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: Central Scotland

Case ref: 201405155, Lanarkshire NHS Board
Sector: Health
Subject: Hospitals; clinical treatment; diagnosis

Summary
Mrs A had a complex medical history, including heart problems and a low blood count. She fell ill, complaining of central chest pain, and an ambulance was called. The paramedics recommended that, due to the possibility of a heart attack, she was taken to Hairmyres Hospital because of the cardiac unit there. Mrs A was reviewed by a junior doctor in the emergency department, who diagnosed stable angina secondary to anaemia (chest pain due to the blood not carrying enough oxygen). Instead of the cardiac unit, she was transferred to Ward 2, the hospital's medical assessment unit. Within 48 hours she was transferred again to Ward 11, then moved to the high dependency unit and, finally, to a side room for palliative care (care provided solely to prevent or relieve suffering) where she died a few days later.

Mrs A's daughter (Mrs C) complained about the care and treatment Mrs A received when she was admitted to the emergency department at Hairmyres Hospital. In particular, she was concerned that staff did not check Mrs A's medical records to see what her anticoagulation level (INR - a measure of how long it takes blood to clot) should be, and that she was given a high dose of aspirin and other blood-thinning drugs, which seemed to cause major internal bleeding. She complained that Mrs A was not admitted to a cardiac ward and that she was moved from Ward 2 to Ward 11 when she was very ill. She also complained about a lack of communication and the junior doctor's failure to listen to Mrs A.

I obtained independent advice from a consultant physician. My adviser said that the doctors missed opportunities early in Mrs A's admission to identify the severity and complexity of her conditions, and to reduce the risk and extent of her internal bleeding. He considered that they failed to carry out the appropriate tests and was critical that, given her symptoms and abnormal blood tests, an early referral to cardiology was not made. My adviser said that Mrs A was incorrectly given her warfarin (a drug used to prevent blood clots) when it should have been withheld. As a result, her INR was raised to a high and dangerous level.

The advice I have received is that the staff caring for Mrs A should have considered the potential seriousness of her illness in more detail, and that they failed to properly monitor her condition. I am concerned that advice from a cardiologist was not sought when Mrs A was admitted to the emergency department. It was also not sought at a time when, according to my adviser, signs were very suggestive that she had had a heart attack. I found that better care would have been provided to Mrs A if she had been transferred to the cardiac unit, as she would have received higher levels of monitoring and specialist care at an earlier stage. I am concerned Mrs A's condition was worsened by the care she received, particularly by continuing to administer warfarin when it should have been stopped. I am also concerned that Mrs A's medical history was not documented in enough detail and that the target INR level in her records was incorrect, despite it previously having been set at a lower level by board staff due to Mrs A's condition.

My investigation found that, given the severity of her illness, Mrs A's outcome may not have been different. However, better care of Mrs A might have increased her chances of survival. It might also have given her family the reassurance that this outcome was despite good medical care, rather than her chances of survival being reduced by poor medical care. In view of the failings identified, I upheld the complaint.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Mrs C for the failings identified in this complaint;	13 January 2016
(ii) present this case at a departmental Mortality and Morbidity meeting and report back to the Ombudsman on any learning or improvements that are identified;	10 February 2016
(iii) ensure that medical staff involved in this case include this case as a significant event analysis in their annual appraisal; and	10 February 2016
(iv) make further attempts to contact doctor 1 and ask doctor 1 to include this case in the educational supervision process of their current post.	10 February 2016

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, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the 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.

Introduction

1. Mrs C complained to the Ombudsman about the lack of clinical treatment her late mother (Mrs A) received when she was admitted to Hairmyres Hospital (Hospital 1) on 16 January 2014.

2. Mrs C explained that Mrs A had a complex medical history, including heart problems and low blood count and normally attended Monklands Hospital (Hospital 2). Mrs A, who had a mechanical valve, had attended Hospital 2 on 16 January 2014 for a pre-assessment to establish her suitability for cardiac catheterisation. Mrs A took ill later that day and an ambulance was called. Mrs C stated that when the paramedics arrived they recommended that, due to the possibility of a heart attack, she should be treated at Hospital 1 as the cardiac unit was situated there. Mrs A was admitted to the emergency department at Hospital 1 complaining of central chest pain. She was reviewed by junior doctors (Doctor 1 and Doctor 2) and a diagnosis of stable angina secondary to anaemia was made. Mrs C was dissatisfied with the care Mrs A received on admittance to Hospital 1. She was also unhappy with the care and treatment Mrs A received when she was admitted to Ward 2, the medical assessment unit for Hospital 1.

3. Mrs A was transferred to Ward 11 (medical ward) on 18 January 2014 and her condition deteriorated. She was transferred to the high dependency unit and, thereafter, referred to the Palliative Care Team. Mrs A passed away on 25 January 2014.

4. Mrs C complained to Lanarkshire NHS Board (the Board) on 28 July 2014 and received their response on 3 September 2014. Thereafter, Mrs C raised a number of further issues with the Board on 12 September 2014 and received their final response on 24 October 2014. As Mrs C remained dissatisfied with the response, she complained to this office.

5. The complaint from Mrs C I have investigated is that, while a patient at Hospital 1, staff failed to provide Mrs A with appropriate clinical treatment in view of the symptoms which she reported.

Investigation

6. The investigation of this complaint involved obtaining and reading all the relevant documentation, including the complaints correspondence and Mrs A's medical records. Independent advice has been obtained from a consultant

physician (the Adviser). In this case, we have decided to issue a public report because of the significant personal injustice to Mrs C.

7. 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: That while a patient at Hospital 1, staff failed to provide Mrs A with appropriate clinical treatment in view of the symptoms which she reported

8. Mrs C raised a number of issues about the care and treatment Mrs A received when she was admitted to the emergency department at Hospital 1. In particular, that Mrs A's previous medical records were not accessed to check what her international normalisation ratio (INR) level should be. Mrs C stated that, having checked Mrs A's anticoagulant book, she advised Doctor 1 that Mrs A's INR level should be 2.5 and not 3.5 as he had noted. Mrs C stated that Mrs A's oral anticoagulation chart in her medical records was not amended. Mrs C was concerned that doctors did not have access to all of Mrs A's up to date medical history in order to make an informed diagnosis. In addition, she was unhappy with the lack of communication at what was a very distressful time for Mrs A and complained about Doctor 1's failure to listen to what Mrs A was telling him. In particular, Mrs C complained that although Mrs A, who had had blood taken many times before, advised Doctor 1 that he would have to take two blood samples, as the laboratory often required extra blood to analyse her potential for adverse reactions with blood transfusions, he did not listen and after taking one sample had to return to take another sample. Mrs C also explained that Mrs A had poor veins and it had taken Doctor 1 several attempts to get the first blood sample and he had to insert another cannula to take the second blood sample, causing Mrs A severe distress. Mrs C also complained that Doctor 1 performed a rectal examination to establish the source of blood loss in an abrupt manner, causing Mrs A further distress.

9. Mrs C was also concerned that Mrs A was transferred to Ward 2 and not the Cardiac Ward as they were originally advised (prior to admission) would happen and that this had an adverse effect on Mrs A's care and treatment. In addition, Mrs C was concerned that Mrs A was moved again from Ward 2 to Ward 11 when she was very ill, and complained that Mrs A's issues were not being addressed.

10. Mrs C stated that Mrs A's troponin levels went up and she was given a high dose of aspirin as well as other drugs, which appeared to have caused a massive internal bleed as her INR levels were subsequently recorded as high. This was shown in her symptoms of episodes of haematemesis, vomiting and pain.

11. Mrs C was concerned that despite Mrs A's past history of a low blood count, blood transfusions given and her reliance on warfarin (blood thinning medication), aspirin was given in addition to her warfarin.

12. Mrs C stated that, while she understood that this had been an emergency situation, all the warning signs were leading to a heart attack and had the risk of a heart attack been taken more seriously then perhaps the outcome could have been different.

The Board's response

13. When responding to Mrs C's complaint, the Board explained that the initial management plan in Mrs A's medical records indicated that intravenous access was obtained and blood sent to the Haematology and Biochemistry laboratories for investigation and cross-matching. They stated that it was noted that the biochemistry sample had haemolysed (the red cells in the sample had burst, rendering the sample impossible to analyse), which was not uncommon, and this was the reason this needed to be repeated.

14. The Board went on to explain that emergency department staff do have access to 'Clinical Portal' records. These are electronic records of a patient's past medical history, investigations, treatment and out-patient referral and discharge letters. The Board stated that it was highly likely this database would have been referenced for Mrs A's presentation on 16 January 2014. The Board further stated that in this case, Doctor 1, who was caring for Mrs A when she was admitted to Hospital 1, no longer worked at Hospital 1 so this case had not been discussed with him.

15. The Board further explained that, while junior doctors may see patients who are significantly unwell, they discuss the care of these patients with more senior doctors, including registrars and the on-call consultants. In this case Doctor 1 discussed Mrs A's care with the on-call Accident and Emergency (A&E) consultant. The Board stated that although Doctor 1 had been unsure initially about Mrs A's management, following their subsequent review of

Mrs A's medical records on the 'Clinical Portal', the consultant haematologist had indicated the desirable INR result for Mrs A and it was likely that, after accessing this information, any uncertainty about the ideal INR would have been resolved. In addition, the Board said that consultation with senior doctors allows junior doctors to seek advice when there is any uncertainty.

16. The Board indicated that they were sorry the communication with Doctor 1 was felt to be inadequate and they understood this would have been distressing for Mrs A. They explained that much of the past history, which is vital information, was accessed through the Clinical Portal and the electronic Emergency Care Summary, rather than asking Mrs A and her family at a time when she was significantly unwell.

17. The Board also indicated that they were sorry Mrs A had to endure two venepunctures but that, unfortunately, venous access was necessary for both blood investigation and administration of vital treatment and it could be difficult to gain access when patients were frail and unwell and their veins had collapsed down. They confirmed that, in this case, the first blood sample had haemolysed making a second sample necessary to access Mrs A's blood chemistry. They stated that, having reviewed Mrs A's medical records from her attendance on 16 January 2014, it would appear that Mrs A was comprehensively assessed by Doctor 1 who initially saw her. He consulted with senior staff and accessed electronic records to supplement information required during history taking.

18. The Board also responded to Mrs C's concern that Mrs A had been admitted to Ward 2 rather than the Cardiac Unit. The Board explained that it is usual practice to admit patients presenting with chest pains who do not have acute-ST-segment elevation myocardial infarction on Electrocardiogram (ECG) to Ward 2. They indicated that Mrs A's treatment plan would not have been any different if she had been admitted to the Cardiac Unit and that the seriousness of her condition was appropriately addressed with investigations and clinical management.

19. In relation to Mrs A's transfer to Ward 11, the Board went on to explain that Ward 2 is an acute receiving ward and patients are normally transferred to a medical ward within 24 to 48 hours. They indicated that they were sorry this information was not clearly communicated to Mrs C.

20. Further, the Board indicated that during the early hours of 19 January 2014 Mrs A developed chest pain. Her troponin was rechecked and was 245, suggesting that Mrs A had sustained a non-ST-segment elevation myocardial infarction. She was also noted to have some ECG changes and on the basis of the diagnosis was prescribed aspirin and clopidogrel. The Board explained that, when this clinical diagnosis was made, Doctor 2 had balanced the risks and benefits of giving these medications.

21. The Board went on to explain that, when Mrs A's INR was found to be high and she had suffered haematemesis, Doctor 2 discussed this with the Haematology Team in order to reverse the effects of warfarin and also asked for a surgical review, informed the consultant who was on call and made arrangements for Mrs A to be moved to the high dependency unit for close monitoring.

22. Mrs A was reviewed by a consultant physician (Doctor 3) on the morning of 19 January 2014 after discussion with Doctor 2 who had managed her overnight. The Board stated that Mrs A was extremely unwell and Doctor 3 discussed her prognosis and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) with Mrs C and her brother. The Board indicated that the final outcome was that Mrs A would be reviewed by medical staff from the Intensive Care Unit (ICU). However, if Mrs A was not considered suitable for transfer to ICU then she should have a DNACPR in place and she would be kept comfortable. Following the review, the consultant from ICU discussed Mrs A's condition with Mrs C and explained that she would not be considered for transfer to ICU. In view of this, Doctor 3 countersigned the DNACPR form on 20 January 2014 when it was noted on the morning ward round that Mrs A had deteriorated further. Mrs A was referred to the Palliative Care Team and was moved to a side room for her comfort and so her family could spend time with her.

Advice obtained - General advice

23. My complaints reviewer asked the Adviser if he considered the care and treatment Mrs A received following her admittance to Hospital 1 on 16 January 2014 was reasonable and appropriate. The Adviser said that Mrs A was anaemic (low blood count or low haemoglobin result) on admission and that her blood tests supported this. He said that this aspect of her diagnosis was superficially correct. However, the severity and nature of her chest pain prior to admission could have prompted clinicians to consider her heart disease

as an additional acute problem. The Adviser said that, in essence, clinicians decided that Mrs A's anaemia and chest pain were both exacerbations of her existing blood loss and angina; and that nothing new or particularly acute was occurring. The clinicians caring for Mrs A planned to transfuse her and discharge her. The Adviser said that, in his view, this was an overly optimistic assessment, which was not correct, particularly given the severity of her blood test abnormalities and the acute nature of her symptoms.

24. The Adviser said that the clinicians overlooked signs which should have made them consider Mrs A's illness in more detail and they failed to perform adequate monitoring of her condition. They failed to monitor Mrs A's anticoagulation (INR blood result test) and incorrectly prescribed additional warfarin for her when her INR was already too high. They also failed to repeat her troponin blood test which should have been repeated the morning after her admission (17 January 2014) to assess the likelihood of acute coronary heart disease. He went on to say that her troponin was elevated on admission and clinicians considered this a 'chronic' elevation, but without clear justification of why they thought this was more likely.

25. The Adviser said that the consultant who saw Mrs A on the morning after her admission (17 January 2014) recorded 'no serial rise' in her troponin but, according to the clinical records, the only two samples taken were taken 50 minutes apart on 16 January at 21:30 and 22:20. He said that, in his view, these were not sufficiently separated in time to judge if there was a 'rise'. The Adviser indicated that Mrs A should have had her troponin rechecked the morning after admission.

26. The Adviser also said that there was no repeat of Mrs A's ECG on the morning of 17 January 2014 to see if this had changed, which could have shown sequential changes suggestive of an acute problem with her heart.

27. The Adviser indicated that Scottish Intercollegiate Guidelines Network (SIGN) 93 states:

> 'To establish a diagnosis in patients with an acute coronary syndrome, a serum troponin concentration should be measured 12 hours from the onset of symptoms'

28. The Adviser indicated that, as Mrs A had intermittent chest pain during the day and prior to admission on 16 January 2014, it was not possible to establish

a definite time of the onset of a single episode of pain. Given this, the Adviser said that a troponin level should have been rechecked a few hours after admission on 16 January 2014, not just checked twice within an hour at the time of admission.

29. The Adviser went on to say that the admitting clinicians also failed to consider the possibility that Mrs A was bleeding acutely into her gastrointestinal (GI) tract and this had caused her low blood count. He said that this should have been considered as Mrs A's serum urea level was raised and this elevation was not explained or commented on by medical staff. Given that Mrs A had blood that was 'thin' as a result of her warfarin medication, and was known to have liver disease and varicose veins in her spleen, much more attention should have been given to the possibility of acute bleeding as the cause of some of her symptoms on admission.

30. The Adviser said that he found there was inadequate monitoring of Mrs A's condition after her admission. Also that her condition was adversely affected by her care; in particular, the failure to manage her warfarin medication and its effects adequately. Further, there was insufficient care taken to assess Mrs A's cardiac disease and blood loss with further blood tests.

31. The Adviser said that Mrs A was suffering from two conditions simultaneously; a heart attack and internal bleeding into her bowel. However, he said that this is not so complex or rare that it could not be managed more effectively.

Specific issues raised

32. My complaints reviewer asked the Adviser if Mrs A's medical records confirmed that her previous medical history had been taken into account, as this was an area of concern raised by Mrs C. The Adviser said that Mrs A's previous medical history was documented but not in sufficient detail. He said that insufficient emphasis was placed on the possibility of acute illness; and clinicians had focussed on the more chronic nature of her condition instead. He went on to say that, in his view, insufficient weight was given to the fact that Mrs A had been seen in the cardiology clinic and was scheduled to have cardiac investigations (a coronary angiogram) to determine the severity of her heart disease the following week. In addition, the details of Mrs A's previous conditions were only a one word or phrase description. The Adviser said that a greater level of detail is important if subsequent clinicians need to make

decisions about care and this level of information was not collected with sufficient detail in A&E.

33. The Adviser went on to say that Mrs A's condition(s) were sufficiently complex and had the potential to interact to such a degree that she needed more detailed recording of these to help inform her subsequent care. For example, the Adviser said that Mrs A's liver disease needed to include details of her severity and her complications, such as the dilated veins (varices) in her oesophagus (gullet). The Adviser further said that he would have expected the details of any recent cardiac events to be detailed, and the results of previous ECGs and troponin levels to be documented. He would also have expected to see documentation of recent blood result tests and her last transfusion, to judge how new and acute her anaemia was on this occasion. The Adviser indicated that, without this level of detail, the care of Mrs A became too generalised and superficial, and not specific to her needs at the time. He explained that with electronic health records it is possible to audit who has accessed records and what sections have been accessed. The Adviser was critical that, in the complaint response, no assessment of the record was made in this case to determine how much information was accessed from Mrs A's electronic health record.

34. As Mrs C had raised her concern that two venepunctures were necessary, my complaints reviewer also raised this with the Adviser. The Adviser said that it was difficult to reach a determination on this point, as the details of the samples taken were not specifically recorded. However, he explained that it is not common practice to document every attempt at blood sampling and this is reasonable, given the volume of work this would entail. Mrs A's blood was being analysed to assess her condition and 'crossmatch' against donor blood. The Adviser went on to explain that it can be difficult to match to donor blood when patients have received multiple blood transfusions previously and have developed the potential to react (with antibodies) to donor blood unless it is very carefully screened and matched. The Adviser noted that, in this case, Mrs A's blood samples may have had to be sent to a specialist centre, rather than being matched and provided locally, which the Adviser assumed was because Mrs A's blood was difficult to match to blood from the donor pool. The Adviser explained that, in this scenario, the volume of blood needed was the crucial factor, not the specific need for two separate samples from different veins. He said that it would have been possible to obtain all the blood needed with one needle.

35. When responding to Mrs C's complaint, the Board explained that Doctor 1 had consulted with senior staff. My complaints reviewer asked the Adviser whether the level of consultation in this case was reasonable. The Adviser explained that Doctor 1, who saw Mrs A initially in A&E, did discuss Mrs A with an A&E consultant, who advised not to treat Mrs A for acute coronary syndrome (ACS). The Adviser said that the decision not to treat Mrs A's ACS was made not because she was not thought to have ACS but because the treatment would be too hazardous given Mrs A's anaemia and high INR. He explained that this can sometimes be an appropriate decision but, in his view, better care for Mrs A would have been to consider discussion with the cardiologists at this point. The Adviser was critical that, given the severity of her condition(s) and abnormal blood tests, she was not reviewed by a consultant, or discussed with the cardiologist on call, before leaving A&E. Even though the cardiology service is in another part of the hospital, the Adviser said it should be possible to discuss cases for advice.

36. The Adviser went on to say after this diagnosis was made in A&E, the main failure was not considering her care in sufficient detail in the day(s) immediately after admission. The medical team the following day (17 January 2014) focused on Mrs A's anaemia rather than her chest pain. They considered her anaemia as relatively stable and that it could be improved simply by transfusion with blood. He said that there was an inadequate assessment of the severity of Mrs A's bleeding and her risk of future bleeding.

37. My complaints reviewer also raised with the Adviser the Board's position that there had been no need to refer Mrs A to the Cardiac Unit. The Adviser said that he did not agree with the Board's position and that better care of Mrs A would have been to provide care for her in a Cardiac Unit or other area caring for patients with high dependency needs. He went on to say that Mrs A had been transferred from home by emergency ambulance to Hospital 1, rather than Hospital 2, her local hospital, specifically for this specialist cardiology assessment and care. He was critical that after admission to A&E this need was not specifically considered. The Adviser said that in a cardiac unit/ward Mrs A would have received higher levels of monitoring and specialist care at an earlier stage. This need should have been considered and anticipated at the time of her admission. He went on to say that, when specialist opinions were sought at a later stage of the admission, Mrs A was too unwell for any

meaningful interventions, such as cardiac catheterisation or even ICU level of care.

38. Further, my complaints reviewer raised with the Adviser the Board's position that they would normally transfer a patient from Ward 2 within 24 to 48 hours. The Adviser said that Mrs A did not have sufficient reassessment after her admission, with blood tests and ECGs, for staff to be confident that she did not have acute coronary syndrome. He said that, in his view, they could also not be sure that acute bleeding was not the cause of her low blood count at this stage. The Adviser considered that Mrs A should not have been moved from Ward 2 to Ward 11 at this stage.

39. In relation to Mrs C's concerns about the monitoring of Mrs A's troponin levels, the Adviser said that he did not consider that Mrs A's raised troponin levels were reasonably monitored. He said that Mrs A should have had a troponin level checked after admission. The SIGN guideline is clear, Mrs A had ongoing chest pain during the day, and her admission troponin result would have been too early to be certain if it was negative. He said that it was not a clearly negative result. Her troponin was slightly elevated at 23 and 26 (normal is less than 14) but staff considered this was a chronic elevation of this blood test, but without clearly documenting why they thought this. In addition, the Adviser said that there was a failure to monitor and respond to Mrs A's other blood tests on 18 January 2014.

40. The Adviser further explained that the failure of Mrs A's blood count to improve after transfusion and the rise in her serum urea should have prompted clinicians to consider that her blood loss was more acute and severe than initially suspected. Mrs A's heart rate was intermittently raised above 100 beats per minute. SIGN 105 Acute (GI) bleeding states:

> 'Elevated blood urea is associated with a need for intervention'

41. The Adviser went on to say that the clinicians caring for Mrs A did not take action after her blood urea result had risen in the blood tests taken on the day of 18 January 2014. He said that the result was written in her results, but no action was taken as a result of this deterioration.

42. The Board when responding to Mrs C's complaint indicated that any uncertainty about the ideal INR would have been resolved after accessing information on the 'Clinical Portal'. My complaints reviewer raised this point with

the Adviser who indicated that he did not agree with the Board's position. He said that review of Mrs A's INR chart contained an error from the medical staff who completed this in the section relevant to the recommended effect of warfarin to achieve for her anticoagulation (INR result). He explained that INR is a measure of the effect of warfarin, the higher the number, the greater the effect of blood 'thinning'. Without warfarin treatment, the INR level in a normal individual should be around one. The usual target INRs raise the level of blood 'thinning' to two to three or three to four depending on the condition being treated. An INR of around three is usually recommended for patients with artificial heart valves. A lower level (two to three is used for patients with DVTs (clots in the leg). He said that Mrs A's INR chart incorrectly stated the target INR for her was 3.5. However, the correct target for Mrs A was actually 2.5. Her target INR was lower than the usual 3.5 because she had recurrent anaemia thought to be related to blood loss. This lower, and safer level, had been specifically recommended by Mrs A's haematologists, who had seen her previously in relation to her blood loss causing her anaemia.

43. Mrs A's INR on admission was 3.7. This was well above her target range. The Adviser indicted that the correct response to this should have been to initially omit, and subsequently reduce, her dose of warfarin. Instead of stopping her warfarin, Mrs A was prescribed and received a further dose of warfarin medication on 18 January 2014, without her INR having been checked that day. Mrs A's INR was not checked until 19 January 2014, when she became unwell. At this time it was 8.0, a very high level, and dangerously high for someone with low blood count already. In addition, Mrs A had low platelets (small cells in the blood that help blood clotting), which compounded the situation and made the risk of bleeding higher, and any bleeding more severe.

44. The Adviser said that the failure to check Mrs A's INR level on 18 January 2014 and the incorrect decision to continue to give her warfarin medication meant that an earlier opportunity to correct this aspect of her care was missed. He considered that this was a major failing in Mrs A's care and fell below a level of care she could expect.

45. The Adviser indicated that on 19 January 2014 her medical record referred to Mrs A's condition(s) of bleeding and her INR as 'iatrogenic' at the time when she deteriorated. The Adviser explained that the use of this term in the medical record at the time suggested that medical staff recognised that at least some

aspects of Mrs A's care had not been as good as they could have been during her admission.

46. With regard to the treatment Mrs A received after developing chest pain at 04:30 on the morning of 19 January 2014, the Adviser said that Mrs A was reviewed by medical staff at 04:30 on 19 January 2014. She was experiencing chest pain, although the nursing notes record this had been present since the evening of 18 January 2014 with pain recorded as high as 3/4. The notes refer to a blood test taken at 01:30 on 19 January which was now a very elevated troponin result of 245 (normal less than 14). The note describes 'further chest pain tonight' but the time of this is not recorded in detail. The Adviser explained that he was unable to locate nursing notes (after 18 January 2014) to see if this was initiated and performed by nursing staff. A doctor also reviewed Mrs A's ECG which had been performed at the same time as the blood test. The Adviser indicated that he agreed with their conclusion that Mrs A was now suffering from an acute coronary event. She was treated with morphine, which he agreed was the appropriate medication to use to control her pain. Mrs A was started on additional medication to thin her blood further at this stage. A cardiology review was proposed but not organised at that stage.

47. The Adviser was critical that no senior or cardiology advice was sought at this stage (on the morning of 19 January 2014). He considered that it was very optimistic to hope that the addition of these two oral medications would alter the course of what was by this stage a very severe heart condition. He said that Mrs A was left within a normal ward, without specific cardiac care. By this time, he was of the view that it was very clear that Mrs A had suffered a heart attack. The Adviser indicated that SIGN 93 states:

> 'Patients with acute coronary syndrome should be managed within a specialist cardiology service'

48. The Adviser was also critical that doctors did not check Mrs A's INR at this time (it was checked later at 05:10) and it was not noted until 08:00 that this had deteriorated significantly and was now greater than eight. At this point it was also noted that Mrs A had vomited blood. The Adviser commented that the combination of vomiting blood and the elevated INR level is a medical emergency. Mrs A's care was discussed by the surgical team, haematologists and her own medical team consultant at this stage, and she was felt to be 'unstable' in terms of her bleeding. He said that no advice was sought from the cardiology team until 15:40, by which time Mrs A was being described by

medical staff as 'very poorly, guarded prognosis'. The medical records record that at this time the cardiologist felt that her condition was too unstable to allow any form of cardiac intervention to treat her heart attack. The Adviser indicated that he agreed with the cardiologist's decision and assessment at this stage but he went on to say that there were missed opportunities earlier in Mrs A's admission to identify the severity of her heart disease and to reduce the risk of and severity of her GI bleeding.

49. The Adviser further explained that by the morning of the 19 January 2014 Mrs A was very unwell; the combination of her illnesses, and their severity, meant she was unlikely to survive. The Adviser indicated that he agreed the decision that Mrs A was not suitable for intervention was appropriate and this was recorded on the appropriate form. The discussion with Mrs A's family was recorded in the medical notes as 'discussed DNACPR and escalation'. However, Mrs A's family stated that they were never made aware the DNRCPR record was in her file, only that she would not be considered for transfer to ICU. The Adviser said that, while he accepted there was some uncertainty in the medical notes over the process discussed with the family and it was subsequently unclear to Mrs A's family exactly what was being proposed, it was correct for clinicians to discuss with them the limits of treatment which should apply to her and he did not find any major failings in relation to this aspect of her care.

50. When responding to Mrs C's complaint, the Board explained that, as Doctor 1 was no longer employed in the West of Scotland, they had been unable to contact him in relation to the complaint. My complaints reviewer also raised this matter with the Adviser, who explained that after trainees leave foundation training they can usually be traced. There is a national training scheme in operation in Scotland, and trainees who remain in the scheme should be traceable. He said he was critical that, in this case, no attempts appeared to have been made to contact the trainee, which was a specific aspect of Mrs C's complaint.

51. The Adviser concluded that the clinicians underestimated the severity of Mrs A's illness(es), failed to carry out the appropriate diagnostic tests, or referrals to cardiology colleagues and incorrectly administered warfarin when it should have been withheld. Despite the family's concerns, they were not listened to and their concerns were not acted upon. The Adviser accepted that Mrs A's outcome may not have been different and even with good care she may

have still died, given the combination and severity of her illness(es). However, better care might have increased her chances of survival and given her family the reassurance that this outcome was despite good medical care, rather than her chances of survival being reduced by poor medical care.

Decision

52. This investigation has taken into account what Mrs C said and how the Board replied. My complaints reviewer has obtained independent advice and this advice has expressed concern about the care and treatment Mrs A received when she was admitted to Hospital 1 on 16 January 2014. In particular, that the clinicians caring for Mrs A should have considered the potential severity of her illness in more detail; also that they failed to perform adequate monitoring of her condition. I am concerned that the advice I have received is that her condition was adversely affected by her care; in particular, that there was a failure to manage Mrs A's warfarin medication and its effects adequately and that warfarin medication was administered when it should have been withheld. Furthermore, that insufficient care was taken to assess Mrs A's cardiac disease and blood loss with further blood tests.

53. I am also concerned that, given the complexity of Mrs A's medical history and her condition(s), the advice I have received is that her previous medical history was not documented in sufficient detail. In addition, Mrs A's INR chart recorded an incorrect 'target' INR for her individual needs, a target that had previously been decided by the Board. The Board explained why they had not asked Mrs A and her family for information given how unwell Mrs A was; however, it is clear that Mrs C and her family gained the impression that the clinicians caring for Mrs A had failed to listen to them and Mrs A.

54. While the Board explained that Doctor 1 had consulted with senior staff and went on to detail the further consultation and discussions carried out in relation to Mrs A's care and treatment, I am mindful that the Adviser is critical that Mrs A was not reviewed by a consultant, or discussed with the cardiologist on call, before leaving A&E; also that no senior or cardiology advice was sought on the morning of 19 January 2014.

55. The Board explained that they were satisfied that transferring Mrs A to the Cardiac Unit would not have resulted in a different treatment plan and that it was reasonable to transfer Mrs A from Ward 2 to Ward 11. However, the advice I have received and accept is that better care of Mrs A would have been

to provide care for her in a cardiac unit or other area caring for patients with high dependency needs, where Mrs A would have received higher levels of monitoring and specialist care at an earlier stage. My finding is that Mrs A should not have been moved when she was from Ward 2 to Ward 11.

56. I recognise Mrs C's concern that Mrs A died as a result of the actions taken by clinicians caring for her while in Hospital 1 and that Mrs A had been frightened and in pain while in Ward 2 and Ward 11. I am also mindful that this concern has added to Mrs C and her family's severe distress at this very difficult time. While the advice I have received and accept is that Mrs A's outcome may not have been different, given the combination and severity of her illness(es), I am mindful of the advice I have also received that better care of Mrs A might have increased her chances of survival and would have given her family the reassurance that this outcome would have occurred despite good medical care.

57. In view of the failings identified, I uphold the complaint.

Recommendations

58. I recommend that the Board	*Completion date*
(i) apologise to Mrs C for the failings identified in this complaint;	13 January 2016
(ii) present this case at a departmental Mortality and Morbidity meeting and report back to the Ombudsman on any learning or improvements that are identified;	10 February 2016
(iii) ensure that medical staff involved in this case include this case as a significant event analysis in their annual appraisal; and	10 February 2016
(iv) make further attempts to contact Doctor 1 and ask Doctor 1 to include this case in the educational supervision process of their current post.	10 February 2016

59. 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

Mrs C	the complainant
Mrs A	the complainant's mother
Hospital 1	Hairmyres Hospital
Hospital 2	Monklands Hospital
Doctor 1	junior doctor
Doctor 2	junior doctor
the Board	Lanarkshire NHS Board
the Adviser	consultant physician
A&E	Accident and Emergency
ECG	Electrocardiogram
Doctor 3	Consulting physician
DNACPR	Do not attempt cardiopulmonary resuscitation
ICU	Intensive Care Unit
SIGN	Scottish intercollegiate guidelines network
GI tract	gastrointestinal tract
ACS	acute coronary syndrome

Annex 2

Glossary of terms

Acute-ST-segment elevation myocardial infarction	type of heart attack – occurs when a coronary artery becomes blocked by a blood clot, causing the heart muscle supplied by the artery to die
anaemia	low blood count
angina	chest pain that occurs when the blood supply to the muscles of the heart is restricted
anticoagulation	process of hindering the clotting of blood, especially by treatment with anticoagulant
cannula	tube which can be inserted into the body, often for the delivery or removal of fluid or for the gathering of data
cardiac catheterisation	an invasive diagnostic procedure which provides important information about the structure and function of the heart
haematemesis	vomiting of blood
haemolysed	the destruction of red blood cells
INR	International normalisation ratio, which measures how long it takes the blood to clot
troponin	a blood marker which detects heart muscle damage; and tends to be raised after a heart attack
venepunctures	process of obtaining intravenous access for the purpose of intravenous therapy for blood sampling of venous blood