Scottish Parliament Region: Highlands and Islands

Case 201102952: Highland NHS Board

Summary of Investigation

Category

Health: Hospital; care of the elderly; clinical treatment; diagnosis; communication

Overview

The complainant (Mr C) raised a number of concerns against Highland NHS Board (the Board) regarding the care and treatment his late father (Mr A) received from Dr MacKinnon Memorial Hospital, Broadford. Mr C stated that the Board failed to provide adequate care and treatment for Mr A from 31 May 2010 up to his death on 4 June 2010.

Specific complaints and conclusions

The complaints which have been investigated are that the Board failed to:

(a) treat Mr A's constipation and subsequent complications appropriately (*upheld*); and

(b) communicate effectively with Mr A, Mr C and Mrs C (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) ensure that treatment is initiated by clinical staff in good time when a patient's condition deteriorates and appropriate details of this are recorded in their medical notes;	30 April 2013
(ii) ensure that all relevant clinical details are recorded legibly by all doctors in the medical notes as and when they have reviewed a patient;	29 March 2013
(iii) ensure that staff consider the reasons for abrupt changes in patients, to ensure that reasonable action is taken to limit the chances of further problems developing;	30 April 2013
(iv) ensure that admission forms include prompts which assess a patient's cognitive function or capacity to	30 April 2013

	participate in decision making;	
(v)	ensure that nursing admission notes are completed appropriately for every patient;	29 March 2013
(vi)	ensure that when a patient displays uncharacteristic behaviour, appropriate and timely cognisance is taken of this and any subsequent action required is recorded;	30 April 2013
(vii)	ensure that measures are taken to feed back the learning from this event to all staff, to ensure that similar situations will not recur;	30 April 2013
(viii)	conduct a review of end-of-life care, with specific reference to completion of Do Not Resuscitate forms;	30 April 2013
(ix)	ensure that DNAR discussions with family members are documented; and	30 April 2013
(x)	issue Mr C with a full and sincere apology for the failings identified in this complaint.	6 March 2013

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

Main Investigation Report

Introduction

1. On 24 October 2011 the Ombudsman received a complaint from Mr C, about the care and treatment his late father (Mr A) received from Dr MacKinnon Memorial Hospital, Broadford (the Hospital). Mr C stated that Mr A, aged 92 years, was admitted to the Hospital on 31 May 2010 for treatment for faecal impaction. He said that on 2 June 2010, Mr A suffered vomiting and faecal aspiration (when a quantity of regurgitated contents enter an airway, precipitating inflammation and perhaps subsequent superimposed infection in the lung such as pneumonia), which followed two doses of Picolax (an oral stimulant laxative), and neither Mr C nor Mr A had been informed that this complication had occurred. Mr C stated that neither the severity of the potential and likely consequences of this, nor the possible treatment options were discussed with Mr A or with him. Mr C said that, subsequently, Mr A's condition deteriorated rapidly and he died in the Hospital on 4 June 2010.

2. Mr C also stated that he found Mr A's rapid demise on the evening of 3 June 2010, with the complete failure of medical staff to treat Mr A appropriately, also deeply disturbing and still does to this day.

3. Mr C complained to the Hospital on 23 May and 13 June 2011 and received consecutive responses from the Chief Executive (the CE) on 21 July and 8 September 2011.

4. The complaints from Mr C which I have investigated are that Highland NHS Board (the Board) failed to:

(a) treat Mr A's constipation and subsequent complications appropriately; and

(b) communicate effectively with Mr A, Mr C and Mrs C.

Investigation

5. As part of the investigation, my complaints reviewer obtained copies of Mr A's clinical records and the complaints correspondence from the Board. Advice was sought from an independent medical adviser, a consultant in acute medicine for older people (the Adviser).

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to treat Mr A's constipation and subsequent complications appropriately

7. Mr C stated that that on 31 May 2010 Mr A was admitted to the Hospital for treatment for constipation. He said that after Mr A received two doses of Picolax, he suffered vomiting and faecal aspiration on 2 June 2010.

8. Mr C said that Mr A was mentally fully competent although he was elderly and Mr A was not informed of the likely seriousness of the faecal aspiration he suffered, which followed the treatment with Picolax. Mr C said that, in his view, there were more appropriate alternative treatments for Mr A's illness. Mr C believed that there was a failure in the medical care of Mr A, in treating him with Picolax and the dosage he received.

9. Mr C said that Mr A's condition deteriorated suddenly and rapidly on the evening of 3 June 2011. He stated that when he arrived for a visit around 18:00, staff seemed unaware that Mr A had developed respiratory distress until he pointed out that Mr A was very unwell. Mr C stated that Mr A was then seen by a doctor (Doctor 1), who prescribed 250 milligrams of oral amoxicillin and oxygen. Mr C said that Mr A's condition continued to deteriorate that evening and he died at 04:10 on 4 June 2010. Mr C said that at no point on 3 June 2010 was any attempt made either to treat Mr A's acute respiratory distress effectively, or to inform Mr C or Mrs C that Mr A's condition was likely to result in death:

> 'this despite [Mrs C] who is a medical practitioner, asking the duty doctor directly if [Mr A] was dying, which it was clear to us he was.' (see also complaint (b).

10. Mr C said that he was not informed of the likely seriousness of the faecal aspiration Mr A suffered, which followed his treatment with Picolax and he wanted to know why prophylactic treatment (measures to avert disease) to prevent the infective component of aspiration pneumonia was not put in place. Mr C said he understood that, with regard to potential aspiration of vomit or faecal matter, best practice was to prevent it happening in the first place. He stated that there was no evidence in any of the clinical notes to suggest that any preventative action from such a powerful dosage of Picolax was in place.

11. Mr C said that after Mr A died, he read a statement in the nursing notes attributed to him, that he had agreed Mr A should not be resuscitated should he

arrest. Mr C said that such a discussion had never taken place with him on 4 June 2010, since the possibility of Mr A dying during his admission was never raised with either Mr A or Mr C (see paragraph 74). I have seen from the CE's letter to Mr C dated 8 September 2011, she stated this discussion had taken place with another doctor (Doctor 2).

12. Mr C said that the Board failed to treat Mr A's constipation safely and he suffered what turned out to be a lethal complication. He stated:

> 'They either failed to recognise, or tried to cover up, the complication which occurred. Thereafter when [Mr A] did deteriorate they failed to identify that timeously, and failed to initiate effective treatment. At no point was he or I given the opportunity to help prepare for his death which followed rapidly, either due to a failure to recognise his deterioration or to regard it as important.'

13. In the Board's response to Mr C's complaint dated 21 July 2011, the CE stated that Mr A was seen by the District Nursing Team during May 2010 for constipation and that a variety of treatments were carried out with little effect. A decision was subsequently taken to admit Mr A to the Hospital on 31 May 2010. The CE said that the treatment plan was to address the constipation and discharge Mr A home with a structured bowel regime to prevent future reoccurrence.

14. The CE said that, initially, a number of laxatives were attempted as well as a phosphate enema, without success. Thereafter, a decision was taken on 1 June 2010 to give Mr A Picolax. She stated that this was a more active treatment to ensure a full evacuation of the bowel and while it did cause discomfort, it was very effective for extreme cases of faecal impactation such as that suffered by Mr A; however, this did leave patients feeling drained. The CE stated that the doctors and nurses make their clinical decisions based on the patient presentation. Picolax is a treatment which is used regularly in hospitals for patients of a variety of ages, including older people. She added that the treatment regime Mr A was placed under was based on resolving his symptoms and for his return home.

15. The CE said that with any treatment there could be a risk of complications and this risk did increase with age. She stated that Mr A had been experiencing constipation difficulties for some time and this had an impact on his general health and wellbeing. She said that the vomiting could have been as a result of

intestinal obstruction or aspiration of the bowel and it was not clear what the actual cause was, however, the staff who treated Mr A had placed him under close observation. The CE said that aspiration of the bowel was considered after the second dose of Picolax and vomiting had occurred and that Mr A was treated with 10 milligrams of Metoclopramide (anti sickness treatment) to alleviate his condition.

16. The CE stated that on 3 June 2010 Mr A's health deteriorated over the course of the day. She noted that it was recorded there was a change in Mr A's behaviour and said this was clearly a marker which should have been picked up sooner in the day and 'we apologise for this oversight and delay in [Mr A's] antibiotic treatment'. The CE advised that the use of oral amoxicillin (as opposed to intra-venous) was a decision taken due to the frailty of Mr A and she said that Doctor 1 stated he had explained this to Mr C and thought that Mr C had understood the implications of gentle management (see paragraph 83).

17. The CE said that the discussion whether or not to resuscitate Mr A was recorded in the nursing notes on 4 June 2010 in the early hours of that morning and stated:

> 'we would not make a record in the notes stating that a discussion took place if this was not the case.'

18. The Adviser noted from the clinical records that in the community, Mr A's constipation had been treated with phosphate enemas, microlax enema and oral movicol (an osmotic laxative). He was treated with oral senna (a stimulant laxative) and oral lactulose (an osmotic laxative) from the point of admission onwards, however, the Adviser was unclear if this was started new or had been taken in the community before admission.

19. The Adviser stated that Mr A's past history included a variety of common comorbid conditions for a patient of this age (atrial fibrillation, benign prostate disease, gastric ulcer, high blood pressure) but said Mr A had not been previously diagnosed with any malignant disease, or life limiting pathology, including dementia.

20. The Adviser noted from the clinical records Mr A was described as frail, the abdomen was soft, non-tender with no palpable masses and bowel sounds were normal. There were some abnormal physical signs in the chest. The Adviser found no documentation of Mr A's cognitive function or capacity to

participate in decision making. The Adviser said that although this was an emergency admission he could see no documented evidence to suggest that Mr A was regarded on admission as being acutely unwell.

21. The Adviser stated that a chest x-ray showed a pleural effusion, with underlying collapse and consolidation of a part of the lung (fluid around the lung with associated loss of volume) which had improved since an x-ray of four months previously. An abdominal x-ray was reported as showing faeces in the rectum by the admitting doctor, however, showed no other specific features by a consultant radiologist. Routine bloods showed slightly reduced haemoglobin of 11.9. Sodium was marginally reduced. These results were from an i-STAT (handheld blood analyser) print out which the Adviser stated was poorly legible. A single additional blood test report, taken on the day of admission, showed a high erythrocyte sedimentation rate (ESR) which was a non-specific finding, but no other significant abnormality.

22. The Adviser said that a decision was made at the point of admission to treat the rectal impaction with Picolax and endorsed at a subsequent ward round that day. Mr A was also started on intravenous fluids. In this regard, a fluid chart showed that he was given two litres of saline over his first 14 hours in the Hospital, then no further fluid until a further litre of saline over eight hours on the morning of 2 June 2010, just after his deterioration was first noted. He added that the nursing admission notes are largely uncompleted.

23. The Adviser stated that Mr A was said to communicate well. He said he could see no prompt in this document to consider Mr A's cognitive function or capacity to participate in decision making. Again, there was no suggestion that Mr A was acutely unwell and the admission Scottish Early Warning Scoring (SEWS) record shows no evidence that he was acutely unwell.

24. The Adviser said that the nursing notes suggested that Mr A's bowels did move on the first evening and that he was then given a phosphate enema on the morning of 1 June 2010. He noted Mr A was then prescribed the Picolax and given this at 15:20 on 1 June 2010. A further dose of Picolax was given at 22:00 on 1 June 2010.

25. The Adviser stated that on 2 June 2010 at 03:00 Mr A had faecal incontinence and at 05:00 he vomited brown faecal fluid and was apparently seen by a doctor, however, the Adviser stated he found no medical entry for this

review. A nurse had noted '? whether has aspirated'. The Adviser stated that the SEWS chart confirms that deterioration commenced at around 04:00 on 2 June 2010 when Mr A had a SEWS score of 5.

26. The Adviser said that from a typed ward round entry later on 2 June 2010, it stated Mr A's bowels were moving and that he should be allowed to drink and that the ESR was very high, however, there were no comments made on the overnight events (see paragraph 25). The Adviser stated Mr A's abdomen was examined; however, he was not apparently examined by a doctor for evidence of aspiration or any other problem which may have caused the overnight events. The nursing notes described Mr A as sleepy, tired and nauseous. He had further faecal incontinence. The SEWS chart suggested that Mr A required oxygen and had a rapid heart rate; however, his blood pressure was maintained.

27. The Adviser said that on 3 June 2010 Mr A was noted to have a low grade temperature. His SEWS chart overnight from 2 June to 3 June 2010 showed on one reading a persisting rapid heart rate but no other concerning recording. Mr A refused to have observations done in the morning of 3 June 2010, which was said to be unlike him (see paragraph 16), but the Adviser stated there was no evidence to confirm whether this situation was due to a delirium or any other specific problem. The Adviser noted from a ward round entry it stated that Mr A was doing fine and could go home on 7 June 2010. However, the Adviser stated there was no comment about Mr A's general condition with regard to the possible episode of aspiration and need for oxygen therapy the previous day; and no evidence that he was examined by a doctor at this point. Later, the nurses documented a fall in oxygen saturations (which required further oxygen) and an irregular pulse. This was confirmed by the SEWS chart. The Adviser stated that at 18:30 a doctor noted that Mr A had an increased pulse and, following an entry which the Adviser described as illegible, he noted the word 'tachypnoea' (rapid respiration) with signs at the left base. The same note then stated 'D/W [???poorly legible] son … gentle Rx. Amoxicillin and O2'. The Adviser stated this review apparently occurred shortly after Mr C had expressed concern to a nurse about his father's condition (see paragraph 9).

28. The Adviser noted that nurses had documented a doctor reviewed Mr A and discussed treatment options with Mr C, who was said to be aware of Mr A's condition. Mr A then received one dose of oral amoxicillin 250 milligrams at 22:00 on 3 June 2010 (see paragraph 9).

29. The Adviser stated that at 03:30 on 4 June 2010 a doctor noted that Mr A had further declined and it was recorded, 'very sweaty, clammy. Undistressed. Pulse weak, thready. Resp rate (down) Appears comfortable'. The Adviser noted the plan documented was to observe Mr A, keep him comfortable and continue with oxygen.

30. The Adviser stated that at 04:10 on 4 June 2010 a nurse documented, 'Dr (? Name) spoke to [Mr C] re treatment and has agreed to oral antibiotics but not to resuscitate if arrests'.

31. The Adviser said he cannot locate any medical documentation of this resuscitation discussion or decision, or any Do Not Resuscitate (the DNAR) Form (see complaint (b)). He said it was unclear to him from the records what the local policy regarding the documentation of resuscitation decisions was in this unit at this time or whether the national policy was in use in this Board. Mr A died at 04:15 on 4 June 2010. No post mortem was performed.

32. Following the Adviser's review of events in paragraphs 19 to 32, he stated that Mr A was not acutely unwell when admitted to the Hospital. Although he was 92 years old, Mr A had not been diagnosed with any life limiting pathology and was living in a house with family members, apparently capable of mobilising alone, however, requiring some assistance with his personal care.

33. The Adviser stated that no formal diagnosis of cognitive impairment or dementia had ever been made and, if present at all, he did not believe it to have been in such an advanced stage that it could reasonably be said to influence subsequent treatment decisions. He stated it was noteworthy that there was no assessment of Mr A's cognitive function or capacity to participate in decision making at any point in the admission and stated, 'I would regard that as below a standard that could reasonably be expected in a unit of this sort' (see paragraphs 22 and 23).

34. In the Adviser's view, he said it was possible that the constipation was straightforward; that is, not related to any sinister underlying colonic disease such as cancer, as he said had been suggested in Mr C's correspondence.

35. The Adviser noted that Mr A's chest x-ray abnormality appeared to have been improving on admission. He said this could have related to a slowly

resolving previous pneumonia, or could have indicated something more sinister, including malignant disease in the lung, although in his view this was less likely.

36. The Adviser stated that Mr A's ESR was elevated; however, this was a non-specific finding and one that was as likely to be caused by benign (including slowly resolving inflammation in the lung) as malignant disease. He said the finding of the elevated ESR was not enough in itself to preclude active treatment of new or unexpected problems which might arise.

37. The Adviser said that frailty was a recognised medical condition with a poor prognosis. It can justifiably be used as a reason for limited intervention; however, from the information available in this case, he would not regard it as being severe.

38. The Adviser concluded that with regard to Mr A's condition on admission, he saw no evidence of established sinister, malignant or life limiting disease which would unequivocally justify a palliative approach to an unexpected acute illness.

39. The Adviser considered that in this case, it was not unreasonable to prescribe and use Picolax for constipation, particularly given the relatively refractory (obstinate) nature of the problem and failure of other treatments. He said there was no evidence of clinical examination or x-ray of the abdomen on admission; that there was impending mechanical obstruction of the bowel (which would have represented a contraindication if present); and he does not believe that the subsequent vomiting related to the development of such an obstruction. He stated that the use of two doses of Picolax a few hours apart was not extraordinary and although it may have been preferable to await the results of one dose in a frailer person, he did not feel that the use of two doses could be said to be unreasonable (see paragraph 25).

40. The Adviser stated it was appropriate and sensible to give intravenous fluids at the time the Picolax was administered, as resultant diarrhoea and fluid loss can be significant and cause problems in frail older people. Furthermore, the choice and volume of fluid given to Mr A was reasonable. Additionally, it would have been appropriate to check bloods before treatment and he said this was done using an iSTAT.

41. The Adviser stated that the likeliest cause of the vomiting was a direct pharmacological effect of the Picolax rather than the precipitation of bowel obstruction and this is a recognised side effect of the drug. He said that he did not feel that it was a sufficiently frequent or severe side effect, that a patient would necessarily have to have the possibility of aspiration as a result of vomiting explained to them, or be specifically consented to take this drug.

42. The Adviser stated the likeliest (but not definite) cause of Mr A's subsequent deterioration was aspiration of regurgitated stomach contents leading to pneumonia. As noted in paragraph 41, vomiting is a recognised complication of Picolax therapy and aspiration a recognised complication of vomiting. The Adviser stated that he did not feel that any specific different action could have been taken to prevent the occurrence of vomiting.

43. The Adviser stated that there seemed little doubt from the nursing record and SEWS chart that Mr A first deteriorated shortly after starting to vomit. Given this, the likeliest cause of his deterioration in the early morning of 2 June 2010 and subsequently, was aspiration (see paragraph 25). He stated that the nurses clearly documented that Mr A was reviewed by a doctor at this time. However, the fact that there was no documented medical review of this, no further x-ray or electrocardiogram (ECG) and no further blood tests, made it difficult to be certain that this was indeed the chain of events (as other possibilities exist to explain the sudden onset of vomiting and changes on observations seen on the SEWS chart, in a patient of this age).

44. The Adviser concluded:

> 'I find the fact that there is no medical documentation or investigation of the incident [in the early hours of 2 June 2010], which clearly concerned the nursing staff and led to a clearly abnormal SEWS score, surprising and concerning. This is, in itself, below a standard that could reasonably be expected in a unit of this sort.'

45. He stated it was possible that, because of the fact there was no medical documentation of the events of the early hours of 2 June 2010; doctors subsequently seeing Mr A were unaware of the need to ensure that no further problems relating to possible aspiration were developing. The Adviser also said he was unclear about the precise form of out-of-hours medical cover available in this unit (that is, resident or non-resident; grade and the specialty of doctors).

46. The Adviser noted that the SEWS charts readings did improve somewhat over 2 June 2010, however, the nursing notes suggested that Mr A was less well than on 1 June 2010 and stated it was unclear if this was communicated effectively to medical staff. He said that Mr A was apparently seen on a routine ward round, however, no note of the events was made.

47. The Adviser said that nursing and medical notes were limited on 3 June 2010, however, the SEWS charts and observations of Mr C suggested that Mr A obviously deteriorated over this day. The Board acknowledged this in their response dated 21 July 2011 and stated that treatment could have been started earlier that day (see paragraph 16).

48. The Adviser noted that Mr C and perhaps also Mr A were not told that there had been a suspicion of aspiration in the early hours of 2 June 2012. He said it may be that staff felt this to be too minor an event to warrant explanation to the family but, given its possible relationship to treatment and the dramatic change in Mr A's overall condition at the time as evidenced by the SEWS chart, it would have been preferable to do so.

49. The Adviser said that he did not believe (as suggested by Mr C), the staff were aware that aspiration had definitely occurred, however, they did not want to admit this. In the Adviser's view, staff did not consider the reason for the abrupt change carefully enough and ensure over the following hours that there was no reasonable action which could be taken that might limit the chance of further problems developing.

50. The Adviser concluded that the medical assessment, investigation and management of Mr A and communication with the family for the 36 hour period following the onset of vomiting until the evening of 3 June 2010 was below a standard that could be expected in a unit of this sort (see also complaint (b)). He said that, essentially, there was a failure to consider the cause of an abrupt change in Mr A's condition and if aspiration was indeed the event that occurred, to consider the need to manage this in any specific manner.

51. The Adviser found it difficult to comment 'with absolute certainty' on events during the evening of 3 June 2010; specifically, to reconcile the views of Mr C (following Mr A's death) that Mr C expressed in a number of letters, with the version of events said to have occurred by the Board.

52. The Adviser stated that the essential issue was:

- whether an inappropriately non-interventional approach to Mr A's care took place at the point that it was felt that he had definitely deteriorated on the evening of 3 June 2010; and
- whether Mr C was sufficiently informed of the situation to be able to participate in decision making relating to treatment options.

53. The Adviser said the care provided to Mr A before this point was, in his view, below a reasonable standard.

54. The Adviser considered the first documented medical review of Mr A's changed condition on the evening of 3 June 2010. He stated that Mr C felt that this review was precipitated by his expression of concern about Mr A's condition to a nurse.

55. The Adviser again stated that the doctor seeing Mr A on the evening of 3 June 2010 (given the absence of any documentation in the medical notes of the event of the early hours of 2 June 2010) may not have been aware that Mr A could have aspirated at this point.

56. The Adviser said the diagnosis of a chest infection at this time was based on findings on examination of the chest, as he cannot locate any x-ray or blood results. He said that if the doctor knew that Mr A had aspirated then this should be taken into account in treatment choice. If the doctor did not know about aspiration then the infection should be regarded as a hospital acquired pneumonia and that fact taken into account in treatment choice.

57. The Adviser said that it was not clear from the medical entry what specific form of chest infection the doctor felt Mr A had, or whether they felt that Mr A's life was in danger. He added that it can often be difficult to decide on the intensity of treatment (or appropriateness of treatment at all) in frail older people who suddenly become unwell. However, all units dealing with frail older people will frequently encounter such unexpected events and should be fluent in their management.

58. The Adviser listed the main factors and rationale that are relevant to decision making in this situation.

The medical assessment of the current and pre-morbid condition of the patient

59. The Adviser stated that in some circumstances it will be clear that a patient is so unwell that intervention of any sort is futile. If this medical judgment is made this should be clearly communicated and it is then reasonable for the doctor to offer palliative (end-of-life) or symptomatic care only, even if family members would prefer active treatment.

The expressed wishes of the patient or, if they are incapable of expressing their wishes, the views of any legally appointed proxy decision maker

60. The Adviser stated that if intervention is felt to have a chance of success (ie not be futile) then the wishes of the patient or relevant others should be taken into account. If the patient lacks capacity, and there is no legally appointed proxy decision maker, family should be asked what they feel their relative would wish to be done, but do not have the right to dictate what is done.

61. With regard to these two points, the Adviser stated although staff documented that Mr A was not for investigation of an elevated ESR, this was in his opinion in no way relevant to management decisions which require to be made about an acute unexpected event in a hospital in-patient, particularly when that event may have occurred as a consequence (albeit unintended) of hospital treatment. Furthermore, the subsequent suggestion of the Board that Mr A may have had sinister underlying colonic disease was, in the Adviser's view, an insufficient justification for a non-interventional approach to care and also unlikely to have been the case.

62. The Adviser stated that frailty is a recognised medical condition with a poor prognosis. It can justifiably be used as a reason for limited intervention; however, from all the information available in this case, he did not regard it as being sufficiently advanced to justify the level of medical input which was actually provided to Mr A.

63. The Adviser also stated that the medical notes themselves gave no indication of whether the doctor regarded Mr A on the evening of 3 June 2010 as having a potentially life threatening illness. Furthermore, he stated that the fact the doctor commenced an antibiotic must be taken to mean that the doctor did not regard the situation as a futile one.

64. In conclusion the Adviser stated the management of Mr A's faecal impaction was not unreasonable. However:

- the documentation of Mr A's cognitive function or capacity to participate in decision making was below a standard that could reasonably be expected;
- the absence of documentation of a medical review of Mr A when he started to vomit was below a standard that could reasonably be expected;
- the medical assessment, investigation and management of Mr A for the 36 hour period following the onset of vomiting until the evening of 3 June 2012 was below a standard that could be expected; and
- the medical management of the decision making process regarding the appropriate intensity of care on the evening of 3 June 2010 was below a standard that could reasonably be expected.

65. The Adviser stated that even if the unit had seriously considered that aspiration had occurred in the early hours of 2 June 2010 and started aggressive intravenous treatment for this, it was perfectly possible that the final outcome (in a man of Mr A's age, described as physically frail) would have been identical. However, the Adviser said that the failure to consider the cause of Mr A's initial deterioration and evaluate its possible impact was not mitigated because of this possibility and also given that Mr A did not suffer from advanced frailty and was not acutely unwell when admitted to the Hospital.

(a) Conclusion

66. Mr C complained that Mr A's constipation and subsequent complications were not correctly treated by the Board and they failed to identify his deterioration and initiate effective treatment. The Board stated that the treatment Mr A received was based on resolving his symptoms and his return home, although as with any treatment, risk of complications increases with age.

67. I have carefully considered all the aspects of this complaint and taken account of the advice I have received. I consider that when Mr A attended the Hospital on 31 May 2010 he was not acutely unwell and had not been diagnosed with any life limiting condition to justify a palliative approach. I have reviewed Mr A's in-patient treatment and in doing so there is no evidence I have seen that, given Mr A's presented symptoms on 31 May 2010, the treatment of Picolax was unreasonable.

68. However, my investigation has established several clinical management failings in this case, after Mr A started to vomit during the early hours of 2 June 2010. This incorporates a failure to ensure there was medical

documentation about Mr A's aspiration and deterioration or that a medical investigation of this had taken place; that for the 36 hour period following the aspiration there was inadequate medical assessment, investigation and management of Mr A and the medical management of the decision making process regarding the appropriate intensity of care on the evening of 3 June 2010 was substandard. I am also critical that the first documented medical review of Mr A's changed condition took place on the evening of 3 June 2010 and it occurred after Mr C expressed concern about Mr A's condition to a nurse. Furthermore, the doctor who reviewed Mr A may not have been aware Mr A had aspirated, as there was no documentation of the events of the early hours of 2 June 2010 or record in the medical notes and the examination carried out was solely based on findings.

69. While I accept that Mr A's outcome, in a man of his age and described as physically frail, may have been identical, that is no reason for the impact of failures outlined above to be diminished. Taking all these factors into account, I uphold this complaint.

(a) Recommendations

70.	I recommend that the Board:	*Completion date*
(i)	ensure that treatment is initiated by clinical staff in good time when a patient's condition deteriorates and appropriate details of this are recorded in their medical notes;	30 April 2013
(ii)	ensure that all relevant clinical details are recorded legibly by all doctors in the medical notes as and when they have reviewed a patient;	29 March 2013
(iii)	ensure that staff consider the reasons for abrupt changes in patients, to ensure that reasonable action is taken to limit the chances of further problems developing;	30 April 2013
(iv)	ensure that admission forms include prompts which assess a patient's cognitive function or capacity to participate in decision making;	30 April 2013
(v)	ensure that nursing admission notes are completed appropriately for every patient; and	29 March 2013
(vi)	ensure that when a patient displays uncharacteristic behaviour, appropriate and timely	30 April 2013

cognisance is taken of this and any subsequent action required is recorded.

(b) The Board failed to communicate effectively with Mr A, Mr C and Mrs C

71. Mr C stated that neither he nor Mr A were informed of the likely seriousness of the faecal aspiration Mr A suffered, which followed his treatment with Picolax. Mr C had also asked why prophylactic treatment to prevent the ineffective component of aspiration pneumonia was not put in place.

72. Mr C said that in the Board's reply to his complaint they stated that Mr A was confused and had refused treatment the day before he died. Mr C asked why he was not informed about this at that time, as both he and Mrs C were in contact with the Hospital at least twice a day either by telephone or in person.

73. Mr C stated that on the day before Mr A died, Mrs C telephoned the Hospital around 11:00 to see if Mr A would be getting home that day or the next and the only information given to her was that staff wanted to make sure Mr A's bowel was completely clear before he was discharged.

74. Mr C stated that no discussion took place about whether Mr A should be resuscitated or not and said that there were no medical notes to indicate that this conversation had taken place. He said that Mr A was not terminally ill, his physical symptoms on admission to the Hospital were related to constipation and '[Mr A] was not someone who should not be resuscitated and I certainly would never have agreed to that' (see paragraph 11).

75. Mr C stated that the Board were willing to apologise for a failure in communication, however, he felt that the failures were more substantial than that and that Mr A died of inappropriate medical care (see complaint (a)).

76. In the Board's response to Mr C dated 21 July 2011, the CE stated that during all admissions, basic tests are carried out and the results for Mr A showed a high ESR. She stated that this test was a valuable screen to indicate if there was any underlying chronic infection, rheumatic or malignant disease. The CE said that according to the notes (both medical and nursing), Mr A's care was discussed with Mr C and the decision not to investigate the ESR further was apparently jointly made. In her letter she stated:

'I am sorry that you feel that there has been a miscommunication with regard to this discussion recorded in Mr [A's] notes.'

77. The CE referred to events on 3 June 2010 and stated that Mr A's health deteriorated over the course of that day. She said that Mr A had uncharacteristically not co-operated with the nurses at that time and this change in his behaviour was clearly a marker that should have been picked up sooner in the day and apologised to Mr C for this (see complaint (a)).

78. The CE stated that Doctor 1 thought he had explained the reasons to Mr C why oral antibiotics (as opposed to intra-venous) had been administered to Mr A. She said, 'We are sorry you feel this was not the case and that there has been a miscommunication and misunderstanding between [the Hospital], staff and family'.

79. The CE said it was recorded in the nursing notes about the resuscitation of Mr A (in the early morning of 4 June 2010) and it would not be recorded if this was not the case.

80. The Adviser stated that there was no evidence that Mr A's capacity to participate in decision-making was considered at any stage during his admission. As noted in paragraphs 33 and 64, he stated the failure to document or assess Mr A's cognitive function or consider his capacity in any way at all at any point in his admission fell below an acceptable standard. Furthermore, if Mr A lacked capacity, then communication should have taken place with family members, bearing in mind the principles outlined in paragraph 59. In this regard, he understood, Mr C did not have Welfare Power of Attorney (POA).

81. The Adviser noted that nursing staff documented a discussion when Mr A was pre-terminal (see paragraph 17), that cardiopulmonary resuscitation had been agreed with Mr C to be inappropriate. He noted that Mr C refuted that any such discussion took place. The Adviser stated that if the Do Not Resuscitate (DNAR) decision was made by Doctor 2 on the grounds of futility, there was no need to agree this with family members even if they have POA, however, it was regarded as good practice to inform them of the decision. As he already noted, there was no medical entry regarding this discussion and also no DNAR form had apparently been completed. He stated that this specific aspect of care, that

is, the lack of medical documentation of the DNAR decision, is in itself below a standard that could be expected in a unit of this sort.

82. The Adviser noted that although the nursing and medical staff had documented that a discussion about treatment did take place with Mr C on the evening of 3 June 2010 and they may have sincerely believed that they had provided sufficient explanation of Mr A's current condition and justification for the selected treatment course, it was clear from the subsequent views expressed by Mr C, he did not feel – at that time or later - that the situation had been adequately explained to allow him to understand the gravity of the situation, what was causing the situation, or to express a view about Mr A's likely treatment preferences.

83. In this regard, the Adviser stated that the use of the term 'gentle' treatment, at the time and subsequently referred to in the Board's response to Mr C dated 8 September 2011, to be somewhat unsatisfactory and perhaps supportive of the view that the discussion with Mr C then was not sufficiently explicit (see paragraph 17).

84. The Adviser said he accepted the view in the second complaint response of 8 September 2011 that the actions of staff were not intended to be callous or uncaring; that the treating doctor sincerely believed that more aggressive treatment would not be in Mr A's best interests; and that symptomatic care was most appropriate. He stated that it did not appear, however, that this was adequately communicated to Mr A's family. Therefore, the Adviser stated on balance, he felt that the medical management of the decision making process regarding the appropriate intensity of care on the evening of 3 June 2012 was below a standard that could reasonably be expected in a unit of this sort (see complaint (a).

85. The Adviser concluded that the communication with Mr C and family for the 36 hour period following the onset of vomiting until the evening of the 3 June 2010 was below a standard that could be expected. He also stated that the lack of medical documentation of the DNAR decision was below a standard that could be expected.

86. The Adviser also stated that Mr A's age and physical frailty was no reason not to have effectively communicated the key aspects of the situation to Mr C and family.

(b) Conclusion

87. Mr C said there was a failure by the Board to communicate with Mr A, Mrs C and him, specifically about the seriousness of the faecal aspiration which followed the Picolax treatment and the DNAR decision. The Board had apologised for failed and miscommunication, however, Mr C felt this was inadequate.

88. I have carefully considered the advice I have received and, linked to complaint (a), have established that the Board had not assessed Mr A's cognitive function. I have also not seen evidence that Mr A lacked capacity.

89. I have seen that a documented discussion about treatment had taken place with Mr C on the evening of 3 June 2010 and that Mr C felt this was inadequate. I have reviewed the Board's phraseology to describe a discussion with Mr C and I consider this did suggest a lack of explicitness. I note the lack of a medical entry about the DNAR form (and that no DNAR form had apparently been completed). I share the Adviser's view that for such an important aspect of end-of-life-care, this fell below an acceptable standard that should be expected. Taking all these factors into account I uphold this complaint.

(b) Recommendations

90. I recommend that the Board:	*Completion date*
(i) ensure that measures are taken to feed back the learning from this event to all staff, to ensure that similar situations will not recur;	30 April 2013
(ii) conduct a review of end-of-life care, with specific reference to the completion of DNAR forms;	30 April 2013
(iii) ensure that DNAR discussions with family members are documented; and	30 April 2013
(iv) issue Mr C with a full and sincere apology for the failings identified in this complaint.	6 March 2013

91. 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

Mr C	The complainant
Mr A	Mr C's late father
The Hospital	Dr MacKinnon Memorial Hospital Broadford (or Broadford Hospital)
The CE	The Chief Executive of Highland NHS Board
The Board	Highland NHS Board
Mrs C	Mr C's wife
The Adviser	A clinical adviser to the Ombudsman
Doctor 1	A doctor who treated Mr A
Doctor 2	A Doctor who in the nursing notes was reported to have discussed Do Not Resuscitate (DNAR) with Mr C on 4 June 2010
ESR	Erythrocyte sedimentation rate
SEWS	Scottish Early Warning System
DNAR	Do Not Resuscitate Form
ECG	Electrocardiogram
POA	Power of Attorney

Annex 2

Glossary of terms

Atrial fibrillation	irregular heartbeat
Amoxicillin	antibiotic to treat infection
Aspiration	breathing in
Faecal impaction	constipation
i-STAT	handheld blood analyser
Osmotic laxative	a type of laxative that draw water from the intestines and make the bowel softer
Palpable mass	the finding of this would warrant further investigation such as radiology
Picolax	an oral stimulant laxative
Prophylactic treatment	preventative measure
Saline	sterile solution of sodium chloride

Annex 3

List of legislation and policies considered

NHS Scotland May 2010: Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy