Scottish Parliament Region: Central Scotland

Case 201103125: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; Care of the Elderly; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns with Lanarkshire NHS Board (the Board) concerning the care and treatment her father (Mr A) received for a gangrenous toe between 4 January and 12 March 2011 while a patient in three different hospitals, including Monklands General Hospital (Hospital 1), Hairmyres Hospital (Hospital 2) and Wester Moffat Hospital (Hospital 3). Mr A died from sepsis (a bacterial infection in the bloodstream) on 12 March 2011.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the treatment provided to Mr A for his gangrenous toe was inadequate and failed to address the infection and prevent him contracting sepsis (*upheld*);

(b) during Mr A's admissions to the three hospitals, staff unreasonably failed to recognise, monitor and address his pain, agitation and confusion (*upheld*);

(c) between 9 and 10 March 2011 Mr A's medication was inappropriately changed causing him to become very distressed and unresponsive (*upheld*);

(d) there was an unreasonable delay in transferring Mr A to Hospital 1 on 12 March 2011 when his condition had deteriorated (*upheld*); and

(e) during Mr A's hospital admissions from 4 January to 12 March 2011, the family constantly raised their concerns about Mr A's deteriorating condition but these were unreasonably ignored (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) ensures that Doctor 1 reflects in his annual appraisal on Adviser 1's comments in terms of the lack of evidence in the medical records to show	16 October 2013

	that all surgical options were considered and discussed with Mr A and the family where relevant;	
(ii)	review the application of the MEWS[1] chart in Hospital 3 to ensure that staff can readily identify patients who have deteriorated and require urgent attention;	16 October 2013
(iii)	conduct a significant event analysis with regards to Mr A's transfer from Hospital 3 to Hospital 1, to ensure that in future patients who are significantly unwell and deteriorating are transferred in a timely manner. This should also take into account Mr A's pain management at Hospital 3; and	16 October 2013
(iv)	apologise to Mrs C and the family for the failings identified in this report.	18 September 2013

[1] Modified Early Warning Score is a guide to quickly determine the degree of illness of a patient

Main Investigation Report

Introduction

1. Mr A was admitted as an emergency to an orthopaedic ward at Monklands General Hospital (Hospital 1) on 4 January 2011 with a gangrenous toe that was leaking pus. Mr A was transferred to the vascular unit at Hairmyres Hospital (Hospital 2) on 14 January 2011 and underwent surgery on 19 January 2011. A further transfer to Wester Moffat Hospital (Hospital 3) took place on 3 March 2011 for rehabilitation purposes. Mr A's health significantly deteriorated during his admission to Hospital 3 and he was, therefore, transferred back to Hospital 1 on 12 March 2011 but died the same day from severe sepsis (bacterial infection in the bloodstream).

2. Mrs C, the daughter of Mr A, and the family, are of the view that Mr A developed sepsis as a result of his toe and the infection not being treated properly. In addition, concerns were raised with staff regarding Mr A's confusion and pain management but the family felt this was ignored and not acted upon.

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

(a) the treatment provided to Mr A for his gangrenous toe was inadequate and failed to address the infection and prevent him contracting sepsis;
(b) during Mr A's admissions to the three hospitals, staff unreasonably failed to recognise, monitor and address his pain, agitation and confusion;
(c) between 9 and 10 March 2011 Mr A's medication was inappropriately changed causing him to become very distressed and unresponsive;
(d) there was an unreasonable delay in transferring Mr A to Hospital 1 on 12 March 2011 when his condition had deteriorated; and
(e) during Mr A's hospital admissions from 4 January to 12 March 2011, the family constantly raised their concerns about Mr A's deteriorating condition but these were unreasonably ignored.

Investigation

4. Investigation of the complaint involved reviewing copies of Mr A's medical records and the complaints correspondence received from Lanarkshire NHS Board (the Board) and the information supplied by Mrs C. As the complaint included clinical issues, my complaints reviewer obtained independent medical advice from a consultant vascular surgeon (Adviser 1) and a consultant geriatrician (Adviser 2).

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

(a) The treatment provided to Mr A for his gangrenous toe was inadequate and failed to address the infection and prevent him contracting sepsis

6. In response to the complaint, the Board outlined that the consultant vascular surgeon (Doctor 1) who had carried out the operation to bypass a blocked artery on 19 January 2011 had said that the surgery was satisfactory albeit technically challenging due to the advanced disease in Mr A's arteries. The Board said that Mr A's pain levels seemed to decrease after the operation, and, although he had dry gangrene, it seemed to have halted its progression.

7. The Board explained to Mrs C that the presence of gangrene is not an indication for removal of the part of the body affected and that there are two fairly well defined clinical scenarios in patients with gangrene.

8. In the first scenario, a patient has what is described as dry gangrene which is where tissue of the body is dead but is very dry and not infected. In this situation, it is entirely safe to leave the area alone, particularly if it is a digit in the body, such as the toe, since there is a fairly high chance that once the circulation has been restored to that part of the body, the gangrene part may separate away on its own – a process called auto-amputation. The Board said that this commonly happens in patients with vascular disease and is regarded as a more satisfactory and safer alternative to amputation of the affected digit. Doctor 1 believed that this was the way forward in Mr A's case.

9. In the other scenario, when the gangrene is moist, this usually implies infection as well as dead tissue. This is a situation that is potentially more unsafe for the patient and at the very least requires powerful antibiotics and may also require amputation of the area affected. However, Doctor 1 did not believe that Mr A had wet gangrene, therefore, at no stage was it deemed necessary to remove the toe. The Board said that, if this had been carried out then it could have left Mr A with a wound that was unable to heal in which case amputation of the leg would then probably follow.

10. The Board also explained that confusion can be made worse with painkillers that are often required around the time of an operation. However, despite this, the vascular team treating Mr A did not think infection was a major issue for Mr A although there would have been some low grade infection in the foot as well, which would contribute to his confusional state. The Board said Mr A was monitored very closely by various ward observations and blood tests but at no stage did Doctor 1 or the vascular team feel that the infection in Mr A's foot was becoming a major concern. Therefore, it was not felt that amputation of the gangrenous toe was necessary. The Board further outlined that Mr A was thereafter transferred to Hospital 3 for rehabilitation as he was not yet fit for discharge.

11. As set out in paragraph 4, independent specialist advice was sought from a consultant vascular surgeon (Adviser 1).

12. Adviser 1 explained that Mr A was admitted to the orthopaedic ward at Hospital 1 on 4 January 2011 with a gangrenous toe which was leaking a small amount of pus and surrounded by an area of erythema (an area of redness on the skin, which is a sign of infection in the context of a gangrenous toe leaking pus).

13. Mr A had a history of intermittent claudication, a condition that is caused by narrowing or blockage in the main artery taking blood to the leg (femoral artery). On 5 January 2011, a vascular specialist recommended that Mr A have a magnetic resonance angiogram (MRA) and that Mr A be transferred to the vascular surgical unit at Hospital 2. Adviser 1 commented that Mr A's MRA scan did not take place until over a week later, nor was he transferred to Hospital 2 until 14 January 2011 due to bed shortages. Whilst Adviser 1 would have expected both the MRA and transfer to Hospital 2 to have taken place sooner, he considered that the delay did not impact on Mr A's outcome as antibiotics had been administered during this time.

14. Adviser 1 explained that Mr A's blood results on 14 January 2011 showed inflammation, most likely due to infection in Mr A's big toe on the right foot. In addition, the radiology report for the MRA showed some narrowing of the arteries. Adviser 1 explained that when an artery is blocked, the blood pressure in the artery beyond the blockage is reduced. This reduction can be measured by comparing the blood pressure at the ankle below the blockage to the blood pressure in the arm, which is above the blockage. This is known as the ankle

brachial pressure index (ABPI) but Adviser 1 could not see any record of this having been recorded in the clinical records to document the level of reduced blood pressure in Mr A's right foot[2].

15. Adviser 1 said that the MRA results were discussed at a vascular meeting on 14 January 2011 and a left femoral endarterectomy and femoral crossover graft was recommended and carried out on 19 January 2011. Adviser 1 explained that the operation was performed to bypass a blocked artery. It would have helped increase the flow of blood to the right leg but is known not to always help patients who have tissue loss in their foot, as in Mr A's case, and, relevant references were given to this in the medical records.

16. Adviser 1 said that a doppler scan (used to measure the blood supply to the legs) was used to listen to the graft on 1 February 2011 when it was considered to be functioning well. However, no other record was made of whether or not the bypass graft improved the blood pressure in the right foot leading up to Mr A's transfer to Hospital 3 on 3 March 2011, nor was any subsequent imaging of the graft performed to see if it was still open and not blocked when Mr A continued to have pain and episodes of infection in the right foot.

17. Adviser 1 said that Mr A continued to be confused after the operation, with episodes of redness and discharge from the toe needing antibiotics. Blood test results contained within the medical records showed that inflammation remained elevated during Mr A's stay in Hospital 2 and by 28 February 2011 this had started to rise but did not appear to have been acknowledged by the staff treating Mr A as the medical record simply stated 'No acute issues'. The inflammation was a sign of on-going infection but appeared not to have been acted upon and this would have contributed to Mr A's state of confusion. Adviser 1 further explained that intervention may have included antibiotic therapy or further surgery. However, no further antibiotics were given and Mr A received six hourly paracetamol for pain and was also given tramadol (a more powerful painkiller). Adviser 1 commented that the reason for the tramadol was not stated in the medical or nursing records and in the absence of any other comment, Adviser 1 is of the view that it was because of the pain in Mr A's toe.

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[2] In commenting on this report, the Board said that the ABPI measurements can be misleading in certain patients, namely those with calcified arteries and are not typically used in the West of Scotland to measure the success of an operation. We are satisfied from further research that this is not an unreasonable position.

18. Adviser 1 said that had he undertaken a bypass graft under such circumstances, he would have a heightened expectation of possible graft blockage, especially in light of Mr A experiencing recurrent infection in his gangrenous toe. Adviser 1 explained that such on-going symptoms, including recurrent infection and pain in the gangrenous toe, would have lead him to investigate the femoral crossover graft function further in case it had blocked because there is the potential for thrombosis to develop. Adviser 1 stated that:

> 'Femoral crossover grafts have a success rate of around 85%. Thus 15% block after they have been put in, some immediately and some after a period of months or years. Where the flow into the graft is reduced, the likelihood of the graft blocking is increased. This patient had some furring (atheroma) of the left iliac artery above the groin, as described in Mr A's operation note, and this atheroma might have reduced the flow into the graft (the inflow). Also, the profunda femoris artery on the right was thickened and blocked at its origin, so the graft had to be placed quite far down the artery where it is not as wide so the flow of blood out of the graft (the outflow) may have been less than usual. While the graft may have functioned perfectly well under these circumstances, there is a greater potential for the graft to block (the blockage is caused by clotting of blood within it because the flow through the graft is not fast enough to stop the blood clotting, known as graft thrombosis.'

19. Adviser 1 said that he would have considered whether or not a further procedure might be of benefit. This would have included 'an attempt to bypass the blocked superficial femoral artery in the thigh by placing a graft from the femoral crossover graft in the groin down to the isolated popliteal artery at the leg where there is tissue loss in the foot'. However, it may have been that the vascular surgeon at Hospital 2 had concluded that the isolated popliteal segment or the diseased calf arteries were not suitable for further attempts at bypass grafting, therefore, transfer to Hospital 3 may have been appropriate as Mr A was not receiving an active treatment on the vascular ward. That being said, Adviser 1 was critical that consideration to further surgery was not stated anywhere in the clinical records.

20. Furthermore, Adviser 1 also considered that if there was some reason not to carry out further bypass surgery, then a toe or leg amputation might also be considered in a patient with continuing pain and recurrent sepsis in the foot which might be contributing to their confusion. Adviser 1 agreed with Doctor 1's

explanation that it is not always necessary to amputate the toe in the presence of dry gangrene. Adviser 1 said that, whilst amputation may not have been justified on the basis of the extent of Mr A's pain during his admission at Hospital 2, in view of the persisting signs of infection and confusion, it should have been considered and discussed with the family. He commented there was no evidence in the clinical records to support that this was done.

21. The Board maintained that there were no clinical signs of on-going infection in Mr A's foot, therefore, it was not necessary to check whether the graft was still working after 1 February 2011 when a duplex ultrasound was carried out on the ward as standard practice. Adviser 1 said that it was documented that a doppler ultrasound had been performed and not a duplex ultrasound, which is a more sophisticated machine that gives a clear picture of blood flowing through the graft rather than an audible signal, as is the case with a doppler scan. A separate formal report would normally be in the notes had a duplex ultrasound been done and if this type of scan was routine on Hospital 2's wards then it would have seemed a simple matter to check the graft at any time after 1 February 2011 when it was clear that Mr A's condition failed to improve – his toe remained gangrenous, he continued to have episodes of infection requiring antibiotics and his inflammatory markers remained elevated throughout his stay at Hospital 2. Whilst it may be that Mr A's failure to improve was due to the severity of the arterial disease in his right leg, Adviser 1 would have expected to see some reference to further intervention being considered and rejected.

22. The Board also commented that a further graft from the groin down to the knee was unlikely to be successful and could expose the patient to significant risk of developing a graft-related infection which they said was invariably fatal. Therefore, a further graft was not considered and consequently not recorded in the notes. Adviser 1 highlighted that there is no particular increased risk of graft infection than there would be from carrying out another type of bypass graft (femoro-popliteal bypass) which Adviser 1 would routinely consider for critical limb ischaemia (inadequate supply of blood to the limb) albeit they are not commonly needed. Furthermore, there are measures that can be taken to reduce the risk of graft infection. Adviser 1 emphasised that the Board were incorrect in saying that a graft related infection is invariably fatal and said that although some patients lose their legs as a result of graft infection, very few lose their lives.

(a) Conclusion

23. Based on the advice I have received, the operation carried out was appropriate but follow-up appears to be inadequate in that: no consideration seems to have been given to the potential for thrombosis to have developed and to have been the possible cause of Mr A's pain requiring stronger painkillers and antibiotics; and the options of a further bypass operation or amputation does not appear to have been considered nor discussed with Mr A or the family.

24. Therefore, in view of the above, I uphold the complaint.

(a) Recommendation

25. I recommend that the Board:	*Completion date*
(i) ensures that Doctor 1 reflects in his annual appraisal on Adviser 1's comments in terms of the lack of evidence in the medical records to show that all surgical options were considered and discussed with Mr A and the family where relevant.	16 October 2013

(b) During Mr A's admissions to the three hospitals, staff unreasonably failed to recognise, monitor and address his pain, agitation and confusion

26. In response to the complaint, the Board acknowledged that Mr A was an elderly gentleman (74 years old) who had been living independently and was not confused before being admitted to hospital. The Board said that the combination of an acute illness such as gangrene of the foot combined with a major operation to improve the circulation to the affected foot, could cause some confusion in most patients of Mr A's age group. As set out in paragraph 10, the Board also explained that the confusion can be made worse with painkillers that are often required around the time of the operation. However, the vascular team treating Mr A did not think infection was a major issue for Mr A although there would have been some low grade infection in the foot as well, which would contribute to his confusional state.

27. The Board said that on 4 March 2011 (whilst in Hospital 3) Mr A was commenced on night time sedation due to being unsettled. The Board explained that a nurse had to be with him over the weekend as he was agitated and continued to be unsettled. Mr A was thereafter prescribed oramorph and regular co-codamol (both of these are opiate drugs) as it was felt his pain was the source of the agitation. On 10 March 2011, Doctor 2 reviewed Mr A and felt

that Mr A's general condition was possibly related to his medication, therefore, the co-codamol was stopped, but oramorph was continued at night to try to reduce Mr A's pain and to let him settle in bed. The Board further set out that another doctor reviewed Mr A on 11 March 2011 and requested that oramorph only be used for dressing changes and not to be given at night. The Board also stated that the nursing staff had noted on 10 and 11 March 2011 that Mr A was lethargic and sleeping for long periods and that the family were informed that this may be due to the medication.

28. Adviser 1 said that neither the medical or nursing notes indicated that uncontrolled pain was a significant feature during Mr A's stay at Hospital 1 or Hospital 2. Drug charts from the 4 January to 3 March 2011 showed that Mr A was given regular six hourly analgesia with either paracetamol or co-codamol. Adviser 1 explained that between 19 January and 18 February 2011, Mr A was prescribed tramadol (a drug from the opiate family and stronger than codeine) on an 'as required' basis and this was given at most once a day at variable times and twice a day on only two occasions, namely 6 and 15 February 2011. On 19 February 2011, the tramadol was discontinued and Mr A received paracetamol four times a day until his transfer to Hospital 3 on 3 March 2011.

29. Adviser 1 also said that the nursing observation charts between 4 January to 3 March 2011 mostly recorded a pain score of 0 (no pain) and that there was mild to moderate pain scores on only four of the recorded days. On this basis, Adviser 1 considered that the pain management by Hospital 1 and Hospital 2 appeared to have been reasonable and appropriate. Although, as set out in paragraph 17, Adviser 1 noted that there was no comment on the on-going need for tramadol three to four weeks after the surgery at Hospital 2 on 19 January 2011. Adviser 1 said that, although it is not documented the reasons why tramadol was given, the implication may have been that Mr A was still getting significant pain from his toe which was not fully controlled by paracetamol or co-codamol and needed stronger analgesic on occasion.

30. Adviser 1 was, however, critical of Mr A's pain management by Hospital 3 and I will explain the reasons for this below.

31. Adviser 1 said that it was noted on the evening of Mr A's admission to Hospital 3 on 3 March 2011 that he became confused and remained so from then on with only an hour or two's sleep recorded each night. Adviser 1

explained that this can occur when elderly patients are moved to an unfamiliar environment.

32. Adviser 1 noted from the clinical records that Mr A was pain free on 4 March 2011, and continued to receive paracetamol four times a day until 6 March 2011 when he then complained of discomfort in his right foot. Adviser 1 said that, whilst Mr A complained of discomfort in his foot on 6 March 2011, it seems that his pain relief was escalated from 7 March 2011 even though he had been well controlled on regular paracetamol from 19 February 2011 during his admission at Hospital 2. Adviser 1 said that the regular paracetamol was discontinued by Hospital 3 on 7 March 2011 and replaced with regular co-codamol four times a day. In addition, oramorph was prescribed on an 'as required' basis in the event that Mr A had difficulty sleeping at night.

33. Adviser 1 said that it is not possible to tell from the clinical records what had changed in the degree of Mr A's toe pain that required him to need oramorph on 7 March 2011. Whilst this may have been appropriate if he had severe pain, he had been well controlled with tramadol before his admission to Hospital 3 on 3 March 2011 and it is not clear why this was increased to oramorph.

34. Adviser 1 explained that Mr A complained of having pain in his right foot on two occasions between 7 and 9 March 2011. During this time, he received 13 doses of co-codamol, three doses of oramorph and one dose of zopiclone (a sleeping tablet). Adviser 1 said that whilst these doses were within normal prescribing limits, it is possible for elderly patients to be adversely affected by them, particularly if there is not a lot of pain to counteract the sedative effects. When Mr A had been receiving tramadol on an as required basis at Hospital 2 the month before, he had rarely required more than one dose a day. Adviser 1 considered this was a very significant increase in Mr A's analgesic prescription and rather more than might be expected from the description of pain symptoms that Mr A was suffering from and taken on top of what appeared to be an acute confusional state.

35. Adviser 1 commented that on 10 March 2011, Mr A was noted to be more confused, not following commands and agitated. Mr A had been requesting the toilet frequently but not passing anything so was catheterised. Whilst only a small amount of urine was drained, this tested negative for infection. Doctor 2

noted that Mr A was drowsy, had no fever, his chest sounded clear and suggested he stopped taking the co-codamol. Adviser 1 said that, although from the nursing notes there was an intention to give oramorph at 22:00 on 10 March 2011, it was given later that night instead at 03:18 on 11 March 2011 for pain relief, even though the co-codamol had been stopped the previous day. In Adviser 1's opinion, it would have been more appropriate for Doctor 2 to have discontinued all opiate analgesia, not just the co-codamol.

36. The clinical records noted on 11 March 2011 that Mr A was unsettled, unresponsive, not speaking, not eating and that his pupils were pinpoint. Adviser 1 explained that analgesics from the opiate family of medicines are known to cause confusion and drowsiness. Adviser 1 also said that pinpoint pupils can be a sign of opiate toxicity and although it was appropriate for Doctor 2 to have discontinued the co-codamol in case Mr A's drowsiness was related to the increase in analgesia, it would have been more appropriate to have discontinued all opiate analgesia, that is, the oramorph.

37. On 12 March 2011, Mr A was given no medication as he was extremely tired and lethargic and he subsequently became septic before being transferred back to Hospital 3 as an emergency, where he died the same day.

38. Adviser 1 explained that a patient who presents with drowsiness, unresponsiveness, and pinpoint pupils might well be suffering from opiate toxicity and this should have at least been considered on 11 March 2011. Adviser 1 said that it would have been appropriate for a test dose of naloxone (an opiate antagonist which would have immediately reversed any opiate effect if this had been responsible for the drowsiness). Adviser 1 explained that where opiate excess is considered a possibility, then it would be better and much quicker to attempt to reverse the effect with naloxone. If the drowsiness is not reversed by naloxone then some other cause might reasonably then be considered.

39. Adviser 1 considered that Mr A's confusion and drowsiness contributed to his development of his severe sepsis but the source of the sepsis was not discovered, therefore, it is difficult to be more precise about this. In view of the pinpoint pupils, it is likely that the opiate drugs, both the codeine (in the co-codamol) and oramorph, contributed to Mr A's confusion and drowsiness and as a drowsy and unresponsive patient is susceptible to both chest and urinary

infection, this was likely a contributory factor to the severe sepsis which developed on 12 March 2011 leading to Mr A's death.

40. As such, Adviser 1 considered that this aspect of Mr A's pain management was below the standard expected.

41. My complaints reviewer obtained further advice from a consultant geriatrician (Adviser 2) regarding the observations that were carried out on Mr A while he was in Hospital 3 between 3 and 12 March 2011. Adviser 2 commented that a Modified Early Warning Score (MEWS) chart was commenced on 3 March 2011 by the nursing staff on the day Mr A was admitted to Hospital 3. The MEWS chart is a system to determine the degree of illness of a patient by monitoring their respiratory rate, temperature, blood pressure, heart rate and neurological response. Adviser 2 noted that although the MEWS chart had been started on 3 March 2011 and that there were no significant concerns at this time, no observations appeared to have been carried out between 4 and 11 March 2011. Adviser 2 was of the opinion that more frequent observations should have been carried out on Mr A until it was certain that his condition was stable in light of him being newly admitted to Hospital 3.

(b) Conclusion

42. Based on the advice I have received and information made available to me, Mr A's pain appears to have been appropriately managed by Hospital 1 and Hospital 2. However, although codeine sensitivity was queried at Hospital 3, the possibility that Mr A was suffering from opiate excess, does not appear to have been fully considered by Hospital 3 despite the symptoms he was displaying. I accept the advice about the likelihood that the opiate drugs contributed to Mr A's confusion and drowsiness, and, that this in turn contributed to the development of severe sepsis. I make a recommendation in connection with this under complaint (d).

43. I am mindful that Hospital 3 is a community hospital set up for the needs of long term elderly patients which in many respects is different from the facilities and care available at an acute hospital. Nevertheless, as set out under complaint (d) below, I consider that staff at Hospital 3 should have identified Mr A's deteriorating condition and the need to transfer him sooner to Hospital 1 when he became unresponsive on 11 March 2011.

44. Therefore, I uphold the complaint.

(b) Recommendation

45. I recommend that the Board:	*Completion date*
(i) review the application of the MEWS chart in Hospital 3 to ensure that staff can readily identify patients who have deteriorated and require urgent attention.	16 October 2013

(c) Between 9 and 10 March 2011 Mr A's medication was inappropriately changed causing him to become very distressed and unresponsive

(c) Conclusion

46. In view of my findings in paragraphs 43 and 44, I consider that the management of Mr A's analgesia by Hospital 3 fell below a reasonable standard. Therefore, I uphold the complaint.

(d) There was an unreasonable delay in transferring Mr A to Hospital 1 on 12 March 2011 when his condition had deteriorated

47. In response to the complaint, the Board outlined that on 12 March 2011, in line with their procedure for accessing medical assistance out-of-hours in 'off site hospitals' (in this case Hospital 3 was a long term care facility), the nursing staff at Hospital 3 contacted NHS 24 at 14:00 in order to arrange for a doctor to review Mr A after he developed a temperature. The Board explained that when the doctor had still not arrived three hours later, the nurse in charge contacted NHS 24 again to inform them of Mr A's deteriorating condition. The Board said that when the doctor attended at 18:20, a 999 call was thereafter made for an emergency ambulance to transfer Mr A to Hospital 1. It was noted in the clinical records that the transfer took place at 18:45.

48. During the course of our enquiries, the Board also informed my complaints reviewer, that as a result of the complaint: a debrief was undertaken; areas of improvement identified; and additional training given to a staff nurse.

49. Adviser 1 considered that it would have been appropriate on 11 March 2011 to refer Mr A back to an acute care centre, that is Hospital 1, when he became unresponsive rather that the next day when he became seriously ill with sepsis.

50. Adviser 1 said that whether an earlier transfer back to Hospital 1 on the 12 March 2011 would have made a difference is difficult to assess. Mr A was already severely ill at this time and his temperature was noted to be raised but it is not know from the clinical records what his blood pressure was, possibly due to the blood pressure machine being broken. In addition, there was a four hour and 45 minute interval between possible septic shock being identified and the transfer of Mr A to Hospital 1, by which stage Mr A was in cardiac arrest. Adviser 1 considered that earlier fluid resuscitation may have raised the blood pressure and prevented cardiac arrest. However, given Mr A's unresponsive state over the previous 24 hours, Adviser 1 is of the opinion that it was unlikely Mr A would have survived from septic shock if the transfer interval had been shorter.

(d) Conclusion

51. Hospital 3 is a community hospital that provides long term care for the elderly. Whilst I accept the advice that it was likely Mr A would not have survived the septic shock if he had been transferred sooner to Hospital 1 on 12 March 2011, I consider that it would have been reasonable and appropriate for Hospital 3 to have arranged transfer on 11 March 2011 when Mr A became unresponsive.

52. In view of this, I uphold the complaint. Whilst I note that the Board have taken further action as a result of the complaint, including a debrief, training and identified areas for improvement, I make the following recommendations.

(d) Recommendations

53. I recommend that the Board:	*Completion date*
(i) conduct a significant event analysis with regards to Mr A's transfer from Hospital 3 to Hospital 1, to ensure that in future patients who are significantly unwell and deteriorating are transferred in a timely manner. This should also take into account of Mr C's pain management at Hospital 3; and	16 October 2013
(ii) apologise to Mrs C and the family for the failings identified.	18 September 2013

(e) During Mr A's hospital admissions from 4 January and 12 March 2011, the family constantly raised their concerns about Mr A's deteriorating condition but these were unreasonably ignored

54. Adviser 1 explained to me that there were a number of entries in the clinical notes by both nursing and medical staff between 10 January and 4 March 2011 about Mr A's family having raised concerns.

55. On an undated nursing record file between 10 and 11 January 2011, the family were noted to be upset and angry because another patient told them that Mr A had been in agony and he had not been given any pain relief all morning. It was further noted that the family did not want to wait for the nurse who was looking after Mr A to return with an explanation, although it was noted that Mr A had in fact been given analgesia.

56. On 18 January 2011 it is noted that the family raised concerns to the medical staff about Mr A's confusion. As a result, action was taken to test Mr A's urine albeit that Adviser 1 noted that there was no record of the outcome written.

57. On 25 January 2011, further concerns were raised by the family about Mr A's confusion so the nursing staff advised the family to contact the relevant doctor in order for their concerns to be discussed.

58. On 27 January and 1 February 2011, it is documented that Mrs C spoke to the nursing staff about Mr A's confusion and it was noted that reassurance was given that they were keeping a close eye on him. The medical staff also reassured Mrs C that there was no serious underlying infection at this time and advised that Mr A was going to be reviewed by the care of the elderly team.

59. On 10 February 2011, it was noted that the family were uncertain of the current plan, therefore, one of the doctors updated Mrs C on her father's condition.

60. On 4 March 2011 it is documented that the nursing staff discussed the family's continuing anxiety about Mr A's confusion with Mrs C. A further entry in the medical records on 10 March 2011 indicated that Mrs C had again discussed her concerns about Mr A and that Doctor 2 had examined Mr A and explained to Mrs C that the co-codamol would be stopped in the event that it was contributing to his confusion.

(e) Conclusion

61. It is evident from the medical records that Mrs C and the family continued to raise concerns about Mr A's condition albeit there are only a few entries documented during Mr A's admission to Hospital 3. Whilst I have identified failings elsewhere in this report, I do not consider that the family's concerns were unreasonably ignored because discussions took place with them and this either resulted in action being taken or reassurance given.

62. Therefore, I do not uphold the complaint.

63. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr A	The subject of the complaint
Hospital 1	Monklands General Hospital
Hospital 2	Hairmyres Hospital
Hospital 3	Wester Moffat Hospital
Mrs C	The complainant and daughter of Mr A
The Board	Lanarkshire NHS Board
Adviser 1	An independent adviser to the ombudsman, namely a consultant vascular surgeon
Adviser 2	An independent adviser to the ombudsman, namely a consultant geriatrician
Doctor 1	A consultant vascular surgeon working for the Board
MEWS	Modified Early Warning System

Annex 2

Glossary of terms

Gangrenous	a term used to describe the decay or death of an organ or tissue caused by a lack of blood supply. It is a complication resulting from infectious or inflammatory processes, injury, or degenerative changes associated with chronic diseases
Magnetic Resonance Angiogram (MRA)	a type of scan to provide pictures of blood vessels inside the body
Sepsis	bacterial infection in the bloodstream