Scottish Parliament Region: North East Scotland

Case 200501564: Grampian NHS Board

Introduction

1. On 8 September 2005 the Ombudsman received a complaint from a man (Mr C) against Grampian NHS Board (the Board) regarding the care and treatment provided for his mother, Mrs C, at Woodend Hospital, Aberdeen (the hospital) in March 2004. Mrs C was admitted to the hospital on 25 March 2004 at about 01:00. Sadly she died there at about 10:55 that day.

2. The complaint from Mr C which I have investigated by the hospital is that the care and treatment provided for Mrs C was inadequate and inappropriate. I did not uphold the complaint *(see paragraph 11).*

Investigation and findings of fact

3. In the course of the investigation of this complaint all the documentation supplied by Mr C and the Board and Mrs C's clinical records have been considered. Advice was obtained from a medical adviser to the Ombudsman, a hospital consultant (the adviser). I have set out my findings of fact and conclusions below. Mr C and the Board have been given the opportunity to comment on the draft of this report.

Mr C's complaint to the Board

4. On 16 September 2004 Mr C formally complained to the Board about the care and treatment received by his mother. He referred to earlier letters written by his father and himself to the Sister in charge of his mother's ward.

The Board's reply to Mr C

5. On 31 January 2005 the Board replied:

> '… You expressed a number of concerns which we identified [as the following] (1) That your mother died due to medical negligence and delay (2) Communication with you following your mother's admission to hospital (3) Concern about the competence of the nursing staff (4) That something was done to your mother that led to her death (5) The fact that your mother

had no family with her when she died.

… I will address each in turn.

(1) Your mother received appropriate care. She was admitted to [the hospital] as an emergency from home via GDOCS at 01.00 hours on 25 March 2004. A doctor saw your mother shortly after her admission to Ward 15. Her pulse rate was regular, at 70 beats per minute, and her blood pressure was a little low. There was no evidence of heart murmurs or any swelling of the limbs caused by fluid retention.

Your mother's respiratory rate was within acceptable limits and her oxygen saturation rate was satisfactory. There were sounds in the right lung but air entry was good and there was no wheeze. …

Your mother's abdomen was examined and was completely normal, as was observation of her neurological condition. Her right pupil was noted to be abnormal but this was due to previous cataract surgery.

It was noted that the medical staff felt that your mother had a urinary tract infection and that the medication she was receiving for her heart condition might have contributed to her becoming unwell. A cardiograph indicated some abnormalities that may have been there before your mother's admission. Blood tests were taken and your mother was started on an intravenous infusion (drip). A chest x-ray was arranged for morning.

A more senior doctor reviewed your mother at 08.00 hours and considered that your mother may have had a chest infection. The chest x-ray was carried out and it was reported that both your mother's lungs were filling with fluid due to the inability of her heart to pump blood round her system effectively.

The doctors in Ward 15 properly examined and diagnosed your mother's condition and she did not experience any delay or negligence in her care.

(2) Medical staff spent a considerable amount of time trying to explain the

extent of your mother's illness to the family. I realise that it can be difficult to comprehend this news when a dearly loved relative is coming to the end of their life but staff made every effort to appraise you of the situation.

(3) Nurses cared for your mother during the night. She was reported as having a settled night. All nurses employed by NHS Grampian are appropriately qualified and undertake regular training.

(4) Medical and nursing staff did nothing which led to your mother's death. Staff acted appropriately to meet your mother's clinical needs.

(5) It is regrettable that a family member was not with your mother when she died. Your mother suffered a cardiac arrest and the medical team worked very hard to resuscitate your mother but were unable to revive her. All appropriate medication to address your mother's condition was administered. The cause of your mother's death was sepsis (overwhelming infection), as a result of pneumonia. …'

Further correspondence with the Board

6. Mr C was not satisfied with the Board's reply and went on to ask the Board's Convener for an independent review of his complaint (stage 2 of the NHS complaints procedure at that time).

7. The Convener asked the Board to provide him with some further information in relation to Mr C's complaint. The information provided by the Board included that:

(1) it was recorded in the medical notes on 25 March 2004 at 02:30 hours that Mrs C did not speak English and that the history was obtained from Mr C. Another entry in the notes during the examination of Mrs C showed that staff were communicating with Mrs C via Mr C. When Mr C left Mrs C was settled and able to communicate to staff that she needed the toilet. The nurses had Mr C's telephone number should a problem arise and staff were also aware of the Board's protocol for contacting a translator if needed;

(2) soon after Mrs C's death medical staff spoke to Mr C. Clinical diagnoses were discussed with Mr C including that a post mortem

examination could provide further information. Mr C wished to discuss the matter with family members. It was subsequently recorded in the clinical records that the family had decided against a post mortem examination.

8. In a letter dated 16 August 2005 the Convener explained to Mr C why he had decided not to set up an independent review panel.

Complaint to the Ombudsman

9. On 8 September 2005 Mr C complained to the Ombudsman that the Board had not adequately addressed his concerns about his mother's care and treatment.

Adviser's opinion

10. The adviser provided the following advice:

'*History.* On 24 March 2004 Mrs C was admitted to the hospital via the GP on-call service. The referral letter written at 22:40 hours describes a collapse at 13:00 hours followed by confusion, vomiting and rigors. The GP queried urinary tract infection (UTI) as a cause for her symptoms. This was a very reasonable diagnosis since UTI is common in elderly women and the symptoms described were typical of that condition.

At the hospital the history of what had happened was obtained from Mr C and recorded by the House Officer on 25 March 2004 at 02:30 hours and Mrs C was examined by the House Officer. The provisional diagnosis was UTI. Arrangements were made for urine examination and for her to have a chest X-ray in the morning. With urinary infections it is usual to wait until a urine specimen has been tested before giving an antibiotic. Slow intravenous fluid was started.

The Senior House Officer on duty at the time was informed of the management plan and he was happy for Mrs C to be reviewed in the morning. By 04:30 hours her blood count result had been obtained and indicated that she had an infection. Mrs C had still not been able to provide a urine sample. At 05:15 hours her blood pressure had improved. Still no urine had been passed. The records indicate that cultures were taken. This probably means blood cultures. In view of the lack of a urine sample to test

for microbiology, it was reasonable to attempt to identify the particular bacteria from a blood culture. It was necessary to identify the bacteria in order to confirm the diagnosis and to select the appropriate antibiotic. An entry in the notes appears to indicate that it was thought reasonable to continue to withhold antibiotics since her condition was stable.

At 07:05 hours Mrs C had still not passed urine. At this stage a sample of urine could have been obtained via a catheter. This was considered because there was an entry in the notes that says *"unlikely patient would tolerate catheter".* Mrs C was still stable. The diagnosis was *"still UTI vs LRTI"* [still urinary tract infection versus lower respiratory tract infection (pneumonia)] meaning that pneumonia was still a possibility.

At 08:00 hours Mrs C was reviewed by the Senior House Officer who recorded a detailed summary of events so far. The differential diagnosis was *"?UTI/?LRTI".* Augmentin (an antibiotic) was started. The Senior House Officer recommended an increase in her intravenous fluids, oxygen and nebulised salbutamol, a chest x-ray, a bladder scan and to catheterise if necessary.

On 25 March 2004 at 09:55 hours Mrs C had an unresponsive episode while on the commode. Following measures to improve her ventilation there was an increase in her heart and respiratory rate and blood pressure. However, this response was only temporary because at 10:05 hours there was marked deterioration and it was clear that it was unlikely she would survive. Full resuscitation including intubation was continued to 10:55 hours.

The Consultant had spoken to her son during the initial resuscitation and again afterwards at 11:35 hours. At this time he discussed the clinical diagnosis. He explained that there was no proof of urinary infection but that it could not be ruled out completely. Mrs C did have sounds in the chest as well on admission. The cause of death was given as:

1a Systemic sepsis
b Bronchopneumonia
11 Ischaemic heart disease and cardiac failure.

Post mortem examination was discussed with the family, but permission for this was refused.

Commentary on clinical management. Some quite difficult clinical decisions had to be made. The clinical picture on admission was very suggestive of a urinary infection. The shivering, the vomiting and the confusion all fit very well with this diagnosis. The standard management for urinary infection is to obtain a urine sample and then to start antibiotics. In this case a sample could not be obtained. Alternative measures would have been either to start antibiotics anyway, to take a blood culture and start antibiotics or to obtain a sample via a catheter and then start antibiotics. Had Mrs C been seriously ill at this stage or had LRTI been considered likely then antibiotics should have been given immediately. However, her condition was described as stable and I think the decision to withhold antibiotics until a urine sample had been obtained was reasonable. It was correct for the House Officer to discuss the management with the Senior House Officer.

The alternative diagnosis was LRTI (pneumonia) and it was concluded that this was the cause of her death. Where there is a provisional diagnosis of pneumonia then management is different from that of UTI. It is important that antibiotics are started immediately without waiting for any samples such as sputum. When she was admitted Mrs C had crepitations in the right side of her chest, and this finding would be consistent with pneumonia. Crepitations are not diagnostic of pneumonia and sometimes they are due to a problem of long standing such as localised lung fibrosis. Moreover there were no other features to suggest pneumonia. Rigors are not a usual feature of pneumonia, whereas they are typical of UTI. There was no increase in respiratory rate and the oxygen saturation was normal. I can therefore appreciate why UTI was the preferred diagnosis.

A chest X-ray was ordered, and this was reasonable, particularly as there were sounds in the chest. Should it have been done immediately? If the likely problem was pneumonia then the answer was yes. Had Mrs C been obviously very ill then again the answer would be yes. However, since the likely diagnosis was UTI, and since her clinical condition did not appear to

warrant an immediate film I think the decision made was reasonable.

The clinical review by the Senior House Officer at 08:00 hours on 25 March 2004 shows some features of concern in that Mrs C's oxygen saturation had fallen, she was dehydrated and had a rapid respiratory rate. Her condition had deteriorated but not to the extent that an arrest was expected. The measures taken at this stage were all appropriate.

The cause of death was given as systemic sepsis caused by pneumonia. This means that Mrs C probably had circulating bacteria in the blood stream and this can cause a rapid deterioration in health. As well as having this problem she had heart failure and the combination of this and her infection was sufficient to cause her death. I suspect that she had UTI as well.'

Conclusion

11. It is clear from the clinical records that Mr C assisted in translating when Mrs C was first admitted to the hospital and when she was examined by the House Officer. Staff were able to contact Mr C if necessary and they were aware of how to obtain a translator if necessary. In these circumstances I do not consider the fact that Mrs C could not speak English adversely affected her care. Although I can understand why Mr C had concerns about his mother's care, taking account of the adviser's comments I am satisfied that Mrs C was properly assessed on her admission to the hospital and the management plan for her care was appropriate. I, therefore, do not uphold the complaint. However, I hope this report helps to reassure Mr C that his mother was afforded appropriate care.

12. Mr C also had concerns that his mother underwent procedures to which she did not consent. The Board have explained that when Mrs C suffered the cardiac arrest, attempts were made to resuscitate her as required by their duty of care to all patients in emergency situations such as this. I accept this explanation.

27 June 2006

Annex 1

Explanation of abbreviations used

GDOCS	Grampian Doctors On Call Service
Mr C	The complainant
The Board	Grampian NHS Board
The hospital	Woodend Hospital, Aberdeen
The adviser	The medical adviser to the Ombudsman

Annex 2

Glossary of terms

Arterial fibrillation	Irregularity of the heart beat
Crepitations	Crackling sounds heard through a stethoscope
Intubation	Insertion of a tube into the trachea to assist ventilation
LRTI	Lower respiratory tract infection (pneumonia)
UTI	Urinary tract infection