Request for Clinical Advice

Clinical Adviser

I set out below my request for clinical advice.

The complainant and their relationship to the patient

Advocate/client.

The complaints subject to investigation

Care and treatment at the [redacted] Hospital between 25 March and 18 April 2019.

Background and the events

Mr X had a history of Multiple Sclerosis, a hiatus hernia, and a pulmonary embolism. On 25 March 2019 Mr X's GP referred him to A&E, he was transferred to a ward. On 26 March Mr X's NEWS was 9 and his suprapubic catheter was changed. That same day Mr X complained of chest pain, Mrs X was concerned about his failing health. Doctors were called at 11:00, he was reviewed at 18:00 (page16).

On 27 March at 20:30 Mrs X complained that Mr X was in constant pain, she was unhappy that the doctors had not said what caused the pain and he was to have further tests and somebody should be called who knew how to replace suprapubic catheter. It was noted that Mr X was fully dependent on staff for turning and he was to be regularly assessed (page 203). Mr X's sacrum was discoloured, but his carers said that it was no different to normal (page 203).

On 28 March (page 24) at 04:45 Mr X was seen by a doctor because Mrs X complained about his care, he had not slept properly for 3 days and had an anxiety attack. Mr X wanted medication to help him sleep and he was administered zopiclone. Mrs X called the ward (page 151) and said that Mr X wanted her to pick him up and take him home, she did not want to speak with the nurse caring for him. The Nurse caring for Mr X spoke with Mrs X and said that Mr X had an enema he had not complained, he was reviewed every hour. Mrs X said that Mr X had been screaming, nobody came to him, the Nurse said that nobody heard him screaming and he had used the bell a few times. When Mr X was reviewed by a doctor and apologised to the Nurse. At 07:30 Mr X threw items at the wall, he was agitated. He shouted that he was kept against his will and called police, the situation was

explained, Mr X refused his medication. During the ward round Mr X was noted to have been hallucinating, but was then lucid, he had felt ignored and had been thirsty. He was angry with Mrs X as he wanted to go home. It was explained he needed further treatment oxygen therapy and IV antibiotics.

On 29 March the ward round noted that Mr X felt he was improving slowly but had been confused and hallucinating overnight. On 30 March an ECG showed that he had 65ml of residual urine.

On 31 March (page 157) at 00.10 Mr X was very anxious, his NEWS was 7, Mrs X was told she would be updated should there be a change. At 00:46 (page 35) Mr X was reviewed at the nurse's request; he became anxious as the request for microlat enema was refused. The chest X-ray was noted as having worsened pulmonary oedema and he was to have the enema. He was reviewed at 06:31 in response to worsening NEWS, he had passed urine and a further review was requested. At 13:55 Mr X was reviewed, he felt better, he was to have an enema Mrs X was happy with this plan. At 14:57 Mrs X was spoken to by a doctor and it was explained treatment was for suspected fluid overload on the chest and AKI. Mrs X asked if Mr X's life was in danger it was explained that Mr X could be stabilised. At 03:30 Mrs X was noted to be very upset as Mr X was very confused, agitated and hallucinating.

On 1 April Mr X's echogram showed severe impairment (page 38) and he was referred to cardiology. On 2 April at 19:30 Mr X was reviewed, he was clinically in heart failure, at 20:00 Mrs X was spoken to and told that the echocardiogram showed his heart was working very poorly affecting kidney function, she was very upset. Between 21:50 2 April and 5 April Mr X was transferred to Cardiac Monitoring Care Unit. There are no complaints about his treatment at the Cardiac unit.

On 7 April Mr X was noted to be drowsy, mumbling in his sleep (page 54), but had no pain. At 14:50 it was noted Mr X was not administered warfarin on 6 April. On 8 April at 11:20, Mrs X agreed with the ceiling of care-ward based care and NIV (page 58). The DNACPR was signed (page 1). At 15:40 it was queried whether Mr X had a blocked suprapubic catheter.

On 9 April Mrs X was present at the ward round, it was noted he had CAP, heart failure and progressive MS. Mr X did not open his eyes to voice or pain. He did not appear distressed, his legs appeared mottled, but Mrs X said they were improved. There was an unsuccessful attempt at cannulation (page 58) and Mr X asked there were no more attempts, he understood this to be potentially life threatening. On 10 April it was noted that Mr X tolerated the NIV mask, his feet looked mottled but were warm to touch. On 11 April Mr X rousable, denied pain and he preferred the NIV on. Mrs X was present, and he grimaced in pain when his feet were touched. At 16:20 Mr X preferred the NIV mask on.

On 12 April at 10:30 the doctor saw Mr X as Mrs X reported that he was not well, he was sleeping and comfortable. At 11:30 Mr X's NIV mask was off and he felt better. There was disagreement with Mrs X as she had employed care and transfer for Mr X at home. At 20:55 Mrs X was concerned that Mr X was still confused and was concerned about the noise in the bay and short staffing levels on 11 April.

On 15 April at 10:35 (page 67) Mr X was seen with Mrs X who was concerned that he had another infection, it was explained there were no pointers for that, and Mr X need IV antibiotics. Mrs X wanted Mr X to die at home, it was explained it would a big physical and emotional undertaking and he would be monitored, and a plan would be made.

On 16 April Mr X was sleepy, verbalising but confused. On 17 April the food chart showed that Mr X was eating well, he was napping, rousable but confused. On 18 April at 10:20 Mrs X was noted to have multiple concerns, Mr X's penis was swollen, he was to continue with chest physiotherapy he was referred that same day (page 70). At 13:20 physiotherapist (page 75) saw Mr X he was noted to have an ineffective cough and he could not clear his secretions; sputum was recovered. On 18 April at 16:05 it was discussed that Mr X's prognosis was near terminal. At 19:40 Mr X sadly died.

Summary of the complaints procedure

The Health Board said that for the duration of Mr X's stay between 29 March and 18 April, his care and treatment was reasonable.

Questions

I set out below questions relating to the complaints. For each question, please would you set out what happened, what should have happened, the impact of any difference between the two, and any remedy or recommendations to prevent recurrence or improve care for the future.

1. The Health Board said that on 1 April 2019 (page 399) there was a 25-hour period when his vital signs were not monitored and that no harm was caused. It said that changes have improved care delivery. Is the response that no harm was caused, and are the changes put in place reasonable?

2. The Health Board accepted that nursing staff failed to adhere to infection prevention control processes whilst delivering care to Mr X, specifically the use of correct personal protective equipment (page 399). It said that staff are 20% compliant with Infection Prevention and Control and PPE was discussed by the ward manager. What would be the impact of not having adhered to infection prevention and are the steps taken to remedy this reasonable?

3. The Health Board said that on 13 occasions medications were not administered at the correct time (pages 385 & 401). Is the explanation given for the delays reasonable?

4. Was it reasonable that Mr X's risk assessments were carried out and reviewed during his admission as opposed to weekly or when transferred to a new ward?

5. Was communication between Nurses and Doctors reasonable?

6. Was Mr X's nursing care impacted because of his MS and was it to a reasonable standard?

7. Please let me know if, in considering my questions, you identify any other relevant clinical matter that gives you cause for concern.

Thank you for your advice. If you need to discuss the case, please do not hesitate to contact me.

Swyddog Ymchwilio/Investigation Officer

TO BE COMPLETED BY CLINICAL ADVISER

Provision of Clinical Advice for Public Services Ombudsman for Wales
Background Information
Case Identifier (Case Reference): 20200XXXX
Clinical Adviser's Name and Qualifications: [Name] [Relevant qualifications provided]
Relevance of qualifications and/or experience to clinical aspects of this case: [Relevant qualifications provided]
Conflict of Interest (clarification of any links with Body or clinicians complained about): I can confirm I have no conflict of interest with the Body or any clinicians complained about

Confirmation that the Ombudsman's Clinical Standards [insert link] have been applied in the provision of the advice https://www.ombudsman.wales/clinical-standards/
Please confirm the chronology provided by the Caseworker in requesting this advice is correct and correctly identifies the relevant clinical events Having reviewed the chronology provided by the Caseworker I can confirm it is correct and identified the relevant clinical events as pertains to Nursing Advice.

Clinical Advice

Any comments on Background and Chronology:

The case worker has provided a suitable Background and Chronology, Therefore I do not need to elaborate further.

Documentation Reviewed:

As provided by the case worker

Questions and Responses:

1. **The Health Board said that on 1 April 2019 (page 399) there was a 25-hour period when his vital signs were not monitored and that no harm was caused. It said that changes have improved care delivery. Is the response that no harm was caused, and are the changes put in place reasonable?**

The HB have acknowledged that vital signs were not monitored as expected in compliance with National Guidelines (NICE [CG50] 2007, Acutely ill adults in hospital: recognising and responding to deterioration section 1.3) which state –

- Physiological observations should be monitored at least every 12 hours unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient.

- The frequency of monitoring should increase if abnormal physiology is detected, as outlined in the recommendation on graded response strategy (in this case the NEWS2).

Although the HB state no harm was apparent at this time and recognise opportunities may have been missed to identify a deterioration in the patient. It is not an adequate response to say they are unable to identify why this occurred and

that the delays did not identify any deterioration. It is evident from the Medical Records that the patient was clearly unstable, he was awaiting a Cardiac Consultant review, an ECHO cardiogram and required oxygen therapy along with other medical interventions which ultimately resulted in his transfer to a Cardiac Care Unit, as such the outcome of his Clinical Observations not being maintained could have resulted in a much worse outcome.

In point of fact on review of the NEWs chart for 1–2 of April it is evident that clinical observations were obtained in the early hours of 01/04/2019 at 02:00 & 06:15 with a score of 3 on each occasion, this indicated Clinical observations should be repeated every 4–6 hours, however, they were not repeated again after 06:15 on the 1 April until some 12 hours later at 18:45 again with a NEWs score of 3, it is then not repeated again for 25 hours at 02/04/2019 at 19:50 with a score of 1.

On further review of the NEWs charts, it is evident that this was not an isolated incident as there are occurrences of missed monitoring times as advised by the NEWs charts, we can also see that this patient was unstable as his NEWs charted score fluctuated from 0–5/6 regularly, this would indicate an unstable patient and close monitoring would be advised.

Having read the HB improvements (p399), which state they are utilising completion of audits, regular observation rounds of the staff and training at ward level from the outreach team. These changes, if implemented effectively should be adequate for maintaining improvements at ward level whilst enabling any further concerns to be identified and managed promptly. The HB need to provide assurance this is ongoing and that all staff have now been trained.

2. **The Health Board accepted that nursing staff failed to adhere to infection prevention control processes whilst delivering care to Mr X, specifically the use of correct personal protective equipment (page 399). It said that staff are 20% compliant with Infection Prevention and Control and PPE was discussed by the ward manager. What would be the impact of not having adhered to infection prevention and are the steps taken to remedy this reasonable?**

From the available documentation (p399) it states the ward staff are 83% compliant with Infection Prevention and Control (IPC) training as recorded on the electronic staff record (ESR). The aim is to be 100% compliant. – The HB need to provide evidence that this is now completed and remains ongoing.

NICE (2012) CG 2 Infection Prevention and control section 5.2.1.1 recommend - Everyone involved in providing care should be:

- educated about the standard principles of infection prevention and control
- trained in hand decontamination, the use of personal protective equipment, and the safe use and disposal of sharps.

The HB have stated that In-patient care audits for general infection control measures which includes the use of correct PPE are completed weekly with average scores of between 85 – 100% compliance. The HB have not shown how this short fall is being addressed and if, following the ward meetings indicated within the response letter, there has been any improvement. They have also neglected to state how this has been addressed i.e., through audit, shadowing or further training to attain compliance with their Personal Protective Equipment (PPE) Infection Prevention and Control Policy (p480) & Hand Hygiene Policy (p500).

Aseptic Non-Touch Technique (ANTT - the key components involved in maintaining asepsis and aims to standardised practice around things like cannula insertion and catheter care) compliance is currently 89.5% for the qualified nurses and 85% for Health Care Support Worker. The HB state training is via E-learning as well as a ward level assessment. They have not explained why compliance is only 85-89.5% if staff have undergone this level of training, nor have they provided an explanation as to how they will ensure improvements with compliance.

The impact of poor adherence to infection prevention and control measures along with poor ANTT is an increased prevalence of cross infection and the transmission of avoidable Hospital Acquired infections within the ward area. This then leads to poor patient outcomes and avoidable death. The HB have not addressed the shortfalls in maintaining their Aseptic Non-Touch Techniques policy (p407).

3. **The Health Board said that on 13 occasions medications were not administered at the correct time (pages 385 & 401). Is the explanation given for the delays reasonable?**

I will address each point as it arises in the response letter

- Intravenous antibiotics – this is a satisfactory explanation, it would not have been possible for staff to give this medication without means of access, there is no evidence to support any other missed doses, the patient received his prescribed regime.

- Salbutamol nebulisers – Although the HB have stated the patient was comfortable and oxygen saturations were within his usual range this medication should not have been omitted.

Salbutamol is a bronchodilator used to assist the airways to open and ease the work of breathing. As the patient had MS this can cause weakness of the breathing muscles and also restrict the ability to get air in and out, we can see from the NEWs chart that the patient had been on CPAP (a form of assisted non-invasive ventilation) up to the morning of the 12/04/2019 this supports the work of breathing by proving continuous partial airway pressure. The effect of omitting the Salbutamol so soon after requiring assisted ventilation would have resulted in an increased work of breathing for an already compromised patient and needs to be addressed.

- Bisocodyl - this is an as required medication for the treatment of constipation, as the Bristol Stool chart did not show the patient was constipated there is nothing to suggest this medication was required at that time.

- Betmiga MR Medication – Not available the response states 5 & 6 March, I assume they were referring to 5 & 6 April as the patient admission started on 25 March. The chart refers to medication being unavailable, as the patient had been an inpatient for 10 days at that time and had been receiving his medication the HB have not provided an explanation as to why the medication was unavailable?
  .
- The omission of medication due to confusion and drowsiness are both acceptable explanations.

Royal Pharmaceutical Society (2019): Professional Guidance On Administration Of Medicines in Healthcare Settings, section 17 state:

> Records are kept of all medicines administered or withheld, as well as those declined.
>
> > 17.1 Such records are completed at the time of the administration/refusal or as soon as possible thereafter and are clear, legible, and auditable.
> >
> > 17.2 Where a medicine is not administered or refused, details of the reason why (if known) are included in the record and, where appropriate, the prescriber multidisciplinary team is notified in accordance with the organisation policies and procedures. Appropriate action is taken as necessary.

From the Datix form (p385) it is evident that the HB addressed this issue at ward level, however, we can also see form the response (p400) that further audits completed in 2020 had shown there are still issues with regards to medication administration with 7/10 charts audited showing errors. The HB have not provided any recourse to address this issue or to ensure their Administration of Medication Procedure (p428) is being met.

4. **Was it reasonable that Mr X's risk assessments were carried out and reviewed during his admission as opposed to weekly or when transferred to a new ward?**

No this is not appropriate. The HB acknowledge the patients risk assessments were not carried out and reviewed appropriately. All risk assessments should be completed on admission, or transfer to another area, these should then be reviewed on a weekly basis or sooner as dictated and/or if there is a change in the patients health or care needs. (All Wales Moving and Handling Assessment, Patient Falls Risk Assessment, Nutritional Assessment).

The HB have introduced monthly audits and discussed the matter of poor documentation with the staff on several occasions as evidence within their response. Although they state the audit provides assurances the documentation is now being completed, they have not provided any evidence to support or refute this claim. Nor have they addressed any further training needs of the staff and provided assurances this is being undertaken as necessary.

5. **Was communication between Nurses and Doctors reasonable?**

From the available documentation it is evident that the nursing and medical staff were all aware of the patients care needs and communication between the teams is evident. There are numerous instances where a doctor has written 'asked to see by nurses' likewise there are numerous examples where nurses have documented instructions from the medical team and ward round minutes.

6. **Was Mr X's nursing care impacted because of his MS and was it to a reasonable standard?**

I am unable to establish any evidence that the patient's nursing care was impacted due to his MS. From the available nursing documentation, it is evident that the overall picture is one of good care, however, due to the poorly completed documentation as addressed in Q5, I am unable to confirm it was of a high standard due to some gaps in the risk assessments.

We can see that nursing staff were attentive to all his medical needs in general, they also responded to any changes in condition, doctor concerns and orders or indeed family wishes. He was assisted with daily hygiene, positional changes, diet, and fluids and provided with medication as charted in the most part. All though the daily record sheets do not provide a substantive picture as to the care he received as these are too generic, from the communication sheets & real time documentation sheets (p149 to p176) we build up a picture of good care and support for both the patient and his wife, with large paragraphs given over to communication between all parties as well as the actions taken by the nursing staff in providing the care he needed.

7. **Please let me know if, in considering my questions, you identify any other relevant clinical matter that gives you cause for concern.**

I have not identified any significant concerns other than I have addressed in the questions above.

Recommendations:

Please see my recommendations as they occur under each question.

Conclusions:

Although the overall picture is one of good care provided in real time to the patient, it is evident that some shortcomings are evident which the HB have acknowledge in the main and addressed in part.

There is work for the HB to do in order to ensure lessons have been learnt and the shortcomings have been rectified.

Clinical Standards – List of Guidance and Policies Referenced (please provide link to relevant/current document)

All Wales Medicines Strategy Group. (2015). All Wales policy for medicines administration, recording, review, storage and disposal https://awmsg.nhs.wales/files/guidelines-and-pils/all-wales-policy-for-medicines-administration-recording-review-storage-and-disposal-pdf/

NICE (2006) CG32 Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition https://www.nice.org.uk/guidance/cg32

NICE (2007) CG50 Acutely ill adults in hospital: recognising and responding to deterioration https://www.nice.org.uk/guidance/cg50

NMC (2018) **The Code** Professional standards of practice and behaviour for nurses, midwives and nursing associates The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council (nmc.org.uk)

Royal Pharmaceutical Society (2019) Professional Guidance on the Administration of Medicines in Healthcare Settings https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567

Wales Governance e-manual, Standard 13: Infection Prevention and Control and Decontamination. http://www.wales.nhs.uk/governance-emanual/standard-13-infection-prevention-and-control-and-decontamination.

Welsh Government (2011). Commitment to Purpose: eliminating preventable healthcare associated infections (HCAI).

Welsh Government (May 2014). Code of Practice for the Prevention and Control of Healthcare Associated Infections. http://gov.wales/docs/phhs/publications/140618appendixen.pdf

Welsh Healthcare Associated Infection Programme (WHAIP) - All-Wales National Model Policies for Infection Prevention and Control. Part 1: Standard Infection Control Precautions (SICP). August 2014. Part 2: Transmission Based Precautions. February 2015. Link: http://www.wales.nhs.uk/sites3/page.cfm?orgid=379&pid=38960

Name & Signature:

Date:
19/01/2022