Scottish Parliament Region: South of Scotland

Case 201201259: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; Gastro-intestinal; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment provided to her late husband (Mr C) by Ayrshire and Arran NHS Board (the Board) between June 2011 and August 2011. Mr C, who was 80 years old, was admitted to Crosshouse Hospital (the Hospital) on three occasions during this period after breaking his hip. He had type 2 diabetes, hypertension, ischaemic heart disease and urinary incontinence and was on a number of medications before the series of admissions. He was finally discharged home on 8 August 2011, but died eight days later.

Specific complaints and conclusions

The complaints which have been investigated are that staff at the Hospital:

(a) failed to appropriately assess Mr C's complex medical conditions (*upheld*);

(b) wrongly decided to withhold Mr C's numerous types of medication and failed to keep his medication under review (*upheld*); and

(c) failed to provide Mr C's GP with sufficient and timely information about his condition on discharge from hospital (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) review their policies and procedures for patients with diabetes admitted to non-specialist wards to ensure that adequate systems in the management of their care are in place;	25 November 2013
(ii) issue a reminder to the relevant staff involved in Mr C's care of the requirement to: keep clear, accurate and legible records; promptly provide or arrange suitable advice, investigations or treatment where necessary; consult colleagues where	25 October 2013

	appropriate; and, refer a patient to another practitioner when this serves the patient's needs;	
(iii)	make the relevant staff involved in Mr C's care aware of our finding in relation to the failure to keep the decision to stop his medication under review;	25 October 2013
(iv)	remind the relevant staff involved in Mr C's care that when an episode of care is completed, they should tell a patient's GP about: changes to their medicines; the length of intended treatment; monitoring requirements; and any new allergies or adverse reactions identified; and	25 October 2013
(v)	issue a written apology to Mrs C for the failings identified in this report.	16 October 2013

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

Main Investigation Report

Introduction

1. The complainant (Mrs C) raised a number of concerns about the care and treatment provided to her late husband (Mr C) by Ayrshire and Arran NHS Board (the Board) between June 2011 and August 2011. Mr C, who was 80 years old, had type 2 diabetes, hypertension, ischaemic heart disease and urinary incontinence and was on a number of medications. He broke his hip on 24 June 2011 and was admitted to Crosshouse Hospital (the Hospital). He had an operation at the Hospital on the following day. He was then discharged to a care home for rehabilitation on 13 July 2011.

2. Mr C was readmitted to the Hospital on 15 July 2011, as he had vomited and could not eat. He was discharged to the care home again on 18 July 2011.

3. Mr C was not able to eat or drink without feeling sick after returning to the care home. He was readmitted to the Hospital on 22 July 2011 and was subsequently placed under the care of a consultant gastroenterologist. During this admission, the Acute Medical Receiving Unit stopped all of Mr C's medication and said that this was being kept under review. Mr C was discharged home on 8 August 2011. His GP visited him at home on 10 August 2011. The family told the GP that Mr C's medication had been withheld for several weeks prior to discharge. Mr C died on 16 August 2011. A discharge letter was dictated by a doctor at the Hospital on 22 August 2011 and typed on 5 September 2011. Mrs C has told us that Mr C's GP did not receive the discharge letter until 6 September 2011.

4. The complaints from Mrs C which I have investigated are that staff at the Hospital:

(a) failed to appropriately assess Mr C's complex medical conditions;
(b) wrongly decided to withhold Mr C's numerous types of medication and failed to keep his medication under review; and
(c) failed to provide Mr C's GP with sufficient and timely information about his condition on discharge from hospital.

Investigation

5. Investigation of the complaints involved reviewing the information received from Mrs C and the Board's medical records for Mr C. My complaints reviewer

also obtained advice from an independent medical adviser, who is a consultant physician and gastroenterologist (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. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of terms used in this report can be found at Annex 2. A list of the legislation and policies considered is at Annex 3. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) Staff at the Hospital failed to appropriately assess Mr C's complex medical conditions

First admission to Hospital: 24 June 2011 to 13 July 2011

7. Mr C was admitted to the Hospital following a fall on 24 June 2011. X-rays showed a femur fracture and he had an operation on 25 June 2011. It was documented after the operation that he was anaemic and that he had renal impairment. The Adviser considered Mr C's medical records and commented that there was nothing in them to suggest concern about hydration, nutrition or gastrointestinal symptoms. There was no specific comment on medications recorded in the clinical records. The Adviser said that the nursing records reported that diet and fluids were tolerated, although there was a comment in the nursing records on 27 June 2011 that Mr C felt nauseous and an antiemetic (an agent to stop vomiting) was given with good effect. There was a further comment on 1 July 2011 that Mr C had nausea and was given an antiemetic. There were no further concerns regarding nausea documented before Mr C was discharged to the care home for rehabilitation on 13 July 2011.

8. The Adviser said that the records showed no specific deviation from standard practice during the admission. He concluded that it was appropriate for the Hospital to treat the two episodes of nausea without further investigation, as Mr C was a post-operative patient and the symptoms settled. However, he said that he could find no documentation of a discharge management plan. He stated that a specific management plan should have been recorded in the notes prior to Mr C's discharge. He also said that the blood tests performed on the day of Mr C's discharge should have been reviewed by a doctor and specific plans should have been made to repeat the renal function tests.

Second admission to Hospital: 15 July 2011 to 18 July 2011

9. Mr C was admitted to Hospital again on 15 July 2011 with nausea and vomiting and was generally unwell. The Adviser said that his urea and creatinine had risen and his potassium had risen to a potentially dangerous level. He was treated with intravenous fluids and agents to reduce the potassium. An abdominal x-ray was taken to exclude gastrointestinal obstruction. Mr C was on a large number of drugs at that time for his cardiovascular problems, diabetes, pain management, constipation and vitamin replacement.

10. The Adviser commented that irbesartan (a drug used to treat hypertension) was stopped and several other drugs were initially stopped. On 17 July 2011, Mr C's urea and creatinine levels were all noted to have dropped and the potassium level was normal. The clinical assessment was acute renal failure due to vomiting and the impact of some of the drugs on Mr C's kidneys. No further nausea or vomiting were recorded in the medical or the nursing notes. The Adviser said that the records showed that simple investigations to exclude obstruction were appropriately performed and the irbesartan that was potentially damaging Mr C's kidneys was stopped. He said that the clinical symptoms settled and the abnormal renal blood tests improved. He stated that the decision not to investigate further, having excluded obstruction, withdrawn some of the drugs and documented that the symptoms had settled, was reasonable.

11. Mr C was discharged to the care home on 18 July 2011. The Adviser said that there was an appropriate management plan in the notes prior to discharge. This included plans to restart some of the diabetic and hypertensive drugs. A discharge note was also issued by the Hospital on that date.

Third admission to Hospital: 22 July 2011 to 8 August 2011

12. Mr C was readmitted to the Hospital on 22 July 2011 with persistent nausea and because he had been unable to keep food down for four days. The Adviser said that there was no firm evidence that the Board could have foreseen or prevented this admission. Mr C's urea, creatinine and potassium were all high and he was noted to have low blood sugar. He was fitted with a urinary catheter, treated with intravenous fluids and all cardiovascular, antihypertensive and diabetic medications were stopped. He was transferred to the gastroenterology ward the day after he was readmitted.

13. The Adviser said that it was noted that Mr C had previously had a normal gastroscopy and that an ultrasound of his kidneys was normal. A plain abdominal x-ray was taken and a gastroscopy was planned. The Adviser commented that the blood tests taken showed a progressive improvement in renal function. He said that various diagnoses were recorded in the clinical and nursing notes, including renal failure from nephrotoxic drugs, due to dehydration and due to obstructive uropathy (Mr C was noted to have an enlarged prostate).

14. The Adviser said that the reason for the nausea was initially thought to be associated with obstruction, but a gastroscopy on 4 August 2011 showed gastritis and duodenitis with erosions extending into the first and second parts of the duodendum. He commented that this was very severe. The clinical notes show that this was initially appropriately treated with high dose omeprazole, which was started on 5 August 2011. However, there are no further clinical entries until 8 August 2011, the date Mr C was discharged.

15. The Adviser said that it was reasonable to assess the effects of urinary catheterisation and the withdrawal of nephrotoxic diabetic drugs and aspirin. At the same time, appropriate steps were taken to exclude intestinal and urinary obstruction by ultrasound and plain x-rays. He continued that it was also reasonable to wait for clinical and biochemical stabilisation before proceeding to gastroscopy. The Adviser stated that given the concerns about renal function on admission, he would have expected a record in the clinical notes of the progress in renal function. He also said that the last renal function tests he could find were on 5 August 2011. This was three days before Mr C's discharge.

16. The Adviser commented that the diabetic charts were incompletely filled in. Despite recording significantly raised glucose levels, there was no evidence of clinical consideration of these results or of increasing the frequency of monitoring. He said that this would have required either specific dietary treatment or the reintroduction of tablet treatment. The minimum expected would have been a referral to the diabetic liaison nurse, who would have involved the diabetic consultant if appropriate.

17. Mrs C also raised concerns about the failure by staff to take action in relation to Mr C's weight loss. We asked the Adviser for comments in relation to this. In his response, he said that the nutrition assessment on admission was incorrect in that it showed the wrong score. He stated that the correct score

would have required a referral to a dietician, who should have taken appropriate action in respect of both deficient oral intake and diabetes. The food record charts were also incompletely filled in and there was no evidence of dietetic input in respect of diabetes or other nutritional considerations. He also said that the actual clinical notes were not clear in respect of the seniority of the doctors involved or the clinical plans, particularly towards the end of the admission.

18. The Adviser commented that there were deficiencies during this admission. He said that after clinical stabilisation, gastroscopy and the omeprazole treatment, there should have been specific management decisions in relation to the multiple admission diagnoses and problems including the renal failure, the cardiovascular problems, the hypertension and the diabetes. He said that the actual quality of the clinical records in relation to these and other aspects of recording did not meet the standards in the Royal College of Physicians' generic medical record keeping standards. He also stated that the overall clinical management did not comply with several standards in the General Medical Council's Good Medical Practice guidance in place at that time. These stated that:

> 2. Good clinical care must include:
> a. adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient;
> b. providing or arranging advice, investigations or treatment where necessary;
> c. referring a patient to another practitioner, when this is in the patient's best interests.
>
> 3. In providing care you must:
> a. recognise and work within the limits of your competence;
> b. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the patient's needs;
> c. provide effective treatments based on the best available evidence;
> d. take steps to alleviate pain and distress whether or not a cure may be possible;
> e. respect the patient's right to seek a second opinion;
> f. keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment;

g. make records at the same time as the events you are recording or as soon as possible afterwards;
h. be readily accessible when you are on duty;
i. consult and take advice from colleagues, where appropriate;
j. make good use of the resources available to you.

19. The Adviser stated that he considered the doctors treating Mr C in the third admission failed in their duty in respect of 2b, 2c, 3f and 3i above.

The Hospital's assessment of Mr C's medical conditions

20. During our investigation, we asked the Adviser if the investigation results and observations were assessed reasonably in order to inform appropriate care and treatment. In his response, he said that the clinical records for the first two admissions did not show deficiencies in the management of Mr C's medical conditions. He said that he was logically and appropriately investigated in the third admission. When the gastroscopy showed severe duodenitis, Mr C was appropriately treated with omeprazole. However, the Adviser said that after this, there was no specific advice on management of the background and admission medical problems.

21. We asked the Adviser if he considered that the investigations and assessment of results took account of Mr C's medical history and his ongoing conditions. In his response, he said that on each admission, the initial clinical management decisions were made in the light of the history in respect of the investigations. He also said that during Mr C's third admission, there was no evidence that they took account of his history of diabetes. He commented that staff should have contacted the diabetic liaison nurse who could have contacted the diabetic consultant if they considered this appropriate. The Adviser also said that after initial drug withdrawal on the third admission, there appeared to have been no further consideration of the background of cardiovascular disease or hypertension and the need to consider further treatment for these.

22. Mrs C also told us that Mr C had hearing problems, but did not always wear his hearing aids. We asked the Adviser if medical staff were aware that Mr C had hearing problems and if they took this into account when communicating with him about care and treatment. In his response, he said that there was no reference to this in the clinical notes and he, therefore, had to assume that it was not taken into account. In their response to a draft copy of this report, the Board said that it was still possible to communicate with Mr C

despite his need for a hearing aid. However, Mrs C stated that a consultant refused to discuss the matter with them when her daughter asked if Mr C had been wearing his hearing aids.

23. In their response to the draft report, the Board said that they considered that Mr C's complex needs were addressed. They said that he had received treatment for renal failure; possible obstructive uropathy; small bowel dilatation and possible pseudo-obstruction; gastritis and duodenitis etc. They also said that the following were monitored: oral intake; blood sugar; blood pressure and other vital signs; skin and pressure area; mobility; and physiotherapy. The Board also stated that it had been recorded that he was mobile and able to dress himself when he was discharged on 8 August 2011.

(a) Conclusion

24. The advice I have received is that the clinical records for the first two admissions did not show deficiencies in the management of Mr C's medical conditions. In addition, Mr C was appropriately investigated on being admitted to the Hospital for a third time. However, the Adviser has stated that the Board's actions in respect of the management of Mr C and the clinical documentation during and after the third admission were unreasonable. There was a failure to adequately manage his diabetes and he should have at least been referred to the diabetic liaison nurse, who would have involved the diabetic consultant if appropriate.

25. After Mr C was stabilised and he received the gastroscopy and the omeprazole treatment, there should have been specific management decisions in relation to the multiple admission diagnoses and problems including the renal failure, the cardiovascular problems and the diabetes. There was a failure to adequately monitor Mr C and to complete adequate clinical records. The nutritional assessment and food charts were also deficient. Mr C should have been referred to a dietician, who should have taken appropriate action in respect of both deficient oral intake and diabetes. In view of all of these failings, I uphold the complaint.

(a) Recommendations

26. I recommend that the Board:	*Completion date*
(i) review their policies and procedures for patients with diabetes admitted to non-specialist wards to	25 November 2013

	ensure that adequate systems in the management of their care are in place; and	
(ii)	issue a reminder to the relevant staff involved in Mr C's care of the requirement to: keep clear, accurate and legible records; promptly provide or arrange suitable advice, investigations or treatment where necessary; consult colleagues where appropriate; and, refer a patient to another practitioner when this serves the patient's needs.	25 October 2013

(b) Staff at the Hospital wrongly decided to withhold Mr C's numerous types of medication and failed to keep his medication under review

27. During Mr C's second admission, the irbesartan that was potentially damaging his kidneys was stopped. We asked the Adviser for his comments on this. In his response, he said that it was appropriate to stop the irbesartan, but no instructions were given as to when and under what circumstances to restart the drug.

28. Following Mr C's admission to the Hospital on 22 July 2011, staff stopped all of the medication. They said that this was being kept under review. In his response to us, the Adviser said that it was appropriate to stop the diabetic and cardiovascular drugs, but they did not appear to have been considered again.

29. The Adviser said that given Mr C's history of hypertension and heart disease, he would have expected to see a decision in the notes about whether to restart some of the drugs. He said that the records showed that Mr C's blood pressure was stable and it may have been reasonable not to reintroduce many of the drugs, but this decision and plans for monitoring the blood tests, blood pressure and general clinical situation in the community should have been communicated to the GP on discharge.

30. In their response to the draft report, the Board said that as part of their review process, the opinions of two Consultant Endocrinologists were sought in relation to the management of Mr C's medication during admission and prior to discharge. They said that both supported the decisions taken by the Gastroenterology team.

(b) Conclusion

31. The advice I have received is that it was reasonable to stop some of Mr C's medication on his second admission and all of his medication on the third admission. However, there is no documentation in the records regarding any decision making in relation to restarting the medication. In view of this, I also uphold this aspect of the complaint. We welcome the fact that the Board obtained the opinions of two Consultant Endocrinologists during the review process. They supported the decisions taken by the Gastroenterology team. The advice we received was that it was reasonable to stop the medication. However, our criticisms are in relation to the failure to document the decision making in relation to restarting the medication.

(b) Recommendation

32. I recommend that the Board:	*Completion date*
(i) make the relevant staff involved in Mr C's care aware of our finding in relation to the failure to keep the decision to stop his medication under review.	25 October 2013

(c) Staff at the Hospital failed to provide Mr C's GP with sufficient and timely information about his condition on discharge from hospital

33. Mrs C complained about the delay in issuing the discharge letter after Mr C was discharged from the Hospital on 8 August 2011. A handwritten discharge form was completed on 8 August 2011. The full discharge note was not issued until 5 September 2011, nearly three weeks after Mr C's death on 16 August 2011. In their response to Mrs C's complaint about this matter, the Board said that they had upheld this aspect of the complaint. They stated that ideally full clinical discharge information should be available sooner to supplement the summarised information in the immediate discharge letter. They also said that the turnaround time was not as quick as it would have been in normal circumstances. The Board have also sent us documentation showing that it was recommended that they re-introduce a target to issue discharge letters within seven days.

34. We asked the Adviser if Mr C's GP had been adequately informed of the care and treatment given to Mr C in the Hospital and about follow-up action. The Adviser stated that the information contained in the handwritten form after Mr C was discharged on 8 August 2011 was totally inadequate for the GP to understand the problems on admission or to base management plans in the light of Mr C's known medical conditions. He also said that there was no advice

to the GP as to why Mr C's medication had been stopped or whether the GP needed to review and consider restarting them.

35. The Adviser said that the handwritten discharge note gave two diagnoses, a very brief incomplete note of the tests and a single discharge drug. He also said that there was no mention of previous medications or advice on monitoring. However, he said that he was unable to comment on the clinical impact of the failings identified based on the evidence available.

(c) Conclusion

36. The advice I have received is that Mr C's discharge on 8 August 2011 was unacceptable. There should have been firm plans made before discharge in respect of the multiple diabetic and cardiovascular drugs on which Mr C was admitted. There should also have been firm plans in respect of blood monitoring. All of the plans should have been promptly communicated to his GP when Mr C was discharged. In view of the failure to do so, I also uphold this aspect of the complaint.

(c) Recommendations

37. I recommend that the Board:	*Completion date*
(i) remind the relevant staff involved in Mr C's care that when an episode of care is completed, they should tell a patient's GP promptly about: changes to their medicines; the length of intended treatment; monitoring requirements; and any new allergies or adverse reactions identified; and	25 October 2013
(ii) issue a written apology to Mrs C for the failings identified in this report.	16 October 2013

38. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	The aggrieved (Mrs C's Husband)
The Board	Ayrshire and Arran NHS Board
The Hospital	Crosshouse Hospital
The Adviser	The Ombudsman's Medical Adviser

Annex 2

Glossary of terms

Antiemetic	an agent to stop vomiting
Creatinine	a substance that can be found in urine
Duodenitis	inflammation of the duodenum
Duodenum	the beginning portion of the small intestine
Hypertension	high blood pressure
Gastrointestinal	relating to the stomach and the intestines
Gastroscopy	a test to look inside the oesophagus, stomach and duodenum
Irbesartan	a drug used to treat hypertension
Ishaemic heart disease	reduced blood supply of the heart muscle
Nephrotoxic	toxic or damaging to the kidney
Omeprazole	a drug used to reduce the amount of acid produced in the stomach
Type 2 diabetes	condition characterized by high blood glucose levels
Urea	a substance that can be found in urine
Uropathy	a disorder involving the urinary tract

Annex 3

List of legislation and policies considered

Royal College of Physicians: Generic medical record keeping standards

General Medical Council: Good Medical Practice