Clinical Advice Form

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OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

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 11am, 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 7:30am 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 the 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 3). 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 62) 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 had physiotherapy 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 (complaints file page 72). 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. Mrs X complained that in view of Mr X's multiple sclerosis he should not have been placed on a respiratory ward. The Health Board said that Mr X was cared for in the appropriate environment on a respiratory ward. Was this an appropriate explanation?

2. The Health Board said that Mr X was too unwell and deteriorated too quickly to have allowed a safe and dignified death at home. Is this explanation and the steps taken to have explained this to Mrs X reasonable?

3. The Health Board said that Mr X was admitted with community acquired pneumonia, his respiratory failure worsened, a hospital acquired pneumonia developed and was treated. Mr X's death was hospital acquired pneumonia, can it be claimed that it was treated and was Mr X's treatment for both community acquired, and hospital acquired pneumonia reasonable?

4. The Health Board's response (page 401) said that patients would be referred for mobility assessment when stable to mobilise and Mr X was not medically fit for such referral. The physiotherapist's internal email response (page 350) said its support and recommendations could have made Mr X's admission more comfortable. Are you able to say whether Mr X was not medically fit for such a referral?

    a) Should there have been an earlier physiotherapy referral for sputum retention and if so, what impact did this have?

5. 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

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Clinical Advice Form

TO BE COMPLETED BY CLINICAL ADVISER

Clinical Advice

Any comments on Background and Chronology:

Provision of Clinical Advice for Public Services Ombudsman for Wales
Background Information
Case Identifier (Case Reference): **20200XXXX**
Clinical Adviser's Name and Qualifications: DR X MB BCh FRCP
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): **Nil**
Confirmation that the Ombudsman's Clinical Standards [insert link] have been applied in the provision of the advice Clinical-Standards.pdf (ombudsman.wales)
Please confirm the chronology provided by the Caseworker in requesting this advice is correct and correctly identifies the relevant clinical events ***Chronology has been reviewed and updated.***

Clinical Advice Form

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The complaints subject to investigation

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

Documentation Reviewed:

578 pages Clinical notes

Background and the events

Mr X was a 69 year gentleman with a history of Multiple Sclerosis, a hiatus hernia, and a previous pulmonary embolism for which he was anticoagulated. On 25 March 2019 Mr X's GP referred him to Medical Assessment in the [redacted] Hospital with confusion and delirium. He had a cough and was short of breath but had also been commenced on antibiotics for a probable urinary tract infection a few days earlier. He was initially assessed at 15:05 and then reviewed by the on-call Dr at 17:48 when he was commenced on treatment for chest infection with intravenous antibiotics and fluids. He was then reviewed by the on-call Consultant at 21:00 who diagnosed urinary tract infection, lower respiratory tract infection and impending sepsis.
He was subsequently transferred to a medical ward.

On 26 March Mr X reported pain in his chest and had and ECG and further blood tests. At 18:30 his NEWS increased to 9 when he was reassessed and his blood tests reviewed. He was given additional fluids and antibiotics (gentamicin) and subsequently had suprapubic catheter changed.

He was reviewed at midnight due to the blood tests suggesting his chest pain could be cardiac in origin but was sleeping and pain free. He was commenced on aspirin and clopidogrel for acute cardiac syndrome in view of the blood tests.

On 27 March at 20:30 Mrs X complained to Nursing staff that Mr X was in constant pain, she was unhappy that the no cause had yet been found. She was concerned that he was constipated and the lack of staff trained to change the suprapubic catheter. Mr X subsequently had an enema with good effect and indicated that he felt better after it.

Later that night (28 March at 04:45) Mr X was seen by a doctor because of Mrs X's concerns about care. He had not slept properly for 3 days and felt he had an anxiety attack. He requested medication to help him sleep and he was administered zopiclone. Mrs X indicated that Mr X had called her and wanted her to pick him up and take him home. The Nurse caring for Mr X spoke with Mrs X and said that he

received an enema but had not complained of specific pain when reviewed which was almost hourly. Mrs X said that Mr X had been screaming, nobody came to him, but the Nurse said that nobody had heard him screaming and he had used the bell a few times.

At 07:30 Mr X threw items at the wall and was agitated. He shouted that he was kept against his will and called the police. Nursing staff spoke to the police and when reviewed later it was acknowledged that Mr X had been hallucinating. Subsequently he was much more lucid but he and Mrs X were concerned about his care. He felt ignored and had been thirsty. He was angry with Mrs X as he wanted to go home. It was explained he needed further investigations of the likely cardiac chest pain and ongoing treatment with oxygen therapy and IV antibiotics. Mr X agreed to remain as an inpatient.

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 blood tests revealed an acute kidney injury with hyperkalaemia (high potassium level) and a high INR. He was treated for the high potassium.

On 31 March (page 157) at 00:10 Mr X was reviewed by the on-call Dr as his NEWS was 7 and he became anxious as his request for microlax enema was refused. A chest X-ray was noted as having worsening pulmonary oedema and a diagnosis of fluid overload, acute kidney injury and constipation was made. He was treated with diuretic and Mrs X was updated at 02:57. It was explained that treatment was for suspected fluid overload and an acute kidney injury.

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.

He was given a diuretic and further reviewed at 06:31 hrs where it was noted that he was comfortable and had passed 400ml of urine..

At 13:55 Mr X was reviewed, he felt better, he was to have an enema Mrs X was happy with this plan.

On 1 April Mr X underwent an echocardiogram which revealed severe left ventricular impairment with an ejection fraction of <10% (page 39).
Mr X was reviewed and Mrs X was updated by the Consultant at 20:00 on 2 April, explaining that Mr X had heart failure with a poor outlook if there was no improvement. She was informed of his transfer to the cardiac unit and although upset appeared to understand.

There are no concerns 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. His legs were swollen and skin on feet appeared mottled. He received treatment for persistently elevated potassium.
It was noted that Mr X was not administered warfarin on 6 April but his INR was satisfactory at 2.9 and further warfarin was prescribed.

On 8 April at 11:20 Mr X was reviewed by the Consultant who reiterated the medical conditions and then discussed ceiling of care as being ward based, Non Invasive Ventilation and CPR status with Mrs X of care. The DNACPR was signed (page 3).

On 9 April Mrs X was present at the ward round where it was noted that Mr X was more drowsy. His diagnoses were reiterated. He did not appear distressed, his legs appeared mottled, but Mrs X said they were improved.
Arterial blood gases indicated that Mr X had developed hypercapnic respiratory failure and he was commenced on treatment with Non Invasive Ventilation.
His potassium was elevated again.

On 10 April it was noted that Mr X was tolerating NIV but his feet looked mottled and warm to touch.

On 11 April Mr X was rousable, denied pain but legs were more mottled and the Dr felt Mr X was becoming shut down suggesting circulatory failure.
Mrs X was present, and he grimaced in pain when his feet were touched.
A plan for “comfort measures”, stop NEWS assessments and suggestion he come off NIV was made but Mr X preferred to remain on NIV.

On 12th April at 11.30 Mr X’s NIV mask was off and he felt better. There was discussion with Mrs X regarding home care arrangements which indicated she had employed care and transfer for Mr X at home.

On 13th April, Mrs X was concerned that Mr X seemed less well and he was reviewed by medical staff who arranged further urine analysis. He was also noted to have some redness and swelling on his arm and was commenced on antibiotics for possible cellulitis.
At 20:55 Mrs X was concerned that he 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 that he needed intravenous antibiotics.
Mrs X expressed the wish for Mr X to die at home should he deteriorate. The Drs felt that it would a big physical and emotional undertaking and suggested he would be monitored over the next week and a plan would be made.

On 16 April Mr X was sleepy, verbalising but confused and 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. It was noted that Mr X's penis was swollen but he had a suprapubic catheter. He had received physiotherapy and was eating and drinking.
At 13:20 the physiotherapist (page 75) noted that Mr X had an ineffective cough and he could not clear his secretions; copious sputum was recovered with suction.
On 18 April at 16:05 it was discussed that Mr X's prognosis was near terminal and a plan made for palliative treatment. (complaints file page 72).
At 19:40 Mr X sadly died.

Questions and Responses:
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.

Q 1. Mrs X complained that in view of Mr X's multiple sclerosis he should not have been placed on a respiratory ward. The Health Board said that Mr X was cared for in the appropriate environment on a respiratory ward. Was this an appropriate explanation?

A1. Mr X was referred by his GP on 25th March having been assessed and found to have breathlessness, raised temperature and low Oxygen saturations . The GP diagnosis was a Lower respiratory tract infection.
The acute assessment team in hospital additionally elicited a history of cough, increasing weakness and abdominal pain. Mr X was reviewed by Dr Y, Consultant Respiratory Physician who was also the oncall Consultant on 25 March and diagnoses of respiratory tract and urinary tract infection were made.

Mr X underwent investigations which confirmed Right lower lobe pneumonia. Subsequently he was also diagnosed with heart failure secondary to severe left ventricular impairment the exact cause for which was not clear. Later in his admission he developed respiratory failure and required non-invasive ventilatory support.

During his admission his care was managed initially in the acute assessment ward and then the respiratory ward. He spent 3 days in the cardiac assessment unit where he underwent treatment for his heart failure and was then transferred back to the respiratory ward for ongoing treatment of his respiratory infection and

subsequent respiratory failure. It would be appropriate to manage a patient with respiratory infection and respiratory failure in a respiratory ward.
Given the acute diagnoses, Mr X was placed in clinical areas with the appropriate skills and expertise to manage his acute medical conditions.

Q2. The Health Board said that Mr X was too unwell and deteriorated too quickly to have allowed a safe and dignified death at home. Is this explanation and the steps taken to have explained this to Mrs X reasonable?

A2. Documented discussions indicated that the intention of clinicians, Mr X and his family were to aim for active treatment and to return Mr X to his previous health status. The progressive development of respiratory failure in conjunction with heart failure and renal impairment indicated multi organ failure and a very poor prognosis and despite active treatment of the acute diagnoses, Mr X's clinical condition deteriorated. On 8th April, a decision was made that the ceiling of care would be ward based and the patient would not be considered a candidate for cardiopulmonary resuscitation in the event of cardiorespiratory arrest. Mrs X agreed with the decisions.

On 11th April there are entries indicating that Mr X was becoming peripherally shut down and that the focus should be on comfort measures and not for "NEWS" scoring. This implied the patient was entering the last few days of his life and in retrospect it is possible that a "fast track" discharge could have been considered supported by palliative care provided Mr and Mrs X understood that no further active treatment would make an impact on the likely outcome.
However, at that stage the patient himself wished to remain on NIV.
Subsequently he was commenced on antibiotics for cellultis (13 April) and his condition did appear to vary on a day to day basis.

On 15th April, an entry suggested commencing discharge planning but uncertainty as to whether this was realistic by the medical staff.

Since Mr X remained on NIV it is unlikely that home NIV and associated training could have been arranged in such a short timescale to facilitate discharge. A comment on the 18 April indicated that Mr X was "near terminal" and the option of palliation with a syringe driver or NIV was offered. The plan opted for was to continue palliative NIV which realistically meant him remaining in hospital to die.

Mrs X expressed the wish for Mr X to die at home and a social worker had written discharge plans could be made once Mr X was medically well for discharge planning. However, at that point Mr X was unlikely to survive and so waiting for him to be medically well for discharge was not feasible.

There are numerous references to discussions with Mrs X throughout the notes regarding many aspects of Mr X's care. Whilst Medical and Nursing staff appeared to have made reasonable attempts to communicate with Mrs X, in retrospect it could have been anticipated that Mr X was unlikely to survive this admission. Discussions and communication appeared to give conflicting views over the likely outcome in the last few days of his life.

Q3. The Health Board said that Mr X was admitted with community acquired pneumonia, his respiratory failure worsened, a hospital acquired pneumonia developed and was treated. Mr X's death was hospital acquired pneumonia, can it be claimed that it was treated and was Mr X's treatment for both community acquired, and hospital acquired pneumonia reasonable?

A3. On admission Mr X clearly had features of infection with CXR changes consistent with community acquired pneumonia (consolidation in Right lower zone) and symptoms suggestive of urinary tract infection for which he had already been commenced on treatment by his GP prior to admission. On admission to hospital, he was commenced on intravenous Tazocin which continued for 8 days and was then switched to intravenous Meropenem which continued for a further 8 days. In addition he received 2 stat doses of intravenous gentamicin. These antibiotic treatments would be appropriate for the management of pneumonia and a urinary tract infection.
The antibiotic regimens were discussed with a Consultant Microbiologist on 2 occasions (27 March and 5 April) who agreed with treatment plans and advised on duration. In addition, Mr X received intravenous fluids and oxygen therapy as supportive treatment.

The treatments for both community acquired and hospital acquired pneumonia were reasonable.

Q4. The Health Board's response (page 401) said that patients would be referred for mobility assessment when stable to mobilise and Mr X was not medically fit for such referral. The physiotherapist's internal email response (page 350) said its support and recommendations could have made Mr X's admission more comfortable. Are you able to say whether Mr X was not medically fit for such a referral?

A4. According to the documentation available, Mr X was able to transfer to his wheelchair but was not independently mobile due to his progressive neurological condition of Multiple Sclerosis. A mobility assessment would not have been relevant therefore and a physiotherapy referral does not constitute solely a mobility assessment.

Mr X was treated for infection and sepsis. He was also experiencing episodes of chest pain felt to be cardiac in nature and was intermittently confused. There are comments that he felt sleep deprived and experienced hallucinations. He was then diagnosed with severe left ventricular dysfunction and required treatment on the cardiac unit, following which he developed respiratory failure and renal dysfunction.
There is no doubt that Mr X was very unwell therefore with progressive multiorgan dysfunction, but the physiotherapy referral form provides referral guidelines which indicate that if patients were able to transfer previously and that the patient's ability to transfer had deteriorated, the patient should be referred to physiotherapy.

Whilst it is understandable that the medical and nursing teams might have assumed that Mr X was not well enough to undergo any significant physiotherapy intervention the best person to make an assessment of what support could have been provided to the patient would have been a physiotherapist and so a referral would have been appropriate.

Q4b. Should there have been an earlier physiotherapy referral for sputum retention and if so, what impact did this have?

A4b. The only physiotherapy referral apparent in the notes relates to one for sputum retention and ineffective cough contributing to mucus plugging on 18 April. There are regular entries in the notes detailing Mr X's chest examination including comments relating to "inspiratory/bibasal crepitations" when he had pulmonary oedema relating to heart failure and later, the chest being clear and poor air entry.
There are no comments relating to a weak cough or difficulty with sputum expectoration earlier in his admission or prior to the physiotherapy assessment on 18 April.

The inability to clear secretions due to weak cough resulted in sputum retention and mucus plugging. This, in conjunction with his hypercapnic respiratory failure were indicative of progressive muscle weakness.

There is nothing to suggest that earlier referral for sputum retention was required therefore.

Q5. Please let me know if, in considering my questions, you identify any other relevant clinical matter that gives you cause for concern.

Recommendations:

Conclusions:

The diagnoses reached by the clinical teams and management of the acute medical problems of pneumonia and heart failure appear reasonable and appropriate. Unfortunately, the severity of Mr X's cardiac condition, previously undiagnosed, appeared to be a major factor in his lack of response and progressive decline.

Generally, the record keeping was of a good standard with evidence of discussions with Mrs X wife being well documented.

However, the main concern relates to the perception that some clinical areas were unable to meet Mr X's specific care needs with respect to the diagnosis of Multiple Sclerosis in a consistent manner.

The Health Board's response acknowledges and apologises for aspects of care and professional behaviours that were below acceptable standards. Reference is made to the All Wales Nurse Staffing Act but it is not clear from the response what the specific nurse to patient staff ratios were on certain days when particular concerns were raised. It is not possible to determine whether staffing levels were compliant with Act therefore and whether they contributed to the standards displayed.

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

Pneumonia in adults

https://www.nice.org.uk/guidance/qs110

Name & Signature: