The investigation of a complaint by Mrs Q against Aneurin Bevan Health Board

A report by the Public Services Ombudsman for Wales

Case: 201000903

Contents

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 Q and to her mother, the patient, as Mrs F. Sadly, Mrs F died in February 2009.

Summary

Mrs Q complained about the care and treatment her mother, Mrs F, received whilst a patient at Ystrad Mynach Hospital (the hospital). Mrs F had been admitted to the hospital for assessment due to a deterioration in her mental health. Mrs Q complained that her mother received a very poor standard of care during her admission which led to a more rapid deterioration in her mental and physical condition and ultimately, contributed to her death.

Mrs Q complained about the following:

- That the family's requests for medical intervention and a transfer to a medical ward were ignored despite signs of Deep Vein Thrombosis (DVT) and deterioration in her condition during the weekend of her passing away.
- That the standards of personal care provided to Mrs F were poor and that Mrs F lost considerable weight during her admission to the hospital.
- That the communication with her and Mrs F's family and the information provided about her care plan were grossly inadequate.

I upheld the majority of Mrs Q's complaints. I found that the hospital's procedures for the earlier detection of DVT in a patient displaying potential symptoms were lacking. I also found that the staff failed to act in an appropriate manner and contact a doctor for a medical opinion following a deterioration in Mrs F's condition. The hospital also failed to seek or provide adequate reasons why access to a doctor over the weekend period was not available. I found that in general, the overall record keeping for the period of Mrs F's admission was extremely poor. This had led to inadequacies in the response provided to the family during the internal complaints process and also in the proposed Action Plan implemented by Aneurin Bevan Health Board (the Health Board) to address the family's concerns. Finally, I found that the standard of care and treatment provided to Mrs F during her admission fell below a

reasonable standard. There was no evidence that Mrs F's personal hygiene or nutritional needs were being met or that the care plans were implemented.

I recommended that the Health Board should reflect on the failings identified and provide confirmation of the further action taken to address the inadequacies in the hospital's procedures and operational policies, to improve its staff awareness of DVT and to ensure that early detection is promoted, to ensure that its staff recognise deterioration in a patient's condition, to provide adequate medical cover support to its nursing staff and a clear pathway for referral of patients with medical needs and also to review the availability of medical cover on the ward including out of hours and weekend cover. I also recommended that an apology be provided for the shortcomings in the care provided to Mrs F and for its failure to act more promptly in light of the family's concerns.

The complaint

1. Having failed to resolve the complaint through local resolution with the Health Board, Mrs Q submitted her complaint to me with the assistance of a complaints advocate. In their letter, the complaints advocate provided detailed information about the background to the complaint and Mrs Q's outstanding concerns and issues.

2. Having carefully considered the complaints as made, I focussed this investigation upon what I considered to be the key issues, namely:

(i) Whether or not the care and treatment provided to Mrs F during her admission at the hospital was reasonable and appropriate.
(ii) Whether there was anything else that could or should have been done differently which may have prevented Mrs F's death.
(iii) Whether the Health Board had provided an adequate response to the issues raised.
(iv) Whether the Action Plan undertaken by the Health Board was appropriate and adequately addressed any shortcomings in the care and treatment provided to Mrs F.

Investigation

3. Comments and copies of relevant documents, including Mrs F's medical records, were obtained from the Health Board and considered in conjunction with the evidence provided by Mrs Q through her advocate. Medical and nursing advice was obtained from two of my professional advisers, Dr Richard McGonigle, a consultant physician and Rona McKay, a senior nurse. Their advice is included in full at Appendices A and B, it is summarised at paragraphs 54 to 79. I have not included every detail investigated but I am satisfied that nothing of significance has been overlooked.

4. Both Mrs Q and the Health Board were given the opportunity to see and comment on this draft report before the final version was issued.

Relevant guidance and standards

5. As part of their advice, the Medical and Nursing Advisers referred to some guidance and standards which they believed were relevant to this complaint. I have listed these below and the significance of each will be discussed in more detail during the course of this report.

6. The Welsh Assembly Government has issued guidance on the "Fundamentals of Care". This includes guidance about the quality of care that adults can expect to receive from those employed to provide care. This states:

> "Personal hygiene, appearance and foot care: People must be supported to be as independent as possible in taking care of [their] personal hygiene, appearance and feet."

7. The Code, Standards of Conduct, Performance and Ethics for Nurses and Midwives, 2008 requires nurses to adhere to the standards of their regulatory body, the Nursing and Midwifery Council (NMC). The NMC has also published guidelines for its members entitled "Record Keeping, Guidance for Nurses 2009". This states:

> "Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow."

8. National Institute for Health and Clinical Excellence guidelines 32; Nutrition Support in Adults and the Essence of Care 2010, Benchmarks for Food and Drink provides guidance on nutritional issues.

9. National Institute for Health and Clinical Excellence guidance 50, 2007, Acutely Ill Patients in Hospital, Recognition of and Response to Acute Illness in Adults in Hospital states:

> "Patients who are admitted to hospital believe that they are entering a place of safety, where they, and their families and carers, have a right to believe that they will receive the best possible care. They feel confident that, should their condition deteriorate, they are in the best place for prompt and effective treatment. Yet there is evidence to the contrary....This may be because their deterioration is not recognised or because – despite indications of clinical deterioration – it is not appreciated, or not acted upon sufficiently rapidly."

10. The "Unannounced dignity and respect visit – Ystrad Mynach Hospital; Heddfan, Anwylfan and Ty Glas wards (Older Mental Health) 2009" report by Healthcare Inspectorate Wales highlights the need for mandatory training on the ward regarding "Fundamentals of Care".

11. "Doing Well, Doing Better – Standards for Health Services in Wales 2010" provides an updated framework of healthcare standards that the Health Board should utilise and meet on a continuous basis.

The background events

12. In 2004, Mrs F was diagnosed with early onset Alzheimer's disease at the age of 54 years. Her mental health deteriorated over the next four years and she was admitted to Ystrad Mynach Hospital in December 2008 for assessment.

13. On her admission to the hospital, Mrs F was physically fit and well. Her only problematic medical condition at that time was severe constipation.

14. During her admission, Mrs F required constant assistance with her personal hygiene. She was also prescribed pain relief for arthritis of the spine and for abdominal pain.

15. As Mrs F's medical and nursing notes are brief, it is difficult to provide a detailed account of events during her time at the hospital. However, Mrs F was regularly reported to be "wandering" and walking throughout the ward during much of December, January and early February 2009.

16. On 7 January 2009, Mrs F saw an ENT (Ear, Nose and Throat) specialist. Mrs F also developed swallowing and chewing difficulties and was seen by a SALT (Speech and Language Therapist) on 8 January. An abdominal scan was also performed on 7 January.

17. On 29 January a Barium Swallow (a test used to determine the cause of painful swallowing, difficulty with swallowing or unexplained weight loss) was performed.

18. On 11 February, Mrs F's family attended a meeting with her doctor, the ward sister, a nurse and a representative from the Alzheimer's Society to discuss Mrs F's care plan.

19. On 16 February Mrs F was prescribed Voltarol gel as she suffered from chronic back pain. She was also referred to podiatry for assessment. On 17 February Mrs F was reviewed by a ward doctor who examined her legs and feet as the family had expressed concerns about their colour and temperature. It was recorded that no further treatment was required at that time.

20. On the weekend of 21 and 22 February Mrs F became excessively sleepy and was unable to be fully woken. Mrs F's family asked for a doctor to be called. They were informed that a doctor could not attend until Monday (23 February). Mrs Q requested that Mrs F be transferred from the ward. Mrs Q was informed that a medical ward would not be suitable for Mrs F's needs due to her mental health condition. The family then requested an emergency appointment to see a doctor on the morning of 23 February to discuss their concerns that Mrs F be transferred to an acute medical ward.

21. Sadly, on 22 February, shortly after the family had left the ward for the evening, Mrs F suffered a fatal pulmonary embolism (PE) and passed away. The family were not informed of her death until Mrs F was taken by ambulance to Prince Charles Hospital an hour later.

22. A post-mortem was undertaken on 24 February. The cause of death was documented as PE caused by DVT in the calf veins of the right lower limb. A pathologist's report indicated that the predisposing factors for the development of Mrs F's DVT were a full bladder and relative immobility.

23. Mrs Q pursued her complaint with the hospital, initially meeting with Mrs F's doctor and a senior nurse in March and meeting with staff from the Health Board in July and again in November following their written response to Mrs Q's complaint dated 5 May. Following this meeting, the Health Board produced an Investigation Report and Action Plan setting out the actions to be taken to address Mrs Q's issues of complaint. In April 2010, a further meeting was held between the Health Board and Mrs Q to discuss her outstanding concerns and the updated Investigation Report and Action Plan. A written summary was received by Mrs Q dated 22 April.

24. Despite meeting with the Health Board's representatives on several occasions, Mrs Q and her family felt that their issues and concerns had not been investigated thoroughly. They therefore referred their complaint to me.

Mrs Q's evidence

25. Mrs Q said that on many occasions the family found Mrs F with very poor standards of personal hygiene. The examples she described included food waste on her clothes, dirty hands and fingernails, and unwashed hair. She said that plaque covered Mrs F's teeth and a mucus on the lining of her mouth caused by untreated thrush was causing her pain and discomfort. She said that this contributed to Mrs F's poor diet and fluid intake. Mrs Q also said that

she repeatedly asked the staff to bathe her mother and her offer to bathe her mother herself was refused.

26. Mrs Q said that Mrs F developed a fungal nail infection in her feet and blue nail beds. She said that she requested a referral to podiatry for her mother to be assessed but eventually had to resort to treating her with an over the counter anti fungal treatment.

27. Mrs Q said that her mother's weight loss was never medically assessed. Also, she said that prescribed medication was not given which caused her mother to suffer high levels of unnecessary agitation, sleep loss and delusions. Mrs Q said that due to Mrs F's dementia, Mrs F was unable to ask for pain relief.

28. Mrs Q said that at no time was the care planning process or care plan discussed despite requests to do so by the family. She said that the family were given conflicting information on a daily basis about Mrs F's condition and the ward staff failed to keep proper records of these conversations. She also said that requests for medical reviews were refused by the nursing staff and observation and fluid balance charts were not completed.

29. Mrs Q said that her mother was immobile during the last week of her life. She said that Mrs F had also developed swollen and discoloured legs and feet which should have indicated the need for further investigations.

30. She said that because the doctor who visited on 17 February relied on incomplete notes to review and treat Mrs F, he would not have been aware of important information regarding the possible symptoms of DVT which might have indicated the need to assess and treat her further which could have led to earlier detection.

31. Mrs Q said that on 20 February, the family became very distressed at Mrs F's condition. She said that they asked for a doctor to be called immediately and also asked for her to be transferred to a

medical ward. However, Mrs Q said that they were informed that a doctor would not be available until Monday 23 February and that a medical ward would not be suitable due to her mother's mental health condition.

32. Mrs Q said that the family were not informed that Mrs F had suffered a fatal PE until she was taken by ambulance to the Prince Charles Hospital. This was despite asking the ward staff on duty to contact them immediately if her condition changed.

33. Mrs Q said that the information provided by the Health Board in response to the family's complaint did not reflect the impact that the experience had had on their family or the distress that was caused during the time Mrs F was hospitalised. She said that she believed that her mother was denied the opportunity to be cared for by her family, and as early onset Alzheimer's is becoming more common, Mental Health Services should be more aware of the different needs of younger people. She said that a ward for elderly patients was not an appropriate placement for her mother.

The Health Board's evidence

34. The Health Board said that there was no evidence within the nursing or medical files or from staff to suggest that the standards of care in respect of Mrs F's personal hygiene were poor. It said that there were occasions when Mrs F would feed herself and therefore it was possible that there would have been evidence of food waste on her clothes. It said that this would have been exacerbated by the fact that Mrs F was restless and wandered. Staff therefore found it difficult to get her to sit down and eat appropriately.

35. The Health Board said that the staff acknowledged that Mrs F's dental and oral health was less than desirable. They said that Mrs F's oral hygiene was difficult to maintain on a consistent basis due to her restlessness. However, it said that staff did attempt to clean Mrs F's teeth twice a day. It said that when Mrs F saw the ENT specialist on 7

January 2009 he diagnosed oral thrush and this was treated with Fluconazole (an anti-fungal drug).

36. The Health Board said that Mrs F was bathed at least every other day by the nursing staff. It acknowledged that staff did not ask Mrs Q to assist as bathing Mrs F was not overly problematic.

37. The Health Board said that Mrs F was referred to chiropody on 16 February and was seen by the Senior House Officer (SHO) the following day as requested by Mrs Q. It said that a thorough examination was carried out and documented. The Health Board said that the medical notes include the comment "no treatment needed".

38. The Health Board said that on admission, Mrs F weighed 89kgs (14 stone). On 21 February she weighed 82.7kgs (13 stone). It said that on 7 January she was referred and seen at an ENT clinic. The following was done;

(i) SALT and dietician referrals. Mrs F was seen by a SALT on 8 January and his/her advice was to continue a normal diet and to encourage Mrs F to swallow whilst eating at meal times. A referral was made for a Barium Swallow.

(ii) An abdominal scan was performed on 7 January which showed the appearance of bowel gas, no signs of constipation, and no kidney stones.

(iii) The Barium Swallow was performed on 29 January. However, Mrs F was unable to co-operate with the examination and a limited amount of water soluble contract swallow (a type of iodine solution that is visible to x-rays) was performed which showed no obvious oesophageal stricture (narrowing or tightening of the tube from the mouth to the stomach that causes swallowing difficulties).

39. The Health Board said that due to Mrs F's mental state and her agitation and restlessness, Mrs F's prescribed medication was administered on a teaspoon. This decision was taken due to the amount only being one mouthful and the majority of the time the ward staff managed to ensure that Mrs F took it. It said that Mrs F was also

prescribed two soluble paracetamol four times a day for pain relief and on 16 February she was prescribed Voltarol gel. It said that unfortunately, Mrs F could not always express her level of pain, and as a result the staff on duty assessed her non verbal communication on a continual basis.

40. It said that it recognised that communication with the family at the time was less than adequate and that there was a definite need to improve in this area. To address this particular problem, an Action Plan had been implemented. The Health Board said that qualified staff would be reminded of their responsibility to ask relatives whether they wished to be part of the care planning process and for relatives to at least read and sign their relative's care plan. The carer's information leaflet includes a section on carer's involvement in the care planning process. This is monitored by the Care Programme Approach (CPA) process which is regularly audited both internally and externally and monitored via the Health Board's Mental Health Management Board and CPA Board (the CPA is for people with a mental illness and requires Health Bodies, in collaboration with Social Services Departments, to put in place specified arrangements for the care and treatment of mentally ill people in the community).

41. The Health Board said that during her admission, Mrs F was reviewed on 26 separate occasions by medical staff. It said that on review it was clear, and the Health Board accepted, that feedback from these medical reviews was not always given to family members when appropriate. The Health Board said that the senior nurse has been tasked with feeding back to senior ward staff the importance of clear communication to relatives and family members when appropriate. The Health Board said that this problem was addressed as part of the Action Plan.

42. The Health Board recognised that record keeping at the time was poor and it said that the need to document accurately and

precisely in medical notes has been highlighted in their investigation. It said that the Action Plan also addressed this problem.

43. On reviewing the daily nursing records, the Health Board said that it was documented that Mrs F was able to walk around the ward two days before her death. It said that Mrs F's physical condition was reviewed by the ward doctor on 17 February who on examination documented that both her feet were warm, had good pulses and a two second capillary refill (rate at which blood refills empty small blood vessels relating to circulation) and that no further treatment was required.

44. The Health Board confirmed that the consultant psychiatrist had discussed the case with the pathologist and was informed that there were no indicators on examination that suggested a DVT. It said that the DVT was silent in nature and only detected by the pathologist after a PE was found. However, all staff had educational sessions regarding DVT since the events complained of and NICE Guidelines on "Venous Thromboembolism – Reducing the Risk" are now available on the ward for all staff to access.

45. The Health Board apologised that a full explanation was not provided to Mrs F's family as to why no doctor was available until Monday 23 February. It said that the family should not have been informed that there was no doctor available until 23 February. It said that the staff should have informed the family that while the hospital has no medical staff on site out of hours, the Health Board provides on-call support for both nursing and medical issues for its mental health patients and staff can use the 999 service for emergencies.

46. The Health Board said that having spoken to its senior medical and nursing staff, they had confirmed that there are no specific operational policies in place relating to medical cover.

47. The Health Board said that the route by which medical advice is obtained on the ward is usually via the duty registrar or senior registrar in medicine or surgery via the SHO request.

48. The Health Board said that there is a SHO and a consultant on-call on the ward. It said that normally it would be the SHO who would contact the consultant.

49. The Health Board said that a psychiatrist does not attend routinely at the weekend and would only visit if asked by the nursing team.

50. The Health Board said that in an emergency, the process or pathway for obtaining medical advice on the ward was through 999 emergency services and an ambulance transfer to the District General Hospital. Alternatively, it said that the SHO or consultant would make a referral to the physician.

51. The Health Board said that there is no specific policy for the nurse in charge stating when to contact the on-call doctors. As part of the nurse's professional role, any concerns relating to a patient's deteriorating condition will be escalated appropriately. The decision to contact the on-call doctors is therefore at the discretion of the nurse in charge based upon the patient's condition and if a nurse is concerned about a patient they will contact the psychiatrist. However, it said that if concerns predominantly relate to urgent or emergency physical problems then they would call the SHO and inform them that they have called for a 999 ambulance to transfer the patient to one of the District General Hospitals.

52. In relation to why a transfer to a medical ward was not arranged or thought of as an option, the Health Board confirmed that this had been discussed with the consultant psychiatrist. It said that a transfer to a medical ward was not considered an option at the time as there was no acute medical condition necessitating admission.

53. The Health Board said that it believed it had now done everything possible to address the concerns raised by Mrs Q. It considered that it had taken matters seriously and apologised for any shortcomings identified as a result of the investigation of Mrs Q's complaint.

Professional advice

The Medical Adviser

54. I have taken advice from one of my Professional Advisers, who is a consultant physician with 20 years experience in the NHS. His advice is attached at Appendix A. It is in two parts as it was necessary to obtain further advice from my Medical Adviser when new information was provided by the Health Board. I have summarised below the most significant findings from his consideration of this case.

55. The Medical Adviser was critical of the lack of documentation of Mrs F's condition over the weekend when she deteriorated and passed away.

56. The Medical Adviser said that reduced or absent blood flow in the veins relating to a DVT was not excluded by the SHO's examination on 17 February and that detection of DVT may have led to an earlier referral to a duty physician and possible prevention of PE.

57. The Medical Adviser said that bladder distension is not considered a major predisposing factor of DVT.

58. The Medical Adviser said that the Health Board's response in relation to the earlier detection of DVT was incorrect. He said that there were comments in the records that confirmed that Mrs F's leg was discoloured on 20 February and swollen on 21 February.

Therefore, the Medical Adviser said that the DVT was not necessarily silent.

59. The Medical Adviser was also critical of the Health Board's failure to address the family's concerns about the possibility that the DVT could have been detected earlier.

60. The Medical Adviser was highly critical of the lack of an adequate response from the Health Board in relation to the complaint that no doctor was available from 20 February until Monday 23 February.

61. The Medical Adviser was also surprised at the Health Board's response that no operational policies are in place regarding the nursing staff and medical cover on the ward.

62. The Medical Adviser said that it is not appropriate to expect nursing staff to dial 999 and that the Health Board should provide a better method for escalation of treatment.

63. In general, the Medical Adviser said that the escalation of medical attention for mentally ill patients who become ill and the on-call service on the ward remains unclear. The Medical Adviser said the Health Board has the opportunity to use this case as an example to improve medical care for mental health patients who may be in hospital for considerable periods of time. The Medical Adviser said that the NHS is moving from "office hours" to providing a better provision of care 24 hours a day 7 days a week.

64. The Medical Adviser confirmed that all patients including psychiatry patients in NHS Hospitals must have both nursing and medical care and support 24 hours a day 7 days a week.

65. In relation to the transfer to a medical ward, the Medical Adviser said that there was a difference of opinion between the concerns of the family and the Health Board's response. The Medical Adviser said

that there was sufficient concern for a junior doctor to attend, that the examination undertaken by the junior doctor was inadequate, that DVT might have been expected and certainly considered at the time and that Mrs F's daughter had expressed concerns about her mother's health throughout the weekend period that were not addressed. The Medical Adviser said that at the very least, an apology should be provided to the family regarding this issue.

66. The Medical Adviser said that it was not unreasonable for there to be an hour's delay in contacting the family following Mrs F's collapse.

67. The Medical Adviser said that the Health Board's Action Plan was inadequate as a more reliable and detailed plan was required to ensure that the earlier detection of DVT was promoted, to ensure that effective lines of communication for the escalation of concerns regarding a patient's condition were in place and to ensure that weekend cover on the ward is improved to avoid the recurrence of similar events in the future.

The Nursing Adviser

68. I have also taken advice from one of my Professional Advisers, who is a senior nurse with extensive experience in acute care in the NHS. Her advice is attached at Appendix B. It is in three parts as it was necessary to obtain further advice from my Nursing Adviser when new information was provided by the Health Board. I have summarised below the most significant findings from her consideration of this case.

69. The Nursing Adviser was highly critical of the record keeping in general and said that there was no documented evidence of ongoing assessment to confirm that all Mrs F's clinical and physical needs were being met.

70. The Nursing Adviser said that while there was some evidence of good nursing practice, this was not consistent, leading to inadequacies in the nursing care given, especially regarding Mrs F's hygiene and nutrition needs.

71. The Nursing Adviser referred to a report concerning Anwylfan ward issued by the Healthcare Inspectorate Wales (see paragraph 10). The Nursing Adviser said that one of the issues highlighted as part of this report was the need for mandatory training for staff at all levels to increase their knowledge of the "Fundamentals of Care".

72. The Nursing Adviser also referred to a document from the Welsh Assembly Government entitled "Doing Well, Doing Better – Standards for Health Services in Wales" which provided an updated framework of standards (see paragraph 11). The Nursing Adviser said that the Health Board should demonstrate how it uses these standards and the action taken to ensure that these standards are met on a continuous basis.

73. The Nursing Adviser said that the care plan could have been improved by involving Mrs F's family.

74. The Nursing Adviser was highly critical of the nursing staff's failure to recognise Mrs F's deterioration or to ascertain why she was becoming increasingly drowsy. The Nursing Adviser said that the records confirmed that Mrs F was becoming unwell but the nursing staff did not recognise or respond to this and failed to carry out any physiological observations or interventions and to seek medical advice. This lack of response was compounded by the fact that the family repeatedly expressed their concern but no action was taken.

75. The Nursing Adviser said that the Health Board should ensure that nursing staff are competent in providing a reasonable standard of care. The Nursing Adviser said that the Health Board's response that nursing staff can call 999 for an ambulance if they have concerns

about a patient did not address the significant issue that they require the ability to recognise deterioration in the first place.

76. The Nursing Adviser was also critical of the Health Board's failure to address the family's request for a doctor and request for a transfer. The Nursing Adviser said that if the nurses had contacted a doctor for a medical opinion, Mrs F may have been admitted to a medical ward.

77. The Nursing Adviser was also surprised at the Health Board's response that no operational policies are in place regarding the nursing staff and medical cover on the ward.

78. The Nursing Adviser also said that the Action Plan was inadequate as it failed to address the inadequacies in Mrs F's care planning and to address how the Health Board can ensure that nursing staff have the knowledge to recognise deterioration in a patient and are able to act on that information. The Nursing Adviser said that the complaint should have been graded at "2 – Serious failure in care".

79. In general, the Nursing Adviser said that the Health Board's response was not adequate and displayed a lack of insight into the failings in Mrs F's care. The Nursing Adviser said that mental health patients may have acute medical problems but this had not been addressed and the Health Board's further responses did not acknowledge this or provide any robust reassurances for future care.

Analysis and conclusions

80. In reaching my conclusions, I have been guided by the advice provided by my Professional Advisers, which I accept in its entirety.

81. My Professional Advisers have highlighted some significant clinical failings and I share their concerns about those. Mrs Q has complained about a number of issues. However, I will turn first to

those which I consider to be the most significant, namely Mrs F's deterioration and the lack of medical attention.

82. I have considered the issue of the potential for an earlier detection of DVT. My Medical Adviser said that the SHO's examination of Mrs F on 17 February was not thorough enough. This is highlighted by the lack of detailed information regarding the SHO's examination contained in the clinical notes. My Medical Adviser said that the SHO should have excluded venous insufficiency and possible DVT rather than concentrating the examination on excluding arterial insufficiency (not enough blood flow in the arteries). My Medical Adviser said that the documented evidence available did not support the Health Board's conclusion that the DVT was "silent". Whilst I am unable to conclude that had such an examination been carried out this could have changed the tragic outcome of Mrs F's death, I agree with my Medical Adviser that it may at least have led to an earlier detection or suspicion of DVT, which in turn may or may not have led to an earlier referral to a physician and possibly the prevention of Mrs F's heart attack. Accordingly, I **uphold** this aspect of the complaint.

83. In relation to the complaint that there was a failure to recognise a deterioration and a lack of further action by the ward staff once they became aware of changes in Mrs F's condition two days before her death, I am of the view that there is evidence of a significant clinical omission which is compounded by the fact that the family expressed concerns about Mrs F's condition on 17 and 21 February. From the information I have seen and the advice I have received, it is clear that there was a significant deterioration in Mrs F's clinical condition during 20, 21 and 22 February. She had become unresponsive, with staff being unable to feed her or give her medication and she had become difficult to wake, yet my Medical Adviser has noted that there is no evidence to suggest that staff perceived this as deterioration in her condition, took observations, intervened, or raised concerns with medical staff. Accordingly, I **uphold** this aspect of the complaint.

84. In relation to the Health Board's comments that a transfer to a medical ward was not considered an option, my Nursing Adviser was critical as she said that it was apparent from the records that Mrs F was becoming unwell. My Nursing Adviser said that the nursing staff did not recognise or respond to this. Again, whilst I am unable to conclude that had staff acted in a more responsive manner, this would have changed the events of Mrs F's passing, I am of the view that if further medical advice had been obtained Mrs F may have been admitted to a medical ward and that this failure is significant. Accordingly, I **uphold** this aspect of the complaint.

85. The ward staff and subsequently the Health Board failed to provide the family with adequate explanations about why a doctor was not available until Monday 23 February. Both of my Advisers have noted that the family were particularly concerned that Mrs F should have access to a clinician on the weekend of her passing away. The Health Board has said that the decision to contact the on-call staff is at the discretion of the nurse in charge based on the patient's condition. However, there are no documented reasons to support this decision not to call a doctor. Again, I agree with my Medical Adviser that this may not have changed the outcome, but the opportunity of medical intervention or a transfer should at a minimum have been available to Mrs F and if not, documented evidence of the exact reasons why this intervention was not available and/or not thought appropriate at the time should have been available. I share my Nursing Adviser's concern that the Health Board's response that the nurses can call 999 for emergency services if they have concerns about a patient's condition does not address the issue that the nursing staff must first recognise that deterioration has occurred. It is alarming that this did not happen in Mrs F's case and this is a significant failure. Also, it is alarming that an improved pathway for the referral and escalation of patients with medical needs for future cases is required. Accordingly, I **uphold** this part of the complaint.

86. I am concerned that no operational policy is in place at the hospital for nurses working on the ward confirming the procedure for

escalating concerns and obtaining a medical opinion on a patient's condition. I am also concerned that there is no policy in place regarding medical cover on the ward.

87. Mrs Q complained about a number of other issues which I now address below.

88. The lack of detailed documentation in this case has made it difficult to draw definitive conclusions on the level of care and treatment that was provided to Mrs F during her admission. However, in the absence of documentary evidence in the form of contemporaneous entries in her medical records, I must conclude that any action which ought to have been taken in relation to Mrs F's care and treatment was not carried out.

89. From the information I have seen, I have concluded that the care and treatment provided to Mrs F during her admission fell below a reasonable standard. This conclusion is largely, but not wholly, based on the lack of documentary evidence and poor record keeping. While I am encouraged by the fact that the Health Board has acknowledged this failing and addressed the poor standard of record keeping as part of the Action Plan, its various responses during the internal investigation appear to have been based upon documentation which was poorly completed. This was inadequate when seeking to retrospectively assess the care provided to Mrs F during her admission.

90. There is no evidence to confirm that all areas of Mrs F's daily living were assessed. As noted by my Nursing Adviser, the assessment and care planning detailed in the medical and nursing records is not robust enough. While there is some evidence that Mrs F had a bath or shower occasionally, and that a referral to chiropody was made on 17 February, in its response the Health Board appears to rely on the particular difficulties which it states it was experiencing in maintaining Mrs F's hygiene levels. While there is evidence in the records to confirm that that Mrs F was restless, in the absence of

documentary evidence confirming that difficulties with self-feeding and the brushing of Mrs F's teeth were experienced by the staff, I must conclude that Mrs F's personal hygiene needs were not being met. I am also of the view that family involvement in carrying out Mrs F's personal hygiene needs should have been encouraged. Issues such as these have been previously highlighted in the Welsh Assembly Government's Guidance "Fundamentals of Care" as areas of particular importance. Therefore, every effort should be made to ensure that reasonable standards of personal hygiene, including dental and oral hygiene, appearance, and foot care are kept. Accordingly, I **uphold** this aspect of the complaint.

91. Again, a lack of documentation is relevant to the issue of whether or not Mrs F's weight was adequately monitored. Mrs F lost approximately one stone in weight during her admission. While weight loss in a hospital setting is not in itself an indication of a failure to ensure that Mrs F's daily nutritional needs were met, my Nursing Adviser has noted that food charts were not adequately completed and that information contained within the assessment sheets was inadequate to monitor Mrs F's intake. My Nursing Adviser has also noted a delay in referring Mrs F to a dietician once she was in the "high risk" category in accordance with a MUST (Malnutrition Universal Screening Tool) assessment (this is used to identify a patient who is not receiving enough food). However, it was documented that prompt action was taken by staff once they were aware that Mrs F was displaying some difficulty in swallowing and chewing. Mrs F was seen at an ENT clinic on 7 January, and a SALT assessment was carried out on 8 February. Also, Fluconazole was prescribed by the ENT doctor to treat oral thrush. In light of this prompt action on behalf of the staff, I **partly uphold** this complaint.

92. Turning to the issue of medication, once again the Medical Administration Records are incomplete, with the last medication recorded as being administered on 21 January. Although I appreciate that it may have been difficult for the staff to assess Mrs F's pain medication needs due to her dementia, in the absence of

documented evidence to support the Health Board's position, I am unable to conclude that Mrs F's medication needs were being met and therefore, I **uphold** this part of the complaint.

93. Turning to the issue of communication and the information that was provided to the family, there is evidence within the nursing and medical records of communication with the family on Mrs F's admission. Additionally, there is evidence of ongoing dialogue with the family and telephone calls from the ward, including several telephone calls to Mrs F's daughter in January, during which the staff provided an update on Mrs F's care. It is recorded that the family attended a ward meeting on 11 February where Mrs F's ongoing care was discussed and documented. My Nursing Adviser noted that it is not usual for the minutes of such meetings to be provided to the family as they form part of the clinical records. My Nursing Adviser noted that Mrs F's care plan could have been improved by involving her family. The Health Board has also recognised that communication with the family was inadequate and that there was a definite need to improve in this area. Having taken the foregoing into account, I **partly uphold** this part of the complaint to the extent that overall, the level of communication and information provided to the family could have been improved on.

94. Whilst I fully appreciate why Mrs Q would have wished to have been informed of her mother's collapse immediately, I am unable to conclude that there was a delay in contacting Mrs F's family as I agree with my Medical Adviser that resuscitation was the priority at the time. In my view, Mrs Q was contacted as soon as was practicable under the circumstances and therefore, I **do not uphold** this aspect of the complaint.

95. Finally, my view is that the investigation and consequently the Health Board's Action Plan was inadequate and does not appear to have fully addressed the concerns of Mrs F's family or covered some of the serious issues identified by my investigation. Therefore, I **uphold** this aspect of the complaint.

96. I appreciate that my report may not provide the definite answers that the family would like in order to establish the exact reasons why Mrs F passed away and who or what was responsible. However, I hope that my findings will provide them with some reassurance, knowing that the shortcomings that have been identified in the care provided to Mrs F and the recommendations made will go some way to help the prevention of similar circumstances in the future.

Recommendations

97. **I recommend** that, within 28 days of this report, the Health Board provides a full apology to the family for the shortcomings that have been identified in the care provided to Mrs F and for its failure to act more promptly in light of the family's concerns.

98. **I recommend** that, within 3 months of the date of this report:

- The Health Board provides details on how nursing staff on the ward are fulfilling the actions required under the Welsh Assembly Government Guidance entitled "Fundamentals of Care".
- The Health Board reflects on the delay in referring Mrs F to a dietician and confirms how nursing staff will comply with NICE guidelines relevant to this issue.
- The Health Board confirms the action it has taken to ensure that nursing staff comply with the NMC guidance on Good Record Keeping.
- The Health Board reviews the failure regarding the earlier detection of DVT in light of the presenting symptoms and confirms what further action it proposes to take to ensure that early detection is promoted.
- The Health Board confirms that the nurses have reflected upon the failings which have been identified in perceiving deterioration in the condition of patients, taking observations,

and intervening or seeking help, and sets out what action has been taken to properly address these failings.

- The Health Board should draft appropriate operational policies for nurses working on the ward. In particular, the procedure in place for escalating concerns and obtaining a medical opinion on a patient's condition should be addressed as part of this policy.
- The Health Board confirms what actions it proposes to take to ensure appropriate medical intervention is available to its patients, when required, in particular over the weekend period and implements an appropriate operational policy and procedure regarding medical cover, including out of hours cover for psychiatric patients on Anwylfan ward.

99. **I recommend** that, within 6 months of the date of this report the Health Board confirms what action it has taken to ensure that it is using and meeting the "Standards for Health Services in Wales 2010" (see paragraph 11) on the ward.

100. **I recommend** that the Health Board should pay Mrs Q £500 for her time and trouble in pursuing this complaint.

I am pleased to note that in commenting on the draft of this report the Aneurin Bevan Health Board has agreed to implement these recommendations. It provided information to indicate the actions it had taken to implement these recommendations prior to the issuing of this report. The adequacy of the action taken will be considered in line with the timescales set out.

Peter Tyndall 2 September 2011
Ombudsman

Appendix A
(In parts A1 and A2)
Medical Advice

Medical Advice **Appendix A1**
Dr Richard McGonigle
Consultant Physician

Introduction

This case concerns the management of Mrs F, aged 58 years, who was admitted to hospital for the management of her worsening symptoms of dementia. She died suddenly some two months later related to a cardiac arrest secondary to pulmonary thrombosis. As a consultant physician of more than 20 years experience I am appropriately qualified to comment on this complaint. I have no conflict of interest with any of the parties involved.

Clinical Summary

Mrs F had a diagnosis of dementia established 4 years before she was admitted to hospital under the care of psychiatry with increasing confusion and aggressive behaviour which the family were having difficulty managing. She was admitted to Anwylfan Ward.

The medical and nursing notes are brief, and as a consequence it is difficult to report on the case in detail based on the medical notes. Mrs F was regularly reported in the nursing entries to be 'wandering' and walking through much of December, January and early February.

She became excessively sleepy on 21 and 22 February and was unable to be roused. On 17 February a medical SHO had been asked to examine the patient at the request of the patient's daughter concerned about prolonged 'capillary refill' (representing poor circulation). The SHO found Mrs F's feet to be warm, with pulses intact with a 2 second 'capillary refill', which is normal. The family were so concerned about Mrs F that an emergency meeting with the consultant psychiatrist, was to be arranged for the following Monday. However, on the Monday evening Mrs F suffered a cardiac arrest as a consequence of a pulmonary thrombosis, and died.

A post-mortem was undertaken on 24 February. At post-mortem occlusive thromboembolism within the main pulmonary arteries and their immediate tributaries was identified. A deep vein thrombosis was confirmed in the calf veins in the right lower limb. 500mls of urine was in the bladder. The cause of death was pulmonary thromboembolism. Precipitating causes included a full bladder and relative immobility.

Complainant concerns

Mrs Q had 12 concerns, which have all been addressed by Rona McKay, Acute Nursing Adviser (the Nursing Adviser). I have addressed those concerns (namely 8, 9, 11 and 12) which relate to the weekend when Mrs F deteriorated and subsequently died. These 'medical' issues relate to the failed diagnosis of deep vein-thrombosis and subsequent fatal pulmonary thrombosis.

There is no significant documentation of the patient's condition over this weekend, and thus it is most difficult to comment on her treatment, or lack of it. The family has repeatedly expressed concerns about the patient's condition, but these concerns have not been documented.

Questions

1. Are Mrs Q's concerns as set out in the letter dated 3 March 2010 in relation to the care and treatment received by her mother, Mrs F, during her admission on the Anwylfan ward reasonable?

The questions and concerns are reasonable. In relation to the detection of deep vein thrombosis, which may be manifested by a painful and swollen leg, the family did have concerns and raised those with medical staff. A SHO did review Mrs F on 17 February and while the SHO felt for pulses, measured the capillary refill time and considered the feet warm, these findings only exclude arterial

insufficiency. Arterial insufficiency would only be part of a differential diagnosis of bluish, discoloured legs in a patient who had been in hospital for two months. The differential diagnosis should include venous insufficiency related to deep vein thrombosis, which was not excluded by the SHO's examination.

It is recorded in a nursing medical entry that the relatives had concerns regarding Mrs F's swollen ankles on 21 February. However, no action was undertaken and nursing staff did not contact medical staff.

2. Was the care received by Mrs F reasonable and/or appropriate, and was there anything else that could have been done different which may have prevented her death?

Death by pulmonary thrombosis/thromboembolism within a hospital setting is preventable. Pulmonary emboli originate from either deep vein thrombosis in the leg veins or the pelvic veins. Clinical signs of deep vein thrombosis in the legs may be difficult to diagnose and not always obvious or symptomatic. However, symptoms or signs might include blue discolouration of the skin, lower limb swelling and discomfort of the lower limb(s). Discomfort would be more difficult to establish in a patient with dementia.

The medical documentation is so poor it is difficult to review this case based on the medical notes alone. However, there is sufficient information in the nursing notes to indicate that the patient's relatives were concerned on 17 and 20 February and indeed during the following weekend. No action was undertaken apart from the SHO's brief clinical examination on 17 February**.** This examination appears to have concentrated on excluding arterial insufficiency, rather than venous insufficiency and possible deep vein thrombosis.

The lack of documentation, and indeed medical attention, from 17 February onwards makes further comment difficult. Detection, or suspicion, of DVT would have led to earlier referral to duty physicians

and probable anticoagulation, and possible prevention of pulmonary thrombosis. However, due to the lack of documentation this must remain conjecture.

3. Please comment on the Health Board's responses to each of the issues raised.

I have commented above on the SHO's examination on 17 February. Girth/calf measurements were not undertaken because a deep vein thrombosis was not suspected.

The minutes of the meeting on 12 March were not forwarded to the relatives. The minutes are relatively inaccurate including dates. This appears to have been an informal meeting with the consultant's secretary undertaking the minutes. The Health Board has not responded to the comments of the nursing staff that no doctor was available from 20 February onwards until the next Monday. This is not an acceptable response. The Health Board must respond in more detail and explain how patients are reviewed at the weekend by on-call medical staff when indicated or requested by either nursing staff, or indeed relatives.

It was not unreasonable for there to be a one hour delay before the family were contacted following Mrs F's collapse, because resuscitation was being attempted, albeit unsuccessfully.

4. Please confirm whether the responses provided by the Health Board in relation to the specific concerns of the family in relation to DVT and bladder distension are adequate and/or are there any outstanding clinical issues that have not been addressed?

Mrs F did not have well recognised risk factors for deep vein thrombosis, except that she had been in hospital for two months. She had been mobile and "wandering". She then appears to have been relatively less mobile over the last 3-4 days.

The pathologist has commented on the bladder urinary retention being a further precipitating factor towards deep vein thrombosis. It is unclear how long she had had bladder distension due to a lack of (documented) physical examination. However, this is not considered a major predisposing factor to DVT even if it had been present for some time.

She had documented urinary tract infections which are recognised as a complication of inadequate bladder emptying.

The Health Board has not really addressed the family's concerns regarding the possibility of earlier detection of deep vein thrombosis. The swollen ankles, the bluish discolouration requiring an SHO review on 17 February and increasing concern over the weekend have not been addressed by the Health Board.

5. Please confirm whether the Action Plan undertaken by the Health Board in response to Ms Q's complaint is appropriate and/or adequate to fully address any of the shortcomings in the care and treatment provided to Mrs F that have been provided by the Health Board as a result of Mrs Q's complaint. If not, please confirm what further action you would recommend the Health Board to undertake in this regard. You might also comment on the Health Board's grading of the complaint as this appears to be an outstanding issue of concern for Mrs Q.

I would agree with the Nursing Adviser's comments about the Action Plan, which is relatively inadequate. The Action Plan needs to be much more detailed. This was a preventable death and earlier recognition of a possible deep vein thrombosis might have led to earlier treatment. There were sufficient warnings mostly raised by the family that were ignored.

An Action Plan to provide improved weekend cover and more effective lines of communication to obtain (more senior) medical

review has not been produced. Although my comments are made in retrospect, it is relatively apparent that the patient had already developed a DVT on 17 February. Thus, potentially an earlier diagnosis might have prevented the fatal pulmonary thrombosis. The Health Board should therefore provide a more reliable and detailed plan to avoid a recurrence. Increased awareness of the risk of DVT amongst all staff is required. Relatives' concerns should not be ignored, and certainly be documented.

6. Any further comments that you may have.

Mrs F would not have been considered a high risk for venous thrombosis. There are some concerning comments from relatives, included in the nursing notes, that would suggest that DVT should, at least, have been considered earlier. This is a comment made with the benefit of hindsight.

The weekend care would appear to have been deficient, but again documentation is poor for a patient whose condition had apparently deteriorated, and for whom the relatives had expressed increasing concern.

Summary

Deep vein thrombosis and complicating, potentially, fatal pulmonary thrombosis is common in hospitalised patients. Clinical signs or symptoms may be negligible. Mrs F would not have been considered at high risk. The lack of documentation by medical staff and nursing staff undermines the Health Board's responses to the patient's family's concerns that Mrs F was unwell throughout the weekend prior to her death.

Medical Advice **Appendix A2**
Dr Richard McGonigle
Consultant Physician

This report includes comments on the response from the Health Board's Chief Executive to the Ombudsman's office dated 18 February 2011.

On-call cover for the weekend

The response is inadequate. The Chief Executive has not explained how psychiatry patients, who become acutely medically ill, are treated. It is not appropriate to expect nursing staff to dial 999 emergency services.

The Chief Executive has stated that there is an on-call doctor available for mental health patients. Is that a SHO, registrar or consultant? Does a psychiatry doctor attend routinely at the weekend? If a nurse is concerned about a patient does he or she contact the psychiatry doctor? What is the process or pathway for obtaining medical advice? Is this route through the on-call duty GP, duty medical registrar or consultant physician at the nearest hospital? The Chief Executive appears to expect that all mental health patients, who have a mild, moderate or serious illness, can only receive medical attention after the nurse has dialed 999. The Board should be expected to provide a better method for escalation of treatment.

Medical transfer

There is a difference of opinion between the concerns of the family and the response of the Health Board. Mrs F did have a swollen leg on 17 February, of sufficient concern for a junior doctor to attend. The junior doctor's examination was not adequate. Deep vein thrombosis might have been expected at that time and certainly considered in the differential diagnosis. Mrs F's daughter had expressed concerns

throughout the weekend of 21 and 22 but her concerns were not addressed. At least an apology is required from the Health Board regarding this issue.

The response from the Chief Executive who has discussed this issue with the consultant psychiatrist is incorrect.

At post mortem there was a deep vein thrombosis present in the calf of the right lower leg. On 17 February the patient's leg was swollen and there are comments that the patient's leg was swollen over the weekend. Thus, the DVT was not necessarily silent in nature and the deep vein thrombosis was identified at post mortem.

Conclusion

This case represents a very unfortunate sequence of events leading to a fatal pulmonary thrombosis. This can be very difficult to anticipate, predict and/or diagnose. However, the response is not entirely adequate. The escalation of medical attention for mental health patients who become ill remains unclear. The on-call service appears uncertain. The Health Board and the Chief Executive have an opportunity to use this case as an example to improve medical care provided to mental health patients, who may be in hospital for considerable periods of time.

The NHS is moving from "office hours" to providing a better provision of care 24 each day for 7 days each week.

Appendix B
(In parts B1 to B3)
Nursing Advice

Nursing Advice **Appendix B1**
Rona McKay
Senior Nurse

Thank you for requesting clinical advice regarding this complaint. I am a senior nurse with extensive experience in acute care and I am competent to offer advice in this instance.

I have the Ombudsman's file including all documentation submitted by the complainant, the clinical records and the Health Board's complaints file to hand, and have no conflict of interest.

In providing this advice I have set out information about nursing assessments. I have then listed the heads of complaint and addressed these individually where possible. This may bring some clarity. My medical colleague will offer further advice.

Background

Mrs F who had Alzheimer's disease was admitted to Anwylfan Ward which provides care and treatment for patients suffering with dementia type illness. She was admitted on 23 December 2008 and died on 22 February 2009.

The nursing records are not in chronological order and some are missing dates which have been lost in photocopying. There have been ongoing assessments which is good clinical practice, but the reassessments refer to specific numbered problems and in most instances I am unable to find which assessment correlates to which problem.

Near the beginning of the nursing records there are care plans which are the outcomes of assessments. For example, care plan 6 relates to continence. It notes the assessment, what the outcome should be, then the plan of how staff can work towards this outcome. Reviewing

one of the reassessments undertaken there is reference to problem 5 which appears to be about hygiene needs but I am unable to locate the correlating care plan.

Assessment underpins every aspect of nursing care. It is the process by which the nurse and the patient (and or family) together identify needs and concerns and is the basis of individualised care. Effective assessment is integral to the safety, continuity and quality of patient care. It provides baseline information for the planning of interventions and the outcomes of care to be achieved. It is a dynamic process that starts when problems or symptoms develop, continuing throughout the care process, taking in continual changes in the patient's condition and circumstances.

It is apparent that in some areas the nurses have undertaken detailed assessment, and have regularly updated the assessments. Unfortunately, there is no evidence that all areas of daily living were assessed and therefore there is no plan of care or interventions. There is also evidence that although an assessment may have been done on a particular aspect of care, there is not a corresponding plan.

It is evident that there has been assessment and care planning undertaken but it is not robust enough to address all the aspects of Mrs F's needs and therefore the Health Board is unable to offer evidence that all her clinical and physical needs were being met.

Generally, the record keeping is of a reasonable standard but there is a need for all assessments to be carried out and recorded. The nurses have to adhere to the standards of their regulatory body, the Nursing and Midwifery Council. Good Record Keeping, Guidance for Nurses, 2009 states:

"Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow."

The principles of good record keeping include within the guidance:

“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.
Records should identify any risks or problems that have arisen and show the action taken to deal with them.
You have a duty to communicate fully and effectively with your colleagues, ensuring that they have all the information they need about the people in your care.”

Complaint

Poor standards of hygiene
The Health Board has stated that it can find no evidence to support or dispel the complaint that Mrs F’s family found her to have food on her clothes, dirty hands and fingernails, and unwashed hair.

If there was evidence of ongoing assessment, the Health Board would have been able to highlight that there may have been problems with trying to maintain good hygiene. Mrs F may have been refusing to wash or to allow staff to help, but there is no documented evidence one way or the other.

Also dental hygiene and oral health poor- plaque covered teeth and tongue and oral mucosa covered untreated oral thrush.

On her admission the nurse has documented “has own teeth, unable to perform any ADL (activities of daily living) by herself.” There is no evidence of any subsequent plan to address this. I would have expected to see evidence of a plan of care which would note the difficulties Mrs F had with ADLs and a plan of nursing care to inform staff of how to address this. Whilst it may have been that Mrs F, in her confusion, would have been non compliant with any interventions,

there is no evidence of any plan of care. The Health Board has responded that staff did attempt to clean Mrs F's teeth twice a day but she was non compliant. This may have been so but there is no evidence within the clinical records of this happening. Whilst not expecting staff to document everything, if this had been within an assessment and care plan, there would be evidence that interventions had been planned.

Family requests for Mrs F to be bathed or showered were ignored by staff.

Again there is no plan of care to address Mrs F's inability to carry out any ADL. There is some evidence that Mrs F had a bath or shower occasionally.

Mrs F's toenails became long resulting in injury to surrounding skin. She developed a fungal nail infection. The complainant repeatedly asked for referral to podiatry. The complainant bought cream to treat. Mrs F was not assessed by medical staff.

There is evidence in an assessment done on 16 January that there is a broken area on Mrs F's toe and that it is to be observed and dressed. At a later date in February (the exact date is unclear) it is noted that her toenails are black and it is apparent that it is believed this is due to bruising, perhaps from walking into furniture. There is no evidence that a doctor diagnosed a fungal infection but there was a referral to chiropody on 16 February.

Weight loss

There is evidence within the documentation that a MUST (Malnutrition Universal Screening Tool) assessment was undertaken on 10, 17 and 31 January, and 21 February. On 10 and 17 February Mrs F was in the 'high risk' category. According to the Health Board MUST documentation, a referral should have been made to the dietician on 10 January, however the referral was made on 19 January, and it was requested that dietary supplements would be prescribed on 19 January. The nurse has documented on Mrs F's admission that she has a poor diet and documented in the care plan

that her dietary intake is to be documented on a food chart. There is only one food chart within the clinical document bundle and this was for 17 January. Staff have carried out the assessments but have not implemented the actions prescribed in the care plan. There is no evidence that food charts were completed and whilst there is some documentation within the evaluation sheets regarding Mrs F's intake, this gives inadequate information to monitor her intake. There is also an apparent delay in referring Mrs F to the dietician.

Mrs F's fluid and nutritional intake was compromised. She had difficulty in swallowing and chewing. Her family repeatedly asked for assessments and tests.

The first note of Mrs F having a problem with her neck is noted on 4 January, when she told the nurse "it hurts like hell." The following day on 5 January, the doctor saw Mrs F regarding the neck swelling and possible difficulty in swallowing and referred her to an Ear Nose and Throat specialist (ENT) who diagnosed a fungal infection. The ENT Specialist writes that Speech and Language Therapist (SALT) and dietician referral (are to be made), if not better to have Barium Swallow. Mrs F was seen by SALT on 8 January where the therapist assessed Mrs F's physical ability to chew and swallow food. The assessment concluded that Mrs F was safe to eat and drink and should continue with normal diet and fluids.

Mrs F's daughter was provided with details of her mother's ENT appointment by telephone on 8 January. On 12 January the Barium Swallow was chased by the SHO. However, the first available date was 29 January. Bonjela was prescribed for sores on Mrs F's mouth.

The above is evidence that staff were aware that Mrs F was displaying some difficulty but they reacted in a prompt manner getting a general medical then specialist review, and then a SALT assessment within a timely manner.

Prescribed medicine not given

It is difficult to make sense of the Medication Administration Records

(MAR) due to the photocopying process and in the documents submitted, the last medication administered was 21 January 2009, a full month before Mrs F died. There is evidence within the medical and nursing records of ongoing manipulating of some of Mrs F's medication in an effort to decrease her agitation.

PRN analgesic not given as patient demented and could not ask for PRN medication.

The Health Board has acknowledged this but staff assessed non verbal communication which is a reasonable response. Due to there not being an MAR from 22 January, I am unable to comment on whether or not any medication was actually given.

Non existent communication and information given to family
There is evidence within the nursing and medical records of ongoing dialogue with the family. They did attend ward meetings where Mrs F's ongoing care was discussed and documented. There is evidence that staff phoned the family to update them with information regarding specific interventions.

Care planning not discussed despite requests from family
The initial assessment and care planning was done with information gained from the family who were present at Mrs F's admission. There is no reason that the family should not have been involved in further care planning, especially as they were attending ward meetings. Their participation would have kept the family involved in the care and have ensured that they had the opportunity to be informed of the care and interventions Mrs F was receiving.

Lower limbs oedematous and blue, particularly when immobile
The records show that Mrs F became pale and unresponsive. Her abdomen appeared distended and her continence pads were dry. Mrs F was not medically assessed regarding this deterioration in her condition. Physiological observations were not recorded and her fluid balance charts were not reviewed.

Girth or calf measurements not done. No ongoing assessment or changes in care plan reflecting changes in Mrs F's condition
It is evident in the nursing records that there was some change in Mrs F in that she had previously been wandering and unsettled, but on 20 February her daughter expressed concern that Mrs F was so sleepy. The nurse has assured her that this is either due to a lack of sleep in the previous two nights or due a change in medication. The nurse has documented "to continue to observe and report back to the ward doctor." There is no evidence that this instruction was followed.

On 21 February (which was a Saturday) she was noted to be very sleepy and almost unrousable. The nurse has documented that she was unable to feed Mrs F due to this. Her drowsiness continued and in the evening the family expressed concern over her sleeping, and swollen ankles. The night nurse reported that she was unable to give medications due to the drowsiness. On 22 February Mrs F is reported to have slept all through the morning and staff were unable to rouse her enough to safely feed her dinner, and all medications were withheld.

From this information there is evidence that there was a significant change in Mrs F's clinical condition. She had become unresponsive enough for staff to be unable to feed her or give her medications. There is no evidence that staff perceived this as deterioration in her condition, took observations, or intervened or sought help. The nurses on the unit are registered nurses who are clinically trained and would be expected to detect physical changes in their patients. It would be reasonable to expect them to be questioning why Mrs F was so unrousable, undertaking physiological observations and raising concerns with medical staff.

This lack of response is compounded by the fact that the family - one of whom is a qualified nurse - again expressed their concerns over Mrs F's change in condition on 21 and 22 February. There is no evidence of how the nursing staff sought to reassure themselves or

the family regarding Mrs F or took any action to address the family's concerns.

It is apparent that the nursing staff failed to recognise Mrs F's deterioration, or to ascertain why she was becoming increasingly drowsy, failed to carry out any physiological observations or interventions, and failed to seek medical advice.

There is no evidence that the Health Board has addressed this issue in its responses to the complainant.

No minutes of meeting from 11 February
This was apparently a ward round meeting, one of which was also held on 14 January. There is no mention of the family expressing concerns regarding Mrs F's care. It is not usual for the family to get records of these multidisciplinary meetings - the events are recorded within the clinical records.

On 21 February, Mrs F's husband asked for a doctor to be called. He was told that no doctor was available until Monday. The complainant requested a transfer to acute medical ward. She was told that Mrs F was not suitable for a transfer to a medical ward due to her mental health needs.
The Health Board has not addressed the aspect of these particular requests for a doctor, nor the complainant's request for Mrs F's transfer. There is no reason given why a doctor would not be available until the Monday. The relatives were very concerned about Mrs F's medical condition but despite repeated requests were denied access to a clinician. The staff have not documented any reasons to support their decision not to call a doctor.

As previously stated the staff should have been considering that Mrs F was deteriorating, taking observations to assess her clinical condition, and contacting medical staff with this information. My medical colleague may conclude that any medical intervention would

not have changed the outcome, but the opportunity of medical intervention should have been available.

Mrs F collapsed after her family left the ward. Her family were not informed until one hour later.

The staff priority would have been the attempted resuscitation of Mrs F and it is reasonable that there was a delay in contacting the family. Staff have documented that they did attempt to contact the daughter but were unsuccessful but that Mr F was informed within thirty minutes of Mrs F collapsing. Whilst the delay may be very distressing for the family, the resuscitation would take priority.

Conclusion

Mrs F was admitted to the ward because of her increasing mental health needs. Whilst there is evidence of some good nursing practice in some of the assessments and care plans, these are not consistent leading to inadequacies in the nursing care given to Mrs F, especially regarding her hygiene needs and nutrition needs. I cannot see that this aspect of the complaint has been addressed in the Action Plan. The care planning could have been improved with the involvement of the family who had been caring for Mrs F at home for about four years.

Mrs F's deterioration was not recognised by the nursing staff and despite requests from her family, she was denied access to medical care. Mrs F became increasingly sleepy and unrousable from 20 February, and they have documented that the family expressed concerns on 20, 21 and 22 February. This failing has not been acknowledged by the Health Board and so there is nothing within the Action Plan. It would be reasonable for the Health Board to address how it can assure that the nursing staff have the knowledge to recognise a deteriorating patient and to act upon the information.

The Health Board should explain why no doctor was available until the Monday and what guidelines are in place for nursing staff to escalate concerns about a patient over a weekend period.

You have asked me to comment on the grading of the complaint. In light of the nurses' failure to recognise or respond to Mrs F's deterioration, and to seek medical intervention, I would grade this at 2.

Nursing Advice **Appendix B2**
Rona McKay
Senior Nurse

You have asked me to comment on the Health Board's responses to the issues raised in its letter of 18 February 2011.

Availability of medical staff
The response is wholly unsatisfactory and I support my medical colleague's comments.

Transfer to a medical ward
This response is not adequate. It is apparent that Mrs F was becoming unwell but the nursing staff did not recognise or respond to this. The family repeatedly raised their concerns but no action was taken by the nurses. There is no reason given why the nurses did not contact a doctor for a medical opinion, and if they had done so, Mrs F may have been admitted to a medical ward.

Conclusion
The Health Board's response is not adequate and displays a lack of insight into the failings in Mrs F's care. Mental Health patients may have acute medical problems but this was not addressed in Mrs F's case, and the Board response does not acknowledge this or offer any robust assurances for future care.

My medical colleague and I have discussed this response and feel it may help inform our advice and perhaps future recommendations to have sight of the Board's operational policy regarding medical cover for the ward and of the operational policies for nurses working within the ward.

Nursing Advice **Appendix B3**
Rona McKay
Senior Nurse

I asked for operational policies regarding the nursing staff on the ward, looking for the standards of care which are to be delivered to patients. You have been advised by the Health Board that it has no operational policies. I believe you may have been incorrectly advised as there must be some clinical standards in place.

Mrs F did not receive adequate assessments and care planning, the underpinning of all nursing care which is delivered. I have cited the NMC guidance Good Record Keeping in my advice (at Appendix B1).

There was a delay in referring Mrs F to the dietician; staff did carry out an assessment but did not carry out the actions prescribed in the care plan; and food charts were not completed.

The Health Board should demonstrate how their staff will comply with National Institute for Health and Clinical Excellence guidelines 32; Nutrition Support in Adults, and Essence of Care 2010, Benchmarks for Food and Drink.

Nursing staff did not recognise or react to the deterioration in Mrs F's clinical condition, and the Health Board should demonstrate how they ensure nursing staff are competent and be able to assure patients of reasonable standards of nursing care.

The Health Board has stated that nurses can call 999 for an ambulance if they have concerns about the patient. This does highlight that the nursing staff need the ability to recognise deterioration in the first place, which did not happen in this case. This lack of recognition is compounded by the fact the family, one of whom is a nurse, repeatedly expressed their concerns to nursing staff.

National Institute for Health and Clinical Excellence guidance 50,

2007, Acutely Ill Patients in Hospital, Recognition of and Response to Acute Illness in Adults in Hospital, states in the introduction:

“Patients who are admitted to hospital believe that they are entering a place of safety, where they, and their families and carers, have a right to believe that they will receive the best possible care. They feel confident that, should their condition deteriorate, they are in the best place for prompt and effective treatment. Yet there is evidence to the contrary. Patients who are, or become, acutely unwell in hospital may receive suboptimal care. This may be because their deterioration is not recognised, or because - despite indications of clinical deterioration - it is not appreciated, or not acted upon sufficiently rapidly. Communication and documentation are often poor, experience might be lacking and provision of critical care expertise, including admission to critical care areas, delayed.’”

This guidance is for patients in acute settings, but some of the guidance is relevant in this case.

The Health Board also needs to demonstrate that there is a clear pathway for the referral of patients with medical needs.

I have experienced difficulty in finding standards which are specifically for mental health care in community hospitals but the Health Board should be fully cognisant with the required standards and should demonstrate how they are meeting them.

I attach a copy of a document from Healthcare Inspectorate Wales which is a report entitled “Unannounced dignity and respect visit - Ystrad Mynach Hospital; Heddfan, Anwylfan and TV Glas wards (Older Mental Health) 1, 2009.” Mrs F was in Anwylfan ward. This report is mainly about Dignity and Respect, but one of the issues is about mandatory training for staff. The report also highlights a lack of knowledge regarding “Fundamentals of Care”, a Welsh Assembly Government initiative included in the Plan for Wales. The Health Board should demonstrate how they are fulfilling the actions required

in response to this report. This may help raise some of the poor standards highlighted in this complaint.

I also attach a copy of Doing Well, Doing Better - Standards for Health Services in Wales 2010. This document from the Welsh Assembly Government replaces the Healthcare Standards for Wales 2005 (copy attached) and provides an updated framework of standards. Health Inspectorate Wales will use these to undertake a level of testing and validation against the standards each year but the onus is on the Health Board to demonstrate that they are using and meeting the standards on a continuous basis.