

**The Scottish Public Services Ombudsman Act 2002**

# **Investigation Report**

UNDER SECTION 15(1)(a)

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**Case 201304714: Lanarkshire NHS Board**

**Summary of Investigation**

**Category**

Health: Hospital, Neurology

**Overview**

The complainant (Mrs C) raised a number of concerns over the care and treatment her late brother (Mr A) received from Lanarkshire NHS Board (the Board) following his admission to Monklands Hospital on 27 February 2013. Mr A was admitted with swallowing difficulties and died on 22 March 2013.

**Specific complaints and conclusions**

The complaints which have been investigated are:

- (a) the Board provided inadequate care and treatment to Mr A (*upheld*); and
- (b) there were unreasonable delays in care and treatment (*upheld*).

**Redress and recommendations**

The Ombudsman recommends that the Board:

	<i>Completion date</i>
(i) review their results 'sign off' process at ward level to ensure all results are reviewed before filing;	13 May 2015
(ii) conduct a review of their complaints handling to analyse why this result from another health board was not identified as part of their investigation;	15 April 2015
(iii) apologise to Mrs C for the failure to diagnose Mr A properly, particularly with the information available from the blood test reported upon after his death; and	18 March 2015
(iv) investigate the delay in the time from referral to review by the neurologist and provide staff with advice about how to obtain specialist neurological advice for patients such as Mr A, when a consultant review may be delayed.	13 May 2015

## **Main Investigation Report**

### **Introduction**

1. Mrs C complained to Lanarkshire NHS Board (the Board) about the care and treatment her late brother (Mr A) received while in Monklands Hospital (the Hospital). He was admitted on 27 February 2013 with swallowing difficulties and died on 22 March 2013.

2. The complaints from Mrs C which I have investigated are that:
- (a) the Board provided inadequate care and treatment to Mr A; and
  - (b) there were unreasonable delays in care and treatment.

### **Investigation**

3. As part of the investigation all of the information provided by Mrs C and the Board has been given careful consideration. This included the complaints correspondence and Mr A's relevant medical records. Independent clinical advice was also provided by:

- a senior hospital physician (Adviser 1); and
- an experienced nurse (Adviser 2).

4. I have taken this advice into account and, although I have not included in this report every detail investigated, 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 Board provided inadequate care and treatment to Mr A**

##### *Mrs C's complaint to the Board*

5. Mrs C complained to the Board on 16 April 2013. She said Mr A was admitted to the Hospital with swallowing difficulties and investigations (including a videofluoroscopy) showed his oesophageal muscles were not functioning appropriately. Mrs C explained that Mr A's cerebral palsy meant he used a wheelchair and, by way of background, outlined his important role within his family group.

6. Mrs C said the Hospital proposed percutaneous endoscopic gastroscopy (PEG) for Mr A. However, as further assessment was required before PEG could proceed, Mr A had a nasogastric tube fitted to provide nutrition. Mrs C said Mr A then had a series of aspirations and chest infections and she felt an alternative feeding option could perhaps have been explored; in Mrs C's view,

her brother was treated as though his symptoms appeared in a textbook and not as an individual person with individual circumstances.

7. Mrs C said 21 March 2013 was 'the worst day'. Mr A aspirated again, causing a further chest infection, and clinical staff simply re-sited his nasogastric tube rather than evaluating the situation. Mrs C explained that Mr A developed respiratory distress that afternoon and, when she and her sister visited at 15:00, she was unhappy how staff spoke to them. Mrs C felt nursing staff – who tried unsuccessfully that afternoon to arrange a physiotherapist to see Mr A - did not grasp quite how unwell he was.

8. Mrs C said Mr A had not seen a physiotherapist by 19:00 that evening, by which point he was increasingly distressed. Mrs C explained that the Hospital telephoned her late that night to explain that Mr A's condition had deteriorated. When Mrs C and her sister arrived, she said continuous positive airway pressure had started (Mrs C thought Mr A had been in respiratory arrest, although she had not been told this). Mr A was then transferred to a ward and sadly passed away the following evening.

9. Mrs C's complaint said Mr A died at 17:50 on 23 March 2013 but the death certificate said 20:15 (several family members were with Mr A when he passed away, while a nurse entered the room shortly afterwards). Mrs C also questioned the recorded cause of death – lower respiratory tract infection – and instead pointed to aspiration pneumonia. She also asked why Mr A's cerebral palsy was noted, despite its not having been related to his death.

10. Although Mrs C felt some of the nursing care had been excellent, she felt Mr A had been let down by the Board; seemingly simple needs were not met, such as the air mattress he was told he would receive (he had a pressure ulcer) but did not. Mrs C said her brother had not suffered from chest or urine infections in the years she had cared for him and, although she acknowledged his physical difficulties, she felt 'he passed too soon due to slow decisions and a lack of urgency'.

#### *The Board's response*

11. The Board acknowledged Mrs C's complaint on 19 April 2013 and expressed regret for her distress. They said they would investigate Mrs C's complaint and aimed to issue their response within four weeks.

12. The Board's formal response of 13 May 2013 extended their condolences for Mrs C's loss. They said Mr A was admitted to the Hospital on 28 February 2013 (sic) with a number of symptoms including swallowing difficulties, weight loss and 'general cognitive and physical decline'. They said a prior endoscopy (before this admission) had been normal and their investigations had pointed to an oesophageal spasm, although not an obstruction.

13. In terms of this admission, they said Mr A's speech and language assessment showed he may have been aspirating and a videofluoroscopy was done (it showed a tightening of a muscle in Mr A's pharynx). Nasogastric feeding was recommended and Mr A was referred to neurology for further investigations as clinical staff suspected his swallowing difficulties may have been neuromuscular. The Board said Mr A was also referred for PEG feeding, although they continued to feed Mr A by a nasogastric tube as they felt this was most appropriate. They acknowledged that his nasogastric tube became dislodged and was re-sited several times.

14. The Board said Mr A was given the appropriate assessments including, among others, for his medical condition and biomedical markers. They said a feeding chart and feeding process were on the ward to assist nursing staff and that Mr A's feeding plan was reviewed several times, with the drip rate reduced due to possible aspiration pneumonia. The Board said the neurologists thought Mr A's condition was either related to his muscles or nerves and organised additional investigations. Sadly, Mr A died before they were completed.

15. In terms of Mr A's sudden deterioration on 21 March 2013, the Board said the notes did not say Mr A had a respiratory arrest and the doctor who cared for him verified this. They explained that Mr A did require continuous positive airway pressure at that time and they confirmed they had spoken with the member of staff whom Mrs C felt had been abrupt. They passed on her apologies and said she would bear this in mind for the future, while they confirmed that Mr A was seen by physiotherapy several times between 4 March 2013 and 22 March 2013 (including the morning and evening of 21 March 2013 and the morning of 22 March 2013).

16. The Board said nursing staff confirmed Mr A died at around 17:50 on 22 March 2013 but it was not documented in the notes. Competing demands meant the on-call doctor had only been able to certify Mr A's death at 20:15

and, when the certificate was completed by a junior doctor the following week, 20:15 was entered as the time of death. They said the recorded cause of death was correct - aspiration pneumonia is a type of lower respiratory tract infection - which was almost certainly caused by Mr A's swallowing problems, although they had been unable to confirm the cause of his swallowing problems. The Board said Mr A's cerebral palsy should have been recorded on the certificate as it would have been a contributing factor, given it affected his mobility. They said they had spoken with the junior doctor who completed Mr A's death certificate to explain the importance of being more precise with the cause and approximate time of death.

*Advice obtained: Adviser 1*

17. Adviser 1 said Mr A was admitted to the Hospital with dysphagia on 27 February 2013, at which point he could not swallow food or liquid. He had lost weight in the prior weeks and the Hospital's blood tests and initial examination did not reveal any abnormalities. Adviser 1 explained that, on 28 February 2013, the consultant noted Mr A's symptoms, his cerebral palsy and his wheelchair use. However, the cause of Mr A's dysphagia was unclear.

18. Adviser 1 said Mr A was seen by the speech and language therapists on 1 March 2013. They were unsure what was causing Mr A's increased dysphagia and recommended thickening his fluids to see if that helped. Adviser 1 said, at that time, clinical staff appeared to principally have been concerned with Mr A's constipation, while the physiotherapists saw Mr A on 4 March 2013 and confirmed he could sit for a videofluoroscopy (done on 6 March 2013). He said the notes showed Mr A was deemed to be at high risk of aspiration and that non-oral feeding was recommended and, as the problem appeared to be neuromuscular, a neurology opinion was requested on 8 March 2013.

19. Adviser 1 said a computerised tomography (CT) scan was requested on 5 March 2013 in light of Mr A's weight loss; the CT scan was done on 11 March 2013 and showed a possible infection in Mr A's lung. Mr A deteriorated on 12 March 2013 and his symptoms indicated a chest infection, which Adviser 1 said was well monitored by staff. Mr A was given antibiotics.

20. Adviser 1 explained that Mr A was seen by a neurologist on 18 March 2013 – ten days after referral – who was concerned about Mr A's condition. The neurologist ordered blood tests and considered transferring Mr A

to a specialist ward in Glasgow, which Adviser 1 said 'was the first time any specific thought had been given to the cause of his symptoms'. Adviser 1 said Mr A's condition deteriorated later that day and his chest infection worsened, while his antibiotics were changed on 21 March 2013 on the advice of the microbiologist. Adviser 1 explained the records indicated 'acute and severe respiratory failure' later that day and Mr A's death was certified on 22 March 2013 at 20:15, although his family noted the time of death as 17:50.

21. Adviser 1 pointed to a blood test from 20 March 2013, which was reported on 26 March 2013 (the neurologist had asked for this test on 19 March 2013, having discussed Mr A with the clinical team). Although the test report was annotated with 'Ward 14' – which Adviser 1 felt presumably meant it was sent to the ward – he said it was unclear when the Hospital received it. The test did not appear to have been noted by clinical staff after Mr A's death, nor was it detailed in the Board's letter of 13 May 2013 to Mrs C.

22. Adviser 1 said the test showed Mr A had an antibody that indicated he had a condition called myasthenia gravis (MG). He explained that dysphagia – such as Mr A's long running swallowing difficulties – is a symptom of MG, as is weakness of the limbs (which may not have been apparent due to Mr A's cerebral palsy).

23. In retrospect, Adviser 1 said it was clear Mr A had MG. He was critical that Mr A had been admitted for several weeks and this only came to light after he had died; he explained that MG is treatable and, had it been diagnosed sooner, Adviser 1 said Mr A's chances of survival would have been significantly increased. He said this was particularly so had MG been identified before Mr A's respiratory failure (a feature of the condition). He also said one of the antibiotics Mr A was given on 12 March 2013 could worsen MG.

24. Although Adviser 1 said MG was rare and this was an unusual presentation, he felt this type of condition should have been considered sooner as structural problems (for example a tumour) had been ruled out. Adviser 1 felt 'it was clear this was a serious and progressive problem' and that the Hospital's diagnostic approach was too narrow. He said it took an unreasonable length of time for Mr A to be referred to neurology and, thereafter, too long from referral to Mr A being seen by a neurologist. It was the neurologist who suggested the blood test that identified MG.

25. Adviser 1 was critical that this test result was not noted on Mr A's record, even after he had died. He was particularly critical that it was not identified by the Board during their investigation and he echoed Mrs C's concerns about the lack of urgency shown for Mr A's condition. In light of the Board's inadequate investigation, Adviser 1 felt this situation could happen again in future.

*Advice obtained: Adviser 2*

26. Adviser 2 said the records showed Mr A's skin was inspected and intact during the early part of his admission, which she felt was reasonable.

27. Adviser 2 also said Mr A's risk of developing a pressure ulcer was assessed upon admission, on 14 March 2013 and then on 22 March 2013 (he was deemed 'at risk', 'at risk' and 'very high risk' in order). In addition, a SKINN care bundle<sup>1</sup> was done from his admission until 4 March 2013 and resumed from 15 March 2013 to 22 March 2013. Although the reason why it was resumed was not documented, Adviser 2 felt it likely that, following the 14 March 2013 assessment detailed above, nursing staff decided to monitor Mr A's pressure areas more closely.

28. Adviser 2 explained that, in line with Healthcare Improvement Scotland's National Standards,<sup>2</sup> she would have expected assessment, monitoring, care and evaluation of Mr A's pressure areas. As Mr A had been assessed as being high risk, Adviser 2 explained this would include continuing skin assessment (to be recorded in a chart) and, if there were a pressure ulcer, a wound chart.

29. However, the Board could not supply the full nursing notes for Mr A. Adviser 2 could only consider the paperwork available, which indicated that Mr A had a pressure ulcer from 15 March 2013. She said Mr A's cerebral palsy would have contributed to his being a high risk and so there should have been a care plan to prevent pressure ulcers. As there was no record of such appropriate steps having been taken, Adviser 2 said Mr A's nursing care was unreasonable in terms of the prevention and care of pressure areas.

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<sup>1</sup> A process outlining steps to take to try to reduce the possibility of pressure ulcers

<sup>2</sup> Healthcare Improvement Scotland, Best Practice Statement – Prevention and Management of Pressure Ulcers (available at:

[http://www.healthcareimprovementscotland.org/previous\\_resources/best\\_practice\\_statement/prevention\\_and\\_management\\_of\\_p.aspx](http://www.healthcareimprovementscotland.org/previous_resources/best_practice_statement/prevention_and_management_of_p.aspx))



*Additional comments from the Board*

30. After reviewing the draft copy of this report, the Board provided some comments. They said the consultant responsible for Mr A's care was sorry MG had not been considered but that Mr A had not displayed the condition's hallmarks, particularly fatigability. The Board said the consultant had thought at the time Mr A may have had a form of swallowing problems called bulbar palsy and the fact that MG had been an 'afterthought investigation' for the neurologist indicated the unusualness of his presentation. However, they confirmed this case would be discussed internally to share learning.

31. Regarding the test result confirming Mr A's MG, the Board pointed to the timescale between Mr A's death and receipt of Mrs C's complaint. In addition, their consultant said the result was not in Mr A's records when she responded to the Board's investigation (the Board could not confirm this). The Board also confirmed the test (requested by the neurologist) was analysed in another health board's laboratory and results were not available electronically, which they acknowledged meant there was a delay until the paper copy was received (after Mr A had died). They said the result was sent to the ward and they felt it reasonable that results not be prioritised where patients have passed away, although they said they needed to 'develop a more robust process to ensure rapid receipt of external investigations and timely upload to [their] online clinical portal'. They said they would take this forward and they would review the process for the responsibility for test results requested by visiting neurologists so clinicians were clear who was responsible for responding.

*Additional comments from Adviser 1*

32. I shared the Board's comments with Adviser 1 and he acknowledged this case's complexity and its challenges for clinical staff. However, he remained of the view that Mr A's swallowing problems were significant enough - even prior to his video fluoroscopy – to have merited a more prompt referral to neurology (Adviser 1 felt the neurologist had suggested MG one day after clinically reviewing Mr A).

33. Adviser 1 acknowledged that the test result was not available to clinicians immediately after Mr A died and he accepted that it was possible in a case as complex as this for a result to have been overlooked. However, he maintained that the Board had sufficient time to address this in their response to Mrs C's complaint; in short, Adviser 1 felt the fact he identified it within Mr A's file meant the Board also should have done so as part of their investigation.

(a) *Conclusion*

34. In coming to my decision, I have taken account of the information that was available to the Board at the time. This does not include the benefit of hindsight and so, although Adviser 1 confirmed Mr A had MG, the Board did not know this. By extension, they would not have known that one of the antibiotics Mr A was given on 12 March 2013 could have worsened this condition.

35. However, I consider that to be a separate question from whether it was reasonable for the Board to have been in the position not to have known about Mr A's MG. I have taken account of Adviser 1's comments that MG is an unusual condition and some of its physical effects may have been masked. Equally, however, Adviser 1 said the result of the blood test was clear and a condition of this type should have been considered sooner. I have also taken account of Adviser 2's view that the nursing care was unreasonable in terms of the prevention and care of pressure areas for Mr A.

36. I have significant concerns about the Board's investigation into Mrs C's complaint - given its failure to identify this blood test – and their inability to provide copies of some of Mr A's nursing records. In any event, I consider the evidence to be clear that the care and treatment Mr A received from the Board fell below a reasonable standard. I uphold this complaint.

37. The Board should now review their results 'sign off' process at ward level to ensure all results are reviewed before filing and conduct a review of their complaints handling to analyse why this result from another health board was not identified as part of their investigation.

(a) *Recommendations*

38. I recommend that the Board:	<i>Completion date</i>
(i) review their results 'sign off' process at ward level to ensure all results are reviewed before filing; and	13 May 2015
(ii) conduct a review of their complaints handling to analyse why this result from another health board was not identified as part of their investigation.	15 April 2015

**(b) There were unreasonable delays in care and treatment**

*Advice obtained: Adviser 1*

39. Adviser 1 said the delay in reaching Mr A's diagnosis was unreasonable. He felt the time between admission, referral and Mr A being seen by a neurologist was too long and, had Mr A been reviewed and referred sooner, an earlier diagnosis and treatment may have been possible.

40. Although Adviser 1 was 'not unduly critical' of the time taken for the videofluoroscopy itself to have been done – he pointed to the Board ensuring Mr A could sit for this procedure as being a reasonable, contributing factor – he felt there was a 'generally slow pace of clinical thinking and [a] lack of urgency or concern'. Finally, Adviser 1 did not think there had been an unreasonable delay in provision of physiotherapy for Mr A.

*Advice obtained: Adviser 2*

41. Adviser 2 said the physiotherapy notes were of a high standard. Based on her nursing experience and care of patients with respiratory distress in similar situations, she felt the records indicated Mr A was appropriately referred for physiotherapy assessments after he aspirated from his feeding.

*Additional comments from the Board*

42. In terms of the neurological involvement, the Board said Mr A's video fluoroscopy was done on 6 March 2013, the neurology referral was typed and sent in the internal mail on 8 March 2013 and the consultant neurologist saw Mr A on 18 March 2013. They said neurology services were provided by another health board and, typically, a neurologist would attend the Hospital once or twice a week. The Board acknowledged a slight delay in the neurologist receiving the referral and said 'a process should be developed for electronic transmission with acknowledged receipt', which they would discuss internally.

*Additional comments from Adviser 1*

43. Adviser 1 reiterated that structural problems had previously been ruled out by out-patient investigations and, in his view, this meant the time taken for referral was not justified.

*(b) Conclusion*

44. The advice I have received is not universally critical of the time taken in providing Mr A's care and treatment. However, I consider it to be clear that Mr A should have been seen by a neurologist sooner than he was.

45. It was the neurologist's involvement that led to the blood test that identified Mr A's MG. Although I clearly cannot say with certainty what the outcome would have been had this test been done sooner, I consider the tenor of the overall advice to be clear that, viewed as a whole, there was a general failure to act with the appropriate urgency for Mr A. I uphold this complaint.

46. The Board should now apologise sincerely to Mrs C for their failure to diagnose Mr A properly, particularly with the information available from the blood test reported upon after his death. They should also investigate the delay in the time from referral to review by the neurologist and provide staff with advice about how to obtain specialist neurological advice for patients such as Mr A, when a consultant review may be delayed.

*(b) Recommendations*

	<i>Completion date</i>
47. I recommend that the Board:	
(i) apologise to Mrs C for the failure to diagnose Mr A properly, particularly with the information available from the blood test reported upon after his death; and	18 March 2015
(ii) investigate the delay in the time from referral to review by the neurologist and provide staff with advice about how to obtain specialist neurological advice for patients such as Mr A, when a consultant review may be delayed.	13 May 2015

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

**Explanation of abbreviations used**

Mrs C	the complainant
the Board	Lanarkshire NHS Board
Mr A	the complainant's late brother
the Hospital	Monklands Hospital
Adviser 1	one of the Ombudsman's advisers who is a senior hospital physician
Adviser 2	one of the Ombudsman's advisers who is an experienced nurse

### Glossary of terms

antibody	a protein produced by the immune system when the body detects infection
aspiration	where food or fluid passes from the mouth into the lungs rather than the gullet
aspiration pneumonia	the infection in the lungs sometimes created after aspiration (see above)
biomedical markers	substances that can be measured and may indicate the presence of a disease, or allow the severity to be measured
continuous positive airway pressure	the use of mild air pressure to keep the airways open, using a mask over the face
computerised tomography (CT) scan	a scan that uses a computer to produce an image of the body
dysphagia	difficulty swallowing, which can vary from mild to very severe
endoscopy	a medical procedure where a tube-like instrument is put (usually into the gullet and stomach) to look inside
lower respiratory tract infection	infection of the airways in lungs and lung tissue
myasthenia gravis (MG)	a medical condition where muscles become easily tired and weak. This is caused by an abnormal antibody produced by the body which disable connections between the nerves and muscles

nasogastric tube	a thin tube inserted through the nose and into the stomach, to provide food and fluid
neurologist	a doctor who specialises in the diseases affecting the nerves and the nervous system
neurology	the speciality of medicine which looks after patients with diseases of the nerves and the nervous system
neuromuscular	the junction of the cells in the body that controls the coordination of nerve signals and muscles
oesophagus	the tube that carries food from the mouth to the stomach
percutaneous endoscopic gastroscopy (PEG)	a thin tube inserted through the skin and into the stomach, to provide food and fluid
pharynx	the cavity behind the mouth and nose that leads to the oesophagus and windpipe
respiratory arrest	where spontaneous breathing stops
videofluoroscopy	an x-ray that looks at the progress of a special 'dye' from the mouth to the stomach as it is swallowed