Scottish Parliament Region: South of Scotland

Case 201100469: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; general medical; clinical treatment

Overview

The complainant (Mrs C) raised a number of concerns against Ayrshire and Arran NHS Board (the Board) regarding the care and treatment her late husband (Mr A) received at Crosshouse Hospital from his admission on 21 May 2010 up to his death on 23 May 2010.

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) failed to administer the prescribed anti-seizure and steroid medication (*upheld*);

(b) failed to recognise and address Mr A's pain (*not upheld*);

(c) failed to implement the Liverpool Care Pathway until 23 May 2010 (*not upheld*); and

(d) failed to provide adequate care and attention on the night of 22 to 23 May 2010 (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) ensure that measures are taken to feedback the learning from all aspects of this event to the medical team involved with Mr A's care, to understand the importance of avoiding similar situations recurring;	20 June 2012
(ii) review the process of pain scoring, its frequency and recording in this case and feedback the learning to nursing staff;	20 June 2012
(iii) complete a review of the LCP within the unit and feedback the learning to all medical and nursing staff within the unit;	11 July 2012

(iv)	complete a full review of their medical staff cover for the night of 22 to 23 May 2010 to ensure such situations do not recur;	20 June 2012
(v)	provide an update of their review on the use of pager numbers; and	20 June 2012
(vi)	apologise to Mrs C for the failures identified in this report.	6 June 2012

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

Main Investigation Report

Introduction

1. On 15 May 2011 the Ombudsman received a complaint from Mrs C about the care and treatment received by her late husband (Mr A), during an admission to Crosshouse Hospital (the Hospital) between 21 May 2010 and 23 May 2010.

2. Mr A presented at the Hospital on 21 May 2010 for a chest x-ray and platelet transfusion. He had a known malignant brain tumour, diagnosed in 2009; however, Mrs C stated this was under control. Mr A died in the Hospital on 23 May 2010 aged 51. Mrs C stated that had it not been for the failures of Ayrshire and Arran NHS Board (the Board), Mr A may have survived his final episode of seizures which occurred at the Hospital. Mrs C also said that the treatment Mr A received at the Hospital was 'barbaric'.

3. The complaints from Mrs C which I have investigated are that the Board:

(a) failed to administer the prescribed anti-seizure and steroid medication;
(b) failed to recognise and address Mr A's pain;
(c) failed to implement the Liverpool Care Pathway (LCP) until 23 May 2010; and
(d) failed to provide adequate care and attention on the night of 22 to 23 May 2010.

Investigation

4. As part of the investigation, my complaints reviewer obtained copies of Mr A's clinical records (the Records) and the complaints correspondence from the Board. Advice was sought from one of my independent medical advisers (the Adviser). The LCP Guidelines were reviewed.

5. I have not included in this report every detail investigated but 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 failed to administer the prescribed anti-seizure and steroid medication

6. Mrs C stated that Mr A was referred to the Hospital by his GP (the GP) on 21 May 2010 to be admitted for a chest x-ray and a platelet transfusion (blood particles vital for blood clotting). Mrs C said that Mr A had a brain tumour;

however, at the time he presented at the Hospital his condition was under control. While Mr A waited to be admitted, he suffered a seizure and was taken to resuscitation. Mrs C stated she was advised Mr A would be taken for a scan and if there was no major change in his condition he would be given his platelets. Mrs C handed over Mr A's medication, which she had taken with her, to staff while Mr A was taken to the High Dependency Unit (the HDU).

7. Later that evening (21 May 2010) Mr A was taken for a scan which revealed no major changes, however, Mr A was not given his platelets transfusion. Mrs C stated she was given no reason for this, despite the enquiries she made at that time. She also said she repeatedly asked medical staff why Mr A had not received his anti-seizure medication and steroids (see paragraph 6), however, again no explanation was given to her for this.

8. According to Mrs C, because of the lack of giving Mr A these drugs, his head, face and neck swelled up until he was unrecognisable. She said Mr A then suffered another seizure, but again received no medication - only oxygen was administered to him. Mrs C stated that Mr A was then moved to another ward as she was told by medical staff his HDU bed was needed for another patient. She said at this time the only other treatment Mr A received was a bed bath and also a fan was provided.

9. Mrs C said that some 40 hours after Mr A was first admitted he was again moved to another ward and seen by a doctor who came from the Ayrshire Hospice. After this visit the steroid and anti-seizure drugs were re-instated, Mr A's swelling went down and he was comfortable until he died late evening on 23 May 2010.

10. In the Board's response to our enquiries, the Executive Nurse Director (the Director) stated that Mr A's GP hospital referral letter stated that Mr A was on levetiracetam (Keppra) 500 milligrams twice daily (anti-convulsant medication). The Director then provided a timeline of the clinical review of Mr A and the prescribed anti-convulsant medication administered to him at the Hospital during his admission.

11. The Director stated that given Mr A's underlying illness, it was predictable that Mr A 'would need ongoing antiepileptic medication and in omitting it could provoke further seizures'. She added that either continuing with the drug phenytoin or switching back to levetiracetam would have been reasonable

options. She added 'there was a 44 hour gap between the phenytoin and the levetiracetam being restarted. This appears to be due to oversight. As deliberate omission was not documented.' The Director stated that this oversight had been communicated to all parties.

12. The Director provided comments on the GP referral letter entry that Mr A was prescribed steroid medication (dexamethasone). She commented that 'it seems that there was confusion about whether the steroids were prescribed' (during the period Mr A was in the Hospital). 'Whilst it is unlikely that any harm came from this over the short timescale, it represents a further failure.'

13. The Director said that a new proforma is being piloted which includes medicines reconciliation to minimise the risk of omissions such as in this case.

> 'By the end of next year we expect to have an electronic prescribing system in place which will also reduce the risk of this type of omission. The doctors involved have been informed of these omissions and are aware of the consequences for the patient and the family.'

14. According to the Director one of the reasons that the GP referred Mr A to the Hospital as an emergency on 21 May 2010 was a low platelet count. The Director stated that a translation of the GP's referral note was 'for platelet transfusion if required' (see paragraph 6). According to the admission records, on 21 May 2010 Mr A's platelet count had risen to 35x10/L. Given this and the absence of scan evidence of bleeding on the brain, a consultant decided there was no need to give Mr A a platelet transfusion at that point (see paragraph 7).

15. The Adviser noted that Mr A was known to have a malignant primary cerebral (brain) tumour (a glioblastoma), diagnosed in 2009, which had been treated by surgery, chemotherapy and radiotherapy and he was referred to the Hospital on 21 May 2010 for low level of platelets. The Adviser said that Mr A suffered an epileptic fit at the Accident and Emergency department (the A&E) of the Hospital and was treated with intravenous anti-convulsant drugs. The Adviser noted at that time, Mr A's conscious state was very poor as demonstrated by the Glasgow Coma Scale (GCS) score of 3 out of 15.

16. The Adviser stated that Mr A had been on (anti-seizure) levetiracetam (Keppra) at home, and noted it was not given to Mr A at the Hospital until about 12 hours before he died, despite there being an intravenous form available.

17. The Adviser considered that the management of Mr A's acute seizures was initially reasonable, in that other drugs (lorazapam, phenytoin) were used in A&E. He stated that during the next two days lorezepam and another drug midazolam were given to Mr A and both can be given in epilepsy.

18. However, given Mr A's diagnosis and that it was likely other fits would and did occur, the Adviser stated that much greater consideration should have been given to a preventative regime of anti-convulsants.

19. The Adviser also specifically commented on the use/discontinuation of the drug levetiracetam (see paragraphs 7 and 16) as follows:

- this drug should not be stopped abruptly and should have been considered and commented on in the notes by the medical team;
- it can paradoxically cause seizures;
- it can cause thromnocytopaenia – the finding on the blood test that was carried out by the GP and the reason he referred Mr A to the Hospital (see paragraph 6). The Adviser stated he could see no evidence that this side effect was thought about at all. 'However had it been recognised, the drug would almost certainly have been withdrawn'.

20. The Adviser stated that while he does not regard the use of levetiracetam as essential, in his view knowledge of the drug by staff was apparently lacking. Furthermore, some form of anti-convulsant therapy should have been prescribed for reasons of prevention (see paragraph 18).

21. The Adviser considered that this error was the fault of the medical team collectively. In particular, the fact that there was nothing in the notes about why anti-convulsive drugs were given in the way which occurred 'is a criticism of the medical staff in its own right concerning standards of note keeping'. Furthermore, he stated that all members of the medical team must bear some responsibility for failure to ensure that required drugs were properly prescribed and administered to Mr A and if a decision was made not to give a specific agent, the notes should have reflected that decision and they did not. In the Adviser's view, the medical registrar and consultant bear most of the criticism in this respect.

22. The Adviser stated that the omission of steroids in this case was an error. Furthermore, Mr A had been on dexamethasone for some time and no steroid drug taken over a long term should be stopped abruptly.

23. The Adviser stated that in his view the omission of administering steroids was unlikely to have caused harm, as there was nothing he has seen in the Records to suggest this. However, while he stated that the stopping of dexamethasone was an error, he could not say whether increased brain swelling occurred as a result, as this was not known (see paragraphs 8 and 22).

24. The Adviser concluded it was important to state that what type of drug to prescribe when any patient is admitted to hospital is part of very basic medical care and can only be achieved by medical education. He expressed surprise at the failures and lack of methodical approach he had seen in this case. However, he noted that the doctors concerned were made aware of the deficiencies and that the Board had instituted a procedure to ensure that reasons were written if a regular drug were stopped. He said that electronic prescribing may enhance this safety procedure (see paragraph 13).

25. The Adviser stated that a low platelet count can cause bleeding and Mr A had shown evidence of bleeding into his skin, however, not the brain. Additionally, on his admission to the Hospital A&E, the platelet count was a little higher. The Adviser stated, therefore, the platelet transfusion was not needed (see paragraphs 7 and 14).

(a) Conclusion

26. Mrs C complained that Mr A's GP prescribed anti-seizure and steroid medication was not administered from when he was admitted at the Hospital on 21 May 2010. As a result, Mrs C said Mr A's medical condition significantly deteriorated and his physical appearance reflected this. However, once Mr A's prescribed medication was re-instated, over 40 hours later, he became visibly comfortable until his death.

27. My investigation has established several systemic failures from Mr A's admission to the Hospital on 21 May 2010, that:

- there was an acknowledged 44 hour gap between phenytoin and levetiracetam being restarted (see paragraph 11 and 16);
- there was an acknowledged confusion whether steroids were prescribed;
- the omission of steroids was an error (see paragraphs 21, 22 and 23);
- inadequate consideration was given to a preventative regime of anti-convulsants (see paragraph 18);

- there was an apparent lack of knowledge of levitraceptam (see paragraph 20);
- there were inadequate standards of note keeping (see paragraph 22).

28. I have carefully considered all the evidence outlined above and taken account of the Adviser's comments alongside the issues and knowledge presented in the Records. In summary, I have seen a degree of poor organisation and lack of attention to detail regarding Mr A's care. For example, with regard to the medical aspect, it has been demonstrated there was a poor medical knowledge of the drug levetiracetam. There was also a poor assessment of the need of preventative anti-convulsant therapy, combined with a basic error made in the discontinuation of steroid treatment. This, combined with a failure to document reasoning for the changes in treatment given to Mr A, indicate a lack of attention to good medical record keeping and/or a lack of knowledge about this. Taking all these factors into account I uphold this complaint.

(a) Recommendation

29. I recommend that the Board:	*Completion date*
(i) ensure that measures are taken to feedback the learning from all aspects of this event to the medical team involved with Mr A's care, to understand the importance of avoiding similar situations recurring.	20 June 2012

(b) The Board failed to recognise and address Mr A's pain

30. Mrs C expressed her upset and said that no pain relief had been administered to Mr A. She said he knew his illness was terminal and that he understood the end could be painful. Mr A did not want to be in pain and Mrs C said he did not get his wish. Mrs C stated she was particularly upset that the Records showed his pain score was nil, as she said she knew he was in pain and questioned how the medical staff could not be aware of this.

31. The Director provided a timeline of pain control and stated that on 21 May 2010 paracetomol was administered and from 22 May 2010 morphine was prescribed as required. She acknowledged that it may be difficult to recognise pain in a patient who was less able to respond and stated that family members know a patient and may be more receptive to signs of pain, 'though agitation and tachyponea may also occur for other reasons'. She added that

despite low pain scores recorded for Mr A, analgesia appears to have been used reasonably liberally, which she said suggested nursing staff were taking family views into account. The Director stated that action would be taken to assess if the pain scores were done at an appropriate frequency.

32. The Adviser stated it was difficult to gauge/assess from the Records the degree of pain Mr A suffered. In this regard he noted that Mr A had complained of increasing headaches in the days before his Hospital admission.

33. The Adviser stated that pain scoring was the province of nursing staff. He said that in this case it was done 'somewhat haphazardly'. However, he noted from the Records that reasonable types and quantities of analgesics were given.

34. The Adviser stated it was more difficult to recognise pain in poorly responsive patients as Mr A. For example, agitation may be a sign that a patient is experiencing pain or discomfort, however, other factors such as cerebral irritation can create agitation.

35. The Adviser said that the frequency of administration of pain killers was documented in the Records and indicated a reasonable standard of Mr A's pain recognition. He stated that the range of analgesics used and the attempts at pain scoring demonstrated that there was not a failure to recognise Mr A's pain in a timely manner. However, a better-ordered analgesic regime was required (see paragraph 32).

(b) Conclusion

36. Mrs C stated that Mr A's pain was not recognised or addressed. The Adviser outlined the difficulties in recognising pain in less responsive patients. He stated that there was adequate and reasonable administration of analgesics to Mr A and in good time. For these reasons I do not uphold this complaint.

37. I have noted that the Director stated action would be taken to assess if the pain scores were done at an appropriate frequency. However, I am critical of the overall pain scoring which was 'somewhat haphazard' and make the following recommendation.

(b) Recommendation

38. I recommend that the Board:	*Completion date*
(i) review the process of pain scoring, its frequency and recording in this case and feedback the learning to nursing staff	20 June 2012

(c) The Board failed to implement the LCP until 23 May 2010

39. Mrs C stated that she constantly asked for the LCP to be put in place when Mr A was in the Hospital, however, doctors refused to implement it.

40. In her complaint to us, Mrs C stated that she had asked the Board why the LCP had not been implemented, when it had been set up and signed off by two doctors. Mrs C stated she had not received a satisfactory response. Furthermore, the LCP was supposed to ensure that when the end came it would be as pain free as possible, but this did not happen (see complaint (b)).

41. The Director stated that the LCP offers a useful framework to guide the managements of symptoms in end-of-life-care. However, it did not substantially change Mr A's management. Furthermore, the LCP does not preclude the administration of necessary drugs such as anti-convulsants. She outlined that the Board proposed to discuss this issue with the medical registrar involved with Mr A's care.

42. The Adviser stated that the LCP is a framework of care for dying patients. He added that it is not in any way a mandatory course of action to be followed 'nevertheless it is a very useful tool to help create an orderly programme of care'.

43. He stated that in his view, the failure to implement the LCP until Mr A's final day on 23 May 2010 did not affect the outcome. However, there was a lack of recognition by the Board that use of the LCP should be a widespread policy. In addition he stated that, while he agreed the proposal to advise the relevant registrar about the LCP was appropriate, he was not satisfied with such singular action. He stated that the value of the LCP required further discussion throughout the Board's medical units.

(c) Conclusion

44. Mrs C complained that the management of Mr A's end of life care was inadequate, in that the LCP was not implemented until 23 May 2010.

45. The LCP is not a compulsory programme; it is an intervention for mutual decision making and organisational care. I have taken account that the LCP was not implemented before 23 May 2010, however, there is no evidence I have seen that this had an effect on Mr A's outcome. For these reasons I do not uphold this complaint.

46. However, taking into account the advice I have received I have one recommendation to make.

(c) Recommendation

47. I recommend that the Board:	*Completion date*
(i) complete a review of the LCP within the unit and feedback the learning to all medical and nursing staff within the unit.	11 July 2012

(d) The Board failed to provide adequate care and attention on the night of 22 to 23 May 2010

48. Mrs C stated that that there was a period when the medical staff either did not attend or delayed to attend to Mr A. She said that on the night of 22 to 23 May 2010 the nurses had difficulty in getting doctors to attend to Mr A. Mrs C stated that the Board told her this was an issue that was out of their control.

49. The Director told me there was generally prompt, frequent and senior review of Mr A throughout his admission; however, there appeared to have been difficulties securing medical review between 00:10 and 07:30 on 23 May 2010. She stated that the delayed review was unsatisfactory, however, would not have altered the care of Mr A substantially. The Director also described the level of staffing at the time of day in question. She said action would be taken by the doctor who would (i) discuss the cause of Mr A's delayed review with the registrar and (ii) check with senior nursing staff to review use of pager numbers.

50. The Adviser stated that there was clear documentation in the Records that medical assistance was requested for Mr A through the night of 22 to 23 May 2010 for a variety of reasons, which included fever, chestiness and possible headache. He noted that an excessive period elapsed without that help arriving. The Adviser stated that while the doctor on call gave the excuse

she was on her own, he said 'this may have been a valid excuse but it does not alter the fact that it was ultimately the Board's duty to provide adequate medical cover at all times'. He also stated that this deficiency was probably compounded by nurses using a wrong pager number to call the doctor. According to the Adviser, this suggested a degree of poor organisation in the unit as a whole. He said that as a result Mr A suffered a variety of unpleasant symptoms for longer than was necessary and would have contributed to his and his family's distress.

51. The Adviser said that the reasons given by the Board for this situation were unacceptable. In his view, it seemed clear that the staff workload ratio was inadequate and the situation should not have been allowed to happen. He stated that the Board's planned action was inadequate as the reason for the delay was 'largely attributable to a lack of on-call doctors' and their proposed action of 'discussions with the registrar' was not a solution (see paragraph 48).

52. The Adviser also disagreed with the Board's view on this matter. He considered that while the outcome for Mr A (death from a cerebral tumour) would not have been altered, it was the responsibility of the Board to ensure that patients in the terminal stage of life should receive full palliative care. He stated that the delay in dealing with Mr A's various problems (see paragraph 49) caused distress to him and his family and the Board's explanation about this was inadequate.

(d) Conclusion

53. Mrs C complained that Mr A did not receive the appropriate level of medical care and attention on the night of 22 to 23 May 2010. The Board agreed there were delays in Mr A's care and treatment, however, stated (i) this was outwith their control and (ii) it did not substantially affect Mr A's care.

54. I have seen that medical assistance was requested for Mr A throughout the night of 22 to 23 May 2010 for a variety of concerns; however, an excessive period lapsed without any medical help forthcoming.

55. I have taken account of the advice I have received and the evidence presented in the Records. The events which occurred in relation to Mr A's management on the night of 22 to 23 May 2010, together with the comments of the on-call doctor, lead me to the view that medical staffing was inadequate/mismanaged and this was a situation which demonstrated poor

organisation and which should not have occurred. Furthermore, the explanations given by the Board for this situation are unacceptable. It is clear that the lack of timely medical care may have contributed to additional distress for Mr A and his family. Taking all these factors into account I uphold this complaint.

(d) Recommendations

56. I recommend that the Board:	*Completion date*
(i) complete a full review of their medical staff cover for the night of 22 to 23 May 2010 to ensure such situations do not recur;	20 June 2012
(ii) provide an update of their review on the use of pager numbers.	20 June 2012

General Recommendation

57. I recommend that the Board	*Completion date*
(i) apologise to Mrs C for the failures identified in this report.	6 June 2012

58. 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	Ayrshire and Arran NHS Board
Mr A	The aggrieved, Mrs C's late husband
The Hospital	Crosshouse Hospital
LCP	Liverpool Care Pathway
The Records	Mr A's medical records
The Adviser	One of the Ombudsman's clinical advisers
The GP	Mr A's local general practitioner who referred him to the Hospital
HDU	High Dependency Unit
The Director	The Executive Nurse Director
A&E	The Hospital Accident and Emergency department

Annex 2

Glossary of terms

Analgesia	Pain killers, used to relieve pain
Chemotherapy (chemo)	Treatment of cancer with a combination of drugs
Dexamethasone	A steroid drug
Gioblastoma	Most common and aggressive malignant primary brain tumour
Levetiracetam (Keppra)	Anti-convulsant medication used to treat epilepsy
Lorazepam	Drug used to treat anxiety
Midazolam	A sedative
Morphine	A narcotic pain reliever
Paracetomol	A widely used pain reliever
Phenytoin	Commonly used anti-epileptic drug
Platelet	Cells which circulate in the blood
Radiotherapy	Treatment of a disease by radiation
Scan	X-ray computed tomography
Steroids	Drugs which increase protein in cells
Tachyponea	Rapid breathing
Thrombocytopaenia	A decrease of platelets in the blood

Annex 3

List of legislation and policies considered

What is the Liverpool Care Pathway For The Dying Patient: The University of Liverpool; April 2010