Parliament Region: Central Scotland

Case 201001239: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; Accident and Emergency

Overview

The complainant (Mrs C) raised a number of concerns that her adult son (Mr A) had received inadequate treatment when he presented at the Accident and Emergency Department at Hairmyres Hospital (the Hospital) on the evening of 7 February 2010 and that it was inappropriate to discharge him from the Hospital. Mr A subsequently presented at the Hospital in the early hours of 8 February 2010 and died after an unsuccessful attempt to resuscitate him.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the treatment provided to Mr A at the Accident and Emergency Department at the Hospital on 7 February 2010 was inadequate (*upheld*); and

(b) the decision to discharge Mr A from the Accident and Emergency Department at the Hospital on 7 February 2010 was inappropriate (*upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) consider the Manchester Triage Scale in their review of ways to introduce an assessment method to establish the clinical needs of patients attending Accident and Emergency; and	16 February 2011
(ii) apologise to Mrs C that staff failed to stress the importance to Mr A of a hospital admission although he was keen to go home.	16 February 2011

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

Main Investigation Report

Introduction

1. On 22 June 2010 the complainant (Mrs C) wrote to my office to submit a complaint against Lanarkshire Health Board (the Board). Mrs C raised a number of concerns that her adult son (Mr A) had received inadequate treatment when he presented at the Accident and Emergency Department at Hairmyres Hospital (the Hospital) on the evening of 7 February 2010 and that it was inappropriate to discharge him from the Hospital. Mr A subsequently presented at the Hospital in the early hours of 8 February 2010 and died after an unsuccessful attempt to resuscitate him. Mrs C complained to the Board but remained dissatisfied with their response.

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

(a) the treatment provided to Mr A at the Accident and Emergency Department at the Hospital on 7 February 2010 was inadequate; and

(b) the decision to discharge Mr A from the Accident and Emergency Department at the Hospital on 7 February 2010 was inappropriate.

Investigation

3. In conducting the investigation in this case my complaints reviewer met with Mrs C and sought advice from one of my independent professional advisers (the Adviser), an experienced Accident and Emergency Consultant, regarding the clinical aspects of the case. He reviewed the clinical records obtained from the Board as well as the complaints correspondence between Mrs C and the Board.

4. 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. An explanation of the abbreviations used in this report is contained in Annex 1 and a glossary of terms is at Annex 2.

(a) The treatment provided to Mr A at the Accident and Emergency Department at the Hospital on 7 February 2010 was inadequate; and (b) the decision to discharge Mr A from the Accident and Emergency Department at the Hospital on 7 February 2010 was inappropriate

5. In her complaint to the Board dated 6 March 2010 Mrs C explained that Mr A attended the Hospital at 19:30 with chest pains and had difficulty

breathing. Three times the family asked that Mr A should be seen by a doctor but they were told to wait. Mr A was then taken to the treatment area and given a morphine injection, which did not help. Mr A had a history of cancer and only had one good lung. At about 23:00 Mr A was told he could go home or be admitted to hospital and, as no further tests were planned, he went home with oral antibiotics. At 04:00 the next morning Mr A had great difficulty breathing; his pain had worsened and an ambulance was called. Mr A died as he was being transferred from the ambulance stretcher to a hospital trolley. Mrs C wanted to know why there was no urgency shown earlier by staff in examining Mr A, as he was in great distress with chest pain and had breathing difficulties.

6. In the Board's response to the complaint dated 6 April 2010, the General Manager at the Hospital (the Manager) explained that Mr A arrived at the Accident and Emergency Department at 19:49 on 7 February 2010. He was called through to a cubicle at 20:00 and the charge nurse carried out routine observations including an electrocardiograph (ECG) in view of Mr A's presenting symptoms. The observations were satisfactory although Mr A remained in pain waiting for a medical assessment. At that time there were 23 other patients who required medical assessment. There was a delay before the assessment could take place due to the ongoing activity and an apology was made for this. The staff at the Accident and Emergency Department were aware of Mr A's past medical history throughout the assessment. The Manager said that medical staff reviewed Mr A at 20:45 and, following initial assessment, he was given morphine and then a further dose as he was in pain. Mr A was able to have a discussion with the doctor about his further treatment and management. The Consultant in Emergency Medicine (the Consultant) noted that Mr A and the staff were aware that he was obviously very ill and, given his rapid deterioration at home, it might have been more appropriate for him to have been admitted to hospital earlier. The Manager advised that aggressive treatment probably would not have helped Mr A and as he expressed a strong desire to be at home, staff had taken into account his wishes and he was discharged at 23:10.

7. The Manager continued that Mr A re-attended the Accident and Emergency Department at 05:12 on 8 February 2010. The Accident and Emergency Senior Charge Nurse (the Charge Nurse) reported that Mr A was gravely unwell and passed away after an unsuccessful resuscitation attempt. The Manager advised that, given Mr A had a very difficult past medical history and his strong desire to be at home, this may have influenced the staff decision to allow him to go home on the first attendance at the Accident and Emergency

Department. However, with hindsight, when Mr A first attended the Accident and Emergency Department staff should have insisted on a hospital admission but he did make it clear he wanted to be at home. The Manager said that staff wished to offer their deepest sympathy for the loss of Mr A and a meeting with senior staff to discuss the matter was held.

8. On 17 April 2010 Mrs C again wrote to the Board. She said she remained dissatisfied with their response and could not understand why Mr A was discharged home when he was clearly very ill. He was correctly triaged and medical staff were informed that there was a patient in the waiting area who had severe chest pain and breathing problems. This should have given him priority over less unwell patients and he should not have had to wait so long for a medical assessment. Mrs C complained that the Board's response indicated that Mr A insisted on going home but that he was not well enough to strenuously insist that he should be allowed to go home. Mr A had asked to go to the Hospital and was aware that he might get kept in, as this has happened before and he had complied with the medical advice. Mrs C said she and her other son were in the treatment area when the Consultant spoke in a casual manner and gave Mr A the choice of admission or going home. It was not suggested that it would be better if he stayed in hospital. Mrs C said it was assumed that Mr A had another chest infection and it was never thought that it was something else which required treatment or interventions, despite the family's concerns. The implication was that the Consultant considered Mr A's presentation was linked with infection and that the blood clot, associated with significant chest pain, was missed.

9. On 14 May 2010 the Manager wrote back to Mrs C with an unreserved apology for the length of time that Mr A had to wait for his medical assessment. He advised the Board were trying to introduce new methods of initial assessment to alleviate the problem and an assurance was made that her concerns had been taken seriously. He said staff shortages should not affect patient care. The Manager explained that there was no intention to infer that blame was put on Mr A for the discharge. The staff felt that Mr A's initial presentation was more likely due to a chest infection than any other cause and they offered him antibiotics. Based on his clinical examination at that time, there was a realisation that he was unwell due to his underlying condition. However, there was no indication that he would deteriorate so rapidly. Patients can only make decisions based on the information provided to them by medical staff and the Consultant regretted that admission was not advised more strongly

to Mr A and his family. The Consultant agreed that Mr A would have been more comfortable in his final moments had he been admitted to hospital on the first occasion. It was confirmed that the Consultant had discussed Mr A's presentation at length with the staff involved.

10. In Mrs C's complaint to my office, she said she was still dissatisfied with the Board's response. She wondered why the staff did not detect that Mr A had a blood clot and instead gave him antibiotics for a chest infection. My complaints reviewer interviewed Mrs C at home on 22 July 2010 and she provided additional information which was helpful in considering her complaint. Mrs C told my complaints reviewer that at no point did Mr A insist on or express any desire to go home rather than be admitted to hospital.

11. The Adviser reviewed Mr A's clinical records and noted that he had a complex medical history where he was diagnosed with bowel cancer at 16 years of age and that he remained in remission until 2009. On 7 February 2010 he attended the Accident and Emergency Department with chest pain which had been present for one day. His vital signs were recorded, an ECG performed, IV access was obtained and blood tests were sent off for analysis. Mr A was seen by a Registrar after an unspecified time and he recorded muscular pain in the right shoulder and chest with no history of trauma. Mr A had a cough but no shortness of breath. Mr A was distressed with a pulse of 90. The ECG showed nothing of note and the Adviser did not think there was any evidence of a pulmonary embolus at that time. In keeping with Mr A's medical history his left lung was collapsed and his right lung was clear. The impression was that Mr A was suffering from musculoskeletal problem or a lower respiratory tract infection. It was recorded, 'discussed with patient, not keen for admission, plan home with oral antibiotics'. Mr A was advised to take a non-steroidal anti-inflammatory pain killer and return to hospital if he was unwell or not settling. Mr A attended the Accident and Emergency Department by ambulance at 05:10 on 8 February 2010 where he was pale but alert, however, on transfer to a resuscitation trolley he lost cardiac output and CPR was commenced. It was thought pulmonary embolus was the most likely cause of the arrest and, despite the on-going resuscitation attempt, it was decided that Mr A was not a candidate for intensive care. Mr A was pronounced dead at 05:47.

12. The Adviser said that the Board had accepted that Mr A had to wait an unacceptable time to be seen on his first visit to the Accident and Emergency

Department. Mr A was in pain at that time and, according to the Manchester Triage Scale (system in which patients are assessed in order to decide upon their clinical need and widely used in the UK), should therefore have been classified as category orange, which translates into medical assessment within five to ten minutes of arrival. Although the Accident and Emergency Department was very busy, the Adviser felt that given the amount of morphine which was administered (in addition to the oral opiates which Mr A had taken at home), he should have been seen more quickly. Medical triage is one way of ensuring that sick patients are assessed and treated rapidly. The Adviser noted that the Board had suggested a form of initial assessment and she would agree with that view. The Adviser felt that it was not unreasonable for the staff to initially diagnose that Mr A may be suffering from a chest infection. There was no evidence from the observations at that time that he had a pulmonary embolus. His pulse was within normal limits and his oxygen saturations were good, particularly in view of his lung disease. The Adviser had no concerns about the medical assessment which was carried out.

13. Insofar as the decision to discharge Mr A from hospital was concerned, the Adviser did not think that he should have been allowed to go home on 7 February 2010. Mr A had presented at the Hospital in pain although he was no stranger to pain and discomfort. The Adviser noted that Mr A had previously been admitted for a chest infection which had led to sepsis and that even although he was not keen to stay he should have been advised that it was in his best interests to be admitted. There was no evidence in the notes that staff had stressed the importance of this to Mr A. The Adviser continued that the burden lies with staff in a situation such as this to persuade the patient to remain in hospital. In the Adviser's view, Mr A was a young man and, although he had metastatic cancer, he was otherwise relatively fit and he should have been treated specifically for a chest infection as that was believed to be the problem. In the circumstances he should have been admitted for intravenous antibiotics. However, the Adviser pointed out that even if the test which would have indicated the presence of a pulmonary embolism had been taken at that time it would have been likely to have shown positive in the event that Mr A was suffering from a chest infection.

14. The Adviser had some concerns about the recordings on the Accident and Emergency documentation, as she could find no obvious timings regarding the admission and discharge on 7 February 2010. Mr A waited too long with chest pain to be seen and should not have been sent home. The Adviser said it was

difficult to say whether the outcome would have changed if Mr A had been admitted to hospital on 7 February 2010. However, any deterioration would have been noted during regular observations and it would have been less traumatic and distressing for everyone concerned if he had been admitted on 7 February 2010.

(a) Conclusion

15. Mrs C's complaint to this office was that Mr A received inadequate treatment when he attended the Accident and Emergency Department on 7 February 2010. I have considered all the evidence and I am satisfied that the actual medical treatment which was provided to Mr A was appropriate and that it was reasonable for staff to reach a diagnosis that he was suffering from a chest infection. However, I am concerned about the length of time it took for Mr A to be assessed by medical staff. His condition warranted a medical assessment soon after his attendance, however this did not take place for some reason. I can accept that the department was busy at the time but there did not appear to be any action taken to prioritise the patients in view of their clinical need. If this had been the case then Mr A would probably have received his medical assessment sooner and this would have allowed staff to begin earlier treatment which would have addressed his symptoms. The Board have also accepted this and have apologised for the time taken until the medical assessment and are considering measures which will speed up the initial assessment of patients' clinical need in order to prevent a similar case happening in the future. I uphold this complaint.

(a) Recommendation

16. I recommend that the Board:	*Completion date*
(i) consider the Manchester Triage Scale in their review of ways to introduce an assessment method to establish the clinical needs of patients attending Accident and Emergency.	16 February 2011

(b) Conclusion

17. Mrs C felt that Mr A should have been admitted to the Hospital on 7 February 2010 and that staff should have stressed to him the importance of a hospital admission. The Board regretted that admission was not advised more strongly. It is clear from the records that Mr A was very ill and the advice which I have received is that Mr A should not have been allowed to go home on 7 February 2010. He had presented at the Hospital in pain and he should have

been treated with intravenous antibiotics. The onus was on the staff to persuade Mr A that it was in his best interests to remain in the Hospital and there was no evidence that they had stressed the importance of this. That said, I note that it was difficult to say whether the outcome would have changed if Mr A had been admitted to hospital on 7 February 2010 but any deterioration would have been noted during regular observations and it would have been less traumatic and distressing for Mr A and his family. I uphold this complaint.

(b) Recommendation

18. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C that staff failed to stress the importance to Mr A of a hospital admission although he was keen to go home.	16 February 2011

19. 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	Mrs C's adult son
The Hospital	Hairmyres Hospital
The Board	Lanarkshire NHS Board
The Adviser	The Ombudsman's professional medical adviser
The Manager	General Manager at the Hospital
The Consultant	Accident and Emergency Consultant
The Charge Nurse	Accident and Emergency Charge Nurse

Annex 2

Glossary of terms

Cardiopulmonary resuscitation (CPR)	First line treatment for a person who has collapsed with no pulse and has stopped breathing
Electrocardiograph (ECG)	Test to establish electrical activity of the heart
Intravenous (IV) access	Direct access into a vein
Metastatic	This is used to describe that a disease has spread from its initial site
Pulmonary embolus	Blockage of the pulmonary artery, usually caused by a blood clot
Sepsis	Bacterial infection in the bloodstream or body tissues