Ombudsman Ombwdsmon

PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

The investigation of a complaint

by Mr C against

Cwm Taf University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201401023

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Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mr C, his mother (the patient) and father as Mr and Mrs M and his brother and sister as Mr A and Ms B.

Summary

Mr C complained to my office about the care given to his mother (Mrs M) by Cwm Taf Local Health Board ("the Health Board"). Mrs M was 86. She had a medical history which included atrial fibrillation ("AF"), Type 2 Diabetes, osteoarthritis and osteoporosis. She was taking a number of medications, including Warfarin (anticoagulation protection for AF). She was admitted to the Royal Glamorgan Hospital on 24 March 2012 because she was suffering with diarrhoea and vomiting.

Mr C said that at approximately 5.00pm on 4 April, while waiting to be discharged, Mrs M suffered a stroke. He said that despite family requests, his mother was not seen by a doctor for over six hours. Then, overnight whilst she was sleeping, she suffered a further significant stroke. Mr C said the Health Board repeatedly delayed responding to the complaint and he was dissatisfied with the way it handled the complaint and the complaint response.

My investigation considered the relevant records, comments from the Health Board and evidence provided by Mr C and his family. I took advice from an experienced physician, a Stroke specialist and an experienced senior nurse.

I **upheld** Mr C's complaint because I concluded that the care provided to Mrs M on, and leading up to, the evening of 4 April was inadequate. During her stay in hospital, by allowing the protection offered by anticoagulation to be inadequate, the Health Board failed to properly protect Mrs M from an avoidable stroke. The Health Board then failed to assess and treat her symptoms promptly and effectively. There was also a delay in her being seen by a suitably trained clinician and in transferring Mrs M to an Acute Stroke Unit.

My investigation also found that the Health Board failed to:

- follow the relevant NICE Stroke Guidance and did not have an adequate stroke protocol;
- provide (or record the provision of) appropriate nursing care;
- keep appropriate records;
- comply with Complaints Guidance.

The Health Board accepted the report and agreed to:

a) Give Mr M an unequivocal written apology for the failures identified by this report.
b) Give Mr C an unequivocal written apology for failing to comply with Complaint Guidance.
c) Make a payment to Mr M of £5500 to reflect the failings in care identified by this report; the uncertainty caused by those failings; the delays in the Health Board's handling of this complaint and the time and trouble taken by his family in pursuing the complaint with this office.
d) So that appropriate lessons may be learned, share this report with the medical, nursing, health care and administrative staff involved in the case.
e) Provide me with evidence of the existing monitoring and quality assurance mechanisms it has in place to prevent a recurrence of:
    - The failure of nursing staff to complete appropriate assessments and implement appropriate care plans.
    - The failure of staff to maintain appropriate records.
    - The failure of administrative, nursing and medical staff to follow the Complaints Guidance.
f) Ensure compliance with current NICE guidance and professional guidelines, by reviewing (and if needed, updating) the current policies/protocols for the:
    - Management of in-patients on pre-existing Warfarin therapy.
    - INR monitoring of in-patients with relevant pre-existing conditions.

    (if needed, the Health Board should implement training for staff who indicate that they are not fully conversant with the relevant protocols)
g) Ensure that staff training in respect of recognising acute stroke is up to date, with particular reference to the current NICE guidance and professional guidelines.
h) Ensure that use of the NIHSS (or similarly recognised tool), in order to identify patients who are likely to have had an acute stroke, is implemented.
i) To ensure compliance with current NICE guidance and professional guidelines - review its arrangements for the identification and treatment of acute stroke and consider including the following measures:
    - All patients who may have had an acute stroke should be immediately assessed by a suitably trained physician to determine

whether thrombolysis is suitable.

- All patients who may have had an acute stroke should have immediate CT scanning (i.e. within one hour).
- All patients who may have had an acute stroke should be assessed immediately for admission to a specialist acute stroke unit.
- All patients who may have had an acute stroke should have a swallowing screening test (using a validated tool) by a trained professional within four hours.

j) Give my office suitable evidence to demonstrate that it has complied with the recommendations.

The complaint

1. In May 2014, Mr C complained to my office about the care given to his mother (Mrs M) by Cwm Taf Local Health Board ("the Health Board"). Mrs M was admitted to the Royal Glamorgan Hospital ("the First Hospital") on 24 March 2012.

2. Mr C said that at approximately 5.00pm on 4 April, while waiting to be discharged, Mrs M suffered a stroke.[1] He said that despite family requests, his mother was not seen by a doctor for over six hours. Then, overnight whilst she was sleeping, she suffered a further significant stroke. In January 2013, Mr M (Mr C's father) complained to the Health Board. Mr C later took over the complaint. Mr C said the Health Board repeatedly delayed responding to the complaint and he was dissatisfied with the way it handled the complaint and the complaint response. He said that to put things right, the Health Board should give his family "a full and honest explanation of what took place, together with compensation."

Investigation

3. My investigator obtained comments and copies of relevant documents from the Health Board. Those were considered in conjunction with the evidence provided by Mr C and his family. I obtained advice from three of my Professional Advisers:

- Dr R Hyatt ("the Physician Adviser") is a physician and geriatrician with over 20 years experience. He is experienced in the assessment and management of a range of medical problems of older adults. He is involved in the initial management of patients presenting acutely with stroke and TIA.[2]
- Dr R Baldwin ("the Stroke Adviser") has over 20 years experience. He is a Consultant in Stroke Medicine who is a Specialist in Hyper acute stroke, Post acute stroke care and Rehabilitation.

[1] A stroke happens when there is some disruption or a blockage to the flow of blood to the brain, or leakage of blood into the brain. This means that blood cannot reach a particular part of the brain, which then becomes damaged. There are two main types of stroke: (1) Cerebral infarction, a blockage of a blood vessel in the brain. This could be caused by a blood clot or fatty clot. (2) Cerebral haemorrhage, a rupture of a blood vessel in the brain.

[2] A transient ischaemic attack (TIA) or "mini stroke" is caused by a temporary disruption in the blood supply to part of the brain.

- Ms K Jarvis ("the Nursing Adviser") is a senior nurse with 14 years experience. She has cared for patients who have suffered a stroke.

4. The Advisers and I are obliged to consider what would have been a reasonable standard of care at the time events took place. My investigator reviewed the records and the Advisers responded to questions that she put to them. Their advice, which I accept in full, is summarised below. However, the conclusions I have reached are my own.

5. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked. Both Mr C and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant legislation guidance and protocols

6. During the investigation the Advisers and my investigator considered:

- Atrial fibrillation: the management of atrial fibrillation. NICE[3]
- Atrial fibrillation patient decision aid: Antithrombotic therapy. NPC[4]
- www.uptodate.com/contents/definition-of-transient-ischemic-attack.
- Stroke: Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA). NICE ("NICE Stroke Guidance")
- A Clinician's Guide to Record Standards – Parts 1 and 2 (Royal College of Physicians).
- Good Medical Practice. GMC[5]
- Guidance for records and record keeping. NMC[6] ("NMC Guidance")
- National Service Framework for Older People, Department of Health ("the NSF").
- The prevention and treatment of pressure ulcers. NICE
- Nutrition support in adults. NICE
- Slips, trips and falls in hospital. NICE
- The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Putting Things Right -

[3] NICE - The National Institute for Health and Care Excellence.
[4] NPC – NHS National Prescribing Centre.
[5] GMC - General Medical Council.

Guidance on dealing with concerns about the NHS (collectively referred to throughout as "The Complaints Guidance")[7]

- The Health Board's "Stroke Thrombolysis Care Pathway" (2011)
  At the start of the investigation, the Health Board's relevant[8] record keeping policy and protocol for the monitoring of INR[9] were also requested. When I issued this report, the Health Board had not provided those protocols.

The background events, with comments from Mrs M's family and the Health Board.

7. Mrs M, age 86,[10] had a medical history which included atrial fibrillation[11] ("AF"), Type 2 Diabetes, osteoarthritis and osteoporosis. She was taking a number of medications, including Warfarin.[12]

8. On **24 March 2012**, Mrs M was admitted to a ward ("Ward A") at the First Hospital with diarrhoea and vomiting; she was bradycardic[13] and her medical history was noted. Her INR was noted as 5.7.[14]

9. On 2 April, the patient re-positioning charts[15] ("the Chart") stated that Mrs M's position (in bed) and skin were inspected five times in the 24 hour period.

10. On 3 April, the records noted that, as she was well enough, Mrs M was to be discharged. The Chart noted one inspection during the 24 hour period.

[7] Version 2 of the guidance applied at the time. See Appendix 2.
[8] The policies that were in place in March and April 2012.
[9] INR - International normalized ratio. When a patient is prescribed Warfarin, the INR is regularly monitored to assess blood clotting. The lower the INR the quicker the blood will clot; the higher the INR the slower the blood will clot.
[10] At the time of her admission to hospital.
[11] Atrial fibrillation (AF) causes an irregular heartbeat. There are various causes of AF. Medication can slow a fast heart rate and ease symptoms. Medicine to prevent clots forming (e.g Warfarin) is usually advised to reduce the risk of having a stroke.
[12] An anticoagulant (it reduces the blood's ability to clot).
[13] Slow heart rate.
[14] The therapeutic INR range for an AF patient taking Warfarin is typically 2 - 3.
[15] To minimise the risk of a pressure ulcers developing, vulnerable patients are routinely repositioned whilst in bed, thereby allowing different parts of the body in turn to be exposed to pressure. Staff make an entry on the Chart each time they check the patient. This helps staff monitor & keep track of how often patients have been repositioned.

11. On 4 April, The Chart noted ten inspections, including: 6.00pm, 6.15pm, 8.00pm, 9.00pm, 9.30pm, 10.30pm and 11.30pm. Ms B helped move her mother at 8.00pm.

12. Mr A and Ms B,[16] Mrs M's son and daughter, both told me that they were with Mrs M during the evening of 4 April. Mr A said that he was with his mother when, at 5.00pm, she experienced problems. He said he twice asked nurses to call a doctor.

13. Ms B said she arrived after Mr A, and it was obvious to her that her mother had sustained a stroke. She had "confused speech" and a right sided weakness. Ms B said she spoke immediately to a nurse who assured her that a doctor had been requested. Ms B said the nurse then repeated the phone request to medical staff while she was present. Ms B said after a while, as a doctor had not arrived, she ensured the request was repeated. She also asked if the times a doctor had been requested were being recorded in Mrs M's notes. She said she was told by the nurse that they "were keeping a note".

14. Ms B said that at about 8.00pm, she and a nursing assistant "struggled to get Mrs M onto a commode at the side of her bed". Ms B said she realized that the extent of the stroke was more significant than she had thought and Mrs M was not able to hold her own weight at all. Ms B said that she again requested a doctor and nurses apologised for the delay, saying that the doctors would be "changing shifts". Ms B said that a doctor did not arrive until after 11.00pm and the family did not leave until after midnight.

15. Mrs M was examined by a doctor ("the On-Call Doctor") at 11.20pm. The records indicate that the On-Call Doctor noted that at 5.00pm she had complained of dizziness and weakness on the right side lasting 20 to 30 minutes. She was found to have impaired coordination in her right arm, but no evidence of complete one sided weakness. She was noted to be very unsteady. Her INR was noted as 1.6.[17] The On-Call Doctor felt that she had suffered a cerebellar stroke and plans were made for a scan the next day.

16. On 5 April, Mrs M was reviewed at 11.50am. By that time she had developed total right-sided weakness. At 3.00pm, the records note that

[16] Ms B said she is a qualified nurse.
[17] Appendix 1.

there was no evidence of a cerebral bleed and Mrs M was commenced on Aspirin, her Warfarin having been stopped.

17. On 10 April, the records note that a CT scan[18] showed that Mrs M had had a large left hemispheric infarct[19] (TACS).[20] It is not clear from the records whether this was the first or a repeat CT scan.

18. On 13 April, Mrs M was noted to be improving and she was transferred to Ysbyty Cwm Rhondda ("the Community Hospital") for rehabilitation.

The Health Board's investigation of the complaint

19. On **6 January 2013**, Mr M complained to the Health Board about the care his wife (Mrs M) had received on 4 April 2012. He said that she had been taking Warfarin for many years and her blood should have been tested while she was in hospital to assess the Warfarin level. He said that his wife suffered a stroke whilst she was waiting to be discharged, but she was not seen by medical staff for five hours. He explained that he had seen frequent TV campaigns[21] which stressed the importance of treating stroke victims promptly. Mr M said he wanted the Health Board to explain why Mrs M was not assessed more quickly. He also questioned why "drugs to reverse the effect of the stroke"[22] were not given. Mr M said that as a result of the stroke, his wife was severely incapacitated. He said that he thought that because of the First Hospital's "apparent negligence" his wife had no chance of recovery.

20. On 10 January, the Health Board told Mr M it would look at his concern and give him an explanation by 20 February.

21. On 22 February, in response to an interim update, Mr M told the Health Board, that following the stroke Mrs M was not given any food or drink for several days. He said his son had then intervened. He asked the Health

[18] A CT (computerised tomography) scan is a method of taking an image of the brain. The process gives an image of the brain that shows abnormalities such as blood clots, strokes, brain tumours or damage due to head injury.
[19] The extent of the stroke, the area of the brain affected and the underlying cause.
[20] Total Anterior Circulation Syndrome.
[21] The FAST campaign: FACIAL weakness - Can the person smile? Has their mouth or eye drooped? ARM weakness - Can the person raise both arms? SPEECH problems - Can the person speak clearly and understand what you say? TIME to call 999.
[22] This comment refers to thrombolysis.

Board to explain what steps had been taken to ensure that Mrs M had been properly fed.

22. In a statement[23] to the Health Board's investigation, the Consultant Stroke Physician[24] said that the records indicated that the original plan (i.e before she had the stroke on 4 April) had been to discharge Mrs M on 5 April. He said, however, that at around 5.00pm on 4 April, Mrs M had an episode involving some transient right-sided weakness. When she was examined at 11.20pm, this had all virtually resolved, but she was a little unsteady on her feet. He said the On-Call Doctor felt she had had a minor stroke from which she was recovering. When Mrs M was reviewed the next morning, overnight she had developed a more severe stroke, with a total loss of power on the right side of the body. A CT brain scan confirmed a stroke with a large left cerebral infarct.

23. The Consultant Stroke Physician said that on 10 April he reviewed Mrs M and she was transferred to the stroke unit on 13 April. He said Mrs M started to improve, but was still totally dependent. She had a long period of rehabilitation, but, unfortunately due to the severity of the stroke and her other medical issues her recovery was very limited. She remained totally dependent, and on 22 February 2013, was discharged from hospital to a nursing home.

24. The Consultant Stroke Physician said that it seemed "...likely this stroke was related to atrial fibrillation...". He said a patient's Warfarin dosage was adjusted to try to prevent a stroke and the target range for INR was between 2 and 3. When Mrs M was admitted in March the INR was 5.7 and the dose was appropriately reduced to bring the INR within the target range. Unfortunately, at one point the INR dropped below 2 and the Warfarin dose was appropriately increased. The INR was gradually rising again, but it was still sub-therapeutic (1.6) at the time of her stroke.

25. He said that "...there was a small risk that the INR below the target range could increase the chances of a stroke occurring and that could have been managed by giving her heparin injections until the INR rose...". He said this would have been done if Mrs M had an artificial heart valve with a high

[23] 28 February.
[24] The Consultant Stroke Physician took over care of Mrs M on 10 April.

risk of stroke, but it was "...not the general practise in other circumstances...".

26. The Consultant Stroke Physician said ischaemic stroke could not be safely treated with thrombolysis if the INR is above 1.5. Also, the exact onset time must be known. He said it seemed that Mrs M's stroke worsened overnight while she was sleeping, and staff were not aware of the change in her condition until she woke.

27. In statements[25] to the Health Board's investigation, a senior nurse ("the Senior Nurse") said that the Ward A charge nurse ("the Charge Nurse") noted that on 4 April Mrs M's pulse, blood pressure and temperature were within normal limits and that Mrs M had been able to walk to the bathroom, with assistance from the nursing staff, at 6.00pm. She said that Mrs M's daughter had also helped staff support Mrs M to go to the bathroom. The Senior Nurse reported that the Charge Nurse said Mrs M had not reported having symptoms prior to the discussion with the doctor at 11.20pm.

28. In response to Mr M's complaint that his wife had not been properly fed after the stroke, the Senior Nurse said that, on 5 April, a swallowing assessment showed that it was not safe for Mrs M to eat and drink normally. Therefore on 6 April, the nursing staff attempted to insert a naso-gastric tube.[26] Mrs M was not able to tolerate the tube. On 11 April, a reassessment identified that it was then safe for Mrs M to eat and drink normally and she was started on a soft diet and normal consistency fluids. The Senior Nurse said that between 5 and 11 April Mrs M received IV fluids. She appreciated that Mr M must have been concerned about Mrs M appearing to not have any food during this time and she was sorry if the situation was not explained to him at the time.

29. On 30 April, the Health Board gave a response to Mr M's complaint. The letter apologised for the delay in responding and that Mr M's "experience of the service...was not as positive as we would have hoped...". The Health Board's response relayed the information given by the Consultant Stroke Physician, a senior nurse[27] and the Charge Nurse (see above). The letter

[25] 1 March, 18 April 2013.
[26] A narrow tube passed into the stomach via the nose. It is used for short and medium-term nutritional support.
[27] The Health Board's records show that the senior nurse mentioned in the response was not the Senior Nurse who was involved in the investigation.

concluded by thanking Mr M for raising his concern and offering a meeting to discuss his wife's care. It also said that, if he "...remained unhappy following the response and any subsequent meetings..." he could complain to this office.[28]

30. On 13 May, Mr M told the Health Board he was disappointed that the letter of 29 April had not answered his question about why Mrs M had not been seen by a doctor for five hours.

31. On 15 May, the Health Board "strongly recommended" that Mr M should accept the offer of a meeting in order to address any outstanding concerns he may have. It also said the Head of Nursing would answer his question about the delay in Mrs M being seen by a doctor.

32. On 18 June, the Charge Nurse gave a statement to the Senior Nurse. He said Mrs M told the On-Call Doctor that the symptoms started at "around five o'clock". The Charge Nurse said he had reviewed the Chart[29] and could only conclude that the symptoms Mrs M reported "were brief and not reported to staff or family". He said he was confident that if symptoms had been present it would have been highlighted as a concern to ward staff by Mrs M's family or acted on by ward staff. He said that this did not happen.

33. On 29 July, Mr M, Mr C and Mr A, met the Head of Nursing, the Consultant Stroke Physician and the Senior Nurse. During the meeting, the family raised concerns about:

- the delay in nursing staff /doctor attending to Mrs M
- the INR readings and why the Warfarin had been stopped when Mrs M was admitted
- whether the CT scan should have been carried out sooner
- whether the decision not to give Mrs M clot busting drugs was due to her age
- whether the medical records noted how many times the family asked for a doctor to be called to see Mrs M.

[28] Putting Things Right ("PTR") 6.74. Also, the Ombudsman will not normally accept a complaint until the public body's formal complaint process has been exhausted.
[29] The Charge Nurse referred to a "Care Intervention sheet" this was the patient re-positioning charts.

34. The Health Board's meeting note indicates that the Consultant Stroke Physician relayed the information to the family that he had previously given in his statements (see above). He also said that:

- nursing staff had alerted the medical team, but the times could not be confirmed as the relevant nursing records (for Mrs M) could not be found during the meeting;
- as Mrs M was on Warfarin, thrombolysis would not have been appropriate (i.e. the decision was not age specific);
- anyone with a probable stroke who is on Warfarin should have a brain scan within one hour to look for bleeding. He said that the On-Call Doctor may not have appreciated what was happening to Mrs M and he (the Consultant Stroke Physician) would raise this issue during the next teaching session;
- the results from Mrs M's CT scan were normal;
- a stroke would have been less likely if Mrs M's INR level had been kept within the 2 to 3 range.

35. The meeting note indicates that the Senior Nurse could not find the nursing communication documentation in Mrs M's records during the meeting. She confirmed that the NEWS charts[30] (that were available) showed that the observations completed at 9.40am, 6.40pm, 8.15pm and 10.40pm, were within the normal range.

36. It was agreed that, following the meeting:

- The Senior Nurse would contact the family after she had found the nursing communication documentation.
- The Head of Nursing would ask the Consultant Physician (who was responsible for Mrs M's care at the time) about the treatment plan for Mrs M during the period up to 4 April.
- The Consultant Stroke Physician would raise the awareness of the need for earlier scans during the next teaching session.

[30] The National Early Warning Score (NEWS) system was developed jointly by the Royal College of Nursing (RCN) and the Royal College of Physicians (RCP). NEWS is designed to enable the timely assessment of, and early response to changes in the condition of, acutely ill patients.

37. On 9 October, the Head of Nursing told Mr M that the Senior Nurse had found the nursing documentation; but that the notes did not record the times that nursing staff had requested a doctor attend the ward to review Mrs M. She said that the Senior Nurse had assured her that the Charge Nurse confirmed that nursing staff made regular requests throughout the evening. The Charge Nurse also confirmed that Ms B was present during the evening. The Head of Nursing told Mr M that staff had been reminded about the importance of accurate documentation. She also relayed the information given by the Consultant Physician to the Health Board's investigation (see above).

38. On 24 October, the Patient Care and Safety Unit ("the Concerns Team") emailed Mr C. The Concerns Team apologised that an explanation of the delay in a doctor seeing Mrs M on 4 April had not yet been provided to the family.

39. On 25 October, the Concerns Team emailed the Consultant Physician. The Concerns Team explained that it had to investigate whether the care Mrs M received fell below an acceptable standard. The email indicated that the Health Board had not, at that stage, given Mr M a response to his question about the five hour delay.

40. The e-mail outlined the events of the evening of 4 April and the uncertainty about whether staff called a doctor. The email also explained how the Health Board could defend against an allegation of negligence if it could "...prove that a reasonable body of reputable practitioners in the relevant field would have carried out the investigations and treatment in the same way as the [Health Board] did...". It said "...the patient must also prove that the allegedly negligent medical treatment has caused or materially contributed to the injuries she suffered. If the patient proves that the standard of treatment received fell below an acceptable standard of care, the patient is entitled to compensation to reflect the difference between (a) the condition which she would have been in if the standard of treatment she received had been of an acceptable standard and (b) the patient's actual condition...".

41. The email asked the Consultant Physician to consider whether the treatment Mrs M received "...fell below the standard of a reasonably competent (field of medicine) at the relevant time...". The Consultant

Physician was also asked to summarise any criticisms of the treatment and, if appropriate, "...explain what ought to have been done for that treatment to have measured up to minimum standards of reasonable professional competence...".

42. In his statements[31] to the Health Board's further investigation, the Consultant Physician said that even in retrospect, apart from ensuring that a missed dose on 1 April was given, he would not have changed the Warfarin dosing schedule. He said Warfarin was normally given to try to prevent strokes, but there was no guarantee that being on Warfarin would prevent a "cerebro-vascular accident".

43. He confirmed that Mrs M was seen by the On-Call Doctor at 11.20pm. He said that he "...could not find the patient re-positioning charts..." but had seen the Senior Nurse's statement about them. He said there was no record of Mrs M expressing symptoms before 11.20pm and there was nothing in the notes to suggest that staff had requested Mrs M be seen by a doctor several times.

44. The Consultant Physician said that, because Mrs M was on Warfarin, thrombolysis would not have been appropriate. Therefore, if the mini stroke had occurred at 5.00pm "...it would not have changed the management [of Mrs M's case]".

45. On 19 November, 18 December and **10 January 2014** the Health Board apologised for the delay in providing a full response to the complaint.

46. On 15 January, the Senior Nurse told the Head of Nursing that it was accepted that the nursing records were "not detailed enough" and this had resulted in there being "two versions of events" for the evening of 4 April 2012. She said that the correct version was that Mrs M was noted as being unwell at 11.00pm and therefore the On-Call Doctor was called to examine her. She also said that Mrs M was not complaining of feeling unwell when Ms B was with her at 8.00pm. She said she understood how devastating this had been for Mr M and she was extremely sorry that the staff did not provide the right information to him.

[31] 8 October, 13 November 2013.

47. The records include a note[32] which indicated that the Health Board decided to offer Mr M a £300 "goodwill payment".

48. On 2 February, Mr C complained to the Health Board about the delay in receiving a response to the complaint. He also complained about the contradictory information he had received so far. He reminded the Health Board that family members were with Mrs M until the On-Call Doctor arrived at 11.20pm. He questioned why the family would be allowed to stay if Mrs M was not unwell.[33] He said that his mother had received dreadful care; the complaint handling was appalling; the £300 offer was an insult; being lied to was an absolute disgrace and the situation had been made much worse by the Health Board's incompetence.

49. The Health Board's records of 11 February include a handwritten note of a phone conversation between the Concerns Team and Mr C. Mr C was told that Mrs M's records were still "...being filed appropriately as [we] had been unable to make any comments on issues that evening due to poor [emphasised on note] state of records...". The note also indicated that the Concerns Team explained that "...there is little evidence in nursing notes that appropriate escalation occurred ([we] may be wrong when [we] see full set of correctly filed notes)...".

[Investigator's comment: the Health Board gave only page 1 of this 2 page note]

50. In May, Mr C complained to the Ombudsman.

Professional advice

The Physician Adviser's comments

51. The Physician Adviser said that the clinical records were poorly presented, random in order, non-chronological at times and probably incomplete. He could not find medical or multidisciplinary records for the period before 27 March.[34] He said the inpatient notes from 2 April recorded normal blood test results and normal observations.

[32] 16 January 2014.
[33] Generally, evening visiting hours finished at 8.00pm.
[34] The records were requested from the Health Board at the start of the investigation, but they were not

52. The Physician Adviser said that it was appropriate to stop Mrs M's Warfarin for 48 hours after her admission because her INR was 5.7. He said an INR at this level would confer an increased risk of potentially life-threatening bleeding. When checked again on 26 March, the INR had come down to 3.2 and this was still slightly above the recommended range.

53. He said that on 30 March the INR had fallen to 1.7 and the Warfarin dose was increased to 2mg and remained at this until 2 April at which time the INR had fallen to 1.4 despite the increased dose. The dose was then doubled to 4mg but the INR increased only slightly to 1.6. The Physician Adviser said there was no record of Warfarin being administered on 4 April. He felt this was probably due to the fact that Mrs M exhibited symptoms suggestive of TIA at 5.00pm and Warfarin was typically administered from 6.00pm onwards.

54. The Physician Adviser said that the correct treatment for TIA and acute stroke in patients on Warfarin is, in the first instance, to stop the Warfarin pending brain imaging. This is because there is a risk of the symptoms being due to cerebral haemorrhage. There is also clinical uncertainty as to whether Warfarin is indicated in the acute phase of ischaemic stroke associated with AF, as in Mrs M's case.

55. He said therefore it was entirely appropriate for the clinical team to stop the Warfarin on admission, due to the prolonged increased INR and risk of haemorrhage; and to have prescribed it with caution thereafter. He said the dosage was appropriately adjusted in response to the INR and the overall clinical context up to and including 4 April.

56. The Physician Adviser also said that it was important to appreciate that Warfarin is given in this context to treat a risk. This meant that Mrs M stood a greater chance of a stroke with a lower INR, but that risk was not 100%. Therefore, although it was statistically more likely, it was not certain Mrs M would have a stroke if her INR was at a lower level.

57. The Physician Adviser said that, in April 2012, the accepted definition of a TIA was "a sudden onset of a focal neurologic symptom and/or sign lasting less than 24 hours". He said the records written at 11.20pm note that Mrs M had had an episode of dizziness and right-sided weakness at 5.00pm which

lasted 20 - 30 minutes. Therefore, based on the relevant definition, Mrs M suffered a TIA at 5.00pm on 4 April.

58. The Physician Adviser said that NICE guidance states that people who have had a suspected TIA, and who are at high risk of stroke (as in Mrs M's case), should have:

- Aspirin (300 mg daily) started immediately
- specialist assessment and investigation within 24 hours of onset of symptoms
- measures for secondary prevention introduced as soon as the diagnosis is confirmed

59. He said the records showed that Mrs M was first given Aspirin at 3.00pm on 5 April.

60. The Physician Adviser said that because her symptoms occurred whilst on Warfarin, and could have been due to haemorrhage, it was appropriate to stop the Warfarin following the suspected TIA. He also said urgent brain imaging (a CT scan) at that time (i.e the evening of 4 April) would have excluded a haemorrhage related to Warfarin and allowed the clinical team to start Aspirin sooner or to initiate more aggressive anticoagulation. He said this action might have prevented Mrs M's subsequent deterioration; but he could not say this with certainty.

61. The Physician Adviser said that the records show that when Mrs M was reviewed at 11.20pm on 4 April, there was no evidence of focal (one sided) weakness. However, some incoordination of her right side was noted. It was felt that she had had a (thrombotic) cerebellar stroke and a CT brain scan was planned for 5 April. However, when she was then reviewed on 5 April at 11.50am, she was found to have a severe right-sided weakness and the CT scan was then arranged urgently. The scan showed a large left hemispheric infarct with thrombus in the left middle cerebral artery.

62. The Physician Adviser said that, in ideal circumstances thrombolysis can be used as emergency treatment for acute ischaemic stroke. However, thrombolytic drugs should be used with caution in older patients and if there is a risk of bleeding. That risk includes recent or ongoing use of anticoagulants such as Warfarin. He said thrombolysis was therefore not

appropriate in Mrs M's case.

63. The Physician Adviser said that national guidance indicated that brain imaging in suspected acute stroke should be undertaken immediately if the following applied:

- indications for thrombolysis or early anticoagulation treatment
- on anticoagulant treatment
- a known bleeding tendency

64. The Physician Adviser said that, given her prior anticoagulant treatment, Mrs M should have had an urgent CT brain scan on the evening of 4 April. However, it was not possible to be certain about whether the failure to carry out a scan at that stage resulted in any detriment to Mrs M.

The Stroke Adviser's comments

65. The Stroke Adviser said Mrs M was reviewed (during the normal ward round) on 4 April and appeared well. There was no note of her renal function, nor was there any note of the prolonged sub-therapeutic INR and Mrs M was not prescribed Heparin[35] until the Warfarin was therapeutic.

66. He said that there was a detailed record of the On-call Doctor's review at 11.20pm. However, the notes were "in such a mess, with missing sections" that he was unable to find any relevant nursing or medical notes for 4 April before that review at 11.20pm.

67. He said the episode, at 5.00pm on 4 April, was clearly a TIA, but no action was taken and no brain imaging or additional treatment prescribed.

68. The Stroke Adviser said that the review at 11.20pm confirmed that the initial episode (at 5.00pm) had lasted 20 - 30 minutes. The review found no right-sided paralysis but did find impaired finger-nose test on the right and incoordination on the right. Mrs M was unsteady and needed two staff members to stand.

[35] Heparin is used to treat and prevent blood clots in the veins, arteries, or lungs. Warfarin and heparin are both anticoagulants but they work in slightly different ways.

69. He said that to be described as a TIA, symptoms should have resolved at the time of assessment. In which case the first documented assessment at 11.20pm noted that Mrs M still had symptoms so the assessment should be of a possible stroke not a TIA. Therefore, he agreed that there was probably an initial TIA of 20 -30 minutes at approximately 5.00pm when the first assessment should have taken place. The Stroke Adviser said that at 11.20pm:

- A diagnosis of Thrombotic Cerebellar Stroke was made.
- The INR was noted to be 1.6.
- A CT brain scan was planned for the following day.
- No formal swallowing screening test was performed but the On-Call Doctor did comment that if Mrs M developed swallowing problems, she should be kept nil by mouth and referred to the therapists.
- There was no referral to the Stroke Specialist to consider thrombolysis.
- An NIHSS[36] was not recorded.
- Aspirin was not prescribed until the 5 April.
- When the swallow screening test was performed at 2.00pm on 5 April, Mrs M was found to have an unsafe swallow.
- When a CT scan was performed at 3.00pm on 5 April, it showed a large left hemisphere cerebral infarction with thrombus in the left middle cerebral artery. Aspirin was started.

70. The Stroke Adviser said that Mrs M was first assessed by the Consultant Stroke Physician on 13 April, at which point she was severely handicapped with a Barthel score[37] of 1/20. The Consultant Stroke Physician then arranged for Mrs M to be transferred to the Stroke Unit.

71. The Stroke Adviser said:

- The therapeutic range for Warfarin in atrial fibrillation is typically 2-3.
- The decision to stop Warfarin on 24 and 25 March was appropriate. There is a significant risk of systemic bleeding and intracranial haemorrhage if the INR rises above 4.

[36] The National Institutes of Health Stroke Scale (NIHSS) is a systematic assessment tool that provides a quantitative measure of stroke-related neurologic deficit. It is widely used as a clinical assessment tool to evaluate acuity of stroke patients, determine appropriate treatment, and predict patient outcome.
[37] The Barthel Index is a commonly used scale that measures disability or dependence in activities of daily living in stroke victims. A low score indicates a high level of disability.

- The decision to continue Warfarin when the INR was falling was also correct. For patients with AF there is a considerable risk of ischaemic stroke if the INR falls below 1.8. The INR is likely to be very changeable if a patient has an acute kidney injury or sepsis or if other drug treatment is changed.
- The decision to stop the Digoxin was correct; this was the cause of the gastro-intestinal symptoms.
- In view of the renal dysfunction, the decision to stop the Co-Amilofruse and the Valsartan was correct. The Metformin should also have been temporarily stopped.
- The INR should have been monitored daily until it had returned to the therapeutic level and was stable. It may have been sub-therapeutic on 28 and 29 March.
- When the INR was found to be sub-therapeutic on 30 March, Mrs M should have been given Heparin until the Warfarin was therapeutic.

72. He also said the TIA should have prompted a more aggressive response from clinical staff. Patients have an 11% risk of stroke within the following seven days but mostly within the first 72 hours. The response should have included a detailed clinical assessment including:

- An NIHSS stroke score.
- A review of the current preventative treatment.
- CT brain scan - the Stroke Adviser said NICE guidance recommends immediate CT scanning for patients on anticoagulation as the symptoms could have been due to a cerebral bleed. He said that, during the meeting on 29 July 2013, the Consultant Stroke Physician confirmed that a patient on Warfarin should have a scan within one hour and acknowledged that the treating staff "...may not have appreciated what was happening to Mrs M..." the Consultant Stroke Physician said he would "... bring this up at the next teaching session in August...".

73. The Stroke Adviser said that, if Mrs M had been seen at the time, a stroke specialist may well have recommended starting Heparin, if there was no evidence for any acute ischemia or intra-cerebral haemorrhage, but would certainly have recommended starting Aspirin.

74. He said NICE guidelines recommend that intravenous thrombolysis should only be considered if:

- there is evidence of persistent neurological impairment, which was not improving. (This should have been determined by a stroke specialist physician using the NIHSS score. Treatment would have been recommended if the score was between 5 and 25);
- the CT scan showed no evidence of intracranial bleeding;
- the treatment could be given within 3 hours of symptom onset;
- the treating physician considered the long-term benefit outweighed the risk of early bleeding.

75. The Stroke Adviser said that in Mrs M's case several issues would need to be considered:

- Her age
- The fact that she was on Warfarin
- Whether the time the stroke began was known - The Stroke Adviser said he did not agree with the Consultant Stroke Physician, who said[38] the time the stroke began was not known. He agreed that Mrs M deteriorated overnight, but said the Health Board did not start appropriate treatment until 5 April.

76. The Stroke Adviser said that Mrs M should have been transferred to the Acute Stroke Unit to facilitate monitoring of her neurological state and to plan further treatment if symptoms recurred. He said that at 11.20pm on 4 April, she clearly had new or persistent neurological symptoms. However, Mrs M was assessed by a doctor (the On-call Doctor) who was not a specialist stroke doctor and who was clearly not familiar with the NICE guidance. At that stage it was too late to consider thrombolysis if symptom onset was 5.00pm. The Stroke Adviser said the Health Board's records were not adequate to confirm this point. However, in his opinion, Mrs M was not a candidate for thrombolysis.

77. He said that, as there was no record of the NIHSS score, it was not clear at what point the impairment became persistent, or whether the

[38] Statement to the Health Board's investigation 28 February 2013.

Consultant Stroke Physician was correct in stating that Mrs M deteriorated overnight whilst asleep and before any specific investigations (CT scan) were carried out or Aspirin was started.

78. The Stroke Adviser said that patients who receive stroke unit care are 29% more likely to be alive and independent if managed in a specialist unit. He said that Mrs M should have been admitted directly to an acute stroke unit. However, there was a 9 day delay before she received specialist care.

79. He said that as Mrs M was not a candidate for thrombolysis a CT scan should have been carried out immediately because Mrs M had new neurological symptoms and was taking Warfarin, so was at risk of Intracranial Haemorrhage. Having excluded haemorrhage Aspirin should have been started immediately as this may have prevented the deterioration which (the Health Board said) occurred overnight.

80. He said the Health Board did not have an adequate functioning stroke protocol and patient decisions were left to junior doctors apparently both in hours and out of hours. He said that was inappropriate.

81. The Stroke Adviser was critical of the overall care given to Mrs M. He said that the main failing was not at the point where she sustained the initial neurological deficit but rather that the Health Board neglected to properly protect her from an avoidable stroke by allowing the protection offered by anticoagulation to be inadequate. He said:

- The INR should have been monitored daily
- Once the INR was below 2.0 separate cover with Heparin should have been initiated until the INR returned to a therapeutic level.

82. He said the Health Board failed to provide adequate thromboprophylaxis[39] for the AF in the days leading up to 4 April. Had this been done better the chance of a stroke would have been much less.

83. The Stroke Adviser said that as the Health Board had already undertaken more than one review of this case the records should have been

[39] Any measure taken to prevent the development of a thrombus (blood clot).

in a much more organised state. This suggested that the Health Board did not accept the importance of this complaint.

The Nursing Adviser's comments

84. The Nursing Adviser said NMC Guidance[40] states: "...You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been... You should record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment...". The NMC Guidance[41] also states:

> "...Good record keeping, whether at an individual, team or organisational level, has many important functions. These include a range of clinical, administrative and educational uses such as:
>
> ...
>
> - supporting patient care and communications
> - making continuity of care easier
> - providing documentary evidence of services delivered
> - promoting better communication and sharing of information between members of the multi-professional healthcare team
> - helping to address complaints or legal processes...".

85. She said that there was no record of any communication between Mrs M or her family and nursing staff, nor between nursing staff and doctors between 5.00pm and 11.20pm on 4 April.

86. She said that before 4 April Mrs M was having her physiological observations taken and recorded twice per day. She said that this was a reasonable frequency leading up to discharge. On 4 April, between 5.00pm and 11.20pm, Mrs M had her observations recorded three times. The Nursing Adviser said this was appropriate. Each time they were recorded they were within normal parameters for Mrs M and would not raise concerns for nursing staff and therefore an escalation of concerns to medical staff was not required.

[40] 2008.
[41] 2009.

87. In her comments on this case, the Nursing Adviser also raised concerns about the nursing assessments performed throughout Mrs M's stay at the First Hospital. She said that the NSF states "...Wherever the older person is being cared for, good management will involve attention to:

- maintaining fluid balance
- pain management
- pressure sore risk management
- acute confusion
- falls and immobility
- nutritional status and risk management
- continence risk management
- cognitive impairment
- rehabilitation potential
- depression
- infection control
- medicines management

This will enable effective acute care, plus an assessment of the older person's functional capacity and the scope for rehabilitation, which together will inform their discharge planning...".

88. The Nursing Adviser said the nursing assessments were very poor and not performed to the standard expected. She said that because there was no evidence of an initial assessment, she was unable to say with certainty what Mrs M's nursing care needs were on admission. She also could not say what appropriate care plans should have been implemented.

89. She said that, from the available records, she was unable to determine the level of nursing care provided to Mrs M. She said that she was concerned that Mrs M was admitted with diarrhoea and vomiting and a degree of acute kidney injury[42] ("AKI") (as determined by the blood results 25, 30 March and 1 April). She said that it is established practice to monitor a patient's fluid intake and output if they are suffering an AKI, but this was not done effectively by nursing staff in this case.

[42] Acute kidney injury (AKI) is sudden damage to the kidneys that causes them to stop working properly. It can range from minor loss of kidney function to complete kidney failure. This type of kidney damage is usually seen in older people who are unwell enough to be admitted to hospital. AKI is common and normally happens as a complication of another serious illness. It is not the result of a physical blow to the kidneys, as the name may suggest.

90. She said she had significant concerns regarding the general standard of record keeping. Due to the limited use of care plans and a significant lack of daily nursing records, she could not confirm that Mrs M received the appropriate nursing care during her stay at the First Hospital.

Comments on the draft of this report from Mr C and the Health Board

From Mr C

91. Mr C said his mother had a stroke whilst awaiting discharge from hospital. If she had received appropriate care she may have had a chance of making a recovery. Unfortunately, because of the appalling care she received, she had none. He said "... that was bad enough, but when [the family] tried to find out what had happened, they were met with an organisation that seemed to be primarily concerned with covering up the facts. He said the responses he was given were disingenuous and cynical.

92. Mr C said the complaints procedure is called "Putting Things Right". However, staff, including the Chief Executive, were "either unaware of this procedure or chose to ignore it". They did not appear to want to "put things right".

From the Health Board

93. The Health Board accepted that the family's requests, that Mrs M be seen by a doctor, were not recorded in her nursing or medical notes. It said Ward Managers (senior nurses) had since been reminded that this was not acceptable, and that requests for medical reviews must be recorded in the nursing notes.

94. The Health Board said it used the term "strongly recommend" in relation to offering a meeting as complaints can often be resolved by a meeting. It said the intention was not to prevent Mr M from approaching the Ombudsman but to offer an "alternative line of communication" which was often successful.

Analysis and conclusions

95. I should start by saying that I was sorry to hear of the events which led to this complaint. It is understandable that Mrs M's family have found the experience distressing and worrying.

96. I am concerned about the care Mrs M was given. The evidence clearly shows that the care and treatment provided to Mrs M by the Health Board fell below a reasonable standard on several occasions.

The evening of 4 April

97. The family said they were with Mrs M throughout and repeatedly asked for Mrs M to be examined by a doctor. Initially, [43] the Health Board said there was no record of Mrs M reporting symptoms to staff until the On-Call Doctor examined her at 11.20pm. Then[44] the Consultant Stroke Physician said nurses had alerted the medical team, but he could not confirm the times. Later,[45] the Health Board told Mr M that the Charge Nurse confirmed that nursing staff had requested a doctor regularly throughout the evening. Then the Senior Nurse told[46] the Head of Nursing that Mrs M was first noted as being unwell at 11.00pm and it was not until then that a doctor was called.

98. The evidence shows that the Health Board failed to keep appropriate records throughout Mrs M's stay at the First Hospital. I comment further on the wider issue of record keeping standards below. However, in relation to the care provided to Mrs M on 4 April between 5.00pm and 11.20pm, it is clear that the records are inadequate. Poor record keeping is a service failure. On this occasion, it has caused an injustice because it has hampered the Health Board's, and this, investigation. It has also prevented both from reaching a definitive conclusion on when Mrs M's symptoms were reported. However, I will say here that the family's version of events is credible. Based on the available evidence, on balance, my view is that Mrs M's symptoms were reported to staff by the family throughout the evening. I have reached this conclusion for the following reasons:

[43] 30 April 2013.
[44] 29 July 2013.
[45] 10 October 2013.
[46] 15 January 2014.

- The Physician Adviser said that the correct treatment for TIA and acute stroke in patients on Warfarin is, in the first instance, to stop the Warfarin pending brain imaging. The records show that Mrs M was normally given Warfarin daily at around 6.00pm. However, she was not given Warfarin on 4 April.
- Mrs M was due to be discharged on 5 April. It would be unusual for a family to be allowed to stay with a patient outside normal visiting hours if the patient was fit and well, particularly if the patient was due to be discharged the following day. However, Mrs M's family were allowed to stay.
- On 2 April the Chart notes five inspections in the 24 hour period. On 3 April, there was one in 24 hours. On 4 April, when she was due for discharge the following day, the Chart indicates that Mrs M's position was checked seven times[47] during the evening.
- Lastly, I can find no record that Mrs M was noted as being unwell at 11.00pm.

99. Taken together, these facts suggest that staff knew of Mrs M's symptoms during the evening.

Record keeping

100. Each Adviser commented on poor record keeping standards, I do not need to repeat all those comments here.

101. The Health Board used the Chart as evidence that either, Mrs M did not have symptoms during the evening, or, the family did not report them. However, it seems that at least one Chart entry was not made contemporaneously. The Chart notes that Mrs M's position and skin were inspected at 11.30pm. Yet the On-Call Doctor started his examination at 11.20pm. Based on the records, it would have taken at least 30 minutes to complete the examination. Therefore, it is very unlikely that a positioning check took place at 11.30pm.

102. Record keeping guidance requires that if an entry in health records is not made contemporaneously, it must be noted as being retrospective.

[47] The Chart - 6.00pm, 6.15pm, 8.00pm, 9.00pm, 9.30pm, 10.30pm and 11.30pm.

When entries are made retrospectively it is plausible that times become less accurate. However, the entry is not noted as being retrospective, but it is unlikely that the check took place at 11.30pm. That discrepancy casts doubt on whether the other entries[48] made by the same member of staff were made at the times noted. As a result, I am less inclined to accept the Chart as conclusive evidence from the Health Board.

103. Lastly, I also agree with the Stroke Adviser's view that the state of the records suggests that the Health Board did not accept the importance of this complaint. Further, the standard of record keeping hampered the Health Board's, and my, investigation. Due to the standard of record keeping I am unable to reach a definitive conclusion about exactly what happened on the evening of 4 April. That is unsatisfactory.

The clinical response to Mrs M's TIA symptoms

104. Regardless of the time the symptoms started, I am concerned about the care given to Mrs M once her symptoms were known. Both the Physician Adviser and the Stroke Adviser were critical of the care provided to Mrs M.

105. At 11.20pm, the On-Call Doctor planned a CT scan for 5 April, but events overtook that plan. Mrs M was not given Aspirin until 3.00pm on 5 April, after her condition had deteriorated further. The Physician Adviser said that when the stroke was suspected Mrs M should have had an immediate CT scan and have been given Aspirin immediately.

106. The Stroke Adviser also criticised the response to the symptoms; he said it should have been more aggressive and more immediate. The TIA was confirmed at 11.20pm, but no action was taken and no immediate brain imaging or treatment was prescribed.

107. Both Advisers said a more appropriate response to the symptoms might have prevented Mrs M's deterioration.

108. Based on the evidence available, and the Advisers' comments, I conclude that the Health Board failed to provide appropriate care to Mrs M once her symptoms were known. That failure caused an injustice to Mrs M

[48] 8.00pm, 9.00pm, 9.30pm and 10.30pm.

and to her family. The Advisers and I cannot say for certain that prompter treatment (with Aspirin and an immediate CT scan) would have prevented her deterioration. However, the injustice to Mrs M is that the Health Board failed to take action when a clear opportunity presented itself. The injustice to her family is the ongoing distress and uncertainty which has resulted from that missed opportunity.

The overall care provided to Mrs M during her stay at the First Hospital

109. I am concerned about the overall standard of care given to Mrs M during her stay in the First Hospital. The Stroke Adviser said that in the days leading up to 4 April, the Health Board neglected to properly protect Mrs M from an avoidable stroke. He also criticised the care given after she had suffered a stroke.

110. I have not seen any explanation from the Health Board about why Mrs M was not seen by the Consultant Stroke Physician until 10 April and why she was not moved to the Stroke Unit until 13 April.

111. Also, it is clear that the Health Board failed to provide (or record the provision of) appropriate nursing care. I am concerned that the nursing assessments performed at the First Hospital were very poor. Also, like the Nursing Adviser, I am concerned about the failure to effectively monitor Mrs M's fluid intake and output while she was suffering an AKI.

Complaint handling

112. The Complaints Guidance sets out specific actions which health boards must complete and specific timescales that they should comply with when considering complaints.

113. The Health Board should have completed an initial assessment of Mr M's complaint and it should have been graded in terms of severity.[49] Further, because Mr M complained about the First Hospital's "apparent negligence" the Health Board should have also considered whether there had been a breach in the duty of care and whether there was a qualifying liability in tort ("a QL"). [50]

[49] PTR 6.47 and PTR Appendix J.
[50] PTR 6.45.

114. I am not satisfied that the Health Board's consideration of Mr M's original complaint complied with Complaints Guidance. The Health Board has not provided any evidence to show that it properly assessed Mr M's complaint or that it considered whether there was a QL.

115. The Health Board's response of 30 April 2013 advised Mr M of his right to refer the complaint to this office if he was dissatisfied. It was therefore a final response.[51] However, it did not comply with the Complaints Guidance. It did not:

- include a summary of what the concern was about;
- explain how the concern was investigated;
- include copies of any relevant medical records;
- explain what action would be taken as a result of the complaint;
- include an explanation of the reasons why the Health Board considered there was no QL;
- explain why the Health Board considered the Redress arrangements were not triggered.

116. The response also wrongly indicated that the senior nurse named in it had provided information to the investigation. I can find no evidence that she had done so.

117. It also failed to give Mr M any explanation of why, once the stroke was diagnosed on 5 April, Mrs M was not seen by the Consultant Stroke Physician until 10 April and not transferred to the Stroke Unit until 13 April.

118. Importantly, the response also failed to address the key issue of why there was a delay in a doctor examining Mrs M.

119. The Health Board took 78 days to give Mr M a final response to his complaint.[52] I acknowledge that he was given an update about the delay. However, the consideration of the complaint was not as thorough as it should have been, therefore I am not satisfied that the delay was justified or that the Health Board dealt with the complaint in a timely manner.

[51] PTR 6.74.
[52] PTR 6.73.

120. Once the final response had been issued on 30 April 2013, Mr M had the right to make his complaint to the Ombudsman.[53] However, when he told the Health Board he was dissatisfied with the response, it "strongly recommended" that he accepted the offer of a meeting. I agree with the Health Board's comment that many complaints can be resolved by the clinical and nursing staff meeting with complainants. However, that type of meeting should typically be an earlier part of the Health Board's complaint investigation process.[54]

121. The Complaints Guidance requires health boards to offer a meeting with the executive officer or their nominated representative as part of the final complaint response.[55] However, I am concerned by the way the letters of 30 April and 15 May 2013 imply that Mr M needed to meet with staff before he could make his complaint to me. That is misleading, once the final response had been issued, Mr M had the right to make his complaint to the Ombudsman, he was under no obligation to meet with the Health Board.

122. Once the final response had been issued (30 April 2013), the Health Board's actions fell outside the scope of the Complaints Guidance. I think the Health Board should have made that clear, but it did not.

123. If Mr M had made his complaint to this office at that point (May 2013) it is likely that it would have been resolved much sooner.[56] More importantly, the family would not have been given the muddled, contradictory information by the Health Board.

124. The Health Board effectively started a second investigation. Unfortunately, that was not handled any better than the first. I am concerned that it failed to recognise the many failings identified by my investigation. That indicates that the Health Board failed to acknowledge the seriousness of the complaint.

125. I conclude that the Health Board failed to "investigate once, investigate well". [57] The reaction, and response, to Mr C's complaint was unsatisfactory. Mrs M's family were, understandably, already distressed by the impact the

[53] PTR 6.74.
[54] PTR 6.26 - 6.28.
[55] PTR 6.74.
[56] The Ombudsman aims to complete each investigation within 12 months of the start of the investigation.
[57] PTR 6.50.

stroke had on her. The poor complaint handling would have added to their distress. The Health Board's "goodwill offer" was also inappropriate. If the Health Board had complied with the Complaints Guidance and handled the complaint more effectively, the added distress that the family experienced would have been avoided.

Decision

126. For the reasons explained above, I **uphold** this complaint.

Recommendations

127. I recommend that, within one month of the date of this decision, the Health Board should:

a) Give Mr M an unequivocal written apology for the failures identified by this report.
b) Give Mr C an unequivocal written apology for failing to comply with Complaint Guidance.
c) Make a payment to Mr M of £5500 to reflect the failings in care identified by this report; the uncertainty caused by those failings; the delays in the Health Board's handling of this complaint and the time and trouble taken by his family in pursuing the complaint with this office.
d) So that appropriate lessons may be learned, share this report with the medical, nursing, health care and administrative staff involved in the case.
e) Provide me with evidence of the existing monitoring and quality assurance mechanisms it has in place to prevent a recurrence of:
    i. The failure of nursing staff to complete appropriate assessments and implement appropriate care plans.
    ii. The failure of staff to maintain appropriate records.
    iii. The failure of administrative, nursing and medical staff to follow the Complaints Guidance.

128. Within three months of the date of this report, the Health Board should:

a) Ensure compliance with current NICE guidance and professional guidelines, by reviewing (and if needed, updating) the current policies/protocols for the:
   i. Management of in-patients on pre-existing Warfarin therapy.
   ii. INR monitoring of in-patients with relevant pre-existing conditions.

   (if needed, and within six months of the date of this report, the Health Board should implement training for staff who indicate that they are not fully conversant with the relevant protocols)
b) Ensure that staff training in respect of recognising acute stroke is up to date, with particular reference to the current NICE guidance and professional guidelines.
c) Ensure that use of the NIHSS (or similarly recognised tool), in order to identify patients who are likely to have had an acute stroke, is implemented.
d) To ensure compliance with current NICE guidance and professional guidelines, review its arrangements for the identification and treatment of acute stroke, and consider including the following measures:
   i. All patients who may have had an acute stroke should be immediately assessed by a suitably trained physician to determine whether thrombolysis is suitable.
   ii. All patients who may have had an acute stroke should have immediate CT scanning (i.e. within one hour).
   iii. All patients who may have had an acute stroke should be assessed immediately for admission to a specialist acute stroke unit.
   iv. All patients who may have had an acute stroke should have a swallowing screening test (using a validated tool) by a trained professional within four hours.

129. The Health Board should give my investigator suitable evidence[58] that it has complied with the recommendations within one month of each due date.

130. I am pleased to note that in commenting on the draft of this report Cwm Taf University Health Board has agreed to implement these recommendations.

Nick Bennett
Ombudsman 25 March 2015

[58] Suitable evidence is, for example, a copy of the apology letters, team meeting minutes, training material and attendance logs, an audit report, a revised protocol.

Appendix 1

The Warfarin chart

Date	INR result	Prescribed dose (mg)	Time given
24 March	5.7	0	
25 March	-	0	
26 March	3.2	1	5.35pm
27 March	2.5	2	6.15pm
28 March	-	2	6.05pm
29 March	-	1	6.35pm
30 March	1.7	2	6.10pm
31 March	-	2	5.50pm
1 April	-	2	not given
2 April	1.4	4	6.45pm
3 April	1.6	4	6.00pm
4 April	1.6	x	Not prescribed
5 April	1.6	stop	

Appendix 2

The Duty of care and a Qualifying Liability

The Welsh Government issued statutory guidance on NHS complaint handling entitled: The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Putting Things Right - Guidance on dealing with concerns about the NHS (collectively referred to throughout as "The Complaints Guidance")

The Complaints Guidance sets out specific actions that health bodies should complete when considering complaints. The Complaints Guidance also covers the "duty of care" and "a qualifying liability in tort." It may be helpful to explain those terms:

Duty of care

The NHS owes a duty of care to the patient. A duty of care is both a professional and a legal obligation. It encompasses avoiding actions and omissions that are reasonably likely to cause harm to the patient. The legal test for a duty of care is:

"You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour."

Qualifying liability in tort

For a qualifying liability in tort to exist, a Welsh NHS body must have **BOTH** (1) failed in its duty of care to a patient, **AND** the breach of duty of care must have been (2) causative of the harm that the person has suffered. It is only when both these tests are satisfied that financial compensation under the NHS Regulations would be considered.

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