SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Tel **0800 377 7330**
SPSO Information **www.spso.org.uk**
SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: Mid Scotland and Fife

Case ref: 201507664, Forth Valley NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mr A, who suffered from schizophrenia (a long-term mental health condition that causes a range of different psychological symptoms), was admitted to the Clinical Assessment Unit (CAU) at Forth Valley Royal Hospital (the hospital). Mr A had been suffering from a sore throat, a cough and a wheeze in his chest.

Mr A was treated for an infection and the possibility was raised that he may have chronic obstructive pulmonary disease (COPD, a disease of the lungs in which the airways become narrowed). The day after his admittance, Mr A was reviewed and was transferred to a medical ward. Mr A died the following morning.

Mr A's mother (Mrs C) complained that Mr A did not receive reasonable care and treatment and that the board failed to take into account his lack of capacity to understand how ill he was. She also complained that the standard of record-keeping was not adequate and that she was not able to obtain accurate information from staff about what had happened to her son. In addition, she complained that she was given unclear information about whether a SAE (significant adverse event) investigation by the board into Mr A's death would be carried out.

As part of my investigation, I obtained independent advice from a senior doctor with experience in acute medicine (adviser 1) and a nursing adviser (adviser 2). I also considered the board's own investigation of the complaint.

The board acknowledged that it was unacceptable that Mr A's observations were not carried out four hourly after his transfer to the medical ward and apologised for this failing. However , adviser 1 said that there were failings in relation to Mr A's care and treatment throughout his admission to the hospital. Adviser 1 said that in a patient with type 2 respiratory failure (which Mr A had), the measurement of arterial blood gases (ABGs) to provide information regarding the amount of carbon dioxide in the blood stream and the acid-base status of the patient was important. Adviser 1 said that Mr A's ABGs should

have been rechecked and despite the deterioration in the ABGs there was no plan or comment in the medical records. In addition, Mr A was not reviewed by a consultant from the respiratory team.

Adviser 1 added that, while it was reasonable that Mr A received treatment for an exacerbation of COPD, other diagnoses should have been considered and treatment for this should have been part of Mr A's management plan.

While the board said that Mr A was deemed to be in a stable position, adviser 1 said that on admission and throughout his admission to hospital he was significantly unwell.

Adviser 2 also indicated that the nursing care Mr A received fell below the standard expected of a patient with a recognised respiratory condition.

I was concerned that, given Mr A's past medical history and in view of his refusal of treatment during his admission to the hospital and that he left the hospital against medical advice, a formal assessment of his mental capacity to understand the seriousness of his illness and ability to make informed decisions was not carried out.

Both advisers said that there was a lack of recognition of the seriousness of Mr A's condition by nursing and medical staff. They said he was not seen by a consultant until over 24 hours after his admission and was not seen again by a senior clinician prior to his death. I am critical of the failings which meant, that potentially, the opportunity to recognise and treat Mr A was missed.

The board also accepted that there were failings in relation to record-keeping and had taken action as a result of these failings. However, I am concerned that there appear to be conflicting reports of how Mr A spent his final hours. I consider that this would have added to Mrs C’s and the family’s distress at a very difficult time. I am also concerned that the advice I received, and accept, is that the lack of prescription of oxygen on Mr A's chart was not in accordance with guidance and that the miscalculation which occurred in relation to the national early warning score (NEWS) was in the view of adviser 1 a serious issue.

While the board explained why they decided that an SAE investigation would not be carried out, adviser 1 said that in this case there were issues around the

recognition of an acutely ill patient, assessment of mental capacity and escalation and treatment of Mr A's type 2 respiratory failure and that an SAE investigation should have taken place. Adviser 1 was of the view that there were serious lessons to be learned from this case which needed to be acted on by the board.

Redress and recommendations

The Ombudsman recommends that the board:		*Completion date*
(i)	apologise for the failings identified in this complaint;	26 October 2016
(ii)	bring adviser 1's comments about the frequency of the ABG measurements to the attention of relevant staff and report back on action taken;	26 October 2016
(iii)	take steps to ensure that, when patients with a known history of mental health problems are formally assessed for capacity, a recognised clinical assessment instrument is used, or alternatively an opinion is sought from the psychiatry service;	26 October 2016
(iv)	take steps to ensure all patients admitted acutely are reviewed within the timeframe recommended by the Royal College of Physicians;	26 October 2016
(v)	take steps to ensure that timely escalation of acutely unwell patients with acidotic type 2 respiratory failure occurs and they are reviewed in person by either a respiratory physician or other clinician with appropriate knowledge and experience;	26 October 2016
(vi)	bring the failures identified in relation to Mr A's prescription chart and the miscalculation of the NEWS to the attention of relevant staff and ensure they are addressed as part of their annual appraisal;	26 October 2016
(vii)	carry out an audit of NEWS charts to ensure the documentation is accurate and report back to this office;	26 October 2016
(viii)	consider the current education and training in place for the care of vulnerable adults in acute care and take any appropriate steps to meet any gaps	26 October 2016

	identified and report back on action taken;	
(ix)	provide a copy of the completed nursing review referred to at paragraph 43;	26 October 2016
(x)	in view of adviser 1's comments, carry out a reflective SAE investigation of this case and provide this office with a copy; and	26 October 2016
(xi)	review their current significant adverse incident guidance in light of adviser's 1's comments detailed in this report.	26 October 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 care and treatment provided to her son (Mr A) prior to his death in Forth Valley Royal Hospital (the Hospital) on 16 August 2014.

2. Mrs C explained that Mr A, who was 38 years old, went into the Hospital on 14 August 2014 with a sore throat, a cough and a wheeze in his chest and 36 hours later he was found dead on the floor of his room in the Hospital. Mrs C stated that when she arrived at the Hospital on the morning of 16 August 2014, staff were unable to give her accurate information about what had happened to Mr A.

3. Mrs C indicated that, on admission to the Hospital on 14 August 2014, Mr A was given oxygen therapy with his blood gases checked every few hours, as his oxygen levels were too low and his carbon dioxide too high. Mrs C stated that Mr A's National Early Warning Score (NEWS) was changed to having acute hypoxia and that his oxygen therapy was stopped but that the medical records failed to record at what time and by whom. Mrs C said that Mr A was moved from the Clinical Assessment Unit (CAU) to Ward B12 on 15 August 2014 at 21:00 and the recommendation on the handover was that Mr A should be monitored and this included his bloods. However, Mrs C said that after transfer to Ward B12 all care was withdrawn, as it was decided that his condition was stable. Mrs C disagreed and complained that no checks were carried out and staff at the Hospital failed to complete a care and comfort chart. Mrs C complained that she remained unclear how long Mr A lay dead on the floor of the hospital room. Mrs C stated that her family felt that Mr A had been put into Ward B12 and left. She was concerned that the inadequate care Mr A received may have contributed to his death.

4. Mrs C was also concerned that, while she was advised a significant adverse event (SAE) investigation would take place, this was not carried out. She complained that Forth Valley NHS Board (the Board) failed to provide adequate answers about the circumstances of Mr A's death.

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

(a) failed to provide a reasonable standard of care (*upheld*);
(b) failed to keep adequate records (*upheld)*; and
(c) gave inconsistent and unclear information about a SAE investigation (*upheld*).

Investigation

6. The investigation of this complaint involved obtaining and reading all the relevant documentation, including the complaints correspondence and Mr A's medical records. Independent advice has been obtained from a senior doctor with experience in acute medicine (Adviser 1) and a nursing adviser (Adviser 2). In this case, we have decided to issue a public report because of the significant personal injustice to Mrs C.

Background

7. Mr A suffered from schizophrenia and in the past had a compulsory treatment order. He was admitted to the CAU at the Hospital on 14 August 2014 at 12:35 with a three day history of sore throat, productive cough but no history of breathlessness and was seen by medical staff at 16:00. He was treated for a lower respiratory tract infection and the possibility was raised that he may have Chronic Obstructive Pulmonary Disease (COPD). On 15 August 2014 at approximately 11:00 Mr A decided to leave the CAU, saying he was going for a cigarette. He returned at 14:00 the same day. Following further review by a medical consultant, it was decided he could be transferred to the medical wards and was transferred to Ward B12 at 21:00 on 15 August 2014[1]. A cardiac arrest call was made at 05:00 on 16 August 2014, however, it was not possible to resuscitate him. Mr A was pronounced dead at 05:51 that morning.

(a) The Board failed to provide a reasonable standard of care

The Board's response

8. In response to Mrs C's concerns about the care and treatment received by Mr A, the Board met with her on 10 December 2014. In addition, in relation to Mrs C's continuing concerns about the circumstances leading up to Mr A's death, a further meeting was held on 17 December 2014. A note of this meeting (the note) was prepared and was subsequently sent to Mrs C. The note explained that the purpose of the meeting was to listen to Mr A's family and to try to answer questions raised.

[1] In commenting on a draft of this report, the Board explained that it would be considered normal practice to move patients from the assessment unit to a ward area and the ward Mr A was transferred to, Ward B12, was a general medical ward specialising in respiratory medicine and was therefore the most appropriate area to care for Mr A.

9. The note indicated that, in response to Mrs C's continuing concern about Mr A's oxygen requirement, there were two measures of the respiratory system primarily in the blood, the oxygen level and carbon dioxide level. When Mr A was admitted to the Hospital on 14 August 2014, his observations had indicated that on his first blood gas analysis, carbon dioxide was raised which was usually a marker of type 2 respiratory failure and subsequently the medical staff tried to get a balance of comfortable oxygen and carbon dioxide. The note indicated that the chest x-ray carried out had indicated that Mr A had increased lung markings and possible cardiomegaly (enlarged heart) but it was noted there was poor inspiratory effort. The medical records noted that another chest x-ray would be required when Mr A was feeling a bit better.

10. The note also indicated that it was explained at the meeting that, when a patient was admitted who had lung disease, parameters were set for their oxygen levels and a comfortable level which should be achieved without increasing the carbon dioxide too high. The note detailed that the report from the pathologist had suggested that narrowing had caused the heart to have not enough blood and caused the heart to stop.

11. The note went on to explain that the narrowed artery would have been present for a long time and that people who have infection or low oxygen levels and have a narrowed artery were more likely to have a heart attack in that context but the infection with a low oxygen level had not caused the narrowed artery. The note further explained that symptoms of narrowed arteries were not always present until someone had a heart attack.

12. In response to a question about whether this could have been picked up or foreseen, the note explained that if someone presented with a throat or chest infection, unless they also described cardiac chest pain, it would not necessarily be picked up. Mr A had a heart tracing performed in the CAU called an electrocardiogram. This had indicated that at the time of undertaking the tracing it had been normal.

13. The Board subsequently responded to Mrs C's formal complaint of 17 December 2014 on 12 January 2015. As Mrs C remained dissatisfied, the complaint was reopened and the Board met with Mrs C on 21 January 2015. The Board provided a written response on 13 May 2015. The Board apologised for the areas where the care and communication could have been improved. They also apologised that Mr A been an in-patient in the CAU for an extended

length of time and explained that this had been due to having to wait for a bed to become available on Ward B12.

14. The Board also accepted that it had been written on Mr A's transfer Situation, Background, Assessment, Recommendation (SBAR) form that he was to be monitored overnight. They explained that, while Mr A had been in the CAU, he had been attached to a monitor which was used to observe heart rate, blood pressure and oxygen saturations. Prior to transfer to Ward B12, it had been decided that Mr A should be observed and his observations were to be monitored four hourly.

15. The Board explained that, when Mr A arrived in Ward B12, his observations were done to establish a baseline and to ensure it was safe for him to leave the ward. However, the Board accepted that Mr A's observations were not carried out four hourly as requested.

16. In commenting on a draft of this report the Board indicated that as it was felt Mr A was a first presentation of COPD, his NEWS chart was changed to 'patients with chronic hypoxia'. They explained that this allowed for oxygen saturations of 88 percent and above. The Board went on to state, in response to Mrs C's position that Mr A's oxygen was stopped, that it would be more accurate to state that his oxygen was titrated as per his oxygen saturations which were to remain above 90 percent. The Board indicated this decision was detailed in Mr A's medical records.

17. The Board also indicated, in response to Mrs C's position that, after arrival at Ward B12 all care was withdrawn, upon arrival to Ward B12 at 21:00 Mr A's temperature, pulse, blood pressure and oxygen saturations were carried out and he was prescribed medication at 22:00.

Medical advice

18. My complaints reviewer raised with Adviser 1 the care and treatment Mr A received following his admission to the Hospital on 14 August 2014 and asked whether this had been reasonable and appropriate. Adviser 1 said that the treatment prescribed by the medical team was appropriate for the differential diagnoses formulated on admission and upon review by a consultant. Adviser 1 said that it was very unfortunate that Mr A did not receive the salbutamol nebulisers which had been prescribed, due to his reluctance and/or discomfort at having them. Adviser 1 explained that, as well as salbutamol nebulisers, it is

also recommended that ipratropium bromide nebulisers are prescribed in cases of exacerbation of COPD. This did not happen for Mr A. Although Adviser 1 said that, as Mr A had not tolerated salbutamol, he was unlikely to have tolerated any other drug by nebuliser.

19. Adviser 1 explained that, according to the NEWS chart, Mr A's oxygen levels were measured by pulse oximetry regularly, notwithstanding the deficiencies in the frequency of his observations being taken which had been acknowledged by the Board. However, Adviser 1 went on to say that more pertinent in a patient with type 2 respiratory failure (which Mr A had) was the measurement of arterial blood gases (ABGs) to give information regarding the amount of carbon dioxide in the blood stream and the acid-base status of the patient.

20. Adviser 1 indicated that there were four ABGs taken, according to Mr A's medical records, showing varying degrees of acidosis (too much acid in the body), hypoxia (low oxygen) and hypercapnia (high carbon dioxide). Adviser 1 said that, according to the medical records, the last ABG taken at 17:23 on 15 August 2014 revealed a pH within normal limits but raised carbon dioxide and low oxygen levels. In Adviser 1's view it would have been important to recheck the ABGs again following the measurement taken at 17:23, given the abnormalities of significant respiratory acidosis earlier in the day demonstrated on the ABG taken at 06:50, and the fact that Mr A was consenting to limited treatment for the condition. Adviser 1 explained that a respiratory acidosis results from a failure of the lungs due to disease state(s) causing biochemical imbalances that are detrimental on the body as a whole.

21. In addition, in Adviser 1's view, the ABG taken at 06:50 on 15 August 2014 should have prompted referral for consideration of non-invasive ventilation at that time, especially as the medical records detailed a discussion with the intensive care registrar at around 20:00 on 14 August 2014, that the intensive care team should be re-contacted if there was evidence of decompensation. Adviser 1 said there was no comment or plan in relation to these abnormalities in the medical records, despite the obvious deterioration in the ABG. Adviser 1 would also have expected Mr A to have been reviewed by a consultant from the respiratory team, given the abnormalities on the ABG, to further aid definitive diagnosis and management.

22. My complaints reviewer also asked Adviser 1 to comment on the possible diagnosis of COPD, as this was an area of concern for Mrs C. Adviser 1 said that Mr A did not have a formal diagnosis of COPD. In the presence of wheeze and type 2 respiratory failure in a smoker, it is reasonable to assume that COPD could be the underlying diagnosis even when it has not been formally diagnosed. As a result, Adviser 1 considered that it was reasonable to give treatment for an exacerbation of COPD in this situation to see if Mr A's condition improved. However, Adviser 1 would have expected that other diagnoses, such as contributory heart failure, which causes fluid to build up in the lungs, to also be considered at the same time and treatment for this to also be a possible part of Mr A's management plan.

23. My complaints reviewer also raised with Adviser 1 Mrs C's concern that she was advised by medical staff that an x-ray which had been taken was 'not clear'. Mrs C stated that the impact of Mr A's heart condition may have shown up if the x-ray which had been taken had been clear. Adviser 1 explained that, when describing chest x-rays, clinicians sometimes use the term 'clear' to indicate that there is no area of consolidation (patch visible within the lungs) that could indicate a pneumonia. The abnormalities on Mr A's chest x-ray did not relate to consolidation. Adviser 1 said that the report from the radiologist stated that there was relative under-inspiration (sub-optimal breath in), which could account for the apparent cardiomegaly, and some focal collapse at the right lung base along with coarse lung markings. Adviser 1 went on to say that the medical records indicated that it had been recommended that a repeat chest x-ray be taken with better inspiration when Mr A's clinical condition permitted. Adviser 1 explained that an enlarged heart is associated with heart problems, especially heart failure (a condition where the heart does not pump as well as it should and so becomes baggy and larger than normal). Adviser 1 indicated that narrowing of the coronary arteries (as was found at Mr A's post-mortem) cannot be seen on a simple chest x-ray. Adviser 1 said that a further chest x-ray would have been helpful to clarify if the cardiomegaly was due to the suboptimal inspiration or due to possible heart failure.

24. When responding to Mrs C, the Board accepted that Mr A's observations had not been carried out four hourly as requested when he moved to Ward B12 and my complaints reviewer raised this matter with Adviser 1. Adviser 1 said that, according to the medical records, at 19:20 on 15 August 2014 a SBAR form was completed in readiness for Mr A's transfer to Ward B12. It was stated that his early warning score (EWS) was 3, and this correlated with the NEWS

chart observations taken at 14:00. Adviser 1 said that this should have prompted a minimum of four to six hourly observations. On arrival at Ward B12 Mr A's EWS was recorded as 0. Adviser 1 indicated there were no further documented observations prior to the cardiac arrest call at 05:00 and subsequent death of Mr A. Adviser 1 said that, while the Board accepted that Mr A had not undergone the planned four to six hourly observations, the conflicting reports of how Mr A spent his final hours indicated that no staff member on Ward B12 overnight had a clear idea of what Mr A had been doing during that time. Adviser 1 said that Mr A was not adequately monitored overnight, either physiologically or as to his whereabouts.

25. My complaints reviewer also raised with Adviser 1 the Board's position that Mr A was deemed to be in a stable condition following his admission to Ward B12. Adviser 1 said that Mr A's condition on admission and through 14 and 15 August 2014 indicated he was significantly unwell, with fluctuating respiratory acidosis and hypoxia. Mr A declined the nebuliser treatments, which work quickly to improve breathing, and so had only received steroids and antibiotics, which take hours to take effect. Adviser 1 indicated that, in this situation, there was always the possibility of deterioration and, although Mr A appeared to be stable from his EWS, this did not measure acidosis or high carbon dioxide levels which can be present even if the oxygen saturations and respiratory rate are within normal limits. Adviser 1 said both hypoxia and acidosis can lead to cardiac arrest.

26. My complaints reviewer asked Adviser 1 whether Mr A's past medical history was adequately taken into account when he was admitted to the Hospital on 14 August 2014. Adviser 1 explained that, according to the medical records, Mr A was reluctant to be in hospital, was refusing treatment and had absconded from the Hospital on 15 August 2014. Adviser 1 said there were several entries detailing that Mr A had left the ward against medical advice to smoke. Given Mr A's previous medical history, Adviser 1 was of the view that a formal assessment of Mr A's mental capacity to understand the seriousness of his illness and ability to make informed decision on refusing treatment and leaving the ward should have been carried out. Adviser 1 went on to say that the need for this would have been further emphasised after Mr A absconded from the Hospital on 15 August 2014, particularly as his ABGs performed earlier that morning showed acidotic type 2 respiratory – a condition which necessitates prompt treatment to reverse the acidosis. Adviser 1 indicated that, had Mr A been formally assessed and found to lack capacity for these

decisions, it would have been possible for the medical team to take steps to ensure he got the medical treatment he needed in spite of his refusal to undergo it voluntarily.

27. When responding to Mrs C's representations, the Board stated that Mr A's cognitive ability had been assessed on arrival to CAU and had been deemed competent. My complaints reviewer raised this matter with Adviser 1, who disagreed with the Board's position. Adviser 1 said that the documented assessment only assessed Mr A's ability to give his age, date of birth, the year and his location. This did not in any way constitute an assessment of mental capacity. Adviser 1 explained that a capacity assessment assesses the ability of the patient to understand, retain and weigh up information pertaining to a specific decision; for example, refusal of treatment in the knowledge that this could result in a serious deterioration in condition.

28. Adviser 1 concluded that, on balance, there was a lack of recognition of the seriousness of Mr A's condition. Mr A was not seen by a consultant until over 24 hours had elapsed after admission to the Hospital. Adviser 1 said this failed to come up to the standards recommended by the Royal College of Physicians. Adviser 1 went on to say Mr A was not seen again by a senior clinician prior to his death and that it was possible that more frequent input from a consultant would have led to the recognition for the need for further assessment and treatment; for example, more frequent ABG measurement, escalation for non-invasive ventilation, repeat chest x-ray, formal capacity assessment and compulsory treatment had Mr A refused treatment when lacking mental capacity to do so.

29. My complaints reviewer also raised Mr A's care and treatment with Adviser 2. Adviser 2 was of the view that Mr A's care was compromised partly due to his mental illness issues, as nursing staff had not appreciated how ill he was. Adviser 2 considered the nursing care to have fallen below a standard expected of a patient with a recognised respiratory condition and was surprised to see from the NEWS chart that the oxygen was not continued after transfer to Ward B12 and that the last recording was on admission to that ward at 21:00.

30. Adviser 2 would have expected vital signs to have been recorded at least four hourly. Adviser 2 explained an oxygen saturation probe can be applied very gently without even waking a patient and this should have been done at some point in the early hours of the morning. While Adviser 2 recognised that

nursing staff want to promote rest and sleep, the reason for Mr A being in hospital was due to the medical concerns and for assessment, monitoring and care. Adviser 2 recognised the Board had accepted this failing and had apologised.

31. Adviser 2 concluded that the nursing care was poor and that no nursing care was carried out from admission to Ward B12 and no checks were done. Adviser 2 said that in a young man with respiratory failure some six hours earlier, this was unacceptable.

(a) Decision

32. Mrs C complained that Mr A failed to receive the care he needed and that the Board failed to take into account his lack of capacity to understand how ill he was. Mrs C said that, following Mr A's transfer to Ward B12, his observations were not monitored and that the lack of care may have contributed to his death. It is clear that the loss of Mr A was and continues to be distressing for Mrs C and Mr A's family.

33. When responding to Mrs C's representations, the Board acknowledged that it was unacceptable that Mr A's observations were not carried out four hourly following his transfer to Ward B12 at 21:00 on 15 August 2014 and apologised for this failure. However, the advice I have received and accept from Adviser 1 is that there were failings in relation to Mr A's care and treatment throughout his admission to the Hospital.

34. In particular, Mr A's ABGs should have been rechecked, given the abnormalities of significant respiratory acidosis demonstrated at 06:50 on 15 August, and given that Mr A had consented to only limited treatment for his condition. In addition, Adviser 1 was of the view that the result of this ABG should have prompted referral for consideration for non-invasive ventilation at that time. The advice I have accepted from Adviser 1 is that there is no comment or plan in relation to these abnormalities in Mr A's medical records, despite the obvious deterioration in the ABG. This is of concern. I am also concerned that, given these abnormalities, Mr A was not reviewed by a consultant from the respiratory team.

35. Further I am also mindful of the advice I have received from Adviser 1 that, while the Board explained that the plan had been for a repeat chest x-ray when Mr A's clinical condition permitted, a repeat chest x-ray would have been helpful

to clarify if the cardiomegaly was due to the suboptimal inspiration or to possible heart failure. While the advice I received and accept from Adviser 1 is that it was reasonable that Mr A received treatment for an exacerbation of COPD, other diagnoses, such as contributory heart failure, should also have been considered and treatment for this should have been part of Mr A's management plan.

36. While the Board stated that Mr A was deemed to be in a stable condition following his admission to Ward B12, the advice I have received and accept is that his condition on admission and through 14 and 15 August 2014 indicated that Mr A was significantly unwell, with fluctuating respiratory acidosis and hypoxia, and that both acidosis and hypoxia can lead to cardiac arrest. The advice I have also received and accept from Adviser 2 is that the nursing care Mr A received fell below a standard expected of a patient with a recognised respiratory condition.

37. In addition, I am concerned that, given Mr A's past medical history and, in view of his refusal of treatment and leaving the Hospital against medical advice, a formal assessment of Mr A's mental capacity to understand the seriousness of his illness and ability to make informed decisions was not carried out. Had Mr A been formally assessed and found to lack capacity to make decisions about his treatment, it would have been possible for the medical team to take steps to ensure that he received the medical treatment he needed. I am mindful that Mrs C stated that, while she was advised that staff were aware of Mr A's medical background, no contact was made with her or Mr A's father prior to his death and they were not as a result aware of any difficulties. Although I am aware that assistance had been sought from Mrs C and Mr A's father when Mr A decided to leave the Hospital on 15 August 2014.

38. Both Adviser 1 and Adviser 2 said that there was a lack of recognition of the seriousness of Mr A's condition by nursing and medical staff. Also, Mr A was not seen by a consultant until 16:00 on 15 August 2014, over 24 hours after his admission to the Hospital and he was not seen again by a senior clinician prior to his death. I accept this advice. I also note the advice from Adviser 1 is that it is possible that more frequent input from a consultant would have led to the recognition for the need for further assessment and treatment. I am therefore critical of these failings which meant that, potentially, the opportunity to recognise and treat Mr A was missed.

39. In view of the failings detailed, I uphold this complaint. While I acknowledge the action taken by the Board as a result of the additional failings identified, I have made the following recommendations.

(a) Recommendations

40.	I recommend that the Board:	*Completion date*
(i)	apologise for the failings identified in this complaint;	28 September 2016
(ii)	bring Adviser 1's comments about the frequency of the ABG measurements to the attention of relevant staff and report back on action taken;	26 October 2016
(iii)	take steps to ensure that, when patients with a known history of mental health problems are formally assessed for capacity, a recognised clinical assessment instrument is used, or alternatively an opinion is sought from the psychiatry service;	26 October 2016
(iv)	take steps to ensure all patients admitted acutely are reviewed within the timeframe recommended by the Royal College of Physicians; and	26 October 2016
(v)	take steps to ensure that timely escalation of acutely unwell patients with acidotic type 2 respiratory failure occurs and they are reviewed in person by either a respiratory physician or other clinician with appropriate knowledge and experience.	26 October 2016

(b) The Board failed to keep adequate records

41. Mrs C complained that, following Mr A's transfer to Ward B12 on 15 August 2014, relevant paperwork was not filled in by staff and there was no record of any member of staff seeing or speaking to Mr A that night (15 August 2014). As a result, Mrs C complained that contradictory information was provided about what happened prior to Mr A's death.

42. When responding to Mrs C's representations, the Board accepted failings in relation to record-keeping. This related to: the care and comfort chart; failure to document when Mr A left the ward; discrepancies in Mr A's medical records, in particular, staff failed to accurately record what he had been doing that night (15 August 2014); there was a discrepancy in Mr A's prescription chart; and Mr A's NEWS had been miscalculated.

43. The Board went on to explain the action which would be taken as a result of these failings. This included:

- staff being reminded of the importance of ensuring all documentation is commenced when patients are admitted to wards;
- ensuring staff recognise that the record of a patient's whereabouts is essential documentation for patient safety;
- staff being reminded that all records are updated and kept clearly, accurately and securely, in line with the Nursing and Midwifery Council (NMC)'s Code of Conduct;
- medical staff being reminded of the importance of correctly prescribing medication;
- staff being reminded of the importance of accurate documentation and the NEWS chart monitored on a monthly basis; and
- a full nursing review visit be undertaken to ensure actions detailed above are checked and verified.

44. The Board explained that, following Mrs C's complaint the following action had been taken:

- an admission checklist in relation to the care and comfort round charts had been developed; and
- the new NMC 'Code of Conduct', NMC 'Documentation Guidelines and the NMC 'record keeping' had been shared with all the staff. This had also been highlighted to all staff during the daily ward safety brief. Also, there would be a monthly monitoring process to ensure good quality documentation.

45. My complaints reviewer raised with Adviser 1 the action taken by the Board, in particular in relation to the discrepancy with Mr A's prescription chart and NEWS chart. Adviser 1 said that the lack of prescription of oxygen on the chart was not in accordance with the British Thoracic Society guidance on emergency oxygen and that the miscalculation of the NEWS score was a serious issue. Adviser 1, having carefully considered the action taken by the Board, said that the action taken failed to detail in what way staff would be appraised and that it would be reassuring to know that this had been addressed formally by the Board via a teaching programme for both nursing and medical staff which was on-going.

46. My complaints reviewer also raised with Adviser 2 the action taken by the Board. Adviser 2 indicated that, while some of the action taken by the Board was reasonable, reference to staff being reminded for the future as detailed at paragraph 43 was a weak action and there may well be wider learning/recommendations around acute care for vulnerable people.

(b) Decision

47. When responding to Mrs C's representations, the Board accepted there were failures in relation to record-keeping and outlined the action taken as a result of these failings. However, I am concerned that there appears to be conflicting reports of how Mr A spent his final hours and, as a result, no one staff member on the ward overnight had a clear idea of what Mr A was doing during that time. I consider that this would have added to Mrs C and Mr A's family's distress at what was a very difficult time. I am also concerned that the advice I have received and accept is that the lack of prescription of oxygen on Mr A's chart was not in accordance with guidance and that the miscalculation of the NEWS score is a serious issue.

48. As a result of the failings identified, I uphold the complaint. There were clearly failures which the Board have acknowledged and have acted on. However, in view of the advice I have received and accept from Advisers 1 and 2, I consider that further action is required and I have made the following recommendations.

(b) Recommendations

49. I recommend that the Board:	*Completion date*
(i) bring the failures identified in relation to Mr A's prescription chart and the miscalculation of the NEWS score to the attention of relevant staff and ensure they are addressed as part of their annual appraisal;	26 October 2016
(ii) carry out an audit of NEWS charts to ensure the documentation is accurate and report back to this office;	26 October 2016
(iii) consider the current education and training in place for the care of vulnerable adults in acute care and take any appropriate steps to meet any gaps identified and report back on action taken; and	26 October 2016

(iv)	provide a copy of the completed nursing review referred to at paragraph 43.	28 September 2016

(c) The Board gave inconsistent and unclear information about a SAE investigation

50. Mrs C stated that two weeks after the death of Mr A she was advised that a SAE investigation would take place and was later advised this had taken place but the Board were waiting on results from the post mortem to finalise the document. However, she complained she was then advised that a SEA investigation had not taken place. Mrs C complained that she was provided with contradictory information about this matter and that she remained unclear about the circumstances which led up to and caused Mr A's death.

51. The Board, when responding to Mrs C's representations, clarified that they had indicated that an SAE investigation was being considered and that the decision about whether this should proceed would be taken by Executive Directors.

52. The Board explained that the reason that a SAE investigation did not take place was because the post mortem report had not indicated that any medical condition had been missed in this case. They went on to explain that an independent review of the case had also been undertaken by a respiratory consultant not involved in Mr A's care. This review had confirmed that Mr A had received appropriate treatment for the indications presented and had not revealed any major medical issues. The Board indicated that a SAE investigation was normally only done in circumstances where something should have been done and was not acted upon which could have prevented death of a patient.

53. My complaints reviewer raised the Board's decision not to progress a SAE investigation with Adviser 1. Adviser 1 indicated that the documentation provided by the Board included an Adverse Event Report form and that, in this case, the process was followed according to Mr A's case being classed as a 'red incident'. Adviser 1 indicated the Board were satisfied there was no direct relationship with the cause of death and omissions of care. While Adviser 1 considered the process itself was reasonable, in Adviser 1's view a SAE investigation should have been carried out. Adviser 1 explained Mr A's death was unexpected. There were issues around the recognition of an acutely ill patient (both by nursing staff and medical staff), assessment of mental capacity

and escalation and treatment of Mr A's type 2 respiratory failure. Adviser 1 went on to say there should have been more consultant input into Mr A's assessment and care throughout the episode. In Adviser 1's view, it was impossible to say that Mr A's cardiac arrest was not the result of acidosis or hypoxia and thus there were serious lessons to be learned from Mr A's case which needed to be acted on and embedded in the Board's operational training policies.

54. In commenting on a draft of this report the Board drew my attention to the findings of Mr A's post-mortem report where it stated that Mr A's death was due to a moderate to severe coronary artery atheroma affecting one of the main coronary arteries in his heart. In the Board's view, Mr A could have suffered a sudden cardiac death at any time.

(c) Decision

55. The Board's position remains that they indicated a SAE investigation would be considered and have explained the reasons for deciding not to progress a SAE investigation. However, it is clear that Mrs C gained the impression that a SAE investigation would take place and I am concerned that she remains uncertain about the circumstances which led up to and caused Mr A's death. I recognise that the Board's position is that Mr A could have suffered a sudden cardiac death at any time, however, the advice I have received and accept from Adviser 1 is that, in this case, there were issues around the recognition of an acutely ill patient (both by nursing staff and medical staff), assessment of mental capacity and escalation and treatment of Mr A's type 2 respiratory failure. Also that there should have been more consultant input into Mr A's assessment and care throughout the episode. In these circumstances I consider that a SAE investigation should have taken place in this case. I am mindful that Adviser 1 was of the view that there were serious lessons to be learned from this case which needed to be acted on and embedded in the Board's training policies.

56. Therefore, I uphold the complaint.

(c) Recommendations

57. I recommend that the Board:	*Completion date*
(i) In view of Adviser 1's comments, carry out a reflective SAE investigation of this case and	26 October 2016

	provide this office with a copy; and	
(ii)	review their current significant adverse incident guidance in light of Adviser 1's comments detailed in this report.	26 October 2016

58. 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 has/ve been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mr A	the complainant's son
the Hospital	Forth Valley Royal Hospital
NEWS	national early warning score
CAU	Clinical Assessment Unit
SAE	significant adverse event
the Board	Forth Valley NHS Board
Adviser 1	senior doctor with experience in acute medicine
Adviser 2	nursing adviser
COPD	Chronic Obstructive Pulmonary Disease
the note	note of the meeting
SBAR	Situation, Background, Assessment, Recommendation
ABG	arterial blood gas
EWS	early warning score
NMC	Nursing and Midwifery Council

Annex 2

Glossary of terms

acidosis	too much acid in the body
cardiomegaly	enlarged heart
consolidation	patch visible within the lungs
decompensation	in medicine, decompensation is the functional deterioration of a previously working structure or system
hypercapnia	high carbon dioxide
hypoxia	low oxygen
inspiratory	relating to the act of breathing in
pulse oximetry	test used to measure the oxygen level (oxygen saturation) of the blood
salbutamol nebulisers	nebuliser or respirator solutions of salbutamol such as Salamol steri-neb are used to treat acute asthma attacks in hospital. A nebuliser is a machine that converts the liquid medicine inside the nebules into particles that can be inhaled
titrate	continuously measure and adjust the balance of (a physiological function or drug dosage)