SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: South of Scotland

Case ref: 201305972, Dumfries and Galloway NHS Board
Sector: Health
Subject: Hospitals; clinical treatment/diagnosis

Summary
Mrs C complained that her late husband (Mr A) was not provided with appropriate care and treatment after he was admitted to Dumfries and Galloway Royal Infirmary. Mr A was admitted with a suspected stroke but developed severe diarrhoea. His condition deteriorated significantly over the next few days and he developed a number of other symptoms, including problems with his oxygen levels, his heart and his breathing. He was transferred to intensive care, but died some four weeks after he was admitted. Mrs C said that although she was very concerned about her husband's condition, he was not seen by a consultant until about a week after he was admitted. She repeatedly raised her concerns with staff, but felt these were dismissed. Mrs C felt it took too long to recognise that Mr A had had a heart attack, and said he lost all his dignity while in hospital and suffered unnecessarily.

The board met with Mrs C some months after she first complained, and wrote two months after that to further clarify what had been said, acknowledging her concerns that the heart attack was not diagnosed sooner. They said, however, that they hoped she was reassured that they had carried out a series of appropriate tests to diagnose Mr A's condition, although with hindsight this could have been done more quickly. They apologised for Mrs C's experience.

The records did not show what was said at the meeting, but there were statements from two doctors within the complaints papers. Both acknowledged that it was unfortunate that Mr A was not reviewed earlier, and that there were issues with availability of consultants. I also took independent advice on the complaint from a consultant cardiologist, who said that Mr A died following a critical illness, which culminated in multi-organ failure. Although he already had underlying health conditions, there was evidence of a recent heart attack and a related life-threatening condition. My adviser identified a number of failings in Mr A's clinical care, including that the heart attack could have been diagnosed sooner, fluid therapy was not appropriately managed, and medical records were inadequate, with electrocardiogram (heart function monitor) results that were not properly labelled and that did not appear to have been compared in

sequence. This meant that Mr A was not adequately reviewed and his heart problems not considered early enough - critical omissions when planning his treatment.

I accepted this advice and upheld Mrs C's complaint. I found that Mr A was not reviewed by a cardiac consultant early enough, and was placed on inappropriate fluid therapy, which compromised his treatment and meant that his care fell below a reasonable standard. I also found the board's complaints handling and apology inadequate, given that two senior members of board staff identified failures in Mr A's care, and that I saw no evidence of the board taking action to improve procedures as a result of Mrs C's complaint.

Redress and recommendations

I recommended that the Board:		*Completion date*
(i)	carry out a critical incident review into Mr A's death;	17 June 2015
(ii)	remind all staff of the importance of contemporaneous, accurate and full medical notes;	20 May 2015
(iii)	provide evidence that the complaint investigation has been reviewed, to establish why failings by the Board identified by staff members were not acted upon;	20 May 2015
(iv)	remind all staff of the importance of discussing completion of the decision to designate a patient as 'not for resuscitation' with either the patient or appropriate family members;	20 May 2015
(v)	provide evidence that the full report has been discussed by the Board at the first meeting following its publication; and	26 August 2015
(vi)	apologise unreservedly to Mrs C for the failings identified in this report.	20 May 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints

procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002. Under the Act, the Ombudsman can publish a public report and lay this before the Parliament where he considers that there is a public interest in the matter and it is appropriate to do so. The Act says that, generally, reports of investigations should not name or identify individuals, so in the draft report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Main Investigation Report

Introduction

1. Mr A was admitted to Ward 12 in Dumfries Royal Infirmary (the Hospital) on 2 April 2012. He had previously been treated on Ward 12 for stroke symptoms. During his admission to Ward 12, Mr A underwent a computerised tomography (CT) scan. This showed no change from previous admissions and he continued to receive his prescribed stroke medication. An electrocardiogram (ECG) was also performed and Mr A was provided with treatment for low levels of vitamin B12, as he was found to have a deficiency. Mr A also developed diarrhoea and samples were sent for testing.

2. Mr A became more seriously unwell on the morning of 4 April 2012, developing a high temperature and tachycardia (a heartbeat exceeding the normal range). Due to his continued diarrhoea, he was moved to a single room and placed in isolation, as a precautionary measure against infection. Mr A's blood pressure had begun to fall, due to dehydration, and he was provided with intravenous (IV) fluids.

3. Mr A's IV required replacement on 5 April 2012, however, due to the condition of his veins, ward medical staff were unable to reinsert it and requested assistance from a specialist. IV fluids were eventually recommenced at 10:00 on 5 April 2012.

4. Mr A's condition did not improve and he was monitored and provided with further IV fluids. On 7 April 2012 blood samples were taken. These were haemolysed (the structures of the red blood cells were damaged), meaning that accurate measurements were not possible. The blood tests were repeated but showed Mr A's condition had deteriorated and his IV fluids were increased.

5. By the afternoon of 7 April 2012 Mr A was found to be difficult to rouse and his oxygen saturation (the levels of oxygen in his blood) had dropped to 88 percent. He was provided with oxygen therapy, which increased his blood saturation levels to 95 percent. Nursing staff requested a medical review at this point and suggested that Mr A's IV fluid input might be causing a degree of cardiac failure. Medical staff felt on review that Mr A had a lower respiratory tract infection, combined with a degree of cardiac failure. He was commenced on antibiotic and nebuliser therapy and no further IV fluids were provided to him.

6. At 22:00 on 7 April 2012 Mr A was reviewed by nursing staff, as his heart rate was very high, without a discernible rhythm. An ECG was performed and Mr A's general observations were taken and medical review was requested. Mr A's condition continued to deteriorate and IV fluids were recommenced. By the morning of 8 April 2012 Mr A was considered to be reasonably stable, although he reported an incident of chest pain at 18:30. As there was no corresponding data from his heart monitoring equipment, Mr A was thought to have suffered pain from a muscular source, due to his chest infection.

7. Mr A's blood test results remained poor, as did his liver function. An ultrasound scan of his abdomen was requested and he was catheterised. On the morning of 9 April 2012, Mr A was reviewed by a consultant physician (Doctor 1). He had crackling in his right lung, but his left was clear. As he had experienced no diarrhoea for a forty eight hour period, he was removed from isolation; his antibiotics were also stopped as a precautionary measure, as there were concerns that they may have affected his liver function. Mr A was transferred to Ward 8 in the Intensive Care Unit (ITU) on 9 April 2012, as he was considered to have multi-organ failure.

8. Mr A was very confused on 12 April 2012 and on 13 April 2012, his wife Mrs C, noted that she was informed by medical staff that Mr A's heart was functioning very poorly, although he was responding to medication. Mr A's blood pressure remained low and his medication was altered again, as it was felt it might still be affecting his liver function. On 16 April 2012, Mr A was considered stable enough to be transferred from ITU to Ward 9.

9. Mr A was suffering from stomach pain and, on 17 April 2012, he was prescribed Gaviscon. Between 17 April 2012 and 24 April 2012, the record showed Mr A's heart and kidneys functioning a little better, although he was continuing to experience breathlessness. Mr A was very unwell on 25 April and he received a chest x-ray, which established he had an enlarged heart with a mild chest infection.

10. On 27 April 2012, Mrs C was advised that although Mr A was receiving the best possible treatment, his prognosis was very poor. It was also established that Mr A had been experiencing difficulty swallowing and had not been eating. An appointment with a dietician was arranged.

11. On 29 April 2012, Mr A was found to be having difficulty breathing and unresponsive to staff. Mrs C was contacted, but Mr A deteriorated rapidly and died before she arrived at the Hospital.

12. The complaint from Mrs C which I have investigated is that following an admission to the Hospital on 2 April 2012, staff failed to provide Mr A with appropriate clinical treatment in view of his reported symptoms *(upheld)*.

Investigation

13. In investigating this complaint I have had access to all the documentation Mrs C submitted, as well as Dumfries and Galloway NHS Board (the Board)'s complaint file. I have also had access to Mr A's medical records and I have taken advice from a consultant cardiologist (the Adviser).

14. 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.

Complaint: Following an admission to the Hospital on 2 April 2012, staff failed to provide Mr A with appropriate clinical treatment in view of his reported symptoms

15. Mrs C said that she felt her husband, Mr A, was not treated competently following his admission on 2 April 2012. Mrs C said that following his admission on 5 April 2012 she became very concerned, as Mr A was very cold and his eyes were yellow. She believed he was jaundiced, but recalls being told by medical staff that his colour was due to the effect of the ward lighting. On 9 April Mr A was transferred to the ITU. Mrs C recalled being informed that Mr A had suffered a heart attack on 10 April 2012, (although the heart attack had in fact happened at some point between his admission on 2 April 2012 and that point) and he was then transferred to the Cardiac Care Unit. Mrs C said that she had repeatedly approached staff about Mr A's condition, but he had not been examined by a doctor until 7 April 2012, when two junior doctors had examined him. Mrs C said Mr A was not seen by a consultant until 9 April 2012, despite her concerns about his well-being.

16. Mrs C said she was a retired ECG technician and had both some medical knowledge and an understanding of Mr A's condition. She said she had made it clear to medical staff that she believed Mr A's condition was not improving and that he was extremely unwell, however, she felt these concerns were

dismissed. Mrs C said she felt it had taken medical staff too long to recognise that Mr A had suffered a heart attack and that, although she accepted that he had suffered a major stroke, he had then suffered unnecessarily during his admission to the Hospital.

17. Mrs C said that, on a personal level, Mr A's death had exacerbated her existing medical conditions. She felt that Mr A had lost all his dignity whilst in hospital and had suffered due to the way he had been treated.

18. Mrs C said following her formal complaint to the Board on 29 May 2012, she had met with medical and nursing staff from the Hospital on 12 October 2012, but that although they had apologised for any failures in communication, she did not believe they had accepted Mr A's treatment had been inadequate.

The Board's position

19. The Board wrote to Mrs C on 12 December 2012. They apologised for the delay in writing to her following the meeting on 12 October 2012, which had been due to a change in staff responsibilities.

20. The Board said they wished to further clarify the discussions from that meeting. Input had been received from Doctor 1 and a consultant cardiologist (Doctor 2), who had been responsible for Mr A's care. The Board said that following Mr A's admission, when Mr A was reviewed by Doctor 1 on 9 April 2012, he had sought an opinion from Doctor 2 and the consensus was that Mr A had probably suffered a silent myocardial infarction (heart attack) several days previously, although there was also the background problem of his longstanding cardiomegaly (enlarged heart). The Board said they acknowledged Mrs C's concern that this was not diagnosed sooner, however, they hoped to reassure her that during Mr A's admission a variety of tests had been carried out on Mr A to establish a diagnosis and provide an appropriate standard of management. The Board said they noted Mr A had been quickly transferred to ITU following this review, however they accepted that, with hindsight, it might have been prudent for this review to have been carried out earlier.

21. The Board said, however, that even if myocardial infarction had been identified earlier, the treatments available would have risked causing a potentially catastrophic intracranial haemorrhage (bleeding on the brain) due to

Mr A's recent stroke. It was not possible to identify the cause of the myocardial infarction, however, it was likely that the stroke was a contributing factor.

22. The Board said they were sorry Mrs C felt her experience as a relative during Mr A's stay in the Hospital had been so poor. They said they hoped the meeting assured her that these matters were being addressed. They expressed the hope that their letter would 'bring Mrs C some closure in time for the festive season'.

The evidence available

23. There was no note of the meeting of 12 October 2012 in the Board's file on the complaint and no record of any actions taken following it. As part of the complaint investigation, however, statements were made by Doctor 1 on 12 June 2012 and Doctor 2 on 22 June 2012. Doctor 1 said that assessment of Mr A by a consultant cardiologist should have been carried out sooner. Although Doctor 1 said he did not believe they would have altered Mr A's outcome, he felt there were learning points to be taken from the care and treatment provided to Mr A.

24. Doctor 1 said that there was currently a lack of specialist registrar (or equivalent) doctors to provide the recommended level of cover set out in the Royal College of Physician recommendations. Doctor 1 said he had been advised by National Health Service Education Scotland that this level was unlikely to be reached due to financial constraints and recruitment difficulties. He also noted that consultant time was currently focussed on Medical Assessment Units, assessing and attempting to discharge less seriously unwell patients.

25. Doctor 1 said, in his view, that consultant time should be focussed outside of normal working hours on seriously unwell patients. Doctor 1 said that reverting to previous rota patterns for medicine for the elderly would have almost certainly resulted in Mr A being reviewed by a consultant over the weekend and possibly, given how unwell he was, on both the Saturday and Sunday.

26. Doctor 2 said that Mr A had first been reviewed by a specialist cardiologist on 10 April 2012 and that he had reviewed Mr A on 13 April 2012. He had noted on review that Mr A's ECG had shown abnormalities on admission, with subsequent sequential changes, but that this had not been recorded in his

notes. Doctor 2 said this would have influenced the approach to the provision of IV fluids to Mr A. Doctor 2 said he had also noted, upon reviewing the case, that Mr A had experienced tachycardia on 7 April 2012, but this had not been discussed with the on-call consultant.

27. Doctor 2 said that Mr A's observations had been stable on the morning of his death and there had been no indication that he was likely to deteriorate, although this had to be placed in context of Mr A's overall prognosis, which was very poor. Doctor 2 noted that Mr A had been designated as not suitable for resuscitation. Doctor 2 felt the decision was medically appropriate, but noted there was no documentation of any discussion with the family to obtain their views.

28. Doctor 2 said Mr A had clearly been very unwell at the point of his admission, however, his management might have been different had the myocardial infarction been identified. Mr A would have received an earlier cardiac review and Doctor 2 said it was unfortunate that Mr A was not reviewed on 6 April 2012, despite his worsening condition, and that he was not reviewed on 8 April 2012 and consequently not referred to ITU until 9 April 2012. Doctor 2 said he felt 'there was some justification for a feeling that our observation and assessment of this unwell patient was suboptimal'.

Advice obtained

29. The Adviser said that Mr A died following a critical illness, which culminated in multi-organ failure. The stroke on 2 April 2012 could well have been a response to the onset of sepsis, given how soon after admission Mr A's diarrhoea began. Mr A was suffering from widespread arterial disease which probably underlay his overall deterioration, although there was evidence of recurrent myocardial infarction and cardiogenic shock (a life threatening condition, caused by inadequate circulation of blood due to heart failure).

30. The Adviser said that Mr A's myocardial infarction could have been diagnosed sooner. An ECG taken on Ward 12 on 4 April 2012 differed from one taken on 2 April 2012. The Adviser noted that, without comparison between these two ECG results, this difference might not have been appreciated. The Adviser also said there was no evidence to show that Mr A's ECGs on either 2 April 2012 or 4 April 2012 were examined, or taken into account in Mr A's diagnosis and management.

31. The Adviser said that due to the inadequacy of the labelling of the ECG results for 2 April 2012, he had requested Mr A's previous records and ECG results to provide context for his assessment. The Adviser said the ECG carried out on 29 February, following admission for a stroke, suggested a myocardial infarction had occurred since 2008. The ECG taken on admission on 2 April 2012, was consistent with Mr A having remained stable since 29 February 2012. The Adviser said that aside from the existing ECG evidence, Mr A's deteriorating clinical picture should have prompted consideration of the possibility that he had suffered a myocardial infarction.

32. The Adviser said the failure to document the comparison of sequential ECG findings was serious, as this was something which should be done for any acute patient and it had impacted on the quality of the care Mr A had received. The Adviser also said that the medical records covering Mr A's first few days in the Hospital were inadequate. There was a failure to provide a review from an experienced cardiologist, which meant that Mr A's clinical information and data were not appropriately examined in order to guide his management.

33. The Adviser said he agreed with the points made by Doctor 1 in his response to the Board's management as part of their complaint investigation. The Adviser said that consultant time should be allocated to ensure that seriously unwell patients were reviewed, as well as ensuring that there was sufficient bed turnover.

34. The Adviser said that Mr A's IV fluid therapy had been inappropriately managed. His diarrhoea had clearly required fluid replacement, but this should have been guided by an accurate knowledge of Mr A's cardiac capacity. The Adviser said the evidence showed Mr A's cardiac capacity was not really appreciated until 9 April 2012, when he was in cardiogenic shock. The Adviser said the notes showed only a cursory review at the start of Mr A's admission, with no medical review at all on 6 April 2012, although the nursing notes referred to a difficult night for the patient between 5 April 2012 and 6 April 2012. The Adviser noted that Mr A's condition had continued to deteriorate on 7 April 2012, when he had been reviewed by a junior doctor. A more senior doctor (although still below consultant grade) had reviewed Mr A that evening, but there was no medical review documented on 8 April 2012. When Mr A was seen by Doctor 1 on 9 April 2012, he was appropriately escalated to specialist cardiology care.

35. The Adviser said that the failure to consider Mr A's highly likely coronary heart disease, together with his poor heart function, when planning and providing his clinical treatment was a critical omission. This meant Mr A was not provided with an appropriate standard of care, particularly in relation to the provision of IV fluids.

Decison

36. The advice I have received has clearly identified a number of failings in the clinical care provided to Mr A. The medical records for the initial part of his admission to the Hospital have been described as inadequate. The Adviser noted that Mr A's ECG results were not properly documented and that there was no evidence that they were compared sequentially. As a result Mr A was placed on inappropriate IV therapy, which appears to have compromised the treatment he received. The Adviser has not concluded that Mr A would have survived if these errors had not been made, rather that they indicate that the care and treatment he received fell below an acceptable standard.

37. I am also critical of the Board's response to Mrs C. It is made explicit in the statements given by medical staff that they recognise the medical care provided to Mr A was initially inadequate. Both Doctor 1 and Doctor 2 highlighted the lack or timeous review by a consultant and the consequent failure to correctly diagnose and refer Mr A within the Hospital. This has not been acknowledged by the Board in their correspondence with Mrs A, which contains an apology for the fact that Mrs A 'felt her experience as a relative during Mr A's stay in hospital prior to his passing was so poor'. I consider this inadequate, given that two senior members of the medical staff had both identified failures in Mr A's care.

38. The Board's response goes on to express the hope that Mrs C will have been reassured that the matters she raised were being addressed by the Board. No evidence has, however, been provided by the Board to demonstrate what actions were identified and put into place following this meeting.

39. I uphold this complaint and make the following recommendations.

Recommendations

40. I recommend that the Board:	*Completion date*
(i) carry out a critical incident review into Mr A's	17 June 2015

	death;	
(ii)	remind all staff of the importance of contemporaneous, accurate and full medical notes;	20 May 2015
(iii)	provide evidence that the complaint investigation has been reviewed, to establish why failings by the Board identified by staff members were not acted upon;	20 May 2015
(iv)	remind all staff of the importance of discussing completion of the decision to designate a patient as 'not for resuscitation' with either the patient or appropriate family members;	20 May 2015
(v)	provide evidence that the full report has been discussed by the Board at the first meeting following its publication; and	26 August 2015
(vi)	apologise unreservedly to Mrs C for the failings identified in this report.	20 May 2015

41. The Board have accepted the recommendations and will act on them accordingly. We will follow up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr A	the complainant's husband
the Hospital	Dumfries Royal Infirmary
CT scan	computerised tomography scan
ECG	electrocardiogram
IV	intravenous
Doctor 1	a consultant physician
ITU	Intensive Care Unit
Mrs C	the complainant
the Board	Dumfries and Galloway NHS Board
the Adviser	a consultant cardiologist who provided independent advice on the clinical care and treatment provided to Mr A
Doctor 2	a consultant cardiologist

Annex 2

Glossary of terms

cardiac	heart related
cardiac failure	heart failure
cardiogenic shock	life threatening condition due to inadequate circulation caused by heart failure
cardiomegaly	enlargement of the heart
computerised tomography (CT) scan	scan that creates computer generated images of the inside of the human body
diarrhoea	condition involving at least three loose bowel movements a day
electrocardiogram (ECG)	monitor that records the electrical activity of the heart, allowing its function to be assessed
haemolysed blood	blood with damaged red blood cells
intracranial haemorrhage	bleeding between the skull and the brain
intravenous (IV)	introduction of fluids directly into a patient's blood stream using a needle
myocardial infarction	heart attack
nebuliser	a device that administers drugs to the lungs in the form of a mist
tachycardia	heart rate above the upper limit of the normal range