Scottish Parliament Region: Highlands and Islands

Case 201104965: Highland NHS Board

Summary of Investigation

Category

Health: Hospital; Oncology; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment given to her daughter (Ms A) prior to her death in October 2011.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) staff discharged Ms A from hospital on 12 August 2011 despite her suffering from a wound infection and temperature (*not upheld*);

(b) during the period 14 August to 21 September 2011, staff failed to provide an adequate level of care and treatment to Ms A (*upheld*); and

(c) during the period 14 August to 21 September 2011, staff failed to ensure that Ms A received an adequate level of fluid and nutrition (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Mrs C for their failures with regard to Ms A's care and treatment;	23 February 2013
(ii) bring the findings of this complaint to the attention of the consultant physician concerned for discussion at his next appraisal;	23 February 2013
(iii) apologise for their failure to properly address Ms A's nutritional status and to follow NHS Standards; and,	23 February 2013
(iv) emphasise to appropriate staff the necessity of following existing standards with regard to food and nutrition and to satisfy themselves that these standards are met.	23 February 2013

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

Main Investigation Report

Introduction

1. Mrs C said that on 7 August 2011, her daughter, Ms A was admitted to Raigmore Hospital (Hospital 1) for a planned operation to remove lymph glands. Ms A had her surgery on 9 August 2011 and, on 12 August 2011, after review, she was discharged from Ward 4C. Ms A required to be readmitted on 14 August 2011 and Mrs C maintained that Ms A should not have been discharged as she alleged that, at the time, Ms A had a leaking wound and a temperature. However, Highland NHS Board (the Board) were of the view that Ms A's high temperature had settled and her wound was fine and that the further management of Ms A's condition was dependent upon a lymph node biopsy.

2. When Ms A was readmitted (on 14 August 2011) to Ward 4A, Mrs C said that this was due to pyrexia (fever). Thereafter, Ms A seemed to have recovered sufficiently to be transferred, on 30 August 2011, to Portree Community Hospital (Hospital 2). She remained there until 12 September 2011 when she was admitted to Ward 6 of Hospital 1 with severe respiratory problems. Ms A was diagnosed as having pneumonia. The next day, Mrs C said, Ms A was transferred into the care of a gastroenterologist on Ward 7.

3. Ms A's condition continued to decline and on 20 September 2011, she was transferred to the Medical Special Care Unit (MSCU) and then on 21 September 2011 to the Intensive Care Unit (ICU). Ms A died in ICU on 13 October 2011.

4. Ms A had complex problems: she had pneumonia; problems with her kidneys (one was ultimately removed and the other was failing to function), for which she was being tested; she had a wound which failed to heal properly and became necrotic; and she was clinically obese. The Board's view was that, throughout, she was treated appropriately according to her presenting symptoms. However, Mrs C complained that her care and treatment were inappropriate.

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

(a) staff discharged Ms A from hospital on 12 August 2011 despite her suffering from a wound infection and temperature;

(b) during the period 14 August to 21 September 2011, staff failed to provide an adequate level of care and treatment to Ms A; and
(c) during the period 14 August to 21 September 2011, staff failed to ensure that Ms A received an adequate level of fluid and nutrition.

Investigation

6. As part of this investigation all the information provided by Mrs C and by the Board (including their complaints file, complaints procedure and correspondence, together with Ms A's relevant clinical records) has been given careful consideration. Independent clinical and nursing advice was obtained and this was also taken into account.

7. 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 have been given an opportunity to comment on a draft of this report.

(a) Staff discharged Ms A from hospital on 12 August 2011 despite her suffering from a wound infection and temperature

8. Mrs C said that Ms A was admitted to Ward 4C, Hospital 1 on 7 August 2011 for a CT ((computerised tomography) scan to be carried out, prior to the removal of lymph nodes. Her operation was carried out on 9 August 2011 and she was discharged on 12 August 2011, Mrs C said, with a leaking wound and a temperature. Mrs C believed this to be entirely inappropriate and complained to the Board on 24 October 2011.

9. In their reply to Mrs C of 16 January 2012, the Board said that although Ms A had had episodes of a high temperature, these had settled before her discharge and that on examination her wound looked fine. It was the Consultant Surgeon's (Doctor 1) view that Ms A was medically fit for discharge on 12 August 2011.

Clinical advice

10. Independent clinical advice was obtained about Ms A's care and treatment and the clinical adviser explained to me the circumstances that applied before Ms A's discharge on 12 August 2011. He said that Ms A had undergone a right nephrectomy for carcinoma of the kidney in February 2011. A routine follow-up CT scan identified further problems and Ms A was admitted to Hospital 1 for a laparoscopic/open surgery biopsy of a lymph node in her right groin. The procedure was undertaken by a doctor on 9 August 2011. On 10 August 2011,

Ms A's wound was noted to be tender and she experienced raised temperatures during the night of 10 August but, on being reviewed at 09:00 on 11 August 2011, everything was considered to be satisfactory. The wound was observed on 12 August 2011 when it was noted that Ms A had a raised temperature and that the wound had opened slightly.

11. The clinical adviser's view was that Ms A's condition appeared to have been reasonable when she was discharged. He noted that it had been discussed with Mrs C. He said that while there had been concern regarding the wound which had opened slightly and was tender, and although Ms A had a raised temperature, these things would not necessarily contradict her discharge if she was to be closely supervised in a local community hospital. He added that it would have been preferable for Ms A to have been as close to home as possible.

12. On reviewing Ms A's case, the clinical adviser said that it was only with the benefit of hindsight that it could be stated that Ms A should not necessarily have been discharged home on 12 August 2011 and that it was only in retrospect that it could be concluded that she was developing a significant wound infection.

(a) Conclusion

13. Mrs C was of the strong opinion that it was not appropriate for Ms A to have been discharged on 12 August 2011 but the independent clinical advice given was that it would only be with the benefit of hindsight that it would have been possible to determine that this was the case. I see no reason why this advice should not be accepted and, accordingly, do not uphold the complaint.

(b) During the period 14 August to 21 September 2011, staff failed to provide an adequate level of care and treatment to Ms A

14. Mrs C continued to question the care and treatment given to Ms A after she was admitted to hospital again on 14 August 2012. Mrs C said she thought that Ms A was suffering from a high fever and severe respiratory problems, yet she was placed in the care of a gastroenterologist. Ms A had problems eating and drinking and was dehydrated but Mrs C complained that she was not given a drip nor nasal gastric feeding; she was also experiencing muscular spasms and her notes were not available. Mrs C indicated that the more she researched the situation, the more she became concerned.

15. When the Board responded to Mrs C's complaints on 16 January 2012, they explained that although Ms A's medical notes were not available on her admission, her medical history was available by computer. While she had had pneumonia, she was responding well to treatment and was, therefore, transferred to a general medical ward. A CT pulmonary angiogram had confirmed that pneumonia was the dominant issue at admission but that she was given intravenous antibiotics, oxygen and a blood transfusion together with blood thinning treatment to try to reduce the risk of a pulmonary embolism.

16. The Board also added that although the consultant (Doctor 2) on Ward 7C was a gastroenterologist, he was, in their view, suitably qualified and experienced as a general physician to deal with Ms A. While Ms A was being treated primarily for pneumonia, she also had an 'ongoing abdominal wound' and while she preferred to lie rather than sit up, there was no evidence of lack of oxygen. Her oxygen saturations were above 90 percent. The Board maintained that Ms A's breathlessness did not impact on her ability to eat if she wanted to, but that Ms A was refusing meals and supplements. Her fluid intake was monitored and a catheter was inserted with her consent but there were no clinical concerns with fluid intake and urine output. The Board said that if there had been, intravenous fluids would have been given.

17. The Board confirmed that following her readmission on 12 September 2011, Ms A experienced a reduction in saturations on 20 September 2011 and was seen by a specialist respiratory nurse. After review, she was transferred to MSCU due to an overall deterioration in her condition. The Board said the transfer was not urgent.

18. The Board concluded in their letter that the primary cause of Ms A's death was pneumonia. They said after a long discussion with Mrs C and her grandson, the decision was taken to take Ms A off the ventilator, knowing that there was a chance she would not manage to breathe independently. The Board also said that Ms A would have been unlikely to benefit from being put back on the ventilator, given her significant chest problems. They said Ms A was kept comfortable until she died.

Clinical advice

19. I asked the clinical adviser about Ms A's condition when she was readmitted to Hospital 1 on 14 August 2011. He said that the notes confirmed evidence of a severe wound infection and that this was reasonably managed by

being appropriately cleaned and dressed. The notes also showed that she had a mildly impaired renal function and her potassium levels were elevated. While there was concern about this, he expressed the view that this was partly due to the lack of specialist expertise and, therefore, in his view, a renal opinion should have been sought; although the clinical adviser was satisfied with the care and treatment given by the surgical team during this admission.

20. Ms A was transferred to Hospital 2 on 30 August 2011 but on 12 September 2011 was readmitted to Ward 6 of Hospital 1, with evidence of respiratory failure related to pneumonia, possible pulmonary embolus and hypoventilation (inadequate ventilation) due, he said, to both obesity and the effects of her wound. Ms A was severely anaemic. Thereafter, she was admitted to Ward 7 under the care of a gastroenterologist (Doctor 2).

21. In the clinical adviser's view he said that Ms A should have been transferred to MSCU at the time of this admission; also that she should have been under the care of a chest physician rather than a gastroenterologist, although he recognised that both types of physician (respiratory and gastroenterology) had general medicine training. He said that, in his view, there was evidence of Ms A having respiratory failure at the time of her transfer to the gastroenterology ward and there was sufficient clinical justification for her to have been transferred to MSCU earlier. However, he added, there was no evidence that the delayed transfer necessarily affected her outcome.

22. The clinical adviser said after transfer to Ward 7C, Ms A was only reviewed twice by Doctor 2: once 48 hours after transfer and the second time four days later, on 19 September 2011. During this time, the clinical adviser said, there was evidence Ms A had developed respiratory failure, which was worsening. Although Doctor 2 stated that Ms A had improved and was feeling and breathing better, the clinical adviser said that this was contradicted by the medical entries in the notes before and after. In the clinical adviser's opinion Doctor 2's review was not entirely satisfactory, nor were reviews sufficiently frequent. He said he should have asked for more specialist advice as there was no evidence that her condition was improving. Nonetheless, he said that Ms A's antibiotics were carefully reviewed as were her monitoring saturations. Later, on 19 September 2011, Ms A was transferred to MSCU

23. After Ms A was transferred to MSCU, the clinical adviser said that the care and treatment given to her were appropriate: non-invasive ventilation was

administered; an arterial line was inserted; appropriate antibiotics were continued; renal function was regularly monitored, as were blood gas levels; and nasogastric feeding was instigated. The clinical adviser explained that a heart scan taken demonstrated severe pulmonary hypertension but that respiratory arrest could not necessarily have been predicted. In his view, before 21 September 2011, there was no absolute indication to consider intubation and ventilation.

(b) Conclusion

24. The Board maintained that Ms A was appropriately treated and that they were satisfied with her transfer to Ward 7C. They said that her subsequent transfer to MSCU was not urgent. However, the independent advice received was that Doctor 2, under whose care Ms A was placed, did not review her satisfactorily or sufficiently frequently during a period when her condition was worsening. He also considered that a renal opinion should have been sought at the time of re-admission to Hospital 1. In addition, he was of the view that Ms A should have been under the care of a chest physician. The clinical adviser was also of the view that there was sufficient clinical justification to have transferred Ms A to MSCU earlier. Although he further stated that this would not have been likely to have affected the outcome for Ms A.

25. For the reasons above, I uphold the complaint and the Board should apologise to Mrs C for their failure in this matter. I also recommend that the Board bring the findings of this complaint to the attention of Doctor 2 for discussion at his next appraisal.

(b) Recommendations

26. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for their failures with regard to Ms A's care and treatment; and	23 February 2013
(ii) bring the findings of this complaint to the attention of Doctor 2 for discussion at his next appraisal.	23 February 2013

(c) During the period 14 August to 21 September 2011, staff failed to ensure that Ms A received an adequate level of fluid and nutrition

27. In Mrs C's complaint to the Board of 24 October 2011, she expressed her concern about Ms A's problems eating and drinking. She said that Ms A had become dehydrated and, therefore, Mrs C questioned why she had no drip or was not being fed by a nasal gastric tube. In reply to Mrs C (letter dated

16 January 2012), the Board said that they had reviewed Ms A's medical records, which indicated that she had refused meals and so she had been offered a selection of supplements but these, too, were refused. The Board said that this was Ms A's choice and that they had to respect it. However, fluid intake continued to be monitored and with Ms A's consent a catheter was inserted. They added that there were no clinical concerns with Ms A's fluid intake and urine output which were closely monitored. In the Board's view there was no medical indication to provide any intravenous fluids as Ms A's intake was satisfactory.

Clinical advice

28. The clinical adviser confirmed to my complaints reviewer that nasogastric feeding was initiated on 20/21 September 2011. Prior to that, he said, there were problems with fluid balance (which continued in ICU) as there would have been concerns about excessive intravenous fluids causing fluid overload worsening Ms A's respiratory function. However, he added that hydration appeared to have been reasonable in that Ms A's renal function remained stable. He said that Ms A did not require feeding intravenously.

Nursing advice

29. A specialist nursing adviser was also asked to review Ms A's clinical records from a nursing perspective. She told me that they contained frequent reference to encouraging Ms A to eat and drink and she observed that many patients with breathlessness and infections lost their appetite and that staff would be expected to provide drinks or foods to tempt them and to refer to a dietician as appropriate.

30. On Ms A's admission on 14 August 2011, the nursing adviser said that she was given an intravenous infusion for hydration and antibiotic administration. On 15 and 16 August 2011 the notes confirmed that Ms A was eating and drinking. On 17 August 2011, Ms A was in theatre to have her wound cleaned and dressed but the next day, the notes stated that she was 'tolerating fluids and diet'. The nursing adviser said that there was no mention of oral intake in the next few days but that focus appeared to be on management of wound and infection. On 26 August 2011, Ms A's oral intake was recorded as satisfactory.

31. Ms A was readmitted to Hospital 1 on 12 September 2011 and on 16 September 2011 she was referred to a dietician. Meanwhile, on 14 September 2011, it was noted that Ms A had a poor appetite but was taking

fluid. The nursing adviser said that between 12 and 20 September 2011 a food/fluid chart was used to monitor fluid intake and that while intake was very poor, food and drinks were offered and recorded as being 'refused'.

32. The nursing adviser told me that dieticians and nursing staff should be able to involve a patient in food and drinking preferences and encourage a reasonable intake. She said that there was a note by the dietician confirming that nutritional supplements were offered and discussed with Ms A. However, she added that the decision to eat and drink would be the patient's as, in Ms A's case, there was no issue about capacity. She said that, in her experience, it was very common for patients with infections (particularly large abdominal wounds) to have a very poor appetite. The nursing adviser said that the question of ensuring that Ms A had sufficient intake of calories (and protein) to allow effective wound healing was an important one but she could find no evidence that this was discussed by the clinical teams.

33. The nursing adviser concluded that there was good documented evidence that nursing staff monitored and recorded Ms A's intake of fluids and foods. However, there was no MUST (Malnutrition Universal Screening Tool) assessment and, therefore, there was a very late referral to the dietician (on 16 September 2011) and no evidence that Ms A's nutritional status was fully assessed. Although Ms A's Body Mass Index was over 50, she would have been burning significant amounts of calories due to her infection and, therefore, the nursing adviser said, nutritional care should have been considered as part of her overall care and treatment. The nursing adviser said that, in her view, NHS Standards (Healthcare Improvement Scotland-Scotland Clinical Standards-September 2003 Food, Fluid and Nutritional Care in Hospitals) were not met and accordingly, she was critical of the nutritional care given to Ms A.

(c) Conclusion

34. While the clinical adviser was satisfied with Ms A's fluid intake as her renal function was satisfactory, the nursing adviser was critical in so far as NHS Standards were not met. She said that there was no evidence that her nutritional status was fully assessed. There was no MUST assessment and referral to the dietician was late. I have carefully considered both these pieces of advice, set against the Board's reply to Mrs C that they were required to respect Ms A's decision to refuse nutrition and that there were no concerns with her fluid intake. The nursing adviser agreed that it was Ms A's decision whether

or not to accept food and drink but she also said that NHS Standards about nutrition were not met. Accordingly, I uphold this complaint.

35. The Board's apology (see paragraph 25) should also take into account their failure to properly address Ms A's nutritional status and to follow NHS Standards. Further, the Board should emphasise to appropriate staff the necessity of following existing standards with regard to food and nutrition and to satisfy themselves that these standards are met.

(c) Recommendations

36. I recommend that the Board:	*Completion date*
(i) apologise (referred to in Complaint (b)), taking into account their failure to properly address Ms A's nutritional status and to follow NHS Standards; and	23 February 2013
(ii) emphasise to appropriate staff the necessity of following existing standards with regard to food and nutrition and to satisfy themselves that these standards are met.	23 February 2013

37. 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
Ms A	The complainant's late daughter
Hospital 1	Raigmore Hospital
Highland NHS Board	The Board
Hospital 2	Portree Community Hospital
MSCU	Medical Special Care Unit
ICU	Intensive Care Unit
CT	Computerised tomography
Doctor 1	A consultant surgeon
Doctor 2	A consultant physician
MUST	Malnutrition Universal Screening Tool

Annex 2

Glossary of terms

Arterial Line	Alphabetical order
Carcinoma	Cancer
Hypoventilation	Inadequate ventilation
Intubation	Insertion of a tube for adding or removing fluids
Laparoscopic	Open surgery
Necrotic	Death or cells/tissue through injury or disease
Nephrectomy	Removal of a kidney
Pulmonary embolism/embolus	Blockage in a blood vessel in the lungs
Pyrexia	Fever