hospital on the evening of 14 January 2008 with a perforated ulcer, having been sent home from Accident and Emergency (A&E) earlier that day with a diagnosis of gallstones. Thereafter, Mrs C remained in the Hospital where she passed away on 25 April 2008.

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

(a) the recorded primary cause of Mrs C's death was inaccurate;

(b) Mrs C's Alzheimer's was managed inappropriately and she was not treated with respect;

(c) Mrs C's nutrition and oral care were managed inappropriately; and

(d) Mrs C's perforated ulcer should have been diagnosed earlier and her initial discharge from A&E was inappropriate.

3. Mr C also raised concerns relating to hygiene levels in the Hospital, particularly in relation to Mrs C's contraction of MRSA. However, after careful consideration of the available information, my office advised Mr C that, in Mrs C's case, it would be difficult to establish the facts relating to the specific hygiene issues raised. In addition, the Board had provided my complaints reviewer with comprehensive evidence that they had numerous measures in place to manage Hospital Acquired Infections, including details of their hand washing audits. I decided, therefore, not to investigate this matter any further.

Investigation

4. In writing this report, my complaints reviewer has had access to Mrs C's clinical records, the complaints correspondence from the Board and he made written enquiries of the Board. He obtained advice from one of the Ombudsman's professional hospital advisers, a consultant in acute medicine for the elderly (Adviser 1) and one of the Ombudsman's professional nursing advisers (Adviser 2), regarding the clinical and nursing aspects of the complaint.

In addition, my complaints reviewer met with Mr C, his two daughters (Mrs D and Mrs E) and the MSP.

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1 and a glossary of terms used in this report can be found in Annex 2. A list of the legislation and policies considered is at Annex 3 and a chronology, outlining the key events, is at Annex 4. Mr C, the MSP and the Board were given an opportunity to comment on a draft of this report.

Background

6. Mrs C's family complained to the Board in a letter of 20 March 2008 and the Board responded in a letter of 24 April 2008. Mrs C passed away the day after the Board's response was issued and the Board wrote to Mr C again on 29 April 2008 to express their sincere condolences. They apologised for the fact that their response arrived at a very difficult time and invited the family to contact them whenever they felt ready to discuss matters further.

7. The family, along with the MSP, then attended a meeting at the Hospital on 12 September 2008. In attendance from the Hospital were the General Manager (the General Manager), the Associate Medical Director (Director 1), the Associate Director of Nursing and Midwifery (Director 2) and the Acting Administration Manager. The MSP subsequently complained to the Ombudsman, on Mr C's behalf, in letters dated 4 December 2008 and 9 January 2009.

(a) The recorded primary cause of Mrs C's death was inaccurate

8. In the meeting at the Hospital, Mrs D stated she did not feel Mrs C died of advanced Alzheimer's disease, as recorded on the death certificate. The General Manager explained that Alzheimer's can, in some instances, have an impact on the overall well-being of patients, however, she advised that the recorded cause of death could be amended if the family were concerned. The MSP asked if there was anything in the notes, other than Alzheimer's, to suggest a cause of death and Director 1 said that, a few days prior to Mrs C's death, he had noted issues relating to kidney deterioration. He stated that infection appeared to have been the main concern but there was no catastrophic event to suggest the deterioration, however, lack of nutrition would most definitely have been a contributing factor. The family felt that this did not

answer their question as to why Mrs C deteriorated and Director 1 stated that there were a number of other contributory factors over and above the Alzheimer's. The MSP asked what the death certificate would be changed to and Director 1 advised that the surgical team who cared for Mrs C would have to review the case again and agree any changes.

9. The Board subsequently wrote to Mr C on 6 November 2008, advising that Director 1 had a detailed discussion with the consultant who issued the discharge letter to Mrs C's GP (Consultant 1) regarding the possibility of amending Mrs C's death certificate. However, Consultant 1 felt that, based on the overall clinical picture, Mrs C did show signs of advanced Alzheimer's disease and that it was, therefore, clinically inappropriate to have the death certificate changed.

10. In their meeting with my complaints reviewer, the family reiterated their concerns regarding the recorded cause of death and expressed dissatisfaction with the Board's decision not to have this amended.

11. Adviser 1 reviewed the records and stated that, in his view, it was misleading and inaccurate to have recorded the primary cause of death as dementia. He noted that alternative possibilities were suggested by the Board in their meeting with the family but that the death certificate was not amended. He advised that, in Consultant 1's discharge letter (dictated 5 October 2008 and typed on 13 October 2008), she listed acute renal failure as the primary cause of death and, in Adviser 1's view, this was a much more accurate description of the terminal event. He stated that infection, the ulcer, poor nutrition and poor cognitive function (dementia) were all contributory causes.

(a) Conclusion

12. The primary cause of death was noted as advanced Alzheimer's and this differed from the discharge letter, in which Consultant 1 listed renal failure. The advice my complaints reviewer has received indicates that renal failure is a more accurate reflection of the cause of Mrs C's death. In light of this, I am critical of Consultant 1's reluctance to amend the death certificate to mirror her assessment in the discharge letter and I uphold this complaint.

(a) Recommendation

13. I recommend that the Board:	*Completion date*
(i) review Mrs C's death certificate in light of the discrepancy with the discharge letter and give the family a definitive answer.	17 September 2010

(b) Mrs C's Alzheimer's was managed inappropriately and she was not treated with respect

14. In their complaint letter to the Board, the family said that they believed Mrs C's basic care had been ignored due to her Alzheimer's. They provided examples of instances where they felt Mrs C had been treated with disrespect, such as being cleaned whilst the curtain was drawn back, being told to use an incontinence pad instead of being assisted to the toilet and being left sitting in faeces during visiting time. In addition, they advised that, on one occasion, they arrived for visiting to find Mrs C with her head trapped between the bed bars and her nightgown ridden up. They also advised of a lack of co-ordination in the administration of Mrs C's medication. They said that staff left Mrs C's medication out for her to take herself despite being aware that she required assistance and they advised of an occasion where Mrs C was not provided with her medication because she refused it. They advised that, when they questioned staff about this, they were told that agency staff did not know Mrs C's history and had not read the notes.

15. In their response, the Board acknowledged that the family had advised the consultant surgeon, whom Mrs C was admitted under (Consultant 2), that Mrs C had been active and well prior to her admission, however, they said that, having been critically unwell, her dementia progressed and resulted in her being dependent for all activities. They noted that Consultant 2 was concerned that Mrs C would not have been able to return home as her co-operation was not likely to have improved and, even with carers and district nurse assistance, the responsibility would have been great for the family.

16. The Board advised that, upon her transfer to Ward 17, the staff were made aware that Mrs C had Alzheimer's disease. They confirmed that Mrs C's case notes accompanied her to each ward and staff, therefore, had full access to her medical history and nursing notes. They apologised if information given to the family was incorrect or if staff did not check before responding to their enquiries. They noted that Consultant 2 had suggested that one member of the family was

elected to communicate with nursing staff in order to avoid conflicting information being provided.

17. The Board indicated that, post-operatively, Mrs C became doubly incontinent and seemed to display a lack of awareness, as she was not asking for the commode or assistance if there was an episode of incontinence. They confirmed that she was managed using incontinence pads.

18. With regards to the situation where Mrs C had her head trapped between the bed bars, the Board expressed their regret. However, they provided an assurance that 'nursing staff would not leave a patient like this once they became aware of the situation'. They said that they aim to ensure patients are treated with dignity and respect at all times. Similarly, they advised that, if the curtains were not closed properly at any time, this would not have been deliberate and they indicated that the curtains sometimes move as the nurses move around the bed area. They expressed their understanding of the family's concerns about Mrs C having been exposed and they confirmed that this should not have happened. They stated that the Senior Nurse for the Directorate had spoken to Ward Managers to remind them of the necessity for dignity and privacy for all patients at all times.

19. In the family's meeting with the Board, Mrs D explained how well Mrs C had been before she went into hospital, although she acknowledged that she did have some form of Alzheimer's disease. She reiterated her concern over Mrs C refusing her medication and the fact that this had continued despite an assurance having been provided that medication would be routinely administered, meaning the nursing staff would not need to ask Mrs C if she wanted it. She also advised that obtaining information from the nursing staff at the changeover was very problematic, as staff going off duty were too busy to help and staff coming on duty claimed they knew nothing as they had just come on. Director 2 advised that nursing staff have a personal responsibility to know their patient and should be checking the case notes. The General Manager acknowledged that the action plan had identified the issue with the medication and they were reviewing whether bank staff should dispense medication, as they are less familiar with the patient. As well as an action regarding administration of medication, the Board's action plan also included actions relating to communication, lack of co-ordination and the maintenance of patients' dignity and respect.

20. Mrs D stated that she felt Alzheimer's was used as an excuse for everything by the staff, and the MSP said that there was an inconsistency regarding Mrs C's degree of Alzheimer's, as staff were seeking her consent before administering medication. Director 1 consulted the notes and advised that it had clearly been recorded on 9 February 2008 that Oramorph was to be given regardless, so consent was not required to administer this to Mrs C.

21. Mrs E advised that she felt that the staff's belief that Mrs C required supervision to go outside prior to coming into hospital would have made them believe her Alzheimer's was more advanced than it was. Director 1 said he could not see a reference to that effect in the case notes. The MSP said staff should be able to determine a patient's level of Alzheimer's by their own daily observations and Director 1 agreed and advised that Alzheimer's should have been considered separate from other factors.

22. When the family met with my complaints reviewer, they reiterated their belief that Mrs C's Alzheimer's was used as an excuse and blamed for everything. They said that, a week prior to her admission, Mrs C had been babysitting her grandchildren and they expressed concern that her Alzheimer's could have progressed at such a rate. The MSP reiterated his concern over the inconsistencies in how Mrs C's Alzheimer's was viewed, with it being regarded as serious, whilst, at the same time, staff were willing to take Mrs C's word when she did not want any medication. In commenting on a draft of this report, the family were keen to point out that, prior to her admission, Mrs C was an active 66-year-old wife, mother and grandmother.

23. My complaints reviewer consulted Adviser 1 regarding the management of Mrs C's Alzheimer's and Adviser 1 noted that the initial nursing notes and medical notes all recorded Alzheimer's disease in the problem lists. He advised that consultations with psychiatry and medicine for the elderly were appropriately obtained. He observed that alternate placement in a unit familiar with the care of dementia (elderly medicine) was attempted but Mrs C's other problems were such that transfer back to a surgical unit was needed. He noted that the problems relating to nutrition (nasogastric tube displacement) were recognised as relating to cognitive impairment and the possible coexistence of depression and delirium (acute confusion due to reversible problems such as infection) were treated. He stated that no inappropriate sedation was used, and the possible effects of strong analgesia on cognitive function were considered.

24. Adviser 1 noted that it was explained to the family that the relatively abrupt decline in Mrs C's cognitive function possibly related to a 'worsening of dementia'. He advised that patients with dementia are vulnerable to the effects of acute illness, surgery and anaesthesia, and abrupt and irreversible deterioration of cognitive function is well recognised in patients with mild dementia who have serious acute illness. He stated that this occurrence could not have been predicted or prevented in this case and, overall, from the information available, he could not see any specific action or omission that was unreasonable with regard to the medical care of dementia.

25. My complaints reviewer had a further discussion with Adviser 1 regarding the family's belief that that Mrs C was not treated with respect and the events they outlined to support this belief. Adviser 1 said that, ideally, surgical units would have more trained staff on hand to prevent incidents occurring, such as patients' heads becoming trapped in bed rails, however, he recognised that staff have competing priorities and would not always be able to be on hand to do so. He said that it was clear that the Hospital failed to maintain Mrs C's dignity to a level that was acceptable to the family, however, he noted that Mrs C would not have been the only frail elderly patient on the unit at that time and, in the absence of continual one to one care, it would not have been possible to constantly supervise her.

26. With regards to the Board's action plan, Adviser 1 stated that it seemed rather superficial. He noted that it contained an action 'Maintain Patients Dignity and Respect at all Times' which stated that 'All patients admitted to hospital should have all of their care needs met and all staff should ensure their dignity and respect at all times, through all of their treatment plan'. He said that this sounded like a simple restatement of policy with no indication of how it was to be achieved and he noted that it was apparently 'Completed' in July 2008. Adviser 2 also indicated that the action plan was vague and she stated that it should have been written using SMART principles (specific, measurable, achievable, realistic and timely) and she suggested that the Board be asked to provide evidence that lessons have been learned.

27. My complaints reviewer contacted the Board and made them aware of the advisers' comments and they confirmed that the component of the action plan relating to the maintenance of respect and dignity had been discussed with the ward staff involved in caring for Mrs C. The provided copies of the following key documents, designed to support staff:

- Delivering a Patient-focused Service (introduced in March 2008)
- An extract from the Senior Charge Nurse/Team Leader objectives
- Caring and Compassionate Practice
- Top Tips in caring for People with Dementia (distributed to all wards in the Hospital in autumn 2009)

28. My complaints reviewer asked Adviser 2 to review the Board's response and she found it helpful and was impressed, in particular, by the latter two papers. Whilst she said these papers were to be commended, she questioned how they were being monitored and measured and how the education and training was being rolled out. In respect of the Senior Charge Nurse objectives, Adviser 2 also suggested that the Board be asked to provide evidence regarding the implementation of the national policy for Senior Charge Nurses entitled 'Leading Better Care'.

(b) Conclusion

29. Whilst the advice my complaints reviewer has received indicates that Mrs C's Alzheimer's was recognised from the outset and reasonably managed, I have real concerns over aspects of Mrs C's treatment and the maintenance of her dignity. Mrs C was clearly vulnerable to the effects of her serious acute illness and I am not satisfied that she was treated with respect amidst her worsening dementia. The family have raised some worrying concerns, such as Mrs C being left exposed on the ward (when her head was trapped in the bed rails and also when the curtain was not drawn when Mrs C was being washed). I find some of the Board's responses to these concerns, such as 'nursing staff would not leave a patient like this once they became aware of the situation', non-specific and unfortunate.

30. In addition, I have concerns regarding the administration of Mrs C's medication and the assessment of her ability to consent. Despite Mrs C's worsening dementia, and indications that medication was to be given without consent, Mrs C appears, on occasion, to have been allowed to refuse medication. I do not consider that Mrs C was competent to make such a decision and this should have been properly assessed and clearly recorded for the benefit of all staff administering medication. The family have indicated that they were told agency staff did not know Mrs C's history and I find this unacceptable. In their response, the Board advised that they were reviewing whether bank staff should dispense medication, however, later in this report

they refer to a 'robust nurse bank system'. I am concerned that the roles and responsibilities of bank and agency staff appear to be unclear, particularly in relation to the administration of medicines.

31. Whilst the Board have acknowledged the family's concerns and are taking some action to address the issues relating to maintaining patients' dignity and respect, I am critical of their overall management of Mrs C in this regard. In the circumstances I, therefore, uphold this complaint.

(b) Recommendations

32.	I recommend that the Board:	*Completion date*
(i)	undertake an external review of nursing care in the wards on which Mrs C was treated following her release from intensive care. The review should consider the following: treatment of Adults with Incapacity, including the assessment of ability to consent and administration of medication; and the use of bank and agency staff;	17 September 2010
(ii)	clarify how their papers/standards 'Caring and Compassionate Practice' and 'Top Tips in caring for People with Dementia' are being monitored and measured, and how the education and training is being rolled out; and	17 September 2010
(iii)	provide evidence regarding the implementation of the national policy for Senior Charge Nurses ('Leading Better Care').	17 September 2010

(c) Mrs C's nutrition and oral care were managed inappropriately

33. The family raised concerns regarding the management of Mrs C's nutrition and, when they met with my complaints reviewer, they stated that they believe she had 'starved to death'. In their letter to the Board, they said that they felt that staff had not been sensitive to Mrs C's needs. In particular, they advised of an occasion when dinner had been left in front of Mrs C and then taken away untouched, as she was unable to lift off the lid. They also said that other patients had told them that staff had forgotten to feed Mrs C and, when they questioned this, the staff indicated that they did not have the time to feed her.

34. The family also advised that hot tea had been left in front of Mrs C when she was still very swollen from fluids and could not move her hands or her body.

They indicated that, at one stage, Mrs C's mouth and tongue were so swollen that she had been unable to close her mouth and staff had not noticed this.

35. The Board responded advising that the records showed Mrs C was initially reluctant to eat or drink but small amounts were documented as having been taken with assistance. They indicated that attempts to feed Mrs C with a nasogastric tube were unsuccessful as she dislodged the tube on several occasions. In light of Mrs C's recent ulcer perforation and the risk of her pulling out the attachments, the Board advised that it was felt that a percutaneous endoscopic gastrostomy (PEG) tube was not appropriate as an alternative. They confirmed that Mrs C was, therefore, dependent on nursing staff and family to assist with her feeding. In correspondence which informed the Board's response, the Charge Nurse who was responsible for Mrs C between 25 January 2008 and 1 February 2008 (the Charge Nurse) stated that 'domestic staff give out the tea, they do not assist patients with drinks and if the nursing staff don't know that the tea is there we can't help'. In addition, Consultant 2 stated that Mrs C was 'dependent on family and understaffed nurses to feed her' and 'the ward staff did their best to attend to [Mrs C]'s needs and dignity in a very understaffed ward'.

36. The Board noted that Mrs C was being seen by the dietician and that she was commenced on a food record chart. They acknowledged that their records showed Mrs C as having missed a meal on 11 February 2008 and they advised that this was due to the fact that the Clinical Support Worker was not informed that feeding assistance was required. They apologised for the fact that this was overlooked.

37. The Board acknowledged that the family had expressed concern, on the evening of 18 February 2008, over Mrs C's swollen tongue. They advised that their records showed Mrs C's mouth as having been sore earlier that day but no swelling had been noted. However, they noted that she was reviewed later that evening and a split to the right side of her tongue was identified. Her dentures were removed, a mouth swab was taken and she was commenced on medicated mouthwash. The Board advised that Mrs C's tongue had black discolouration and that this was due to the iron tablets which had been administered that day.

38. In their meeting with the Board, the family advised that they were distressed by Mrs C's treatment over the Easter holiday weekend (21 to

24 March 2008) when Consultant 1 suggested 'nil by mouth'. They stated that they were given no explanation of this despite repeatedly asking. Director 1 advised that a peripheral intravenous (IV) line would have been in place and that a central IV line was put in that weekend. He said that Mrs C was noted to have had abdominal tenderness at 10:00 on 21 March 2008 and it was recorded that she was allowed to have a few sips of water for comfort. On the following day, it was suggested that oral intake could be increased if Mrs C could tolerate it and, on 24 March 2008, the central IV line was stopped and she was commenced back on diet. He advised that, overnight, Mrs C vomited and was noted as having difficulty swallowing and a referral to the Speech and Language therapist was made.

39. Mrs D acknowledged that the records may have shown Mrs C as having received diet and nutrition, however, she contested this and advised that a member of the nursing staff had suggested that the family make up a rota to come in and feed Mrs C as the staff were too busy to do so. The General Manager stated that such a response was unacceptable and that staff could request additional resources if one-to-one nursing was required. However, she said that she would expect staff to balance this with the wishes of the relatives, some of whom wish to be very much involved in their relative's care.

40. The General Manager advised the family that a detailed action plan had been put in place as a result of their complaint and she explained this plan to the family. This plan included an 'Assistance with Meals' action to 'ensure there are always nursing staff available to feed patients if required, within the ward area'. She also explained that staff were shown complaint responses and that they were involved in debriefs to discuss the issues raised and what could be learned from them. In addition, she advised that the issues raised were picked up at monthly senior nurse meetings. Finally, Director 2 stated that feedback was invaluable in allowing them to monitor performance and to provide them with the opportunity to improve their care.

41. In their meeting with my complaints reviewer, the family reiterated their concerns about Mrs C's care over the Easter holiday weekend. They also questioned why it had been left so late to commence PEG feeding. They expressed concern that this was left until three days before Mrs C's death when she had been in hospital for 15 weeks.

42. In commenting on this matter, Adviser 1 noted that numerous comments regarding nutrition were made in the 'ward round' section of the notes. He advised that, following surgical review on 20 March 2008, 'nil by mouth' and sips of water were suggested and he stated that, at that time, there was concern that Mrs C may have been developing intra-abdominal problems or was infected, or both. He indicated that the action was standard practice and reasonable, even in a patient with already poor nutrition, and he advised that it was relaxed following a computerised tomography (CT) scan and improvement on 24 March 2008.

43. Adviser 1 informed my complaints reviewer that the decision to insert a PEG tube for feeding purposes was never easy in a patient with dementia. He advised that, if poor intake was due to dementia in itself, then PEG tube feeding would not be standard practice in the UK. It would, however, be used if it was felt that there were reversible problems, and that nutrition would help the patient overcome these problems, and the patient could not tolerate nasogastric feeding (as was the case with Mrs C). He said that it was unclear why Mrs C was unable to feed but he believed it in part to have related to her dementia and, therefore, it would not have been correctible. He indicated that the surgical team must have felt that some of the underlying problems were still reversible, hence the suggestion of the PEG tube. In Adviser 1's opinion, the medical staff clearly felt that all other feeding possibilities had been exhausted. He observed from the records that there was an appropriate discussion with the family by a consultant and appropriate completion of an 'Adults with Incapacity' form.

44. Adviser 1 summarised that poor nutrition would have contributed to Mrs C's decline but was not the primary cause of her illness or death. Given Mrs C's overall condition, her fluctuating medical problems and dementia, the risk of injury from the PEG if she manipulated it, and the nutritional measurements taken in previous weeks, in Adviser 1's view, it was reasonable not to have suggested PEG treatment any earlier.

45. Adviser 2 also reviewed the records and stated that Mrs C was appropriately commenced on nasogastric feeding when she was in the Critical Care Unit. However, Adviser 2 observed that, when Mrs C was discharged to the ward, the nasogastric feeding had to be interrupted on numerous occasions due to her pulling out the feeding tube. Adviser 2 also indicated that Mrs C was appropriately referred to the dietician, who also recommended a period without the tube feeding, and food charts were completed to assess the amount of food

and fluids Mrs C was taking. A high protein diet and high calorie drinks were also ordered for her, however, although the food charts were completed and there was regular review by the dietician, Mrs C continued to have a very poor intake of food and fluids. Adviser 2 agreed with Adviser 1 that PEG feeding would not have been considered lightly and she noted that it was apparent from the records that Mrs C was often very agitated and all other options for feeding were considered.

46. Adviser 2 commented that there was very little written in the notes to describe the help Mrs C needed for eating and drinking. She stated that the care planning was very sparse, with no individual detail about how staff could have assisted Mrs C with eating and drinking, such as foods that she enjoyed at home or any specific arrangements for mealtimes. She advised that this kind of information should be available to all patients, and is highlighted in the NHS Quality Improvement Scotland 'Food, Fluid and Nutritional Care in Hospitals' standards. Adviser 2 noted that, on 11 February 2008, Mrs C did not get any support with feeding because staff were not aware she needed help. Whilst the Board have apologised for this, Adviser 2 stated the importance of systems being in place to prevent this happening, such as the 'red tray' system, which means that all patients who require assistance with feeding are clearly identified. There was no indication that the Board had such a system in place.

47. Adviser 2 was critical that nursing staff did not appear to give priority to the nutritional care of Mrs C. She advised that criteria no 3.6 in the 'Food, Fluid and Nutritional Care' standards stated that:

> 'The nurse with responsibility for the ward is responsible for having in place a protocol that ensures that:
>
> - staff assist and support patients as required; and
> - patients' intake of food and fluid is monitored, and the necessary action is taken if this intake is inadequate.'

She also noted Consultant 2's reference to the staffing levels not being adequate (outlined in paragraph 35) and she noticed that the Board did not refer to this in their response to the complaint. Adviser 2 questioned whether the Board considered the staffing levels to have been adequate. My complaints reviewer wrote to the Board to query this and they informed him that there was short-term sickness at ward level during this period. They provided an assurance that they have a robust nurse bank system to backfill any staffing shortfalls. Despite this assurance, this was clearly not effective in this instance.

48. Finally, Adviser 2 stated that patients with poor nutrition require regular mouth care to prevent ulcers and promote eating and drinking. She advised that the nursing notes made very little reference to the provision of oral hygiene until 15 March 2008 when Mrs C's tongue was noted to have been sore. Whilst Adviser 2 said that she appreciated that patients with dementia may not tolerate mouth care, she was critical of the lack of information in the nursing notes about such care. She advised that good oral hygiene was a fundamental aspect of nursing care and noted there to be limited evidence that Mrs C received this (or that it was attempted and refused).

(c) Conclusion

49. The advice my complaints reviewer has received indicates that the medical staff took appropriate steps to exhaust all feeding possibilities and the timing of the commencement of PEG feeding was reasonable. However, I have concerns regarding the overall standard of Mrs C's nutritional care and specifically the assistance she was given with feeding. Staff do not appear to have given priority to Mrs C's nutritional care and I am critical of the Charge Nurse's comment that nursing staff cannot help if they do not know that tea is there. I also have concerns reqarding the apparent reliance on Mrs C's family to assist with feeding due to understaffing (as referred to by Consultant 2). The Board advised that they have a robust nurse bank system in place, however, this was not seen to be effective in Mrs C's case.

50. In addition, I am critical of the standard of Mrs C's oral care and associated record-keeping. Despite an indication that Mrs C had a sore mouth on 18 February 2008, Adviser 2 said that the notes made very little reference to the provision of oral hygiene until 15 March 2008. Overall, there is little evidence to suggest that Mrs C received appropriate levels of nutritional and oral care and I, therefore, uphold this complaint.

(c) Recommendations

51. I recommend that the Board:	*Completion date*
(i) ensure that there are systems in place for assisting patients with feeding, as outlined in the NHS Quality Improvement Scotland 'Food Fluid and Nutritional Care in Hospitals' standards; and	17 September 2010

(ii)	ensure that there are systems in place for the provision of oral hygiene, including policies and procedures; education and training; and audits.	17 September 2010

(d) Mrs C's perforated ulcer should have been diagnosed earlier and her initial discharge from A&E was inappropriate

52. In their complaint letter to the Board, the family advised that Mrs C presented to A&E on 14 January 2008 with abdominal pains and, after being assessed, was discharged with a diagnosis of gallstones and sent home with co-codomol. However, her distress increased at home and she went back to A&E, where, after a three hour wait, blood was taken and it was discovered that 'the actual cause of her pain was a burst ulcer'. Mrs C was admitted to the Intensive Care Unit (ICU) and subsequently received surgery, however, the family stated that they had no concerns about Mrs C's time in ICU and their complaint was about the initial incorrect diagnosis and her treatment post-ICU.

53. In their response, the Board confirmed that, upon her initial attendance at A&E on 14 January 2008, Mrs C's examination revealed her to be in pain with tenderness in the right upper area of her abdomen. Her management consisted of analgesia (pain relief) and anti-emetics (to treat sickness). They advised that x-rays of Mrs C's chest and abdomen did not demonstrate any evidence of intra-abdominal perforation and, as the pain had settled with the medication given, the doctor who reviewed Mrs C (the Doctor) felt that it may have been biliary colic (gallstone pain). Mrs C was, therefore, discharged home with analgesia and advised to return if the pain returned or worsened in severity. The Board confirmed that she returned later that same day and was admitted to the Emergency Care Unit with a perforated duodenal ulcer. Following a surgical review, she was transferred to the Adult Critical Care Unit (ACCU). They said that, upon admission, Mrs C was noted to have been critically unwell and she required resuscitation prior to going to theatre. They stated that the operation was uneventful, however, due to respiratory complications, she spent a week in the ACCU.

54. At the meeting in the Hospital, Mrs D advised that, upon the initial diagnosis of gallstones, no investigations were done and she asked how gallstones are determined, other than by just pain. Director 1 stated that the A&E notes suggested the diagnosis of gallstones was based on the symptoms noted and Mrs C having had pain in her side. He confirmed that, in order to determine this, further clinical assessments and blood tests would have been

required. He explained that no gross abnormalities were evident and Mrs C was prescribed morphine and tramadol for pain and she was discharged with lactulose and co-codamol. The family raised concerns that an ultrasound scan was not carried out and Director 1 advised that this would not be done within an A&E setting, but as an out-patient, if required. He said that an ultrasound scan would have been most unlikely to have identified an ulcer. He confirmed that, on the second set of x-rays following Mrs C's admission, evidence of a perforated ulcer was present.

55. Mrs D stated that, on a later x-ray (CT scan of 20 March 2008), Mrs C's 'surgery bubbles' (visible air within the abdominal cavity) were present suggesting the possibility of another perforation. Director 1 explained that it was very unusual to get a repeat perforation, however, opening the abdomen lets air in and he suggested that this would have been a reasonable assumption for the bubbles present on the x-ray. The MSP asked if it was possible that part of the original perforation could have been missed and Director 1 advised that perforations could not be partly missed. He said that he suspected that the bubbles were residual from the operation and he explained that the CT scan would have been carried out to look for infection, which he advised was more common than a repeat perforation. He confirmed that there was no collection of infection present in a later CT scan.

56. In their meeting with my complaints reviewer, the family expressed their continued concern that an ultrasound scan had not been carried out. They acknowledged that this may have been unlikely to have detected the perforated ulcer, however, they believed it would have confirmed that it was not gallstones and prompted further investigation. In relation to the Board's advice that an ultrasound scan would not have been performed in an A&E setting, they said that such a scan had not been mentioned and arrangements had not been made for one to be carried out. They stated that Mrs C had merely been sent home with painkillers. The family also reiterated their concern over the surgical bubbles and their belief that these may have been indicative of another perforation.

57. My complaints reviewer asked Adviser 1 to comment on this matter. Adviser 1 stated that, when Mrs C first attended A&E, the nursing record documented the basic observations and showed that Mrs C's heart rate was increased. However, he advised that this could have been a non-specific response to pain. He stated that the overall pattern of the observations did not

suggest that perforation of an intra-abdominal organ had occurred at that time. He observed that an Abdominal Pain triage sheet, which he presumed was designed to help staff manage abdominal pain consistently, was not filled in. Adviser 1 noted that the prescription sheet recorded that Mrs C was given two powerful analgesics, tramadol and morphine, and bloods were also taken at this time. He advised that the white blood cell (WBC) count was significantly raised and the C-reactive protein (CRP - a non-specific marker of inflammation in the body) was mildly raised. He stated that neither of these tests specifically suggested perforation but, equally, it would not be typical for a patient with straightforward biliary colic to have, in particular, a high WBC.

58. Adviser 1 observed that the Doctor had noted Mrs C's pain and her known Alzheimer's dementia, as well as the fact that she had recently vomited. A possible diagnosis of ischaemic bowel (lack of blood to part of the bowel) was considered, however, the final impression was of biliary colic. The Adviser said that there was nothing to indicate whether the Doctor reviewed the blood results and whether he appreciated that the WBC result was abnormal.

59. In respect of the A&E consultant's retrospective comments which informed the Board's complaint response, Adviser 1 noted that he made no comment on the presence of vomiting or the elevated WBC count. The x-ray report did not suggest evidence of perforation, however, Adviser 1 informed my complaints reviewer that it did show right basal chest infection which was not commented upon elsewhere. He stated that the A&E consultant's comments were brief and inferred that the complaint was really about the surgical unit and he did not feel that the issues regarding the initial diagnosis were adequately addressed in the Board's response.

60. Adviser 1 noted that, when Mrs C returned to A&E 15 hours later, her heart rate had risen and her blood pressure and oxygen saturation had fallen. He said that her CRP had dramatically increased and that, somewhat strangely, her WBC had fallen. Her kidney function had also declined and her abdomen was tender and distended. He confirmed that further x-rays now showed evidence of a perforation.

61. Adviser 1 stated that he found the Board's response regarding the initial diagnosis, as outlined in the minutes from their meeting with the family, unhelpful in tone and content. He said that they appeared defensive, evasive and made no effort to explain what may have happened, or to investigate the

issue themselves. He indicated that there were factual inaccuracies as they stated that 'no gross abnormalities were present', which was incorrect given that Mrs C's WBC was elevated.

62. With regards to the family's concern that an ultrasound scan was not carried out, Adviser 1 believed they were correct to question this. He said that, if the Doctor had wanted to prove that gallstones were present, an ultrasound could have been arranged. He indicated that it was misleading for the Board to have stated that this would be done as an out-patient as it was a common emergency test in patients with abdominal pain. He advised that the Board's indication that it was unlikely that an ultrasound would have detected a burst ulcer was correct, however, in his view the Board's response was unhelpful and evasive. He stated that, if the ultrasound had not shown evidence of gallstones or other disease of the bile system, the Doctor could have reviewed the diagnosis and reconsidered peptic ulcer disease (which Mrs C actually had).

63. Adviser 1 informed my complaints reviewer that Mrs C's clinical history was more compatible with acute cholecystitis (inflammation of the gall bladder) than biliary colic, as was her elevated WBC. He stated that the suggestion that the diagnosis of biliary colic was supported by the fact that the pain had resolved with analgesia was misleading, given the type of analgesia used.

64. However, Adviser 1 stated that Mrs C had no clinical features which would have proved, or disproved, the presence of a perforation and there was no definite evidence that a perforation was present and overlooked at the time of her initial presentation. He advised that the need to admit would be based on an overall perception of how unwell the patient was and that, in cases of doubt, surgical review in A&E would be preferred. He acknowledged that the decision to discharge Mrs C was, with hindsight, erroneous but he stated that it was not unreasonable. However, Adviser 1 indicated that, whilst not unreasonable, the overall quality of the assessment at Mrs C's initial presentation could have been better, as could the Board's subsequent response to the family's complaint.

65. My complaints reviewer asked Adviser 1 to provide clarity on whether he felt an ultrasound should have been carried out and Adviser 1 stated that it was not unreasonable to have discharged Mrs C with a clinical diagnosis of gallstones. He said that, even if an ultrasound had been carried out, whilst it could have ruled out gallstones, it would not necessarily have led to Mrs C being kept in the Hospital. Even if they had reached a diagnosis of acute

cholecystitis, which Adviser 1 felt was more likely given the symptoms presented, he advised that this would not have provided a definitive reason to keep Mrs C in the Hospital. He stated that, whilst the assessment was not perfect, it would be harsh, in his view, to say that it was unreasonable. He indicated that appropriate tests were carried out and that, even if the assessment had been fuller and further tests had been carried out, this would not necessarily have led to a successful diagnosis or a decision not to discharge Mrs C.

66. With regards to the family's concerns that the surgical bubbles indicated that a re-perforation was missed, Adviser 1 confirmed that the air bubbles on the CT scan of 20 March 2008 could have related to a re-perforation, retained post-operative air (which he advised was less likely), or infection. He noted that the senior surgical team carefully considered and documented the finding of the bubbles and they considered the possibility of re-perforation. However, given the absence of other supporting evidence, along with Mrs C's overall condition, they judged that further operative intervention was not advisable. Adviser 1 said that this was entirely reasonable and he noted that it appears to have been explained to the family at the time, including the fact that a conservative approach was preferred.

67. Finally, with regards to the records not providing a clear indication as to whether Mrs C's high WBC and chest infection were appreciated, Adviser 1 said that, ideally, medical staff would have documented whether these were noticed. However, he said that this would not necessarily have changed their management of Mrs C, although it added to the impression that the assessment could have been better.

(d) Conclusion

68. The advice received by my complaints reviewer indicates that there was no evidence of a perforation at Mrs C's initial presentation. Whilst it appears as though the initial assessment could have been of a better standard, there is no evidence to suggest that an earlier diagnosis of Mrs C's perforated ulcer should have been made. In addition, the advice concluded that it was not unreasonable to have discharged Mrs C with a clinical diagnosis of gallstones without having arranged further tests. Adviser 1 indicated that, had the initial assessment been more complete and, for example, the Doctor had seen all the blood tests, or an ultrasound had been carried out, Mrs C's management would not necessarily have been any different. I, therefore, conclude that the

discharge was reasonable, based on the information available to the medical staff at the time, and I do not uphold this complaint.

69. However, I do have some criticisms of the Board's record-keeping and complaint handling. First, with regards to record-keeping, Adviser 1 has noted failures to complete an Abdominal Pain triage sheet and to document whether Mrs C's WBC and chest infection were appreciated. With regards to the Board's complaint handling, he indicated that the level of comment in relation to the initial misdiagnosis was inadequate and some aspects of the response were inaccurate or misleading. Adviser 1 considered that the Board could have given a more detailed response to the family regarding the problems of diagnosis in a case such as Mrs C's.

(d) Recommendations

70. I recommend that the Board:	*Completion date*
(i) remind staff of the importance of detailed record-keeping, particularly in relation to doctors' recognition and appreciation of any abnormalities; and	17 September 2010
(ii) remind complaint handling staff of the importance of providing an accurate response to complaints and, where possible, a detailed explanation of events.	17 September 2010

General recommendation

71. I recommend that the Board issue an apology to Mr C for the failings identified in this report.

72. 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

The MSP	Mr C's MSP
Mr C	The complainant
Mrs C	Mr C's late wife
The Hospital	Wishaw General Hospital
The Board	Lanarkshire NHS Board
A&E	Accident and Emergency
Adviser 1	The Ombudsman's professional hospital adviser
Adviser 2	The Ombudsman's professional nursing adviser
Mrs D	Mr C's daughter
Mrs E	Mr C's daughter
The General Manager	The General Manager of the Hospital
Director 1	The Associate Medical Director
Director 2	The Associate Director of Nursing and Midwifery
Consultant 1	The on-call consultant surgeon who reviewed Mrs C on 20 March 2008
Consultant 2	The consultant surgeon Mrs C was admitted under on 14 January 2008

PEG	Percutaneous endoscopic gastrostomy
The Charge Nurse	The Charge Nurse responsible for Mrs C between 25 January 2008 and 1 February 2008
CT scan	Computerised tomography scan
ICU	Intensive Care Unit
The Doctor	The trainee doctor who saw Mrs C when she first attended A&E on 14 January 2008
ACCU	Adult Critical Care Unit
WBC	White blood count
CRP	C-reactive protein

Annex 2

Glossary of terms

Alzheimer's disease	The most common form of dementia
Biliary colic	A pain most frequently caused by obstruction of the common bile duct or the cystic duct by a gallstone
Central IV line	A long tube (catheter) inserted into a large vein (commonly in the chest)
Co-codamol	A type of analgesic used to treat mild to moderate pain
Gallbladder	A small sac located below the liver
Gallstones	Solid lumps or stones that develop in the gallbladder
Lactulose	A synthetic sugar used to treat constipation
Morphine	A type of analgesic used to treat moderate to severe pain
Nasogastric feeding	Where a feeding tube is passed through the nose into the stomach
Oramorph	Analgesic medication, containing morphine sulphate, used to treat severe pain
PEG feeding	Where a feeding tube is passed through the abdominal wall into the stomach
Peripheral IV line	A short tube (catheter) inserted into a peripheral vein (commonly in the arm or hand)

Tramadol	A type of analgesic used to treat moderate to severe pain

Annex 3

List of legislation and policies considered

NHS Quality Improvement Scotland's 'Food Fluid and Nutritional Care in Hospitals'

NHS Scotland's 'Leading Better Care: Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project'

NHS Lanarkshire's 'Delivering a Patient-focused Service'

NHS Lanarkshire's 'Caring and Compassionate Practice'

NHS Lanarkshire's 'Top Tips in caring for People with Dementia'

Annex 4

Chronology

14 January 2008	Mrs C admitted to the Hospital with perforated ulcer (having been discharged earlier that day with diagnosis of gallstones)
25 January 2008	Transferred to Ward 17 (from ACCU)
1 February 2008	Transferred to Ward 18
15 February 2008	Transferred to Ward 16
20 February 2008	Psycho-geriatric assessment carried out
6 March 2008	Review carried out by a 'care of the elderly' consultant. Transferred to Ward 12 with a view of rehabilitation
12 March 2008	Reviewed by psychiatric nurses
20 March 2008	Became unwell again, transferred to Ward 18 for surgical observation. CT scan carried out. Nil by mouth suggested. Family raised formal complaint
21 March 2008	Reviewed by Consultant 2. Central IV line inserted
24 March 2008	Reviewed by Consultant 2. Commenced back on diet
25 March 2008	Referred to the Speech and Language therapist
24 April 2008	Board responded to formal complaint
25 April 2008	Mrs C passed away
12 September 2008	The family and the MSP met with the Board
8 December 2008	Complaint brought to the Ombudsman