The investigation of a complaint

by Mrs X

against Aneurin Bevan University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201503082

Contents

	Page
Introduction	3
Summary	4
The complaint	6
Investigation	6
Relevant guidance and policies	6
The background events	7
The Aneurin Bevan University Health Board’s evidence	8
Professional advice	9
The Aneurin Bevan University Health Board’s response	12
Analysis and conclusions	13
Recommendations	15

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 Mrs X.

Summary

Mrs X complained to the Ombudsman about the care her father Mr Y received at the Royal Gwent hospital between Friday 5 December 2014 and over the following weekend after his admission suffering with constipation. Mr Y died on 8 December. Mrs X complained her father's raised blood glucose levels were not managed and he was not seen by a doctor for several hours. Mrs X said that despite her father having a full care package in place at home, he remained on an unsuitable ward and had an undignified end of life. Mrs X also complained that the Aneurin Bevan University Health Board's ("the Health Board") investigation of her complaint had been unhelpful.

The Ombudsman upheld Mrs X's complaints. He found that no action was taken in relation to Mr Y's elevated blood glucose levels over the weekend. Further, nursing staff had not informed the medical team of Mr Y's aspiration or fluctuating swallowing ability (dysphagia). He was not referred to a Speech and Language Therapist ("SALT") and he had not been kept nil by mouth ("NBM") in the interim.

The Ombudsman found that on Sunday, Mr Y's condition deteriorated and he was not reviewed by a doctor for over six hours. Nursing staff had not escalated the failure of a doctor to attend Mr Y. Consequently, antibiotics were not administered in a timely manner. The Ombudsman could not be certain whether earlier intervention might have led to a different outcome for Mr Y. The Health Board had not recognised that Mr Y had a full care package in place at home, and he had been placed on an inappropriate ward.

The Ombudsman did not uphold Mrs X's complaint about her father's end of life on an open ward. Side rooms were in use by patients with priority need.

The Ombudsman found that the Health Board's own investigation of Mrs X's complaint did not identify the failings in Mr Y's care.

In addition to a number of steps it was already taking, the Health Board agreed to implement the following recommendations:

a) apologise to Mrs X for the identified failings and, in recognition of the distress and uncertainty associated with her father's care, make a financial redress payment of £2000 to her

b) remind all nursing staff that patients with dysphagia should be referred without delay to SALT and kept NBM until formally assessed

c) review – with Educational Diabetic Nurse input - whether there are training issues for nursing staff on this ward in relation to the identification and management of hyperglycaemia

d) (i) establish why escalation procedures were not followed in this case

(ii) review the escalation process, in light of the outcome, to ensure it will be more effective in the future.

The complaint

1. Mrs X said that her father Mr Y had been admitted to the Royal Gwent Hospital ("the Hospital") on Friday 5 December 2014 suffering with constipation. He died on 8 December. Mrs X complained that she had been told her father could not be discharged because of his raised blood glucose levels, which were not managed. Mr Y had not been seen by a doctor for eight hours, despite nurses raising concerns about him. Although her father had a full care package in place at home, he had been placed on an unsuitable ward and had an undignified end of life on an open ward. Mrs X said that the Health Board's complaint investigation had been unhelpful.

Investigation

2. My investigating officer obtained comments and copies of relevant documents from the Aneurin Bevan University Health Board ("the Health Board") and I considered those in conjunction with the evidence provided by Mrs X. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

3. I have taken advice from my professional advisers, Dr Richard McGonigle a Consultant Renal and General Physician ("the Medical Adviser") and a Senior Nurse, Liz Onslow ("the Nursing Adviser").

4. Both Mrs X 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 guidance and policies

5. I summarise the guidance and reports relevant to the investigation of this complaint.

6. National Institute of Clinical Excellence ("NICE") 2006, Clinical Guidelines ("CG") 32, Nutrition support in adults. The guidance recommends that people with obvious or less obvious indicators of dysphagia (swallowing difficulty) should be referred to health care professionals with relevant skills, normally Speech and Language Therapists ("SALT").

7. NICE 2011, CG 87, Type 2 Diabetes national clinical guidelines for management in primary and secondary care. In order to ensure that blood glucose levels remain as normal as possible, blood glucose monitoring is required. A normal blood glucose level is 4.9mmol/litre before and less than 10mmol/litre after meals, although this can vary from person to person.

8. The Royal College of Physicians in 2012, introduced a National Early Warning Score ("NEWS") which has been adopted by the Health Board. The graded scoring system informs the recorder of action that must be taken in accordance with the score as indicated. A score of five means an hourly observation and review by a qualified nurse; a score of five for two hours means a doctor or Advance Nurse Practitioner ("ANP") should be contacted to review the patient within 30 minutes. A score of six or more means hourly observations, blood glucose test and Sepsis tool. A doctor or the ANP should be contacted to review the patient within 30 minutes.

9. Surviving Sepsis Campaign 2012. Provides international guidelines for the management of severe sepsis and septic shock. Each hospital should have its own protocol (Sepsis Screening Tool) and take specific clinical action. Sepsis is diagnosed or suspected from NEWS measurements amongst other clinical factors.

10. The General Medical Council's guidance entitled, "Good Medical Practice" place a responsibility on doctors to properly supervise staff they are responsible for. Further, those doctors must provide or arrange advice, investigations or treatment where necessary and refer a patient to another practitioner when in the patient's best interest.

11. Frances report, February 2013. Berwick report, August 2013. The failures of appropriate escalation procedures are not always the fault of nursing staff. Inadequate medical cover is usually responsible with a lack of consultants' presence in hospitals (not just emergency admissions) and junior doctors' reluctance to contact seniors, out of hours.

The background events

12. Mr Y was 93 years old, he had pre-existing health conditions. Mr Y had not opened his bowels for 12 days. On **4 December 2014**, he was admitted at hospital. On **Friday 5 December** at 8.00am, the admitting

Consultant saw Mr Y on his ward round. It was noted Mr Y had opened his bowels twice overnight with enemas and he was due a third enema.

13. The nursing records on Friday showed that Mr Y on two occasions had coughed and possibly aspirated (food and fluid entering the lungs). On four occasions Mr Y's blood glucose levels had been elevated. The Senior House Officer ("SHO") was informed Mr Y's blood glucose levels were raised and nursing staff awaited a plan. Later, Mr Y had been nursed by the nursing station as he had tried to get out of bed.

14. On **Saturday 6 December** at 1.50am, Mr Y had again been moved to the nursing station. An untimed nursing entry said since admission Mr Y's blood glucose levels were elevated. Mr Y's blood glucose levels were elevated on two other occasions that day. A SHO was bleeped who advised Mr Y be referred to a diabetic nurse on Monday (8 December).

15. On **Sunday 7 December**, Mr Y's blood glucose levels were elevated on six occasions. Mr Y had difficulty swallowing his lunch and the SHO had been informed. At 1.45pm Mr Y's NEWS was six. The nursing notes said the SHO had twice been notified (1.05pm and 2.00pm) and at 2.40pm Mr Y had not been medically reviewed. Two of Mr Y's later NEWS were five. At 7.45pm a doctor was still awaited. At 8.10pm, Mr Y was seen by a doctor who diagnosed hospital acquired pneumonia (HAP). The Sepsis Screening Tool was implemented.

16. Early on **Monday 8 December**, Mr Y's family were informed he had deteriorated. Mr Y's condition was discussed with the family, who were concerned as he had been admitted with constipation. Sadly, Mr Y died soon after.

The Health Board's evidence

17. The Health Board said that Mr Y's plan, on Friday, had been for him to have gone home once he opened his bowels more freely; there was no surgical plan for him. The Health Board said it is ill-advised to discharge an elderly co-morbid patient on a Friday because of the uncertainty surrounding weekend care and that it is wiser to discharge after a weekend, following a multi agency risk assessment.

18. The Health Board said that on Saturday, Mr Y was not seen by doctors because there was no obvious acute medical or surgical problem and he had not been flagged as a high risk patient for medical review. The nursing entry showed no nursing issues. He had been nursed at the nursing station to maintain dignity and safety, as he had tried to get out of his bed. Mr Y's blood glucose levels had been high, otherwise he was well.

19. The Health Board said, around lunchtime on Sunday, Mr Y presented with acute pneumonia; there was no prior evidence of this. The SHO on call had twice been bleeped. The team had been very busy with acute admissions and a complicated theatre procedure. The three junior doctors were stretched and there had been a delay in attending Mr Y. Mr Y was seen at 8.00pm by a junior doctor, diagnosed with HAP and prescribed immediate intravenous antibiotics. The Health Board said Mr Y was potentially a high risk patient with regards to HAP, because he had multiple co-morbidities and following a fall he had been in bed at home for 12 days.

20. The Health Board said that it had been explained to Mr Y's family on 8 December, that HAP is a common occurrence in frail, elderly patients. It was unlikely an earlier prescription of antibiotics would have helped. It had been an extremely busy period, with no empty beds on the surgical wards. Mr Y's ward was an orthopaedic one, adept at managing elderly patients. The Health Board apologised Mr Y had not been placed in a side room at the end of his life, but each one was occupied by patients with infections or those returning from surgery.

Professional advice

Medical Adviser

21. The Adviser said that because of Mr Y's dangerously elevated blood glucose levels,[1] it was right to have kept him in Hospital. The decision to discharge was a medical one, however, there is no evidence the medical team were aware of his markedly high blood glucose levels. It is unclear who had weekend responsibility for Mr Y or decided he stayed; he was not medically reviewed over the weekend. The Adviser said that the failure to address Mr Y's persistent markedly elevated blood glucose levels was a

[1] Apart from one reading, Mr Y's blood glucose levels were above 20mmol (normal range is less than 10mmol)

significant failing in his clinical management. There had been a complete lack of medical staff involvement.

22. The Adviser said that nursing records noted at meal times Mr Y had problems with possible aspiration. Mr Y's aspiration had been recognised but not medically investigated or managed. The Adviser said the Health Board's response, that Mr Y had no nursing issues on Saturday, ignored markedly elevated blood glucose levels and the documented risk of aspiration. The Adviser said that Mr Y had not benefitted from the hospital stay, his hyperglycaemia was not managed and the risk of aspiration was not lessened.

23. The Adviser said that on Sunday at 1.45pm, following Mr Y's NEWS of six, he should have had further observations within an hour, and a doctor or ANP contacted to review him within 30 minutes. When the nurses' requests for medical assistance had not been forthcoming; it should have been escalated to senior medical staff. There did not appear to be an escalation policy for junior nurses when junior doctors failed to attend. He said NICE and the Health Board's guidelines had not been followed for Mr Y's NEWS deterioration. The Health Board's response had been dismissive of the seriousness of the case and offered no plans for improvement. The Adviser said that it was concerning that Mr Y's medical review was delayed for between six and seven hours. This was a failure.

24. The Adviser said that following Mr Y's Sunday's NEWS of six at 1.45pm, antibiotics had only been administered at 8.40pm. The delayed administration of antibiotics compromised Mr Y's ability to overcome HAP. The Sepsis Screening Tool should have been started earlier. A long delay in administering antibiotics and intravenous fluids increases mortality. It was a significant clinical failing that should have been reported as a serious incident.

25. The Adviser said the Health Board's claim there were no signs of Mr Y's pneumonia before Sunday was undermined as he was not medically examined or reviewed and his possible aspiration had not been taken into account. The Adviser thought it likely Mr Y aspirated after admission and his high blood glucose levels increased the possibility of an adverse outcome. Hyperglycaemia is unequivocally associated with an adverse outcome for conditions such as sepsis, with an increased mortality rate.

26. The Adviser said that if Mr Y was kept in hospital because of high blood glucose levels he should have been moved to a medical ward which was more appropriate than an orthopaedic ward. This was evidenced by the lack of action to manage and lower Mr Y's blood glucose levels and he said there was a lack of expertise to understand the importance of such hyperglycaemia.

Nursing Adviser

27. The Nursing Adviser said that there are two nursing records for Mr Y, both with different entries. However, she found the Health Board's explanation, in response to the draft report, to be reasonable (see paragraph 35), as it explained why there were two contemporaneous nursing notes.

28. The Adviser said that because of an incomplete nursing assessment, it was difficult to establish whether Mr Y had swallowing difficulties before admission. On Friday, Mr Y twice experienced swallowing difficulties when eating and possible aspiration. The Adviser said guidance recommends those with dysphagia should be referred to SALT and it is good practice to keep patients "Nil By Mouth" ("NBM") until they have been formally assessed. The Adviser said Mr Y had not been NBM or referred to SALT and there is no evidence the medical team were told of his fluctuating swallowing ability. She said whilst it was reasonable that Mr Y could not be kept NBM over the weekend unless he was reviewed by a doctor, it is essential that a person at risk of aspiration is kept NBM regardless of the day of the week. The Adviser said that these were serious failings in Mr Y's care.

29. The Adviser said that on Friday, Mr Y's blood glucose levels were markedly above normal levels. Late on Friday and very early Saturday there were indications Mr Y had been confused when he tried to get out of bed. Nursing staff should have been aware that with Mr Y's confusion and high blood glucose levels, an infection may have been developing and requested a medical review. Apart from a conversation with the SHO on Friday and Saturday, the medical team were not asked to review Mr Y's blood glucose levels. The failures to identify Mr Y's possible infection and to request medical reviews were serious failings.

30. The Adviser said that in respect of Mr Y's Sunday NEWS of six, the nurse took appropriate action and contacted a doctor. Nursing records showed the SHO had been called at 1.05pm and 2.00pm, but there were no further calls for medical assistance. Nursing staff should have been more proactive to have escalated their concerns to senior medical staff or the ANP when there was no medical response, to ensure their attendance. The Adviser said that this was a serious failure.

31. On Sunday, Mr Y's NEWS was five at 2.30pm (not entered on the NEWS chart) and 4.15pm. The Adviser said that the Health Board's NEWS policy said further observations should have been made within an hour of these times and a Doctor/ANP asked to review Mr Y. Mr Y did not have further observations within an hour and there was no contact with the medical team. Mr Y's observations were not repeated until 8.20pm. These were serious failings.

32. The Adviser said that in the circumstances, the rationale of admitting Mr Y to the orthopaedic ward, had been reasonable. It was unclear whether an attempt had been made to admit him to a specialist elderly care ward. Mr Y had multiple co-morbidities and would have benefitted from a comprehensive geriatric assessment. It was regrettable Mr Y could not be moved to a side room, but those rooms are for those with infections.

33. The Adviser said that the Health Board had not recognised the significant failures she identified and consequently no action has been taken to address them.

The Health Board's response to the draft report

34. The Health Board accepted that Mr Y's blood glucose levels should have been medically reviewed. Also, on Sunday he had not been medically reviewed for between six and seven hours. It said that nurses had not fully used the escalation policy. The Health Board agreed that the level of care it provided in this case fell below its normal standards. However, the Health Board said that Mr Y had been on an acute ward which was an appropriate setting.

35. The Health Board disagreed with the Nursing Adviser's comment that there appeared to be two simultaneous nursing records for Mr Y. It said that

there were Evaluation Care Records, kept by the patient's bed, and a Multi Disciplinary Team ("MDT") booklet with the patient's medical records. The Evaluation Care Records had been used twice in error instead of the MDT booklet.

36. The Health Board said that Mr Y had not been assessed by SALT as the service does not cover weekends. It would have been inappropriate for Mr Y to be NBM, unless he was medically reviewed. The Health Board said that SALT resources are to be evaluated for provision of a seven day service.

37. The Health Board said that this complaint would be discussed at the Directorate meeting and it will ensure that junior doctors will understand the management of diabetic patients. Ward staff have received training on the escalation policy, NEWS and the deteriorating patient, and Health Care Support Workers assessed on blood glucose sampling. Three diabetic nurses are attached to the Ward. The draft report had been discussed at the Sisters's meeting and is to be discussed at the ward meeting. The Health Board conducted a Risk Assessment audit, which led to an action plan being developed for documenting the management of patients with dysphagia.

38. The Health Board apologised and acknowledged there had been shortcomings in Mr Y's care.

Analysis and conclusions

39. My investigation has revealed occasions when delivery of care to Mr Y over a weekend was of concern. I set out below the reasons for reaching these conclusions. In drawing my conclusions I have been greatly assisted by the advice of my Professional Advisers. The respective Advisers have commented on aspects of Mr Y's care (paragraphs 21 - 33) and I will not reiterate the details of those points here.

40. Nursing staff did not inform the medical team that Mr Y had aspirated or of his fluctuating swallowing ability. He was not kept NBM or referred to SALT. Throughout the weekend Mr Y's blood glucose levels were significantly elevated but there was no request for him to be seen by a doctor in light of this. The failures to inform the medical team of Mr Y's aspiration

and of persistent high blood glucose levels are significant.

41. On Sunday, Mr Y deteriorated. At 1.45pm his NEWS was six. Nurses sought a medical review. However, he was not seen by a doctor for over six hours. In line with the Health Board's own guidelines, Mr Y should have been medically reviewed within 30 minutes, so this was a significant delay. As a result, antibiotics were not administered as soon as they might have been. The Health Board has said this made no difference to the outcome, but we cannot be certain of that. I am concerned both by the delay in a doctor attending, and that nurses did not escalate the lack of a medical review to senior staff.

42. Also on Sunday, Mr Y's NEWS was five on two occasions. I note that one of these readings was not entered on the NEWS chart. Mr Y did not have further observations taken within an hour of these readings, as required by the Health Board's own guidelines, nor were requests repeated for medical review, or escalated.

43. Mr Y was admitted to hospital for severe constipation. Overall, I cannot rule out the possibility, albeit small, that earlier medical intervention may have led to a different outcome for Mr Y. Mr Y does not appear to have benefitted in any way from remaining in hospital that weekend. **I uphold** the complaints about clinical management and delays in Mr Y being seen by a doctor.

44. The orthopaedic ward was not a suitable setting for Mr Y; he did not have an orthopaedic problem. The nursing staff took no action in relation to Mr Y's aspiration, they did not identify that his confusion and high blood glucose levels were possibly indicative of an infection, and it does not appear the importance of his persistent elevated blood glucose levels was appreciated. There is no rationale for the decision not to discharge Mr Y once his bowels opened, as per the original plan, and he was not medically reviewed over the weekend. There is no recognition that Mr Y had a nursing package in place at home. **I uphold** these aspects of the complaint, and conclude that there were shortcomings in the decision making about Mr Y's stay in hospital.

45. Mrs X expressed concern that her father died on an open ward. In this respect I do not consider that Mr Y's end of life could have been better

managed. While I appreciate Mrs X's concern and distress, side rooms were in use by patients with infection and returning from surgery. I **do not uphold** this aspect of the complaint.

46. The Health Board's complaints investigation failed to identify that Mr Y had been aspirating or that there had been a lack of action in respect of his persistent elevated blood glucose levels, and it did not appear to recognise the seriousness of the delay in response to Mr Y's raised NEWS. I therefore **uphold** this aspect of the complaint.

Previous investigations and reports

47. I have previously considered and upheld complaints at the Royal Gwent Hospital which raised similar issues. Complaint reference 201401016, concerned the lack of timely medical review of a patient. Complaint reference 201501821, concerned the lack of action following a patient's escalating NEWS. To see repetition of similar issues is clearly troubling.

48. I have also issued a thematic report earlier this year which highlighted my concerns about the quality of patient care at weekends across Wales.

Recommendations

49. I **recommend** that the Health Board within one month of the final report date:

a) apologise to Mrs X for the identified failings and, in recognition of the distress and uncertainty associated with her father's care, make a financial redress payment of £2000 to her

b) remind all nursing staff that patients with dysphagia should be referred without delay to SALT and kept NBM until formally assessed

c) review – with Educational Diabetic Nurse input - whether there are training issues for nursing staff on this ward in relation to the identification and management of hyperglycaemia

d) I **recommend** within three months of the date of the final report, the Health Board:

e) (i) establish why escalation procedures were not followed in this case,

and

(ii) review the escalation process in light of the outcome to ensure it will be more effective in the future.

50. I am pleased to note that in commenting on the draft of this report the Aneurin Bevan University Health Board has agreed to implement these recommendations.

Nick Bennett
Ombudsman

24 November 2016

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