Scottish Parliament Region: Central Scotland

Case 200500691: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Ms C) raised concerns that her mother (Mrs C) should not have been given sedatives, that doctors should have diagnosed a stroke earlier than they did, that there were no nursing observations one night and that the clinical records were poor.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) inappropriate giving of sedatives (*not upheld*);
(b) timing of a diagnosis of stroke (*not upheld*);
(c) lack of nursing observations (*not upheld*); and
(d) poor standard of clinical records (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations.

Main Investigation Report

Introduction

1. I shall refer to the complainant as Ms C. On 7 June 2005 the Ombudsman received her complaint about her late mother (Mrs C)'s medical and nursing care in hospital in 2003.

2. The complaints from Ms C which I have investigated are:

(a) inappropriate giving of sedatives;
(b) timing of a diagnosis of stroke;
(c) lack of nursing observations; and
(d) poor standard of clinical records.

3. I should say here that Ms C also complained about remarks allegedly made by a ward manager, who denied them, and about Lanarkshire NHS Board (the Board)'s failure to pursue the ward manager about the remarks. I have not investigated these because it was clear it was not going to be possible to prove what had happened. I am also satisfied the Board did pursue the manager as far as possible, given that the ward manager was on long term sickness absence and that he then left his employment, and given that the Board's Human Resources Department and Occupational Health Department had advised that further contact would be inappropriate.

4. Ms C also complained to me about ward choice, initial refusal of the family's request to stay overnight, Mrs C's fall and the lack of an incident report. I have not investigated these for a variety of reasons. For example, after examination of Mrs C's clinical records and the Board's complaint correspondence, I was satisfied that the Board had investigated, acknowledged shortcomings (where appropriate), fully apologised for them and taken action where appropriate, given explanations to Ms C where possible, and apologised for being unable to explain the fall or the lack of an incident report. Further investigation by this office could not have produced a different outcome. Ms C also said that an entry had been added to the clinical records after Mrs C's death. The records show an entry for 3 August 2003 that is not chronologically in the right place (the entries before and after it are for 21 July 2003). However, that is not in itself evidence of when the entry was or was

not written. As it would not be possible to prove the facts, I have not investigated this further.

Investigation

5. I was assisted in the investigation by three of the Ombudsman's clinical advisers – one of whom is a consultant physician specialising in geriatrics (a branch of medicine dealing with the health and care of old people), and one of whom is a nurse. Their roles were to explain, and give an opinion on, the medical and nursing aspects of the complaint. We examined the papers provided by Ms C, the Board's complaint file and the hospital's clinical records for Mrs C. To identify any gaps and discrepancies in the evidence, the content of relevant correspondence on file was checked against information in the clinical records and was compared with my own and the advisers' knowledge of the issues concerned. I am, therefore, satisfied that the evidence has been tested robustly. In line with the practice of this office, the standard by which the events were judged was whether they were reasonable. By that, I mean whether the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical and nursing professions in terms of knowledge and practice at the time. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) Inappropriate giving of sedatives;
(b) timing of a diagnosis of stroke;
(c) lack of nursing observations; and
(d) poor standard of clinical records.

6. I turn now to complaints (a) to (d), which I shall cover as they arise. Mrs C was aged 78, with dementia and various other conditions, such as severe carotid artery narrowing. Mrs C had started to have absence attacks – spells of unresponsiveness/unconsciousness, lasting several minutes. Therefore, on 9 July 2003 the emergency services took her to one of the Board's hospitals, where she spent time in the Emergency Receiving Unit (ERU) before being transferred to a ward.

7. ERU records for the night of 9 July 2003 describe Mrs C as sleepless, agitated and unwilling to stay in bed. Therefore, she was given 2 mg of haloperidol

at 05:30 on 10 July 2003. This is an antipsychotic drug, used (for example) to calm patients. The records for various times during 10 July show Mrs C as wandering around the ward, disorientated, aggressive, agitated, disturbing other patients and pushing nurses aside. This continued after her transfer from ERU to Ward 20 at around 17:00 on 10 July.

8. The records say that, because Mrs C's difficult behaviour during 10 July continued, the nurses contacted a doctor, who prescribed 5 mg of haloperidol to settle her. This was given at around 18:00 on 10 July. As it had no effect, a doctor reviewed Mrs C and prescribed lorazepam, a drug used (for example) for anxiety or insomnia. At around 23:00 this and 2 mg of haloperidol were given. The records say the behaviour continued during the night of 10 July until, eventually, Mrs C slept. (No more sedative-type drugs were given until 30 July, when diamorphine was started. The diamorphine was not part of the complaint, but, for the record, the advisers consider it to have been appropriately given.) I should explain here that Ms C did not believe that the sedation was recorded in the drugs record card. However, in the records provided to me by the Board, there were two types of prescription form – one for medication that had to be prescribed by a doctor each time it was to be given and one for medication that was to be given on a more regular basis. Those forms contained references to all the lorazepam and haloperidol in question.

9. On 11 July 2003 Ms C was horrified to find Mrs C was almost falling from her chair. A nurse said she had been given sedatives, which angered Ms C because she had told a nurse the previous evening that Mrs C was not to be given any sedative. Ms C explained that this was because the family had been told during previous admissions that it could mask the symptoms of her heart condition and had told the nurse the family should be contacted if Mrs C became agitated so they could come and calm her. If they had done so, Ms C felt that no sedative would have been given. In a file note about a meeting with the family (as part of the NHS complaints process), the Board are recorded as acknowledging to the family that there had been an opportunity here for the staff to have allowed them to have participated in Mrs C's care. Ms C said that, because of the sedatives on 10 July, her mother was never able to speak to her again and never regained any real alertness (passing away on the ward on 3 August 2003). Ms C also blamed the sedatives for Mrs C's fall. (I have already said (see paragraph 4) that, despite

investigation, the Board were unable to find out the circumstances of the fall, and I would not be investigating it.)

10. The clinical notes do not record any request from Ms C, in the early evening of 10 July, not to give sedatives, and there seemed to be no recollection of it by the nurse on Ward 20 to whom Ms C had spoken. In Ms C's first complaint letter to the Board, she said the nurse had told her (in answer to a different matter) that, at the time of her conversation with Ms C, Mrs C's records had not yet arrived on Ward 20 from ERU. If Ms C did tell the nurse sedatives were not to be given, the advisers have said they would have expected the nurse to have recorded the request somewhere, even though the records were not yet available. However, I cannot comment further on this because there is no evidence that establishes the facts about the conversation that Ms C has described. In any case, by the time that Ms C indicates the conversation took place, and unknown to Ms C and the staff on Ward 20, haloperidol had already been given in ERU (05:30 on 10 July). Somewhere around or before the time Ms C indicates the conversation took place, Mrs C's behaviour prompted the second dose, which was given on Ward 20 at around 18:00 on 10 July. In other words, it is not possible to establish what Ms C told the nurse about sedation, but in any case, by the time of her conversation with the nurse, one, and possibly two, doses had already been given. I do not consider it would be helpful to pursue this issue any further.

11. At paragraphs 11 to 12, I summarise the advisers' comments about the haloperidol which was given on 10 July at around 05:30, 18:00 and 23:00. The sedation of frail, confused and agitated or wandering elderly people is notoriously difficult to get right. This is because sedatives of any category can have unwanted but common side-effects. Some of these are related to the level of dose given and some are idiosyncratic (that is, individual to the occasion). So there can be an adverse response even at low dose. Also, the use of any sedation is always a balanced clinical decision between efficacy and side-effects, so doctors have challenging decisions to make. In this case, Mrs C started to show resistive and restless behaviour soon after her admission. This was probably due to a combination of long-standing confusion, made worse by recent events, such as her absence attacks, and some disorientation. ERU's decision to give haloperidol was reasonable, and the dose which was, therefore, given in ERU at 05:30 on 10 July was also reasonable. The records show the agitation and wandering continued,

accompanied by verbal aggression. The doctor prescribed 5 mg of haloperidol, which was given at around 18:00. This was a reasonable dose in view of the fact that the earlier 2 mg had had little, if any, effect. However, this dose, too, seemed to have little effect, and so another 2 mg was given at around 23:00. Again, this was a reasonable dose in view of the lack of effect of both earlier doses.

12. The following day (11 July) Mrs C was said to be sitting by her bedside but was very sleepy, and, later that night, she was said to be drowsy. The following morning (12 July) Mrs C fell. In other words, she did wake up from the sedation. Mrs C may have been drowsy for longer than one would have liked and there may have been a delayed action from the sedatives. But such a delay is a common occurrence, in that there is a delay in a dose's action so another dose is given, which can result in an over-sedative effect, which can last 12 to 24 hours, or sometimes longer. By later that afternoon (12 July), Mrs C developed a very low blood pressure. Although it is difficult to be sure, that is probably the time that she started to have a stroke (progressing through that evening and into the afternoon of 13 July) and it is unlikely that she was over-sedated at that time or that the sedation had caused the low blood pressure. She remained unresponsive for at least 72 hours because of the stroke, and the sedation cannot be blamed, therefore, for that unresponsiveness.

13. The family wanted Mrs C moved to a cardiac ward, but a doctor explained that this was not necessary and that investigations had been arranged and observations were showing stable results. The clinical records state that another doctor reviewed Mrs C, although there is no record of his diagnosis. I record here that Ms C disagrees that that review took place. However, I have to say that the clinical records note that a doctor did review Mrs C and also that a doctor discussed her case with another doctor. The level of detail and the number of staff involved in these entries suggest they were not falsified. Mrs C's blood pressure fell again in the early evening of 12 July. The family stayed with Mrs C during the night of 12 to 13 July. Nursing staff asked a doctor to see Mrs C, and he recorded on the morning of 13 July that she was unco-operative and would not allow a proper examination. Ms C has explained that the nursing staff only called a doctor because the family demanded this. I make no comment as there is no evidence to prove or disprove this. It was not until a doctor saw Mrs C in the afternoon of 13 July that a fairly firm diagnosis of stroke was made.

14. I summarise in this paragraph the advisers' views about the timing of the stroke diagnosis. On the night of 12 July, Mrs C had a weakness in the right hand which gradually spread to the whole of her right side over many hours. A doctor ordered neurological observations and, on 13 July, another doctor felt that she might have had a transient ischaemic attack (a 'mini stroke', which would resolve within 24 hours). Later thoughts were that the stroke might be due to brain haemorrhage (escape of blood from a blood vessel). A brain scan showed a large area of dead brain. One can only guess, but this was more likely to have been a thrombosis (solidified blood in a blood vessel) than a haemorrhage. That is because of the level of Mrs C's blood pressure and her history of carotid artery occlusion. (The Board later told me that the stroke was, indeed, due to a thrombosis.) Even after diagnosis, confirmation took a few days. There was no unwarranted delay in the diagnosis and there was no urgency in obtaining a scan because no treatment for stroke would have been given, other than the supportive management that Mrs C was given. It would have been helpful if a doctor had reviewed Mrs C on the evening of 12 July, as this might have allowed an earlier diagnosis, and she could have had the scan earlier. This might have helped the family. However, it would definitely have made no difference at all to the outcome. The family do not appear to have been given these explanations at the time and so, understandably, were anxious, feeling that the diagnosis was later than it should have been.

15. Ms C also complained that, although a doctor had requested observations, none were done during the night of 12 to 13 July. The records did show some, but Ms C said they were wrong because the family were present all night and saw none being done. The clinical records state that a decision for telemetry was taken, and put in place, on 12 July. Telemetry means the sending of observations (in this case, blood pressure and pulse, which would help to assess the condition of the heart) to a separate location by, for example, radio waves, so no physical nursing presence was required at Mrs C's bedside for certain observations. I note that Ms C disputes that any telemetry was in place. I can only say that the clinical records make detailed references to the telemetry's being established and that the records record telemetry readings. The level of detail in the records, and the number of people involved in writing them, suggest to me that they were not falsified. The advisers consider that the overall recording of observations could

have been clearer but that there is evidence in the clinical records to show that nurses observed Mrs C enough overall to be able to make an ongoing assessment of her condition and to consult doctors at appropriate times. For example, I have seen fluid balance charts, dating from the night of 12 to 13 July, which was when Mrs C was started on intravenous fluids. Again, there is no evidence that these records were falsified.

16. The brain scan (see paragraph 14) showed a large stroke. Mrs C also developed a fever, which was thought to be due to a chest infection, and developed lung crackles which indicated aspiration pneumonia. Her general condition continued to worsen until she sadly passed away in the hospital on 3 August 2003.

17. Ms C also complained about the poor standard of record keeping. The advisers and I carefully examined the records, finding they were quite detailed and gave a good overall picture about what was happening. They were more legible than records often are and usefully showed signatures and job titles against some of the entries. On the other hand, we found illegible, and missing, dates and one entry which was out of chronological order. Also, some sheets which were meant to be used to record communication with patients' families had been used for medical and nursing notes. And one of the haloperidol prescription charts could have been clearer as we had to check it against other records before we could clearly understand it. Overall, the advisers consider that there is, therefore, room for improvement but that the records are reasonable and within the bounds of acceptability indicated at paragraph 5.

(a) to (d) Conclusions

18. It is clear (see paragraphs 3 and 4) that Ms C had many concerns and that the Board had already acknowledged shortcomings in respect of some of them. I have considered the evidence presented by Ms C and by the Board. As explained at paragraph 5, I am satisfied that the evidence has been tested robustly. I have also considered the advisers' advice. It, too, was checked to ensure (where relevant) that it was clearly and logically based on the evidence. Therefore, I accept that advice. The advisers consider the actions taken in respect of the issues at paragraph 2 were reasonable. Therefore, I do not uphold the complaint.

(a) to (d) Recommendations

19. The Ombudsman has no recommendations.

31 October 2006

Annex 1

Explanation of terms used

Ms C	The complainant
Mrs C	Ms C's mother
The Board	Lanarkshire NHS Board
ERU	The hospital's emergency receiving unit