Scottish Parliament Region: North East Scotland

Case 200600121: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Miss C) raised a number of concerns about her late uncle (Mr A)'s care at Ninewells Hospital (the Hospital), to which he was admitted on 20 December 2005 and where he died on 25 December 2005, aged 62.

Specific complaint and conclusion

The complaint which has been investigated is that Mr A's care in December 2005 fell below a reasonable standard (*upheld*).

Redress and recommendations

The Ombudsman recommends that Tayside NHS Board (the Board):

(i) put in place a policy, protocol or guidance in relation to infective exacerbations of chronic lung disease;

(ii) advise urgent contact from clinical staff to carers in particularly grave situations and, more generally, encourage proactive communication from clinical staff to patients and their carers;

(iii) provide evidence of the systems in place to monitor and audit nursing records; and

(iv) provide evidence of the main improvements which they have made in the standard of care as part of their 'safer patient' initiatives.

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

Main Investigation Report

Introduction

1. The complaint from Miss C which I have investigated is that Mr A's care in December 2005 fell below a reasonable standard.

Investigation

2. I was assisted in the investigation by two clinical advisers, a consultant physician and a nurse, whom I shall refer to as the Advisers. Their role was to explain and comment on Mr A's care. We examined the papers provided by Miss C and (from Tayside NHS Board (the Board)) clinical records, replies to my enquiries and complaint correspondence. In line with the practice of the Ombudsman's 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 have been considered to be acceptable practice in terms of knowledge and practice at the time in question.

3. I am satisfied that no matter of significance has been overlooked in the investigation. However, my enquiries to the Board and their replies have been copied to Miss C and I have, therefore, considered it unnecessary to put much of the detail into this report, focusing instead on the Advisers' comments and on improvements for the Board. Miss C and the Board were given an opportunity to comment on a draft of this report.

Complaint: Mr A's care in December 2005 fell below a reasonable standard

4. I turn now to the complaint. A reminder of the terms used is at Annex 1. On 20 December 2005 Mr A was admitted to Ninewells Hospital (the Hospital), through his GP, for investigation and general rehabilitation. His already-poor condition had been declining for several months and he was coughing up blood and had increasing breathlessness and reduced appetite, with significant weight loss. He was known to have chronic lung disease (COPD – chronic obstructive pulmonary disease).

5. By way of a brief overview of Mr A's first few days in the Hospital, I should say that plans were drawn up, and, amongst other things, a chest x-ray was done and fluids and protein were started intravenously. A slight fever became evident. A computed tomography scan was done (a CT scan - a special

radiographic technique that uses a computer to assimilate multiple x-ray images into a cross-sectional image). Mr A's temperature rose further, so blood cultures were arranged and oral antibiotics were restarted from the afternoon of 22 December. (Mr A had been taking antibiotics before admission for a chest infection, and these had been discontinued on admission.)

6. On 24 December Mr A's condition deteriorated. Worsening of his chest infection was suspected, as was a pulmonary embolus (clot of blood in the arteries of the lungs). A further chest x-ray showed shading over one lung. Soon after 02:00 on the night of 24/25 December, the on-call registrar (a Specialist Registrar – that is, one with significant experience – whom I shall call the Registrar) saw Mr A, who was now much worse. Because of the gravity of Mr A's situation, including his unresponsiveness and decreasing level of consciousness, the Registrar considered that it would not be appropriate to refer Mr A for intensive care, introduce assisted breathing or attempt resuscitation if Mr A had, for example, a respiratory arrest. The medical records for that time state that the family were to be contacted urgently about the situation. The Registrar considered that the oral antibiotic should be changed to an intravenous preparation, although this was not to start until 08:00 on 25 December. Sadly, Mr A died at 03:10 on the night of 24/25 December. The causes of death were recorded at the time as pneumonia and chronic lung disease.

7. Miss C's complaint concerned, for example, delay in review by a senior doctor when her uncle's condition deteriorated, delay in prescribing intravenously-given antibiotics, delay in starting such antibiotics, the decision not to attempt resuscitation and lack of communication with the family. When the Board dealt with the complaint (before it came to the Ombudsman's office), their records showed them to have upheld part of the complaint – that is, that there had been 'some poor communication' with the family.

8. I received from the Board comments on initial concerns that I had put to them after discussion with the Advisers. As indicated at paragraph 3, these have been copied to Miss C and need not be repeated here. However, key points, and more detail about the nature of Miss C's complaints, will be clear from the Advisers' further comments, which I summarise at paragraph 9.

9. Following the Board's comments on our initial criticisms, this paragraph summarises the Advisers' further views:

(i) 'The Board have accepted that there was undue delay in responding to Mr A's deterioration on 24 December, fully apologising and saying that he should have been reviewed earlier by a more senior clinician than was the case. They state that this was a public holiday, that clinicians throughout the Hospital were, therefore, relatively sparse and that the Registrar could not attend earlier because he was with another patient, adding that these were intended as explanations, not excuses. We do not consider this is entirely satisfactory.

(ii) There are two issues relating to the use of antibiotics. Firstly, with reference to treatment on 24 December, a consultant's diagnosis of likely pulmonary embolus (see paragraph 6) was only one possible diagnosis. As stated at paragraph 6, a worsening of Mr A's chest infection had also been identified as a possibility. A CT scan had been done on 23 December and showed very widespread changes. These tend to support a diagnosis of pneumonia, although they were not incompatible with pulmonary embolism. Although, therefore, a diagnosis would still have been unclear from the scan, we consider that the possibility of fresh infection should have been considered and that possibility covered by a change of antibiotics and a change from oral to intravenous delivery. The Board have said that with the benefit of hindsight, they feel that a change of antibiotics could have been considered earlier in the day. However, we consider there was enough evidence at the time for this: in other words, we do not consider that this can only be seen with the benefit of hindsight. Secondly, the decision was made to change the antibiotics delivery from oral to intravenous soon after 02:00 on the night of 24/25 December; this was not listed to start until 08:00 on 25 December. We consider the change should have taken place immediately. The fact that Mr A would not have had the intravenous preparation in any case because of his death does not alter this.

(iii) The Board have now told the Ombudsman's Complaints Investigator they fully accept there was a distinct lack of communication between the medical team and the family. They say that there was a consultant presence on the ward in question every day, including holidays, and that nursing staff knew they could arrange for him or her to speak with relatives if requested. They say that on-call medical staff were also available to discuss patients' immediate care if necessary and that, in Mr A's case, his condition deteriorated so quickly that it would not have been possible to discuss this in detail with the family. However, we consider that the level of under-oxygenation of the blood during 24 December should have

caused sufficient concern for the family to have been warned during that day. We accept that medical staff were available to speak with patients' families if requested. However, this places the responsibility for approach onto families, which is not entirely satisfactory. We would want to see more proactive communication from medical and nursing staff to patients/relatives. We turn now to communication of the resuscitation decision. When the Registrar made that decision (see paragraph 6), the family should have been contacted urgently because of the gravity of Mr A's condition at that time. The fact that Mr A died very soon after that decision does not alter this. We note the Board's comment that the Hospital would have contacted the family in the morning, to discuss the situation, including the resuscitation decision. However, we are clear that immediate contact should have been prompted by the resuscitation decision, by Mr A's unresponsiveness and decreasing consciousness at this time, and by the fact that the family were still unaware of the perilousness of his situation.

(iv) We had queried the ward's use of an early warning scoring system. This was because, despite the fact that that system had correctly triggered the need for nursing intervention in Mr A's case, repeated nursing observations did not follow, as should have happened. We accept that medical staff were informed of the warning score. However, it is the nursing staff's responsibility to ensure that continued monitoring is in place in such cases to evaluate the effect of any medical treatment. We note that the Board have explained that, at the time, the early warning score system was in its early stages of implementation, and that the ward's senior charge nurse had been monitoring, and continued to monitor, this tool and was actively supporting staff's improvement in this aspect. The Board say they continue to provide intensive support to teams in this aspect, that embedding the system's usage continues to be a priority across all wards and that teams are making steady improvements. We welcome this and are reassured by it.

(v) The Board acknowledge that on 24 December, the ward in question was staffed by a significant number of bank nurses, including untrained ones. We note the Board's statement that this is highly unusual and the steps they have said they took before considering using bank nurses on this occasion, and, overall, we find these explanations satisfactory. (Bank staff are employees of a health board who work in a 'bank', or 'pool', and are sent where needed to increase flexibility of nursing provision. They may include those with specialist nursing skills and those who are untrained.)

(vi) The Board accept that the record-keeping (mainly nursing) fell short of what was expected. For example, there are a number of omissions in the nursing records, such as any observations done in relation to Mr A's poor oxygen saturation and any observations that were done when Mr A started to decline significantly; Mr A's nursing assessment was incomplete (in that his shortness of breath was not addressed by a proper nursing care plan); and the serious decision (by the Registrar) not to provide intensive support or attempt resuscitation was not fully documented in the medical notes. We are pleased to note that the Registrar has been spoken to about that particular medical note. The Board say that a new senior charge nurse has been appointed to the ward in question, with improved nursing record-keeping as one of his priorities. They say that changes have been made to ensure records are easier to use and to provide a more robust record of nursing care. However, we do not know what these changes are and have been given no evidence of them'.

10. Miss C was concerned about the Registrar's decision not to increase the level of support (for example, to intensive care) and not to attempt to resuscitate Mr A if he suffered, for example, a respiratory arrest. The Advisers consider that such a decision was appropriate because of Mr A's condition. Finally, the Advisers considered Mr A's chances of survival and whether the Hospital's actions influenced his death. If Mr A's deterioration on 24 December had not occurred, the Advisers say that his chances were very poor. He had severe chronic lung disease. Most patients with this condition eventually succumb to infection, as was the case here. Indeed, a British study reported that 43% of patients who had been in hospital with an acute worsening of this form of disease died within a year. In relation to Mr A's management by the Hospital, this did produce some improvement. The Advisers explain that Mr A's deterioration on 24 December was severe and rapid. They say that, even if different antibiotic treatment had been given on 24 December, the outcome would almost certainly have been no different and that it is not possible to be more definite than that.

Conclusion

11. As stated at paragraph 2, I was assisted in this investigation by the Advisers, whose role was to explain and comment on Mr A's care. I accept their advice, and it follows that I accept their criticisms of the Board. In the following paragraphs I note some particular points about their advice.

12. I have thought carefully about the medical staff cover on 24 December (see paragraph 9 (i)). On the one hand, patients should receive reasonable care, no matter what day of the year they need it, but on the other hand, one has to be realistic. I note that the Registrar could not see Mr A earlier because of another patient's needs, and I would say that such a scenario will always be possible, even with high numbers of clinicians. In the circumstances, the Ombudsman has decided not to make any recommendations on this aspect but hopes that the Board will not be complacent about it. And, in view of the Board's welcome acceptance that Mr A should have been reviewed earlier, she is now satisfied that no further action by her office is needed in that respect.

13. In relation to the antibiotics (see paragraph 9 (ii)), I note that this is not a clear-cut issue. In other words, Mr A's diagnosis was not straightforward, and it could not have been clearly identified that he had pneumonia. However, the Advisers are very clear that this possibility should have been considered further, and the possibility covered. They have said that infective worsening of chronic lung disease is a very common reason for acute admission to hospital and that the Hospital should, therefore, have some form of policy about this for medical staff.

14. Paragraph 9 (iv) comments on the use of the early warning scoring system. In this case, the tool correctly gave a warning score, which was not adequately actioned by nursing staff. The Ombudsman accepts that the system had recently been introduced at the time in question and notes that it continues to be a priority and that progress is continuing. In the circumstances she has decided to make no recommendations in this respect, although she would hope that staff have now had time to become familiar with the system and the need to respond to warnings produced by it.

15. In relation to the use of bank staff (see paragraph 9 (v)), I would comment that high usage of bank or agency staff can have a direct, adverse, effect on the quality of patient care, although I accept the Board's statement that their competencies are checked, and I am aware that bank staff often work on the same wards quite frequently, therefore, becoming familiar with the practices of those wards. In general, the Ombudsman would hope that any hospital's nursing skill mixes are appropriately reviewed and that use of bank and agency staff is minimal, as far as reasonably possible. In this case, as the Board have said that the high usage on 24 December was highly unusual, the Ombudsman has decided that no recommendation would be appropriate.

16. The Ombudsman considers good record-keeping to be important, and it is worth saying a few words about this in general terms – that is, not specifically in relation to this case. It is important to keep good and accurate records so that any other healthcare professional who sees the patient later can see what has been happening and – importantly – why. In relation to examinations done or the results of tests, it is important to record negative findings as well as positive. So, for example, if an examination that would normally be expected is not carried out, that fact, and the reason, should be recorded. Likewise, if a doctor takes a patient's blood pressure, and it shows a normal reading, that should be recorded, despite being normal, to show that it was done. Healthcare professionals often say they do not have time to write down everything. It is not necessary to write down everything – simply to record enough to show what was done or (where appropriate) not done and why. This can benefit not just patients but also healthcare professionals in helping them to respond to, and defend themselves against, complaints and claims of negligence. Often, accurate, legible and complete records are the only defence in such cases. We were pleased to note the positive stand taken on this in a recent edition of the magazine produced by the Medical and Dental Defence Union of Scotland for their members.

17. As well as referring to various specific improvements, the Board's letter to me of 8 May 2007 said that a number of initiatives had been implemented since the time of Mr A's admission to make improvements in the care given to patients as part of the Board's 'safer patient' initiatives. The Ombudsman welcomes this and would appreciate further details.

18. It will be seen from paragraph 9 that the Board have moved from the stand at paragraph 7 to an overall acceptance of our criticisms. This is positive and welcome but does not go quite far enough, and the Ombudsman considers that it is important, now, to build on this by having concrete evidence of the improvements described by the Board as having been put in place and by encouraging further improvement. The recommendations, therefore, flow from this.

19. In the circumstances, I uphold the complaint.

Recommendations

20. The Ombudsman recommends that the Board:

(i) put in place a policy, protocol or guidance in relation to infective exacerbations of chronic lung disease;
(ii) advise urgent contact from clinical staff to carers in particularly grave situations and, more generally, encourage proactive communication from clinical staff to patients and their carers;
(iii) provide evidence of the systems in place to monitor and audit nursing records; and
(iv) provide evidence of the main improvements which they have made in the standard of care as part of their 'safer patient' initiatives.

21. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when recommendations (i) and (ii) have been implemented and provide the information at (iii) and (iv) as soon as possible.

24 October 2007

Annex 1

Explanation of terms used

Miss C	The complainant
Mr A	Miss C's uncle
The Advisers	Clinical advisers to the Ombudsman
The Board	Tayside NHS Board
The Hospital	Ninewells Hospital
COPD	Chronic obstructive pulmonary disease
CT scan	Computed tomography scan
The Registrar	The registrar who saw Mr A shortly before his death

Annex 2

Glossary of terms

Pulmonary embolus	Clot of blood in the arteries of the lung