Scottish Parliament Region: North East Scotland

Case 200902198: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; care of the elderly, clinical treatment

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment her late father (Mr A) received from Ninewells Hospital (the Hospital) after he was admitted on 20 April 2008 with collapse and expressive dysphasia (difficulty in using language). Mrs C is also aggrieved about the length of time it took for Tayside NHS Board (the Board) to respond to her complaints.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was inadequate monitoring of blood pressure (*upheld*);
(b) there was lack of intervention to increase blood pressure (*upheld*);
(c) the reintroduction of blood pressure and cardiac medications all at once was inappropriate (*not upheld*);
(d) there was a delay in the swallow assessment and nasogastric tube being inserted (*not upheld*); and
(e) there was a delay in the Board responding to the complaint (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) review its policy regarding the monitoring of patients with acute stroke who are given treatment that may cause unexpected and precipitous falls in blood pressure;	13 October 2010
(ii) provide ongoing evidence, such as Scottish patient safety reports, which demonstrates consistency and continuity of care for those patients being transferred between wards or units; and	13 October 2010

(iii)	review the need for a protocol in the stroke unit regarding the immediate management of patients with acute stroke who suffer sudden, severe and symptomatic falls in blood pressure.	13 October 2010

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

Main Investigation Report

Introduction

1. On 11 November 2008, Mrs C complained to Tayside NHS Board (the Board) about the care and treatment her late father (Mr A) had received from Ninewells Hospital (the Hospital) between 20 April 2008 and 19 May 2008. The Board provided a formal response to the complaint on 26 February 2009. Following the death of Mr A in April 2009, Mrs C complained to the Ombudsman's office on 25 August 2009 as she remained dissatisfied with the Board's response to the issues concerned. Mr A was an 86-year-old man who had been admitted to hospital after collapsing at home. Mr A was showing signs of expressive dysphasia (difficulty in using language) that had developed approximately three hours earlier. Mr A was thereafter diagnosed with a stroke. Over the previous four days, Mr A had also suffered diarrhoea and vomiting. He had a number of known pre-existing heart related conditions and was on a variety of drugs that would lower blood pressure, prevent further chest pain or heart attack, control the speed or rhythm of the heart or treat and prevent symptoms of heart failure.

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

(a) there was inadequate monitoring of blood pressure;
(b) there was lack of intervention to increase blood pressure;
(c) the reintroduction of blood pressure and cardiac medications all at once was inappropriate;
(d) there was a delay in the swallow assessment and nasogastric tube being inserted; and
(e) there was a delay in the Board responding to Mrs C's complaint.

Investigation

3. Investigation of this complaint involved obtaining and reviewing the Board's complaint correspondence alongside Mrs C's correspondence and Mr A's clinical records. My complaints reviewer then sought the views of a specialist medical adviser (the Adviser) and discussed aspects of the case with Mrs C.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of terms used can be found at Annex 2 and a list of the legislation and policies

considered are in Annex 3. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) There was inadequate monitoring of blood pressure

5. Mrs C complained that Mr A's blood pressure was not monitored. Mrs C was particularly concerned there were no blood pressure recordings on 23 April 2008 until after a relative had arrived at the hospital and alerted staff that Mr A had become unresponsive.

6. In their written response to Mrs C's, the Board stated that the clinical records indicated that Mr A's blood pressure was monitored throughout his stay.

7. The clinical records documented that Mr A's blood pressure was significantly high on admission to hospital on 20 April 2008 and the management plan clearly stated that Mr A's blood pressure was not to be reduced acutely. At this time, Mr A was being cared for within the Acute Admitting Unit. The Adviser said that Mr A's elevated blood pressure had resulted in a high Scottish Early Warning Score (SEWS) which prompted hourly observations to be recorded. On 21 April 2008, the medical staff instructed that the frequency of blood pressure monitoring be reduced to two-hourly checks. The Adviser considered these observations to be appropriate.

8. However, the Adviser highlighted that the frequency of blood pressure observations changed significantly later that evening when Mr A was transferred to Ward 5. It was noted by my complaints reviewer that Mr A was supposed to have been transferred to Ward 4 where the Acute Stroke Unit was located but there were no beds available at this time.

9. The Adviser explained that only three further blood pressure recordings had been recorded in the following 25 hours. Furthermore, there was no specific documentation to justify this change in either the nursing or medical notes which the Adviser would have expected.

10. The Board responded to the Adviser's comments by suggesting that the SEWS guidance can be overridden by clinical judgement in terms of the need for observations. However, the Board acknowledged that such clinical decision making is not always clearly documented in the medical records and as a result they have amended the SEWS chart to ensure that any clinical decisions relating to observations are clearly captured.

11. The Adviser raised further concerns with the lack of blood pressure monitoring when medication was administered on 22 April 2008 and 23 April 2008. On the evening of 22 April 2008 the stroke consultant (the Consultant) made the decision for two specific drugs to be administered which would help lower blood pressure. The Adviser said that there was nothing recorded in the clinical notes to indicate the frequency of blood pressure monitoring after these drugs had been administered or again when Mr A's usual medication was reintroduced on the morning of 23 April 2008 which would have assisted in the monitoring of their effects.

12. The Adviser is of the opinion that had more frequent observations been carried out, between the time Mr A's usual medication was reintroduced at 08:00 and at 11:00 when a family member had found him to be unresponsive, then staff may have acted more quickly.

13. The Adviser also noted that there was no evidence in the clinical records to show that the effects of the drugs administered on 22 April 2008 had been clearly assessed by the medical staff before reintroducing Mr A's usual medication on 23 April 2008.

14. The Adviser concluded that the monitoring of Mr A's blood pressure fell below the standard that could reasonably have been expected in a patient who had suffered an acute stroke and been given blood pressure treatment.

(a) Conclusion

15. Although the Board have stated that Mr A's blood pressure was monitored throughout his hospital stay, I do not consider the frequency of the monitoring to be of an adequate standard following Mr A's transfer to Ward 5 and at the crucial time medication was administered on 22 and 23 April 2008. Therefore, I uphold the complaint.

(a) Recommendations

16. I recommend that the Board:	*Completion date*
(i) review its policy regarding the monitoring of patients with acute stroke who are given treatment that may cause unexpected and precipitous falls in blood pressure; and	13 October 2010

(ii)	provide ongoing evidence, such as Scottish patient safety reports, which demonstrates consistency and continuity of care for those patients being transferred between wards or units.	13 October 2010

(b) There was lack of intervention to increase blood pressure

17. Mrs C complained that no attempt was made by the hospital staff to reverse the effects of Mr A's usual medications when they were reintroduced all at once on 23 April 2008.

18. The Board told Mrs C in their response to the complaint that:

> 'it would not have been appropriate to administer any type of medications to reverse the low blood pressure in this instance, however action was taken in that the blood pressure medications were stopped and Mr A was given intravenous fluids to try to increase the blood pressure.'

19. The Adviser agreed with the Board that, in this instance, it would not be standard practice to attempt to use drugs to further elevate blood pressure.

20. The clinical records indicated that after the event had occurred, Mr A was transferred from a chair onto the bed in order to help raise his blood pressure. The Adviser commented that it was not noted whether Mr A's feet were elevated which may have been helpful. Although the initial medical assessment documented the use of high flow oxygen, which the Adviser said was appropriate, there was no mention of fluid therapy until a subsequent medical review suggested that additional fluid treatment be given. However, the Adviser could not see any record in the fluid prescription chart or the nursing notes to indicate that additional fluids had been administered or that the infusion already running was quickened.

21. The Board commented that there had been problems with the positioning of Mr A's cannula which had resulted in delays in the administration of intravenous (IV) fluids. However, the Board accepted that the documentation of fluids was not of their expected standard and have taken steps to raise awareness of accurate fluid balancing and the appropriate checking of IV access among the nursing staff. The Board also said that

> 'there is now improved access to medical devices to support timely infusion of intravenous therapy. A peripheral vascular catheter bundle has

been implemented to ensure the appropriate observation and checking of intravenous access.'

(b) Conclusion

22. The Adviser concluded that even although there is no evidence to support that Mr A's outcome would have been any different had more fluid been given immediately, the actions by the hospital staff were suboptimal in this respect.

23. I welcome the steps that the Board have taken in respect of fluid balancing monitoring. However, based on the Adviser's advice, I consider that these measures do not fully address the issue of managing patients who suffer a sudden drop in blood pressure. Therefore, I uphold the complaint.

(b) Recommendation

24. I recommend that the Board:	*Completion date*
(i) review the need for a protocol in the stroke unit regarding the immediate management of patients with acute stroke who suffer sudden, severe and symptomatic falls in blood pressure.	13 October 2010

(c) The reintroduction of blood pressure and cardiac medications all at once was inappropriate

25. Mrs C complained to the Board that Mr A's usual medications to treat high blood pressure had not been gradually re-introduced which resulted in his blood pressure dropping very low. Mrs C expressed concern that there was a significant deterioration in Mr A's condition after his usual medicines had been administered all at the same time on 23 April 2008.

26. The Board told Mrs C that it is normal to re-introduce a patient's usual medications after it had been identified that they can take oral medication. The Board also said it was unlikely that the re-introduction of Mr A's regular medicines was the singular cause of the abrupt drop in blood pressure experienced on 23 April 2008.

27. The nursing notes documented that Mr A collapsed and became unresponsive at 11:15 on 23 April 2008. Mr A's blood pressure was noted to be significantly low and the subsequent medical review, according to the Adviser, suggested that Mr A's speech had worsened. During the course of our

investigation, it was not initially clear from the clinical records whether Mr A's usual medicines had been re-introduced at 08:00 or 11:00 on 23 April 2008.

28. The Adviser told my complaints reviewer that had the medication been administered at 08:00 – approximately three hours prior to Mr A collapsing – then it would be 'likely that they were the primary cause of the subsequent severe and sudden decline in blood pressure, associated clinical event and deterioration in the patient's function'. The Board later clarified that all Mr A's usual drugs were administered at 08:00 on 23 April 2008.

29. The Adviser commented that Mr A's usual medicines had multiple potential benefits, and several of them could each have an effect on blood pressure, even if it was not their primary purpose. The Adviser does not consider it unreasonable for all the medicines to have been restarted all at once because continual withdrawal could also lead to adverse consequences. The Adviser stated:

> 'The prescribing doctor could reasonably assume that the patient had tolerated the drugs previously in this combination, and in the absence of evidence of marked blood pressure lability (fluctuation) in this setting of acute stroke, or continuing hypovolaemia (low blood pressure caused by, for example, dehydration), or worsening renal function, it was not unreasonable to judge that this would continue to be the case.'

30. Furthermore, the adviser explained that:

> 'In cases of acute stroke, the optimal management of blood pressure and high blood pressure in particular, is a matter of considerable uncertainty. The potential importance of the issue and the level of uncertainty that currently exists is reflected in the fact that several major clinical trials are currently underway to attempt to define the best treatment strategy.'

31. However, the Adviser pointed out that it would have been preferable if the medical staff had clearly documented the advantages and disadvantages of continuing to withhold or restart each of these treatments.

(c) Conclusion

32. Given the Adviser's opinion, the reintroduction of the usual medicines altogether were likely to be the main cause of the sudden drop in blood pressure and worsening of Mr A's condition. That being said, the effects are known in hindsight and given the potential for harm with continued withholding

of these medicines, together with the fact that Mr A previously tolerated this combination, I do not consider the actions of the medical staff to be inappropriate or unreasonable. Therefore, I do not uphold the complaint.

(d) There was a delay in the swallow assessment and nasogastric tube being inserted

33. Mrs C complained that there was a delay in the swallow assessment being undertaken and nasogastric tube being inserted which resulted in Mr A not receiving nutrients and his usual medications to treat high blood pressure for three days.

34. The Board told Mrs C that they did not consider there had been any significant delay in the swallow assessment being conducted or nasogastric tube being inserted. The Board said that a swallow assessment had been requested on 20 April 2008 and thereafter conducted by Speech and Language Therapy (SALT) on 22 April 2008. The Board further commented that Mr A had been given IV fluid to ensure hydration was maintained during this time.

35. The clinical records indicated that a nurse had undertaken an initial swallow assessment on 20 April 2008. The nursing note suggested that Mr A was experiencing delayed swallowing and, as a result, nil by mouth (NBM) was instructed. The records by SALT on 22 April 2008 also suggested that Mr A was to remain NBM and a nasogastric tube be inserted as an alternative method of feeding.

36. The Adviser told my complaints reviewer that the actions by the nurse on 20 April 2008 demonstrated good practice because an initial swallow assessment was conducted in order to identify if Mr A required to be reviewed by SALT. The Adviser considered that the subsequent review by SALT on 22 April 2008 did not represent an unreasonable or unusual delay, either for Mr A or in general. The adviser further commented that the decision to commence IV fluid was appropriate because Mr A could not swallow and may have been dehydrated due to his recent episode of diarrhoea and vomiting.

37. The Adviser considered whether earlier placement of the nasogastric tube and administration of Mr A's usual medication might have avoided the subsequent deterioration in his condition on 23 April 2008. The Adviser told my complaints reviewer that it would not be correct to assume that the four day gap, from when Mr A would have last taken his medication at home until their

reintroduction on 23 April 2008, made it more likely that an adverse effect would occur. The Adviser explained 'If the patient was volume depleted or dehydrated on admission then it could be argued that adverse consequences would be more likely to occur if the drugs had been given on day 1 or 2, before fluid deficit was corrected'.

(d) Conclusion

38. I recognise Mrs C's concerns that Mr A's blood pressure remained high at this time and he had not been receiving his usual medication for high blood pressure until three days after being admitted to hospital. However, based on the adviser's advice, appropriate steps had been taken to address Mr A's hydration level while awaiting review from SALT and the stroke team. I am satisfied with the Board's response and agree that there was no unreasonable delay in either the swallow assessment being conducted or nasogastric tube being inserted. Therefore, I do not uphold the complaint.

(e) There was a delay in the Board responding to the complaint

39. Mrs C complained that the Board did not respond to her complaint in a timely manner. Mrs C thought that the delay was a result of the Board taking their time to seriously investigate the issues which she had raised on 11 November 2009.

40. From the time the complaint was submitted, it took approximately 15 weeks for the Board to write to Mrs C with the results of their investigation. The Board initially wrote to Mrs C on 14 November 2008 acknowledging receipt of the complaint and requesting written consent from Mr A in order that the issues could be investigated. The Board then wrote to Mrs C five days later acknowledging that they had received the completed consent form and that they aimed to respond to the complaint within four weeks time. The letter also explained that if this was not possible, a reason for the delay would be given.

41. Between 1 December 2008 and 16 February 2009, the Board wrote to Mrs C on five separate occasions to inform her of the delay in their investigation. However, none of the letters clearly explained the reason for the delay. The Board have since been unable to provide any specific reason for the delay, although they have subsequently stated that it was an unacceptable time to respond to any complaint. Furthermore, they have since introduced a number of measures to ensure timely responses to complaints.

(e) Conclusion

42. My complaints reviewer has reviewed the relevant guidance issued by the Scottish Parliament in relation to the NHS Complaints Procedure and it is clear to me that the Board did not handle Mrs C's complaint in accordance with the guidance which states:

> 'The investigation of a complaint should be completed wherever possible within 20 working days following the date of receipt of the complaint. Where it appears the 20 day target will not be met, the complainant must be informed of the reason for the delay with an indication of when a response can be expected. The investigation should not normally be extended by more than a further 20 working days.'

43. My complaints reviewer noted that the Board did not seek agreement for the investigation to be extended beyond 40 days; they did not give a full explanation to Mrs C for the delay; nor indicate when a response could be expected. Although I agree with the Board's comments that 15 weeks was an unacceptable length of time to respond to any complaint, the Board did retain contact with Mrs C to explain that the investigation had not yet been completed and offered an apology. While I am satisfied that the Board have taken reasonable steps to prevent the problem recurring, I uphold the complaint. I do not require the Board to take any further action.

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

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Board	Tayside NHS Board
Mr A	Mrs C's father
The Hospital	Ninewells Hospital
The Adviser	A specialist medical adviser to the Ombudsman
SEWS	Scottish Early Warning Score
The Consultant	A specialist stroke consultant at Ninewells Hospital
IV	Intravenous
SALT	Speech and Language Therapy
NBM	Nil by Mouth

Annex 2

Glossary of terms

Cannula	a tube for inserting into the body which can be used to administer fluid
Dysphasia	Difficulty in using language
Nasogastric tube	A tube that is inserted through the nasal passages in order to pass liquids or other substances into the stomach
Scottish Early Warning Score	A guidance tool used to identify early clinical deterioration in patients
Scottish Early Warning Score chart	A chart to document the Scottish Early Warning Score

Annex 3

List of legislation and policies considered

NHS Complaints Procedure 2005 Guidance – Can I help you?