Scottish Parliament Region: North East Scotland

Case 200501038: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; Care and Treatment

Overview

Ms C complained about the care and treatment provided to her father, Mr A, in the Royal Dundee Liff Hospital.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) it was incorrectly stated in Mr A's clinical records that he had been discharged from the Royal Victoria Hospital because he was unmanageable (*upheld*);
(b) there was a delay in diagnosing a sub-dural haemorrhage (*upheld*);
(c) Mr A's stick was taken from him inappropriately and no further mobility assessment was done (*not upheld*);
(d) Mr A was over-sedated (*not upheld*);
(e) there was a failure to diagnose a pseudo-obstruction (*upheld*);
(f) a restraint was used unnecessarily (*not upheld*);
(g) a restraint was used inappropriately (*upheld*); and
(h) there was an unexplained delay in transferring Mr A to Ninewells Hospital (*upheld*).

Redress and recommendations

The Ombudsman recommends that:

(i) the Board remind staff of the need to ensure that entries in clinical records are appropriate;
(ii) the Board remind staff of the need for clinical records to be updated each time a patient is seen by a doctor;
(iii) the Senior House Officers (SHOs) involved in Mr A's care raise the issue of record-keeping at their next appraisals;
(iv) the SHOs involved in Mr A's care raise the issue of failure to diagnose the return of pseudo-obstruction at their next appraisals;
(v) the Board develop and implement a policy on the use of restraints at the

Hospital in line with Mental Welfare Commission guidelines;

(vi) the Board include patient and family communication as an item to be appraised in the regular appraisals on trainee doctors carried out by Educational Supervisors (Consultants) and, for nursing staff, that the Board demonstrate that communication has a high priority in the supervision of trainee nurses and is included in the programme for any review of nursing standards; and

(vii) the Board apologise to Ms C for the failures identified in this report.

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

Main Investigation Report

Introduction

1. Mr A was a 90-year-old man who suffered from insulin dependent diabetes and dementia. Mr A had been a patient at the Royal Victoria Hospital (a hospital for the elderly requiring continuing care) from where he had been discharged. He attended the Accident and Emergency department at Ninewells Hospital (a general hospital) early in the morning of 20 March 2005 (a week after his discharge from the Royal Victoria Hospital). Mr A's behaviour had culminated in physical aggression towards his family, carers and district nurse. This behaviour accompanied episodes where his blood sugar was low and had been recurring over a period of about four months. Mr A was treated in the short stay ward where he was encouraged to eat and his blood sugar levels were monitored. When these returned to normal, which they did on the same day, Mr A was transferred to the Royal Dundee Liff Hospital (the Hospital, a hospital for people suffering from mental illness and degenerative illnesses associated with old age). Ms C's complaints are about this hospital. Mr A remained in the Hospital for observation and treatment over the next three weeks during which time he sustained several falls, often with soft tissue injuries. On 13 April 2005 he fractured his left hip following a fall from a chair and he was transferred back to Ninewells Hospital for surgery. His condition deteriorated, however, with the development of a chest infection, a distended abdomen and drowsiness. A sub-dural haemorrhage was diagnosed and he died on 29 April 2005. The death certificate stated that the causes of death were '1. a sub-dural haematoma and 2. pseudo-obstruction'.

2. On 20 May 2005 Ms C complained to Tayside NHS Board (the Board) about her father's care and treatment when he was a patient at the Hospital. The Head of Service, Primary Care Division responded on 22 June 2005 but Ms C remained dissatisfied and on 14 July 2005 she complained to the Ombudsman.

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

(a) it was incorrectly stated in Mr A's clinical records that he had been discharged from the Royal Victoria Hospital because he was unmanageable;

(b) there was a delay in diagnosing a sub-dural haemorrhage;

(c) Mr A's stick was taken from him inappropriately and no further mobility assessment was done;

(d) Mr A was over-sedated;
(e) there was a failure to diagnose a pseudo-obstruction;
(f) a restraint was used unnecessarily;
(g) a restraint was used inappropriately; and
(h) there was an unexplained delay in transferring Mr A to Ninewells Hospital

Investigation

4. In order to investigate this complaint I have had access to Mr A's clinical records, the correspondence in connection with the complaint and the Mental Welfare Commission for Scotland's document 'Rights, risks and limits to freedom'. I have also obtained further documents from the Board. I have corresponded with the Scottish Ambulance Service (the Service). I have obtained independent professional advice from an adviser who is a hospital Consultant (the Adviser). Some of the complaints were not raised with the Board previously by Ms C but rather than refer her back through the NHS complaints procedure I decided to exercise the Ombudsman's discretion and accept all of Ms C's complaints for investigation. 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.

5. In line with the practice of this office, the standard by which I have judged the care and treatment provided to Mr A was whether it was reasonable. By that, I mean whether it was within the boundaries of what would be considered to be acceptable practice by the medical profession in terms of knowledge and practice at the time.

(a) It was incorrectly stated in Mr A's clinical records that he had been discharged from the Royal Victoria Hospital because he was unmanageable

6. Mr A had been a patient in the Royal Victoria Hospital and was discharged on 13 March 2005. Ms C complained that her father had been designated in the Hospital notes as 'unmanageable' at the time of his discharge. Ms C said that her father was not discharged from the Royal Victoria Hospital because he was unmanageable but to give him the opportunity to see how he would manage at home. Her father had been desperate to go home and the Royal Victoria Hospital said that they would keep his bed for three days in case his home placement broke down. Ms C did not believe they would have said that if Mr A was being discharged because he was unmanageable.

7. Ms C made this complaint to the Ombudsman after she had read her father's clinical notes. At the time when Ms C complained to the Board she had not read the notes and did not put this complaint to them. The Board have, therefore, not had the opportunity to respond to this specific complaint.

8. The Adviser said that Mr A's designation as unmanageable appeared to be based solely on a comment recorded by the Senior House Officer (SHO) at Accident and Emergency at Ninewells Hospital which was then copied into the Hospital's nursing records. The SHO unfortunately used this term as shorthand for Mr A's behavioural problems (which had been the reason for his admission to the Royal Victoria Hospital) and not, the Adviser believes, to indicate that Mr A was discharged because he was unmanageable. The Adviser said that the discharge plan to keep Mr A's bed for three days was appropriate as a way of making sure that Mr A resettled at home. As it turned out he only managed for a week before, aggravated by low blood sugars, his behaviour became a serious problem.

(a) Conclusion

9. Ms C was concerned that the fact that her father appeared to have been designated as unmanageable could have affected the way that he was subsequently treated during his stay in the Hospital. Although I can find no evidence that this was the case there was clearly a chance that misunderstandings could arise due to this inaccurate 'shorthand' term being used in his clinical records. I uphold this complaint.

(a) Recommendation

10. The Ombudsman recommends that the Board apologise to Ms C and remind staff of the need to ensure that entries in clinical records are appropriate.

(b) There was a delay in diagnosing a sub-dural haemorrhage

11. Mr A sustained head injuries while he was in the Hospital. On the day that he was admitted he was pushed by another patient and hit the back of his head against a doorframe. The incident was recorded in his records but no loss of consciousness or scalp injury was noted. Mr A fell on the night of 28/29 March 2005 causing a laceration to the left side of his forehead which required treatment with steristrips (small strips of adhesive used instead of stitches). A further fall was recorded on the afternoon of 29 March 2005 but

with no injury recorded. On 6 April 2005 Mr A fell again and injured the right side of his forehead requiring stitches. On 12 April 2005 Mr A kept sliding off his chair so was put to bed. On 13 April 2005 Mr A was said to have risen from his chair, lost his balance and fallen forward, landing heavily on his left side. He sustained a laceration to his left eyebrow and complained of pain in his left hip. Mr A was transferred to Ninewells Hospital for repair of a fracture of the left neck of the femur but died of sub-dural haemorrhage before surgery could take place.

12. Ms C complained that her father had been injured. She blamed lack of supervision on the ward and thought that there should be a member of staff for every two patients. Ms C said that Mr A's injuries were not properly investigated or treated, that there was a lack of medical care and that the sub-dural haemorrhage should have been diagnosed earlier.

13. The Adviser said that the staffing ratio suggested by Ms C was unrealistic and not available in NHS psychiatric units. Unfortunately falls in confused and partially mobile patients are almost inevitable despite risk management forms being filled in and staff supervision. The Adviser noted that following Mr A's falls he was examined by the ward doctor and treated appropriately but there appeared to be a lack of care on 12 April 2005 because there are no medical notes (data recorded by doctors) recorded. The Adviser said that there was only one medical note (made on 30 March 2005) between the admission notes of 21 March 2005 and 13 April 2005. The Adviser said that is a serious omission although the nursing records (data recorded by nurses) show that doctors did see Mr A on 28, 29 March and 5 April and possibly also on 12 April 2005. The Adviser said that the ward SHOs who were caring for Mr A should have recorded their visits and examinations. The omission is worrying because it could explain the lack of reaction to Mr A's deteriorating condition.

14. The Adviser explained that sub-dural haematoma is a collection of blood from the veins outside the brain but inside the skull which rupture due to a blow to the head. The effects may take a few days or even weeks to become apparent and may include headaches (which Ms C said her father suffered from but there is no mention of in the records), drowsiness, confusion and even stroke-like neurological signs. This can make the link between a blow on the head which may have happened some time before and subsequent changes in awareness or neurological function difficult to recognise. The Adviser said, however, that the changes in Mr A which occurred over the three weeks he was

in the Hospital, following several falls with head injuries, should have alerted the staff to the possibility of a sub-dural haematoma. He said they could then have ordered a brain CT scan to exclude this as a cause for the deterioration in Mr A's physical and mental function which was happening despite the reduction in sedatives and the existence of more stable blood sugars. The Adviser said that it is not clear from the notes whether staff were made aware of the fact that Mr A had headaches but if that was the case then that should have further raised their suspicions that Mr A had brain damage.

(b) Conclusion

15. It is clear that the doctors should have demonstrated in the medical notes that they were reviewing Mr A's condition and care on a regular basis but there are no contemporaneous notes to demonstrate that this was the case. There is no evidence that doctors were following the deterioration in Mr A's condition and it appears that Mr A's mounting symptoms were overlooked. The possibility that Mr A was suffering from a sub-dural haematoma was, therefore, not investigated until Mr A was admitted to Ninewells Hospital with a fractured hip. I am satisfied that there was a delay in diagnosing his condition and I uphold this complaint.

(b) Recommendation

16. The Ombudsman recommends that the Board apologise to Ms C, that staff are reminded of the need for clinical records to be updated each time a patient is seen by a doctor and that the SHOs involved in Mr A's care raise the issue of record-keeping at their next appraisals.

(c) Mr A's stick was taken from him inappropriately and no further mobility assessment was done

17. Ms C complained that when her father was admitted to the Hospital his stick, which he depended on for balance, was taken away from him. No other walking aid was suggested and no assessment was done.

18. In response to Ms C's complaint the Head of Service replied that Mr A was initially using his walking stick as an aid to mobility but when he had been threatening to hit other patients and staff with it, it was temporarily removed. The walking stick was later returned to him but Mr A left it lying around the ward. As he appeared to be walking independently without the aid of his stick it was not considered necessary to reassess him.

19. The Adviser noted from the records that Mr A was initially aggressive and the stick was taken away. He remained quite mobile and wandering for the next week but was less aggressive. Mr A then became more unsteady and drowsy because he was unwell. The Adviser said that Mr A's falls were not solely due to his being without his stick. The reason for taking it away was reasonable and his mobility was not particularly impaired early in his admission but was only compromised later by his worsening mental and physical state.

(c) Conclusion

20. I am satisfied that Mr A's stick was taken from him for good reason when he was admitted and was later returned to him. I also accept that if Mr A was not using his stick and was walking independently there was no need to reassess him. I do not uphold this complaint.

(d) Mr A was over-sedated

21. Ms C complained that her father's notes show that on 28/29 March he was restless and he was given medication with good effect. She was not clear what that medication was but three hours later he was heard falling out of bed. He became less mobile round the ward and increasingly drowsy. Ms C thought that her father was over-sedated.

22. Ms C made this complaint to the Ombudsman after she had read her father's clinical notes. At the time when Ms C complained to the Board she had not read the notes and did not put this complaint to them. The Board have, therefore, not had the opportunity to respond to this complaint.

23. The Adviser said that there was documented evidence in the medical and nursing notes that Mr A's level of awareness fluctuated considerably while he was in the Hospital. On some occasions his drowsiness was most probably due to the sedative medication he had received but at other times there appeared to be no correlation with medication. The Adviser said that swings of agitated wandering and obstreperous behaviour, alternating with drowsiness and passivity, are a common feature of advanced dementia and although the medication was adjusted it can be very difficult to get the balance right. The Adviser examined the drug sheets which I obtained from the Board. He said that, on the advice of the Psychogeriatrician, Chlorpromazine (a drug used to treat mental illness) was prescribed for regular use by Mr A. Diazepam (a sedative) was prescribed 'if agitated' and was given to Mr A on only a few occasions during his stay at the Hospital, in the evening during January and

February 2005 but more frequently in March 2005 when Mr A's agitation worsened. The Adviser said, however, that there was no evidence that Mr A had been deliberately or consistently over-sedated.

(d) Conclusion

24. I accept that there were occasions where the sedation given to Mr A made him drowsier and less motivated but I can find no evidence that the doctors over-prescribed. The evidence is clear that sedation was only prescribed for use when Mr A became agitated and it was not used all the time. Mr A became more drowsy and less motivated as he became more ill. I do not uphold this complaint.

(e) There was a failure to diagnose a pseudo-obstruction

25. In her complaint to the Board on 20 May 2005 Ms C said that on 5 April 2005 her father's stomach was very distended. No tests, to her knowledge, were carried out to find out why. When he complained to the family about severe stomach pain the nurses gave him laxatives. Ms C was concerned that might not be the right treatment. Ms C said that her father also had abdominal distension when he was transferred to Ninewells Hospital on 13 April 2005. A secondary cause of her father's death was pseudo-obstruction.

26. The Head of Service said that Mr A had a large bowel movement on 8 April 2005. The Symptomatic Relief Policy allowed first level registered nurses to administer medication such as laxatives when required.

27. The Adviser said that pseudo-obstruction is the term used for abdominal distension often associated with a constipated stool causing the sigmoid colon (lower end of the bowel) to become twisted around itself and, therefore, causing partial or temporary bowel stoppage. Although it is very upsetting and sometimes painful for the patient because of abdominal discomfort, the treatment usually involved giving laxatives and passing a 'flatus tube' through the rectum which may successfully 'untwist' the lower bowel, releasing flatus and stool. In Mr A's case he was given laxatives which cleared his bowel and presumably deflated his abdomen, as there was no more mention of it. When the Adviser examined the x-ray taken at Ninewells Hospital on 13 April 2005, however, he noted that Mr A was grossly constipated. Further abdominal x-rays taken on 16 April 2005 at Ninewells Hospital showed a classically distended large bowel typical of pseudo-obstruction.

28. The Adviser said that the Board's response did not answer the complaint about this problem very well. Ms C's comment about her father not having medical input for his distended abdomen because the nurses just gave him laxatives, is not substantiated because the ward SHO did see Mr A's abdomen on 5 April 2005 and the nurses appropriately gave him laxatives which had the desired effect. The SHO should, however, have recorded his findings and proposed treatment in the medical notes. The Adviser said that pseudo-obstruction is often recurrent.

(e) Conclusion

29. When Mr A first had a distended stomach on 5 April 2005 he was examined by a doctor and treated appropriately by the nursing staff. When the problem returned, however, it was not recognised. It is clear from the 13 April 2005 x-ray, however, that Mr A was by that time grossly constipated. The SHO did not record his original findings and proposed treatment in the notes so it may be that staff were not alert for a recurrence of the problem. As the Adviser pointed out, recurrence is a common problem and staff should have considered it as a possibility. The Board should also have explained Mr A's condition fully to Ms C. I uphold this complaint.

(e) Recommendation

30. The Ombudsman recommends that the Board apologise to Ms C for the failure to diagnose the return of pseudo-obstruction and failure to explain the position to her and that the SHOs involved in Mr A's care raise the issue of failure to diagnose the return of pseudo-obstruction at their next appraisals.

(f) A restraint was used unnecessarily

31. Ms C said that after Mr A's fall on 13 April 2005 he was complaining of hip and thigh pain. The ward doctor decided that a restraining belt was necessary even if that would lead to more pain. Ms C said that her father was so unwell by that time that she did not consider it necessary.

32. Ms C made this complaint to the Ombudsman after she had read her father's clinical notes. At the time when Ms C complained to the Board she had not read the notes and did not put this particular complaint to them. The Board have, therefore, not had the opportunity to respond to this complaint.

33. The Adviser said that a lap restraint form had been completed and the lap

restraint put in place on 13 April 2005 following Mr A's fall. The Adviser said that the restraint was applied because Mr A had fallen because of his drowsiness and confusion not because of any tendency to wander. He agreed with Ms C that Mr A was indeed not well enough to wander by that time but he was still capable of falling off a chair and hurting himself.

34. The lap strap restraint form stated that Mr A required the use of the restraint due to 'poor gait resulting in falls putting him at increased risk of injury'.

(f) Conclusion

35. I accept that the lap restraint was used with the intention of keeping Mr A safe. I note that he was recorded as being 'not weight bearing' following his fall and, therefore, could have been at increased risk of further injury. I, therefore, do not uphold the complaint that the lap restraint was unnecessary.

(g) A restraint was used inappropriately

36. Ms C complained that neither her mother nor she herself was contacted about the decision to use the restraint even though she had left her mobile telephone number. The medical record stated that Mr A was unable to comprehend. Ms C felt that the family should have been consulted about this decision.

37. Ms C made this complaint to the Ombudsman after she had read her father's clinical notes. At the time when Ms C complained to the Board she had not read the notes and did not put this complaint to them. The Board have, therefore, not had the opportunity to respond to this complaint.

38. In the Mental Welfare Commission's document 'Rights, risks and limits to freedom' there are guidelines regarding the use of restraints. I have checked these guidelines and they state that:

1. relevant outsiders should be consulted with and informed about any intended restraint;
2. a multi-disciplinary discussion should take place also involving the family;
3. each episode of restraint must be recorded in a clear format with the time for which the restraint was applied.

There is no evidence in Mr A's medical records that any of these things were done.

(g) Conclusion

39. The lap strap restraint form said that Mr A was informed of the reasons for use of the lap belt but there is no indication that his family were consulted. One of the guidelines on the form is that the patient's next of kin should be fully informed. I can find no evidence of any attempt to contact Mr A's family. I can find no evidence of a multi-disciplinary discussion involving the family or of the timed recording. It is a matter of concern to me that the evidence shows that significant elements of the guidelines were not followed in his case. I uphold the complaint.

(g) Recommendation

40. The Ombudsman recommends that the Board apologise to Ms C and that they develop and implement a policy on the use of restraints at the Hospital in line with the Mental Welfare Commission guidelines.

(h) There was an unexplained delay in transferring Mr A to Ninewells Hospital

41. Ms C said that she was informed by telephone at approximately 17:00 on 13 April 2005 that her father had fallen and was to be taken to Ninewells Hospital 'as a precaution'. Ms C said that the ambulance did not come for him, however, until 21:00. When she spoke to Ninewells Hospital later that evening she was told that her father was in a semi-conscious state and very poorly. Ms C complained about the lack of urgency in dealing with her father's condition and that while he was waiting to be transferred he became much worse.

42. The Head of Service replied that following the fall Mr A complained of pain in his left hip and he was not weight bearing. The SHO examined him but found no suggestion of a fracture. There was no tenderness in his thighs but Mr A winced when his hips were examined and the SHO decided to refer him to Ninewells Hospital for an x-ray. The Staff Nurse on duty requested an ambulance and informed Mr A's family. The Service later contacted the ward to advise them that there would be a delay due to an emergency situation. Mr A was subsequently transferred to Ninewells Hospital at 20:30. The Head of Service apologised for the fact that the family were not updated on any delays.

43. The Adviser examined Mr A's pelvic x-ray taken on 13 April 2005. He noted that the hip fracture was not obvious on examination by the SHO. The Adviser said that a hip fracture can be difficult to diagnose and the SHO took the appropriate action in referring Mr A for an x-ray when he complained of pain

and was non weight bearing. The Adviser said that the delay in the transfer was explained by the excessive emergency demands on the Service but that was very regrettable for an elderly confused patient in pain. The Adviser was critical of the Head of Service's response in that it did not answer Ms C's concerns about how her father was transported to Ninewells Hospital and how his condition had changed rapidly. It was not made clear, for instance, that the SHO sent Mr A to Ninewells Hospital as a precaution to exclude a fracture although he found no obvious sign of a fracture at examination. The letter should also have explained Mr A's semi-comatose state rather than letting Ms C's perception that her father's serious condition was ignored, go unexplained.

44. I checked the history of the ambulance request with the Service. They said that the request for an ambulance for Mr A was received at 16:51 on 13 April 2005. The classification was 'urgent within 2 hours to the patient'. Allowing 30 minutes for travel to hospital this meant that an ambulance should have been with Mr A by 18:51 and at hospital by 19:21. At 18:26, however, it was realised that due to demand, the agreed time scale would not be met. The Service contacted the Hospital to apologise and advise of the reason for the delay. There was no indication that the case should be reclassified or upgraded. Between 16:51 and 19:48 there were no suitable local ambulances available to deal with Mr A's transfer due to the level of higher priority cases. At 18:48 an ambulance was sent but diverted to deal with an emergency. No other ambulances were available until 20:21 when another ambulance was sent. This crew were also redirected to an emergency a few minutes later. However, that ambulance was re-allocated to Mr A's transfer at 20:28 and arrived at the Hospital at 20:38. Mr A reached his destination at 20:58.

(h) Conclusion

45. I am satisfied that the SHO acted appropriately in referring Mr A for an x-ray and I can see from the clinical records that an ambulance was ordered with an appropriate classification. The Service said that making contact with the Hospital presented them with the opportunity to upgrade the request. There is no indication in the records, however, that any consideration was given to upgrading the request for an ambulance in view of Mr A's deteriorating condition. I note that although the Head of Service apologised for the delay she offered no explanation for it other than excessive demand. I uphold this complaint.

(h) Recommendation

46. The Ombudsman recommends that the Board apologises to Ms C, include patient and family communication as an item to be appraised in the regular appraisals on trainee doctors carried out by Educational Supervisors (Consultants) and, for nursing staff, that the Board demonstrate that communication has a high priority in the supervision of trainee nurses and is included in the programme for any review of nursing standards.

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

22 August 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mr A	Ms C's father
Royal Victoria Hospital	A hospital for the elderly requiring continuing care
Ninewells Hospital	A general hospital
The Hospital	Royal Dundee Liff Hospital (a hospital for people suffering from mental illness and degenerative illnesses associated with old age) – the subject of this complaint
The Board	Tayside NHS Board
The Adviser	The Ombudsman's Independent Professional Adviser
The Service	The Scottish Ambulance Service
SHO	Senior House Officer

Annex 2

Glossary of terms

Sub-dural haematoma	A collection of blood from the veins outside the brain but inside the skull which rupture due to a blow to the skull
Pseudo-obstruction	Abdominal distension often associated with a constipated stool causing the sigmoid colon (lower end of the bowel) to become twisted around itself and, therefore, causing partial or temporary bowel stoppage
Weight bearing	The amount of body weight that can be borne while standing