The investigation of a complaint by Mrs W against Betsi Cadwaladr University Health Board

A report by the Public Services Ombudsman for Wales

Case: 201001167

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 W and her husband, the patient, as Mr W. Sadly Mr W died in May 2009.

Summary

Mrs W complained about the care and treatment her husband, Mr W, received whilst a patient at Ysbyty Gwynedd (the Hospital). Mr W had been admitted to the Hospital for treatment due to dysphagia (swallowing difficulties) experienced when eating and drinking. He was discharged but was readmitted four days later due to worsening dysphagia. Mrs W complained that there was a very poor standard of care provided to her husband during his admissions which led to deterioration in his condition and, ultimately, contributed to his death.

Mrs W complained about the following:

- That a procedure to stretch Mr W's gullet did not go ahead as planned due to a nursing staff error.
- That her husband was discharged without having this surgery and once readmitted, due to his declining health, he was too weak to have the procedure carried out.
- That there was a delay in obtaining a second opinion on her husband's condition and arranging a transfer to a specialist hospital.

I upheld the majority of Mrs W's complaints. I found that the clinical care provided to Mr W was inadequate as it was insufficiently intensive and lacked input from his consultant physician. I found that there were a number of clinical failings which contributed to the health problems that emerged during Mr W's readmission. The most significant of these was the decision to discharge Mr W from the Hospital's care without carrying out an oesophageal dilatation (a procedure to stretch the gullet) and the delay in raising its concerns regarding Mr W's deteriorating condition with a specialist hospital. I found that whilst the errors identified were significant, there was no definitive evidence to conclude that the ultimate tragic outcome could have been avoided but for those errors. Finally, I found that in general, the nursing care and management of Mr W was reasonable. However, inadequacies in some of the nursing records prevented a definitive conclusion from being reached in respect of the adequacy of care delivered when the tubing attached to his chest drain became disconnected.

I recommended that the Health Board should reflect on the failings in the care identified and provide confirmation of the further action taken to address the inadequacies in its staff awareness of national guidelines in relation to oesophageal dilatation, the Hospital's transfer procedures for critically ill patients, the availability of medical cover over Bank Holiday weekend periods and the insertion of chest drains. I recommended that a payment of £500 be provided to Mrs W in recognition of the time and trouble in pursuing her complaint together with a full apology for the shortcomings in the care provided to Mr W and for the Health Board's failure to recognise these failings sooner.

The complaint

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

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

(a) On 7 May due to poor communication between hospital staff the procedure to stretch Mr W's gullet did not go ahead as planned;

(b) Mr W was discharged from hospital on 14 May without having the procedure to stretch his gullet carried out;

(c) That the delay in carrying out the stretching procedure caused the problems that later emerged with Mr W's health;

(d) That the hospital staff did not provide adequate care and treatment to Mr W;

(e) That Mr W's health problems were not as serious as described by the Health Board in its response to the complaint;

(f) That there was a delay in obtaining a second opinion on Mr W's condition;

(g) That there was a delay in arranging Mr W's transfer to a specialist hospital;

(h) That Mr W was critically ill on the day of the transfer and was not well enough to make the journey;

(i) That the ambulance crew fought to save Mr W's life during his transfer to the specialist hospital on 28 May;

(j) That it was inappropriate for the Health Care Assistant (HCA) to reinsert Mr W's chest drain;

3. Whilst Mrs W's complaints were not restricted to the above issues, I have taken the decision to narrow the focus of my investigation on the basis that I consider these issues to be the most important ones and also because I do not consider it likely that further investigation of many of the more peripheral issues (such as a complaint about the attitude of a member of nursing staff, where it is not possible to reconcile differing accounts of events) would achieve anything further. This was explained to Mrs W at the outset of the investigation.

Investigation

4. Comments and copies of relevant documents, including Mr W's clinical records, were obtained from the Health Board, Liverpool Heart and Chest Hospital and the Welsh Ambulance Services NHS Trust (the WAST) and considered in conjunction with the evidence provided by Mrs W through her advocate. Medical and nursing advice was obtained from two of my professional advisers, Dr Richard McGonigle, a consultant physician, and Cherilee Angland, a registered adult nurse. Their advice is included in full at Appendices A and B, it is summarised at paragraphs 70 to 105. I have not included every detail investigated but I am satisfied that nothing of significance has been overlooked.

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

Relevant guidance and standards

6. As part of their advice, the medical and nursing advisers referred to 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.

7. Nurses are required to adhere to the standards of their regulatory body, the Nursing and Midwifery Council (NMC). The NMC has published guidelines for its members entitled "Good Record Keeping, Guidance for Nurses 2009".

8. British Thoracic Society guidelines for the insertion of a chest drain Thorax 2003. This states:

> "14.4 Ward instructions: Patients with chest tubes should be managed on a specialist ward by staff who are trained in chest drain management."

9. British Thoracic Society guidelines for the management of spontaneous pneumothorax (collapsed lungs). This states:

> "Significantly, earlier referral (2–4 days) [to a thoracic surgeon] should be considered in those with underlying disease, a large persistent air leak, or failure of the lung to re-expand."

10. The General Medical Council guidance on the consultant's responsibility for their juniors and referring to other consultants.

11. Royal College of Physicians: hospital out of hours service.

12. National Institute for Clinical Excellence guidelines: acutely ill patients in hospital.

13. National Confidential Enquiries into Patient Outcome and Death: late referrals.

14. British Society of Gastroenterology Guidelines on the use of oesophageal dilatation in clinical practice; Riley SA, Attwood SEA, GUT 2004. This states that the:

> "primary aim of oesophageal dilatation is to alleviate symptoms, permit maintenance of oral nutrition and reduce risk of pulmonary aspiration (food falling in to the lungs)."

The background events

15. On 28 April 2009, Mr W was admitted to the A&E Department at Ysbyty Gwynedd (the Hospital) with a 24 hour history of increased breathlessness and coughing mucus.

16. On admission, Mr W had borderline severe Chronic Obstructive Pulmonary Disease (COPD) (a progressive disease that makes it hard to breathe), recurrent collapsed lungs due to air leaks and persisting low blood oxygen levels. He had also experienced significant weight loss and was due to have a stretching procedure carried out on his gullet.

17. However, on 14 May, Mr W was discharged without having this stretching procedure carried out.

18. He was readmitted on 18 May as an emergency case due to worsening dysphagia (swallowing difficulties).

19. During his readmission, Mr W remained fairly comfortable, but there were times when he had increasing breathlessness and chest pain.

20. On 20 May, Mr W was seen by an on-call doctor due to increasing breathlessness. He also required a chest tube drain to be inserted due to an air leak and collapse of his left lung. He was then transferred to a respiratory ward for further management.

21. On 21 May, Mr W was seen by his doctor during his ward round. Mr W was still breathless, his chest drain was still bubbling and his left lung had still not completely re-expanded. Chest suction was initiated that morning in an attempt to complete the re-expansion and allow sealing of his left lung. Unfortunately, the leak continued over the weekend of 23 and 24 May.

22. On 22 May, Mr W was seen by a dietician who encouraged a soft diet and dietary supplements.

23. On 23 May, the malnutrition assessment of Mr W was reassessed and a care plan about Mr W's dysphagia was prepared.

24. At 22:00 on 23 May, the tubing to Mr W's chest drain became disconnected.

25. On 24 May, there was no record that clinical observations were taken by a nurse between 03.00 and 14:45. Mr W was not seen by a doctor until 22.00. When he was seen by the doctor, this was about his poor nutritional and fluid intake and not about his chest drain.

26. On 26 May, the dietician once again reviewed Mr W. The consultant physician's registrar also discussed Mr W's condition with his family. The plan was to continue encouraging dietary supplements and give intravenous fluids. The registrar also discussed Mr W's ongoing problems of a persistent air leak in his lung following 4 to 5 days of drainage and a continuing dysphagia. The medical team informed Mr W's family that they would need to discuss his situation with the Cardiothoracic Centre in Liverpool.

27. On 27 May, Mr W's medical team discussed his condition with the Cardiothoracic Team at Liverpool Heart and Chest Hospital (referred to in this report as Broadgreen Hospital). Having discussed Mr W's current situation, the Cardiothoracic Team at Broadgreen Hospital said it would be happy to take over his case. It said that it would require Mr W's x-rays, that Mr W would need to be accompanied by trained staff, and that the medical team would need to organise the transfer.

28. On 28 May, Mr W was transferred to Broadgreen Hospital (a journey of approximately ninety miles). At this point, Mr W's C-reactive protein (CRP) (a blood test indicating either increasing infection or inflammation) had significantly increased. This turned out to be a developing pneumonia at the bottom of his collapsed lung which itself was already diseased with COPD. Sadly, Mr W died the following day. His cause of death was respiratory failure secondary to a collapsed left lung and COPD.

29. Mrs W pursued her complaint with the Hospital in her letter of 29 July 2009. She also had a meeting with the hospital staff, including the

Head of Nursing and Mr W's consultant physician in April 2010 following the Health Board's written response of 13 October 2009.

30. Despite receiving a written response and attending a meeting with the Health Board, Mrs W remained dissatisfied with the responses provided in relation to her concerns. She therefore referred her complaint to me.

Mrs W's evidence

31. Mrs W said that on 30 April, her husband had the telescopic investigation of his gullet carried out as an inpatient. Mrs W said that it was agreed that Mr W would remain in hospital for the procedure to stretch his gullet. Mrs W said that the family were informed that the operation would take place on 7 May. However, due to poor communication on the ward, Mr W was given a slight amount of dietary supplements that morning and was unable to have the procedure carried out. Mrs W said that her husband remained in hospital for a further week and was discharged on 14 May without having the surgery.

32. Mrs W said that her husband was readmitted to hospital on 18 May by his GP who said that he required immediate treatment to help him eat and drink. Mrs W said that on arrival, Mr W was given intravenous fluids. She said that he informed her at this time that he felt like he was drowning.

33. Mrs W said that by 20 May, Mr W's lung had collapsed leaving him short of breath. She said that this had occurred in the past and Mr W had always recovered very well.

34. Mrs W said that although the operation to stretch Mr W's gullet had been arranged for 21 May, his declining health meant that it could not go ahead. Mrs W said that she believes that the failure to proceed with the surgery during the week of 7 May was the cause of the problems that later emerged with her husband's health. Mrs W said that Mr W was too weak to fight infection or recover from his collapsed lung.

35. Mrs W said that the history provided by the Health Board of her husband's health gave the wrong impression. She said that he was not

the sick man that it had implied and that he had been told by his doctor 6 months prior to hospitalisation that his lungs were a lot better.

36. Mrs W said that the medical team treating her husband left it far too late to transfer him to Broadgreen Hospital. She said that they had not contacted Broadgreen Hospital days before as it had claimed and this was confirmed at her meeting with the hospital staff in April 2010. She said that staff spoke to Broadgreen Hospital the day before the transfer and it was only with the family's insistence that they eventually did so. Mrs W said that the family believe that if Broadgreen Hospital had been contacted earlier, with its expertise, her husband's chances of survival would have improved.

37. Mrs W said that the doctor's statement that Mr W was not critically ill on transfer was untrue. She said that the ambulance crew fought to save his life on the way to Broadgreen Hospital and the consultant thoracic surgeon at Broadgreen Hospital confirmed in a letter of 3 June 2009 that Mr W's overall condition on arrival was extremely poor and his chances of survival even poorer.

38. Finally, Mrs W said that she did not believe that the HCA who took care of her husband had the authority to reinsert any parts connected to his chest drain and that, at the very least, this procedure should have been checked by a doctor.

The Health Board's evidence

39. The Health Board said that Mr W underwent a telescopic examination (OGD) of his gullet on 30 April as an inpatient. It said that a narrowing of the throat was noted and a repeat OGD and dilatation (a procedure to widen this narrowing) were arranged. It said that on 5 May the registrar booked an urgent OGD and dilatation for Mr W. However, due to the waiting list in the endoscopy unit, they were arranged as an urgent outpatient appointment.

40. It said that Mr W advised his family that he was anticipating undergoing the procedure on 7 May, but nurses gave him breakfast. It said that neither Mr W's medical team nor the ward staff were informed of or aware of this appointment and as Mr W was provided with food, the

procedure could not go ahead. It apologised for this shortfall in communication and said that as a result, Mr W was required to undergo the procedure as a day patient.

41. It said that an early appointment would have been booked if cancer was suspected. However, this was not the case and a delay before the procedure could be undertaken was anticipated.

42. It said that although a stricture had been identified and Mr W continued to have problems swallowing, he did not receive the procedure as an inpatient.

43. The Health Board said that at the time of discharge, the requirement to stretch Mr W's gullet was not regarded as urgent as his intake on the ward with a liquidised diet and dietary supplements was satisfactory. It said that at the time of discharge it was expected that this matter would be addressed in the near future and that it was not desirable to keep him in hospital with the inherent risks of prolonged hospitalisation.

44. It said that unfortunately Mr W was readmitted to hospital on 18 May with a clear deterioration in the degree of dysphagia from that which had been apparent when discharged home on 14 May. It said that the symptoms were significantly worse which indicated inpatient management. It said that he was seen again by the registrar on 19 May who again noted Mr W's history of dysphagia and arranged for an urgent OGD and dilatation.

45. In relation to the delay in carrying out the procedure, the Health Board said that there may have been a capacity issue for the procedure, although the ward staff continued to chase for it. It said that this was regrettable but unavoidable.

46. The Health Board said that on 20 May, while waiting for the OGD and dilatation, Mr W developed acute breathlessness and he was noted to have a left collapsed lung. It said that it was regrettable that Mr W's OGD and dilatation could not be carried out as planned due to a sudden

deterioration of his clinical condition. It said that this deterioration was mainly due to his collapsed lung rather than as a result of the stricture.

47. The Health Board said that Mr W's overall condition had deteriorated and his lungs were not well enough to recover. It said that although Mr W had experienced a collapsed lung on previous occasions and his condition improved quickly, the cause may have been very small whereas this was a more severe event.

48. The Health Board said that the leak in Mr W's lung was sufficient for the lung to fail to fully re-expand and it was for this reason that Mr W had to be transferred to Broadgreen Hospital. It said that Mr W's condition was exacerbated by hospital acquired pneumonia of the lungs in addition to his COPD. It said that this can often be an unfortunate complication in older patients with a pre-existing condition.

49. The Health Board said that it is speculative to say that the stricture may have led to Mr W's pneumonia. It said that Mr W had had this condition for some considerable time and it had caused no such complications earlier. It said that Mr W's age, immobility and severe COPD were all factors predisposing him to hospital acquired pneumonia. It also said that the appearance of the pneumonia on Mr W's lung x-ray did not suggest that it was caused by aspiration from the stricture.

50. The Health Board said that in the days up to and including the day of transfer there was frequent input by the registrar who was in contact with Mr W's consultant physician on regular occasions discussing his condition. It said that both the registrar and consultant physician discussed Mr W's condition and fitness for transfer with the team at Broadgreen Hospital.

51. The Health Board said that guidelines for pneumothorax advise transfer to a thoracic surgeon after 5 to 7 days of a persisting air-leak.

52. It said that Mr W's consultant physician was unaware of any particular issues over the weekend period which had had any adverse influence on the decision-making process in the last few days that Mr W was on the ward.

53. It said that the registrar and consultant physician were jointly involved with Mr W. It said that the consultant physician's ward rounds are done twice weekly and on this occasion a third attendance was made to Mr W a few hours prior to his transfer. It said that the registrar in discussions with the consultant physician had also discussed Mr W's condition with the team at Broadgreen Hospital and also with the bed manager concerning his condition for transfer. It said that their advice was to transfer Mr W.

54. The Health Board said that all members of Mr W's medical team were aware that any concerns are automatically escalated to the consultant physician for discussion and this was the pattern of interaction in the days leading to Mr W's transfer.

55. The Health Board said that it was quite clear that Mr W had severe, disabling COPD and was in an extremely poor condition. It said that he would not have been accepted for Intensive Therapy Unit (ITU) because of his very poor quality of life at home requiring long term oxygen therapy and the high likelihood that he would not be "weanable" from the invasive ventilation that would have been initiated.

56. The Health Board said that although Mr W could have remained at the Hospital with continued antibiotic treatment, it was not known how much that would have helped as the pneumonia was not improving. It said that apart from embarking on an 'End of Life' pathway, the consultant physician felt that the only chance of improvement with Mr W was to have his collapsed lung addressed by a thoracic surgeon. It said that Mr W's son was informed that his father might well sadly pass away although this was not documented in Mr W's clinical records (Mr W's son denies that this conversation took place between him and the hospital staff). It said that resolving his respiratory difficulties was the only chance that he had.

57. The Health Board said that although Mr W was receiving appropriate treatment, there was no improvement in his condition and contact was therefore made with Broadgreen Hospital as a specialist hospital. It said that once Mrs W raised concerns with staff, contact had

already been made with Broadgreen Hospital. It said that although efforts were made to transfer Mr W quickly, there was a delay as there was no bed available. It said that treatment by suction continued in the interim and that Mr W was on the maximum treatment available at the Hospital.

58. It said that Mr W's doctor acknowledged that the Hospital was acting on the advice and recommendation of Broadgreen Hospital which was aware, in detail, of his condition. It said that the consultant physician was fully satisfied that the condition of Mr W had been conveyed to the thoracic surgeon at Broadgreen Hospital, although he accepted that ideally a consultant to consultant discussion could have taken place. The Health Board said it was Broadgreen Hospital's clinical opinion that the transfer was Mr W's best option.

59. The Health Board said that Mr W was not critically ill at the time of leaving the Hospital and did not warrant being moved to ITU. It said that it accepted that he was extremely unwell but that this distinction was important when the decision was made to transfer. It said that it was not thought that he was critically ill to the extent that he would shortly die. It acknowledged that sadly patients can deteriorate and die very quickly. It said that if Mr W had demonstrated a further deterioration or the hospital staff felt that he was critically ill, his family would have been informed and it was unlikely that the transfer could have gone ahead. It said that the clinical observations noted by Broadgreen Hospital were worse than those that had been observed prior to discharge.

60. The Health Board confirmed that a nurse accompanied Mr W in the ambulance to Broadgreen Hospital. It said that his lung was completely collapsed on arrival. It said that suction facilities are not available on ambulances and portable suction equipment was not available elsewhere for use during transfer. It said that the decision to transfer was based on "a likely adverse outcome otherwise."

61. In relation to the chest drain, the Health Board said that the tube did not come out of Mr W's chest drain, as the tube into the body is stitched in place. However, it said that this tube has an attachment which leads to the drainage tube and this is what the family saw the HCA

replacing. It said that this tube can occasionally dislodge, it is simple to reattach and it was appropriate for the HCA to do so. It said that a doctor was informed but no further action was required.

62. The Health Board said that the chest drain tube was inserted in the correct place by an extremely competent staff member, appropriately and according to guidelines. It said that it started bubbling and was therefore in the correct place and could continue to draw air out of the chest.

63. The Health Board said that although Broadgreen Hospital inserted another tube into Mr W's chest in an attempt to get the air out quicker, this would not have made much difference. It said that suction was attempted to improve his condition but with little success. It said that Broadgreen Hospital may have looked at things from a different perspective but there was little more that the Hospital could offer and the staff at Broadgreen Hospital believed that Mr W's transfer offered him alternative options.

64. In relation to the nursing care provided to Mr W, the Health Board said that a dietician saw Mr W on 11 and 22 May. It said that Mr W's lungs were not performing well and options for feeding were limited. However, it said that his diet was reviewed regularly. It said that attempts were made to maintain or improve Mr W's weight which was low but this could have taken several weeks. It said that the medical notes from 18 May document that Mr W was being given fluids and dextrose (a type of sugar) as well as oral feeds.

65. The Health Board said that the medical team involved had learned from Mr W's case and if another patient in a similar condition was not responding to treatment, it would consider negotiating an earlier transfer.

66. The Health Board said that Mr W's case was complex and it could not see what the staff could have done differently.

Information obtained from correspondence in the clinical records

67. I have noted that in a referral letter from his GP of 16 March 2009 it appears that Mr W was described as having "respiratory failure possibly end stage".

The WAST's evidence

68. The WAST said that due to the time that had elapsed since the transfer to Broadgreen Hospital, the paramedic did not have a clear recollection of Mr W's journey from the Hospital to Broadgreen Hospital. However, having reviewed the records relating to the transfer he said that Mr W's condition did not deteriorate to a level that required a further set of observations being undertaken or an entry in the narrative of the records and these are the two actions he would have considered had Mr W deteriorated further during the transfer.

69. It confirmed that a trained nurse accompanied Mr W during the transfer.

Professional advice

The medical adviser

70. I have taken advice from a consultant physician with over 20 years' experience. 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.

71. The medical adviser said that Mr W was inappropriately discharged home on 14 May and this is emphasised by his readmission with severe dysphagia only 72 hours later. The medical adviser said that the oesophageal stricture did not worsen over such a short period of time.

72. The medical adviser noted that at the time of Mr W's discharge there was no appointed date for the oesophageal dilatation despite the dietician's entry in the medical records on 11 May that Mr W was worried about swallowing and having to wait for the OGD.

73. In relation to the oesophageal stricture, the medical adviser was critical of the Hospital's lack of urgency in carrying out the operation to stretch Mr W's gullet during his first admission from 28 April to 14 May. The medical adviser said that it was not possible to undertake the procedure during the second hospital admission and that his concerns related to the previous hospital admission.

74. When he was first admitted on 28 April with a chest infection, the medical adviser said that the medical records show that Mr W and the family were very concerned that he was unable to eat and that he was losing weight progressively.

75. The medical adviser said that the tight oesophageal stricture should have been regarded as a medical emergency. The medical adviser said that as Mr W had severe underlying respiratory disease, this narrowing and difficulty in swallowing would have increased the risk of aspiration with potential fatal consequences. The medical adviser said that there was also evidence that Mr W was severely malnourished with a two stone weight loss over the previous few months.

76. The medical adviser was critical of the Health Board's response to the issue of the treatment of Mr W's oesophageal stricture. The medical adviser said that Mr W's chest infection on his first admission may or may not have been related to aspiration but this possibility should have been considered.

77. In relation to the delay in arranging an appointment for the procedure, my medical adviser said that the Health Board's response that there were scheduling difficulties and that an early appointment for the procedure would have been booked if cancer was suspected were not acceptable. The medical adviser said that cancer was not the issue and that Mr W continued to lose weight due to malnutrition caused by his inability to swallow food.

78. The medical adviser said that it is possible that Mr W aspirated and the consequences of aspiration are significantly more adverse in a patient with severe lung disease. The medical adviser said that British Society of Gastroenterology (BSG) Guidelines on the use of

oesophageal dilatation (referred to at paragraph 14) did not appear to have been followed to alleviate his symptoms.

79. The medical adviser noted that the final chest x-ray carried out on 28 May revealed extensive pneumonia and collapse which would be consistent with aspiration. The medical adviser said that the Health Board's comment that aspiration pneumonia is not a feature of physical obstruction due to oesophageal stricture is inaccurate. The medical adviser said that the Health Board's response contradicts BSG Guidelines and that the failure to carry out this procedure may have contributed to Mr W's final deterioration.

80. The medical adviser said that a second opinion on Mr W's condition was first considered on 27 May. The medical adviser said that the second opinion from a thoracic surgeon should have been obtained earlier, but not necessarily the transfer to Broadgreen Hospital, as consultant to consultant discussion might well have sufficed. The medical adviser said that Mr W's chronic lung disease made any consideration of surgery difficult and unlikely. However, advice regarding a second drain or repositioning of the drain already in place should have been considered. The medical adviser was again critical of the consultant physician's failure to carry out more regular reviews of Mr W himself as this may have raised concern and triggered earlier contact with Broadgreen Hospital.

81. The medical adviser said that British Thoracic Society Guidelines (referred to at paragraph 13) indicate that a referral to thoracic surgeons within 2 to 4 days should be considered for those with underlying disease, persistent air leak or failure of the lung to re-expand. Therefore, the consultant physician's comments that guidelines recommend a transfer after 5 to 7 days were not correct.

82. The medical adviser is of the view that Mr W's transfer to Broadgreen Hospital on 28 May was inappropriate. The medical adviser said that Mr W was critically ill on 28 May and the transfer should have been cancelled or occurred earlier. The medical adviser said that the Health Board's comments regarding the difference between critically ill and extremely unwell is unclear. On the day of the transfer, the medical

adviser said that Mr W's condition had significantly deteriorated and this was probably due to pneumonia.

83. The medical adviser was critical of the Health Board's response to the issue of Mr W's transfer. The medical adviser said that Mr W was diagnosed with pneumonia on 28 May. It is not clear how long it had been present and the medical adviser said that it should have been detected sooner. Therefore, the comment made by the Health Board that Mr W's pneumonia was not improving was not relevant. The medical adviser said that Mr W's CRP measurement on 28 May exceeded 200mg per litre (normally value less than 10mg per litre) with no previous recent measurement and that his heart rate was elevated at 145 BPM. The medical adviser said that this indicated that Mr W had an extremely high level of infection and this had not been addressed in the Health Board's response.

84. The medical adviser said that alternative arrangements to transfer Mr W to ITU at the Hospital to be stabilised should have been considered. The medical adviser said that an ITU assessment would have provided additional expert advice prior to transfer as Mr W was having severe difficulties absorbing oxygen.

85. The medical adviser said that the registrar communicating with Broadgreen Hospital informed the staff that Mr W had a background of moderate COPD and was previously independent, mobilising over 50 to 100 yards. However Mr W's lung function readings indicated that he had severe lung disease. The decision to transfer was discussed with the consultant who agreed that Mr W could be transferred to Broadgreen Hospital without suction.

86. In relation to the care that was provided to Mr W, the medical adviser said that while there was evidence that the actions that were taken by the staff were correct, the overall care was insufficiently intensive and there was little evidence of a consultant-delivered or even consultant-led service. The medical adviser said that the responsible consultant physician should have been more closely involved, possibly on a daily basis and if absent, appropriate covering medical attention should have been provided to Mr W. If there were insufficient medical

staff, the medical adviser said that Mr W should have been considered for transfer to ITU.

87. The medical adviser said that junior medical staff should have reviewed Mr W on a daily basis including the weekend and that no weekend plan appeared to be in place for this purpose as there was a lack of medical attention received by Mr W during the Bank Holiday period 23 May to 25 May.

88. The medical adviser also said that a respiratory registrar should have been more involved, that there was no pro-active planned review of Mr W by the ITU Team, the duty medical registrar or the duty consultant physician over the Bank Holiday period.

89. Overall, the medical adviser was critical of the lack of registrar or senior staff involved in Mr W's care during his admissions. The medical adviser said that during his first admission, Mr W was reviewed by the registrar on 28 April. However, he did not receive a further consultant review until 7 May and this lack of consultant review has not been explained by the Health Board.

90. The medical adviser said that the chest drain was inserted by the SHO on 20 May without prior discussion with either registrar or the consultant. The medical adviser said that there was no evidence that the consultant's advice on 21 May "may need intercostal drain in second left intercostal space, if persistent pneumothorax. If continuing bubbling, withdraw chest drain slightly" was acted upon.

91. The medical adviser noted that during his second admission the consultant physician did not review Mr W during the period 21 May to 28 May and would not have been aware that his condition was not improving. The medical adviser said that the consultant physician restricted his review of Mr W to his formal ward rounds which appeared to be on a Monday and Thursday and no allowance was made for Bank Holiday Mondays. The medical adviser said that Mr W required more intensive and specialist input.

92. The medical adviser said that the Health Board's response that the registrar had also discussed Mr W's condition with the bed manager at Broadgreen Hospital concerning his fitness for travel was not appropriate. The medical adviser said that this decision should have been made by the referring physicians.

93. The medical adviser noted that no explanation has been provided by the Health Board for the consultant thoracic surgeon at Broadgreen Hospital's statement that Mr W's lung was completely collapsed on arrival. The medical adviser said that something must have happened at the time of Mr W's journey or during the journey which had a negative impact on his health.

The nursing adviser

94. I have taken advice from a registered adult nurse with 15 years' experience in general adult nursing across secondary and primary care provision in a number of settings, including six years as a COPD specialist nurse. Her advice is at Appendix B. It is in two 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.

First admission

95. In relation to Mr W's admission from 28 April to 14 May, the nursing adviser said the nursing care provided to Mr W was appropriate. The nursing adviser also noted that the nursing documentation provided complied with expected standards.

96. The nursing adviser said that the nursing notes confirmed that Mr W's needs were assessed on admission and appropriate care plans were identified, implemented, monitored and updated. Also, the nursing adviser said that referrals to specialist areas namely dietician, respiratory nurse specialist and physiotherapist, were appropriate and timely.

97. The nursing adviser noted that there was evidence that Mr W's nutritional needs were identified and monitored.

Second admission

98. In relation to Mr W's admission from 18 May to 28 May, the nursing adviser said that in general, the nursing documentation provided reflected that a good standard of nursing care had been provided to Mr W and an appropriate monitoring of his needs maintained.

99. The nursing adviser said that there was evidence of a referral to a dietician for a review of Mr W's nutritional needs and accurate completion of nutritional and fluid balance charts as requested. Also, that appropriate monitoring of clinical observations was completed and changes in Mr W's condition were escalated to medical staff when triggers were reached.

100. The nursing adviser agreed with the Health Board's response that there was no evidence that Mr W's chest drain had fallen out and had been reinserted by a HCA. The nursing adviser said that it was likely to have been the tubing which is attached to the drain which had become disconnected.

101. The nursing adviser said that several complications can occur when managing a patient with a chest tube. If the tubing becomes disconnected from the drainage system and is left untreated, this could allow air to enter the lung which can alter the pressure. If this pressure changes because of excess air, the lung may collapse again. There is also an added risk of infection being introduced into the chest cavity.

102. The nursing adviser said that there are guidelines in place which state that patients with chest tubes should be managed by staff who are trained in chest drain management. There was no evidence that Mr W's drain had been assessed by a qualified nurse to ensure that it was working effectively. The nursing adviser said that it is reasonable to expect documented evidence of this in the assessment chart that was in use on the ward.

103. The nursing adviser said that during the night that Mr W's chest drain tubing became disconnected it is reasonable to expect documented evidence of an increase in frequency of clinical observations to monitor for signs of deterioration.

104. In light of the omissions set out above and on the basis of the inadequate written records, the nursing adviser was unable to conclude that appropriate care was given to Mr W on the issue of his chest drain management.

105. The nursing adviser said that the use of a trained nurse escort to accompany him during his transfer to Broadgreen Hospital was entirely appropriate and reflected good nursing care. The nursing adviser confirmed patients can be transferred without suction.

Analysis and conclusions

106. In reaching my conclusions, I have been guided by the advice provided by my professional advisers, which I accept in its entirety.

107. My professional advisers have highlighted some significant clinical failings and I share their concerns about those. I will consider below each of Mrs W's complaints in turn as set out in paragraph 2.

Complaint (a)

108. I have considered the shortfall in communication regarding the appointment for the stretching procedure on 7 May. The Health Board has recognised that this was an error on its part and has apologised for the confusion. Therefore, **I uphold** this aspect of the complaint.

Complaint (b)

109. My medical adviser has highlighted the inappropriate discharge of Mr W from the Hospital on 14 May. Although the Health Board said that the discharge was reasonable, in circumstances where Mr W was readmitted within such a short period with severe swallowing difficulties, I am unable to conclude that this was the case. The Health Board said that Mr W's symptoms were significantly worse when he was readmitted which indicated inpatient management. However, my medical adviser has confirmed that the oesophageal stricture did not worsen over such a short period of time. My medical adviser has also confirmed that Mr W was at high risk of aspirating and that this can be potentially fatal in a patient with severe COPD. Therefore, it appears that the decision to discharge Mr W on 14 May was wholly inappropriate.

110. In relation to the oesophageal dilatation, my medical adviser confirmed that this required urgent attention, especially in light of Mr W's COPD and history of a collapsed lung, and should have been considered as a medical emergency. Therefore, I have concluded that the decision to discharge Mr W without carrying out this procedure was inappropriate. Accordingly, I **uphold** this aspect of the complaint.

Complaint (c)

111. My medical adviser said that the explanation provided by the Health Board in relation to the delay in arranging and carrying out the procedure is not adequate. As my medical adviser noted, cancer was not the issue. Mr W was losing weight due to malnutrition. As this was being caused due to his inability to swallow food, this should have been addressed quickly to alleviate his symptoms and prevent the risk of pulmonary aspiration, in accordance with national guidelines. However, this guidance was not followed and my medical adviser said that it is possible that Mr W aspirated. From the evidence I have seen it is clear that the failure to carry out this procedure at an earlier stage increased the risk of aspiration and it is also possible that Mr W's pneumonia may have been related to aspiration.

112. Although the Health Board said that aspiration pneumonia is not a feature of physical obstruction due to oesophageal stricture my medical adviser has confirmed that this is inaccurate and contradicts BSG guidelines. However, whilst it would appear that it is possible that this failing contributed to the problems that later emerged with Mr W's deterioration in health due to the complexity of his condition, I am unable to conclude with any degree of certainty that the ultimate tragic outcome could have been avoided but for this error. Accordingly, **I uphold** this aspect of the complaint to the extent that the oesophageal dilatation should have been carried out sooner.

Complaint (d)

113. From the information I have seen I am unable to conclude that the medical treatment received by Mr W was adequate. Firstly, there is little evidence that Mr W received adequate care from his consultant physician during his hospital admissions. After his readmission to the

Hospital on 18 May, Mr W received the majority of his care from junior grade staff. My medical adviser said that middle grade or senior chest physicians should have reviewed Mr W on a daily basis.

114. Mr W was reviewed by his consultant physician on 21 May (three days after his readmission) and again on 28 May, at which stage, arrangements for his transfer to Broadgreen Hospital were made. There is no evidence that a medical review of Mr W was carried out over the Bank Holiday period during 23 to 25 May. This was inadequate as Mr W's care appears to lack both the appropriate level of seniority and frequency that it would have been reasonable to expect in light of the serious nature of his condition and his continued deterioration. From the information I have seen and having had regard to the advice obtained from my medical adviser, I am of the view that this represents a significant clinical failing. Accordingly, **I uphold** this aspect of the complaint.

Complaint (e)

115. My medical adviser said that on admission to the Hospital Mr W had chronic lung disease with recurrent collapsed lungs. I have noted that in a referral letter from his GP of 16 March 2009 it appears that Mr W was described as having "respiratory failure – possibly end stage". Therefore it appears that Mr W had serious respiratory health problems prior to his admission to hospital. Accordingly, I am unable to conclude that there had been a noted improvement in Mr W's lung function and accordingly, I **do not uphold** this aspect of the complaint.

Complaint (f)

116. In relation to the delay in obtaining a second opinion on Mr W's condition from a thoracic surgeon, my medical adviser has said that this should have been obtained sooner and that national guidelines in relation to referrals were not followed. Following discussions with the family on 26 May and further discussions between the registrar and consultant physician on 27 May, it appears that first contact was made with Broadgreen Hospital. This was nine days after Mr W's readmission.

117. There is no evidence that the consultant physician reviewed Mr W between 21 May and 28 May. In these circumstances, it is very unlikely

that the consultant physician would have been sufficiently aware of Mr W's deteriorating condition. If Mr W had received more frequent input from his consultant physician, it may have led to concerns being raised at an earlier stage and possibly have led to an earlier discussion with Broadgreen Hospital regarding his condition. While once again I am unable to say that this would have necessarily changed the tragic outcome of Mr W's death, I agree with my medical adviser that it may at least have led to an earlier discussion between the consultants, which in turn may or may not have led to further specialist advice being obtained, for example, about the possibility of inserting a second chest drain, the repositioning of the chest drain already in place or the appropriateness of Mr W's transfer to Broadgreen Hospital at an earlier stage. Whilst therefore I am unable to conclude with any degree of certainty that the failings identified resulted in Mr W's premature death, there is no doubt that these failings have resulted in ambiguities which have caused an injustice to Mrs W by exacerbating her grief at the loss of her husband. Accordingly, I **uphold** this aspect of the complaint.

Complaint (g)

118. Turning to the issue of the delay in transferring Mr W to Broadgreen Hospital, this is a complicated issue. While certain inadequacies with the frequency of Mr W's medical reviews have been identified by my medical adviser (which are discussed later on in my report), I am unable to conclude that these inadequacies directly resulted in a delay in transferring Mr W to Broadgreen Hospital. My medical adviser has said that the transfer on 28 May was inappropriate. However, this does not mean that an earlier transfer would have been more appropriate, or again, would have changed the tragic outcome. As noted by my medical adviser, it seems unlikely that earlier referral to Broadgreen Hospital for treatment would necessarily have altered the outcome as Mr W's chronic lung disease made consideration of any surgery difficult and unlikely. Also, there is evidence to suggest that he had already developed pneumonia, although there appears to be some delay in this diagnosis. Therefore, I am unable to say with any certainty that if the consultant physician had been aware of Mr W's deteriorating condition sooner and had made contact with Broadgreen Hospital, an immediate transfer would have been arranged.

119. In light of this, I am not persuaded that the lack of input by Mr W's consultant physician resulted in the delay in his transfer. However, I do agree with my medical adviser that at the very least, contact between Mr W's consultant physician and the thoracic surgeons at Broadgreen Hospital should have been established at an earlier stage, as this would have facilitated earlier consideration of the possibility of transferring Mr W to Broadgreen Hospital prior to 28 May. Whilst it may be that evidence of earlier contact with Broadgreen Hospital would assist in allaying Mrs W's concerns about her husband's transfer, I cannot conclude that a failure to do so was as clinically significant as Mrs W believes. Accordingly, I **do not uphold** this aspect of the complaint.

Complaint (h)

120. While I am unable to conclude that there was a definite delay in transferring Mr W, I have concluded that he was critically ill on 28 May and too unwell to make the journey. My medical adviser has said that the transfer on 28 May was inappropriate, that Mr W's fitness to travel should have been discussed with ITU staff and that the transfer should have been cancelled because of his deteriorating condition. The letter from the thoracic surgeon at Broadgreen of 3 June confirms that Mr W was extremely unwell when he arrived and that his left lung was completely collapsed. I understand that the evidence shows that this occurred between leaving the Hospital and reaching Broadgreen Hospital. However, Mr W's medical records clearly demonstrate that his chest x-ray on 28 May showed extensive consolidation, that his CRP measurement exceeded 200mg per litre (normally at 10mg per litre) representing pneumonia and also, that his heart rate was elevated at 145 BPM, I am therefore unable to agree with the Health Board's comments that Mr W was not critically ill and could reasonably be thought well enough to make the journey without suction. Accordingly, I **uphold** this aspect of the complaint.

Complaint (i)

121. In relation to the ambulance transfer and Mrs W's comments that the crew fought to save her husband's life, the paramedic has confirmed that Mr W's condition did not deteriorate to a level that required a further set of observations being undertaken or an entry in the narrative of the records and these are the two actions he would have considered had Mr

W deteriorated further during the transfer. Therefore, I am unable to conclude that Mr W's condition deteriorated to a state which required intervention by the crew during the ambulance transfer. Accordingly, I **do not uphold** this aspect of the complaint.

Complaint (j)

122. I have concluded that in general, the nursing care and treatment provided to Mr W during both admissions was of a reasonable standard. Having said that the majority of the records made by nursing staff were of a good standard, there are significant omissions, which have been highlighted by my nursing adviser. In relation to the issue of the chest drain, my nursing adviser noted there is no documented evidence to confirm that a qualified nurse checked the tubing to Mr W's chest drain after it had fallen out on 23 May to ensure that it was working effectively and that appropriate clinical observations were carried out on Mr W after this incident. Although there is no evidence to allow me to conclude that the reconnection of the tubing by the HCA was carried out incorrectly, nor that the failure to increase overnight observations was clinically significant in respect of the ultimate outcome, I am unable to conclude that appropriate nursing care was provided to Mr W in relation to the management of his chest drain, as the Hospital failed to follow national guidelines in this respect. Accordingly, I **partly uphold** this aspect of the complaint.

123. In summary, it is clear from the professional advice that I have received that Mr W should not have been discharged from hospital on 14 May without carrying out the operation to stretch his gullet. Mr W's oesophageal stricture should have been treated as a medical emergency to alleviate his symptoms, to assist him with eating and drinking and to reduce the risk of aspiration in accordance with national guidelines. There was a failure to adequately monitor Mr W's condition once readmitted with the same swallowing difficulties and carry out the necessary chest x-rays and CRP measurements. The lack of input of Mr W's consultant physician in his care also appears to have resulted in the delay in identifying Mr W's pneumonia. It also meant that earlier discussions with thoracic surgeons at Broadgreen Hospital on a consultant to consultant basis were not facilitated. There was a failure to consider Mr W's transfer to the ITU at the Hospital. Instead,

arrangements were made for Mr W transfer to Broadgreen Hospital at a time when he was critically ill. Finally, there was also failure to involve middle grade or a senior staff member in the decision to insert/the insertion of the chest drain, in accordance with national guidelines.

124. From the information I have seen therefore, it is difficult to reach any conclusion other than that there are a significant number of examples of poor and delayed decision-making, coupled with, on occasion, a failure even to give consideration to an appropriate option. This was most likely due to the lack of consultant involvement in Mr W's care.

Recommendations

125. **I recommend** that, within 28 days of this report, the Health Board provides an apology to Mrs W for the failures that have been identified and for the additional distress caused by its failure to recognise the shortcomings that occurred in the care provided to Mr W at an earlier stage. I also recommend that the Health Board should pay £500 to Mrs W in recognition of the time and trouble taken to pursue her complaint.

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

- The Health Board reviews its policy and procedures for nurse management of chest drains, ensuring these are in line with best practice.
- The Health Board addresses the issue of nurse training in the management of chest drains and confirms the exact content of future training that will be provided to its staff in relation to this issue. All ward staff should be reminded of the requirements of the British Thoracic Society's Guidelines regarding the insertion of chest drains by staff specifically trained in chest drain management.
- The Health Board reviews its decision to discharge Mr W on 14 May and the reasons for failing to relieve the oesophageal stricture by oesophageal dilatation which should have been considered as a medical emergency. All relevant staff should be reminded of the guidelines on the use of oesophageal dilatation in clinical practice.

- The Health Board carries out a hospital audit of acute care setting to satisfy itself that there is adequate direct consultant involvement in the care that is provided.
- The Health Board carries out an urgent review of its weekend cover policy and implements an appropriate operational policy and procedure regarding medical cover particularly over Bank Holiday periods.
- The Health Board reviews and standardises its decision making process and policies for the transfer of seriously ill patients to other hospitals, having regard to the condition of the individual patient.

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

Peter Tyndall 4 October 2011
Ombudsman

Appendix A
(In parts A1 and A2)
Medical Advice

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

As a consultant physician of more than 20 years experience I am appropriately qualified to review this case which involved the management of pneumothorax (collapsed lung), oesophageal stricture (a narrowing of the throat) and pneumonia, possibly due to aspiration (food falling in to the lungs).

I do not know any of the individuals in this case and there is no conflict of interest.

Documentation Reviewed

I have reviewed the relevant hospital's medical records, the correspondence from the complainant and the Health Board's responses. Guidelines from the British Thoracic Society and British Gastroenterology Association are included. If you think it would be appropriate or helpful I can provide references/guidelines for the following:

GMC - consultants' responsibility for their juniors
- referring to other consultants
RCP - hospital 'out of hours service'
NICE - acutely ill patients in hospital
NCEPOD - late referrals

Introduction

This case concerns the care provided to 67 year old Mr W who had chronic lung disease with recurrent pneumothoraces (collapsed lungs), and who also had dysphagia from a benign oesophageal stricture.

A chest drain to re-inflate his lung failed to improve his condition and he was transferred to Broadgreen Hospital where he died shortly afterwards.

Mrs W's concerns include:
1. The lack of care provided to Mr W during his admission. Mrs W had said that this led to a dramatic deterioration in her husband's condition.
2. Why a second opinion on Mr W's condition was not obtained sooner.
3. Why Mr W's transfer to Broadgreen Hospital did not happen sooner. Mrs W had said that Mr W was too ill to make the journey by the time he was transferred.
4. Concerns regarding the positioning of Mr W's chest drain and why it came out. It was not re-inserted by a qualified doctor.

Further advice is sought by the Ombudsman's office whether each of Mrs W's concerns as set out above are valid.

In addition
1. Was the care and treatment provided to Mr W reasonable and/or appropriate?
2. Was there a delay in obtaining a second opinion on Mr W's condition? Is the explanation given for this issue adequate? Would Mr W's chances of survival have increased if this opinion had been obtained sooner?
3. Was there a delay in Mr W's transfer to Broadgreen Hospital? Is the explanation given for this issue adequate? Was Mr W too ill to make the transfer and similarly did the decision to transfer on 28 May have a negative impact on his chances of survival?
4. Are there any action(s) that the clinicians involved in Mr W's care should have taken that was not and/or should have been done differently?
5. Generally, are the Health Board's explanations given to Mrs W adequate and/or are there any outstanding clinical issues that have not been addressed?
6. Is the Health Board's explanation regarding the family's concern about Mr W's oesophageal dilatation (stretching procedure) and the apparent communication shortfall in relation to this adequate? Did the failure to carry out this operation contribute to the problems that later emerged?
7. Is the Health Board's explanation regarding the family's specific concerns about the chest drain adequate?
8. Any further comments you any have.

Clinical Summary

Mr W aged 67, presented with a pneumothorax in 2003 and at that time chronic obstructive pulmonary disease (COPD) was diagnosed. From the medical notes it would appear that Mr W had been admitted in February/March 2009 with a right pneumothorax and a chest drain was inserted and later pleurodesis (procedure to prevent further pneumothorax) was undertaken with good effect.

Mr W was admitted on 28 April with a 24 hour history of increased breathlessness and coughing green sputum. It was reported that Mr W used home nebulisers, but he had not had any admissions to ITU and had not previously required BIPAP (non-invasive ventilation).

He was considered to have an infective exacerbation of COPD and dysphagia. There had been significant weight loss. He underwent an endoscopy (telescope examination of the stomach) on 13 April which showed a tight oesophageal stricture with ulceration. Cytology was obtained (possibly after discharge) showing the stricture was benign with no malignancy and there was chronic inflammation with candida (fungal) infection. Dilatation of the stricture was not undertaken during this hospital admission. The consultant physician discharged Mr W on 14 May.

His dysphagia did not improve and he was readmitted at his GP's request on Monday 18 May only able to swallow liquids with difficulty. His blood was low at 95/50 suggesting dehydration and the registrar reviewed him on his ward round. He was transferred to a respiratory ward with the intention that oesophageal dilatation would be undertaken.

There was no medical review on 19 May.

A retrospective medical entry on 20 May describes Mr W developing acute breathlessness, which proved to be related to a further pneumothorax. The duty SHO inserted a chest drain through the left axilla which led to an improvement in Mr W's oxygen saturations from 67% to 90% on 35% inspired oxygen.

It is reported there was good but not complete lung expansion which is confirmed on the chest x-ray.

The consultant physician reviewed the patient at 09.50 hours on Thursday 21 May and a decision made to apply suction at 2kPa (this denotes the rate of pressure that suction was to be applied). The left pneumothorax was still present and had not fully re-expanded. The drain might need repositioning if there was not complete expansion or there was any reduction in the bubbling which was ongoing. The tip of the drain was directed towards the sternum on the chest x-ray. There was a question of inserting another chest drain into the second left intercostal space. Over the next few days there was continued bubbling through the chest drain implying a persistent air leak.

The next consultant review appears to have been on Thursday 28 May after contact had been made with Broadgreen Hospital and arrangements were made to transfer Mr W on the same day.

Mrs W's issues

1. Overall the care provided to Mr W during his admission was not adequate. It was insufficiently intensive. Mr W was re-admitted only two to three days after discharge with the same symptoms of dysphagia. He was unable to swallow solid foods and reportedly had difficulty swallowing liquids. He should not have been previously discharged home before oesophageal dilatation. The Health Board has not addressed this issue adequately. There would be a significant risk of aspiration which, particularly in a patient with severe COPD this would have serious adverse consequences.

During Mr W's final admission to hospital he developed a further pneumothorax. A SHO inserted a chest drain and discussed this with the registrar afterwards. It does not appear there was any middle grade or senior staff involved in the decision to insert the chest drain who should undertake this procedure. It is unusual for a SHO to insert the chest drain.

There were no documented medical reviews on 19, 23 and 25 May. It is

documented that he was only reviewed by the consultant chest physician on the two Thursdays, 21 and 28 May.

There does not appear to have been any middle grade or senior review between 20 and 26 May. The clinicians were reassured by the continuing ‘bubbling’.

2. A second opinion on Mr W’s condition was first considered on 27 May after telephone discussions between the junior doctor, the registrar and the consultant physician.

The consultant physician did not review the patient between 21 and 28 May and would not have been aware that the patient’s condition was not improving.

The consultant physician has responded to this issue stating that guidelines for pneumothorax recommend transfer to a thoracic surgeon after 5 to7 days of a persistent leak. However, this comment is not entirely correct as indicated later in a reference. Nonetheless, Mr W’s co-existing chronic lung disease would have made any major thoracic surgery, requiring general anesthetic, very dangerous, and unlikely to have been undertaken.

The consultant physician restricted his review of the patient to his formal ward rounds (presumably Monday and Thursday, and Bank Holiday Monday missed). However, Mr W required more intensive and specialist input from his consultant physician.

A second opinion should have been obtained earlier, but not necessarily the patient’s transfer to Broadgreen Hospital. Consultant to consultant discussion might well have sufficed.

3. Mr W’s transfer to Broadgreen Hospital on 28 May would appear to have been inappropriate.

Contact between the two departments should have been at a consultant level and held earlier.

Mr W's fitness to travel could/should have been discussed with ITU staff. The transfer either should have been cancelled because of his deteriorating condition, or, it should have been arranged earlier.

It is apparent from the consultant thoracic surgeon at Broadgreen Hospital that Mr W arrived at the Hospital in an extremely unwell condition according to his letter dated 3 June 2009. Indeed he states that the left lung was completely collapsed and a further intercostal drain was inserted.

A chest x-ray on 28 May shows extensive consolidation and the CRP exceeded 200mg/l, representing pneumonia. His heart rate was 145 and temperature 38. Intravenous ciprofloxacin (an antibiotic) was administered (empirically). The patient's left lung appears to have collapsed completely between leaving Ysbyty Gwynedd and reaching Broadgreen Hospital.

The Health Board's response to this issue is not appropriate. For instance pneumonia was only diagnosed on 28 May and antibiotics administered, so the comment 'his bronchopneumonia was not improving' is not relevant. Earlier and more frequent chest x-rays and CRP measurements would have detected pneumonia before 28 May.

Mr W was critically ill on 28 May as indicated by the medical entry on 28 May.

4. There is no evidence that Mr W's chest drain fell out and that it was reinserted by a nurse. It may be that tubing attached to the drain, which was sutured to the skin, become disconnected, and then needed to be secured.

Ombudsman Questions

Mrs W's concerns are relatively valid except for issue 4.

1. I have addressed the care and treatment provided to Mr W above. The oesophageal stricture should have been treated during the previous

hospital admission. The presence of this tight stricture and consequent difficulty swallowing would increase the risk of aspiration with potential fatal consequences in a patient with severe underlying respiratory disease.

2. The patient's chest did partly expand, but not completely, following insertion of the chest drain. He had severe underlying chronic obstructive airways disease and his improved condition was variable.

The final chest x-ray on 28 May reveals extensive consolidation (pneumonia)/collapse, which would be consistent with aspiration, and almost certainly contributed to his final deterioration. This is confirmed by his CRP (C-reactive protein, measure of infection/inflammation, normally less than 10mg/I), which measured 231mg/I. He died shortly after arriving in Broadgreen Hospital.

Expert advice regarding the persistent leak was required. However, it seems unlikely that earlier referral to Broadgreen Hospital for treatment of the patient's pneumothorax would necessarily have altered his outcome. He had already developed pneumonia (belatedly diagnosed) in the Hospital. However, no explanation has been provided for the thoracic surgeon's statement that the patient's lung was completely collapsed on arrival in Broadgreen Hospital.

Reference
Henry M, Arnold T, Harvey J,
Thorax 2003
BTS guidelines for the management of spontaneous pneumothorax.
Referral to thoracic surgeons
- for secondary pneumothorax (patients with pre-existing lung disease), significantly earlier referral, to thoracic surgeon (2-4 days) should be considered for those with underlying disease, a large persistent air leak, or failure of the lung to re-expand.

3. This issue is similar to 2.

Earlier discussion with thoracic surgery at Broadgreen Hospital was justified, but earlier transfer would have been unlikely. Mr W's chronic

lung disease made any consideration of surgery difficult and unlikely. However, advice regarding a second drain or repositioning of the in situ drain might have been considered or suggested.

Mr W was too ill to be transferred on 28 May and this appears to have been a poor decision which is inferred in the consultant thoracic surgeon's letter.

The consultant thoracic surgeon states that the patient's lung was completely collapsed on arrival in Broadgreen Hospital. Therefore something happened at the time of the journey or during the journey, which had a negative impact on his health. His prognosis was compromised by severe underlying chronic respiratory disease.

Hospital acquired pneumonia developed which may have been related to aspiration, or incomplete re-expansion of the lung and the diagnosis appears to have been delayed.

His clinical deterioration in the Hospital on 27/28 May was related to pneumonia.

The alternative arrangement would have been to transfer Mr W to Intensive Care in hospital be stabilised. This should have been considered.

4. Junior medical staff should have reviewed the patient on a daily basis including the weekend.

The respiratory registrar should have been more involved.

25 May was a Bank Holiday Monday which presumably explains the lack of medical attention received by Mr W on 23, 24 and 25 May. A SHO only reviewed the patient (at 10.00 pm?) on 24 May at the request of nursing staff.

No weekend plan appears to have been in place. There was no pro-active planned review of the patient by the ITU Team, the duty medical registrar or the duty consultant physician.

The responsible consultant physician should have been more closely involved, possibly on a daily basis. And, if absent, he should have arranged appropriate covering medical attention for the patient.

There was a delay identifying pneumonia manifested by the elevated CRP and radiological changes on 28 May.

Two chest x-rays were undertaken on 20 May, before and after insertion of the chest drain. A chest x-ray on 26 May revealed the lung was still well inflated. The chest x-ray on 28 May revealed consolidation in the left lower zone.

In addition, all these x-rays indicate soft tissue shadowing on the lateral aspect of the left lung with 7th rib destruction suggestive of malignancy.

Mr W should have been considered for transfer to ITU if there were insufficient medical staff.

5. The oesophageal stricture should have been dilated during the previous admission and the patient was inappropriately discharged home. A chest x-ray should have been undertaken on the day of admission. The middle grade or senior chest physicians should have reviewed this patient on a daily basis.

If the consultant physician had undertaken more regular reviews and if he had any concerns he could have made contact with Broadgreen Hospital consultant to consultant earlier.

Reference
This reference provides advice on the insertion of a chest drain.
British Thoracic Society, December 2008
Chest drain insertion - improving patient safety
- only inserted by staff with relevant competencies
- ultrasound strongly advised
- written evidence of consent obtained from patients
These guidelines were produced following concerns from the NPSA Rapid Response Report, 2008

6. Mr W's tight oesophageal stricture was a medical emergency and should have been addressed during the hospital admission from 28 April to 11 May.

The Health Board's response is not adequate. Cancer was not the issue (and histology was not available or documented at the time of his discharge). Mr W was losing weight due to malnutrition due to an inability to swallow food.

It is possible that Mr W aspirated. He was certainly at high risk of aspiration.
Reference
Guidelines on the use of oesophageal dilatation in clinical practice Riley SA, Attwood SEA,
GUT 2004
- primary aim of oesophageal dilatation is to alleviate symptoms, permit maintenance of oral nutrition and reduce risk of pulmonary aspiration.

7. Yes.

The specific concerns of the family regarding the chest drain have been adequately addressed.

8. There is little evidence of a consultant-delivered or even consultant-led service.

There was no pro-active review of, or plan for, this patient over a Bank Holiday weekend.

Pneumonia should have been detected earlier.

Recommendations

1. The Health Board should review the decision to discharge Mr W on 14 May and the reasons for failing to relieve the patient's oesophageal stricture by oesophageal dilatation, which should have been considered a medical emergency.

2. The lack of consultant chest physician involvement in Mr W's care requires review. It probably resulted in the delayed discussion with thoracic surgeons at Broadgreen Hospital.

Most consultant job plans would require minimal twice-weekly ward round.

3. Weekend cover, particularly involving Bank Holidays, requires urgent attention by the Health Board.

4. The decision, condition of the patient and medical/nursing escorts regarding the transfer of seriously ill patients to other hospitals requires review and standardisation.

Conclusions

This is a complicated case.

More urgent attention to the oesophageal stricture was needed.

Earlier discussion with thoracic surgery in Broadgreen Hospital was indicated, on a consultant-to- consultant basis.

Much more frequent medical supervision at all levels was required for this ill patient throughout his hospital admission.

There was no obvious weekend plan, especially for a Bank Holiday, for this patient. Mr W was not sufficiently well to be transferred, and the reason for transfer is unclear. Mr W's arrival in Broadgreen Hospital with a completely collapsed lung has not been explained.

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

Documentation Reviewed

The Health Board's response dated 16 May 2011.

Questions and Responses

It is acknowledged that Mr W had severe lung disease (COPD) and his life expectancy was reduced as a consequence. However, at the time of his transfer to Broadgreen Hospital the severity of his background COPD was described as moderate. Furthermore, on 27 May the patient was described as previously independent and mobilising over 50 to 100 yards. The consultant physician contradicts these comments, which are documented in the medical records and were relayed to Broadgreen Hospital, in the Health Board's response.

It is inaccurate to state that aspiration pneumonia is not a feature of physical obstruction due to oesophageal stricture. This comment contradicts BSG guidelines.

1. Inappropriateness of Mr W's discharge on 14 May

Mr W had a tight oesophageal stricture. He had been admitted on 28 April with a chest infection. He had lost two stone in weight since Christmas. On 29 April the "family wanted to speak to the medical team and his wife was very concerned regarding dysphagia and weight loss 2 stone" and "very concerned he was unable to eat and losing weight progressively". An albumin measuring 31g/l is reduced and would support malnourishment. It should not be considered in isolation as a measure of nutrition, without the weight loss and BMI being considered.

The risk of pulmonary aspiration in a patient with severe COPD is potentially fatal. Mr W's chest infection on his first admission may or may not have been related to aspiration, but this possibility should have been considered.

The inappropriateness of Mr W's discharge on 14 May is emphasised by

his readmission with severe dysphagia only 72 hours later. The oesophageal stricture did not worsen over such a short period.

At the time of his discharge there was no appointed date for oesophageal dilatation. The dietician's entry in the medical records on 11 May also includes "weight 43.4 kg, patient states rather worried about swallowing and having to wait for OGD. Will monitor weight and review".

2. Concerns regarding lack of input from middle and senior grade doctors

During Mr W's first hospital admission, the registrar reviewed him on the ward round on 28 April. He did not receive a further consultant review until 7 May, which was by the consultant physician, who then reviewed the patient again on 11 and 14 May before his discharge on 14 May.

The lack of consultant review between 28 April and 7 May has not been explained.

During the second hospital admission from 18 May onwards, the consultant physician reviewed the patient on 21 May and 28 May. There was no documented medical review on Tuesday 19 May. A medical registrar reviewed Mr W on 21 and 28 May (both Fridays). On 26 May the registrar asked to speak to the family and reviewed the patient. The consultant physician's ward rounds appear to be on Monday and Thursday and no allowance is made for Bank Holiday Mondays.

The chest drain was inserted by a SHO on the evening of 20 May without prior discussion with either the registrar or the consultant.

The registrar did discuss Mr W's situation with the consultant physician on 27 May. The consultant physician's comments on 21 May "may need intercostal drain in second left intercostal space, if persistent pneumothorax. If continuing bubbling, withdraw chest drain slightly" does not appear to have been undertaken or certainly not documented.

3. Lack of urgency with operation to stretch Mr W's gullet

It was not possible to undertake this procedure during the second hospital admission and my concerns relate to the previous hospital

admission. Mr W's tight oesophageal stricture should have been regarded as urgent because of the risk of aspiration and the evidence of severe malnourishment with two stone weight loss over the previous few months. The risk of aspiration pneumonia is hugely important in a patient with severe lung disease. The consultant physician has not acknowledged BSG guidelines.

4. Concerns regarding Mr W's transfer to Broadgreen Hospital on 28 May

Concerns about the hospital transfer include:

a) If the transfer was indicated, then it should have occurred earlier.

b) Pneumonia had developed and it is unclear how long this had been present. The patient was septic. The CRP measured 231mg/l (C-reactive protein, measure of infection/inflammation, normal value less than 10mg/l) on 28 May with no previous recent measurement. The consultant physician does not mention the CRP.

c) The response from the Health Board that discussion with Broadgreen Hospital and the bed manager regarding fitness for transfer is not appropriate. The decision was required to be made by the referring physicians. An ITU assessment would have provided additional expert advice prior to the transfer. Mr W was severely hypoxic (deprived of oxygen) on 40% inspired oxygen.

d) Suction was discontinued leading to lung collapse during the transfer. The Health Board's comment regarding the difference between critically ill and extremely unwell is unclear. On the day of transfer Mr W's condition had significantly deteriorated, probably in relation to pneumonia, which had developed. This issue does not appear to have been a consideration at the time of transfer.

The registrar communicating with Broadgreen Hospital stated that Mr W had a "background moderate COPD", and "previously independent, mobilizing over 50-100 yards". However, FEV1 32% represents severe lung disease.

The decision to transfer was discussed with the consultant physician, who agreed the patient could be transferred to Broadgreen Hospital without suction.

Summary

Mr W was at constant risk of aspiration and remained severely malnourished from his tight oesophageal stricture. Despite only managing to swallow small quantities of water, oral nutrition and fluids were still being encouraged.

Mr W's eventual transfer to Broadgreen Hospital was too late. He was ill with pneumonia, severely hypoxic and he appears to have been too unwell for the transfer.

Discontinuing suction contributed to or caused collapse of Mr W's lung and a further deterioration in his condition.

The consultant physician's advice regarding adjustments to the chest drain on 21 May was not followed.

Advice from critical care clinicians was not requested.

Conclusions

The Health Board's response to my initial advice does not clarify the concerns raised.

The Health Board's response is uncompromising and does not seem to acknowledge any deficiency of care provided to Mr W.

Appendix B
(In parts B1 and B2)
Nursing Advice

Nursing Advice **Appendix B1**
Cherilee Angland
Registered Nurse

I am a Registered Nurse (Adult) with 15 years experience in general adult nursing. I have a breadth of experience across secondary and primary care provision in a number of settings including 6 years as a COPD Specialist Nurse. I confirm that I am qualified and informed to provide advice on this case.

I have no conflict of interest with this case and do not know any of the parties involved.

I have reviewed the relevant hospital's medical records, the correspondence from the complainant and the Health Board's responses available to me.

I note that you are requesting both general physician advice and general nursing advice. My colleague Dr McGonigle has provided a thorough clinical summary and responses to all the questions posed by the assessor. I therefore shall not be repeating this here.

Having discussed the case with the Ombudsman's Investigator it was identified that a nursing response to question 1 and 7 only were required.

1. Was the care and treatment provided to Mr W reasonable and or appropriate from a nursing care opinion?
The nursing care provided to Mr W for the above admission appears to be appropriate.

For admission 28 April to 14 May 2009
The nursing care provided to Mr W for the above admission appears to be appropriate.

Patients with chest tubes should be managed on a specialist ward by staff who are trained in chest drain management.
Several complications can occur when managing a patient with a chest tube. If the tubing becomes disconnected from the drainage system, if untreated, this could allow air to enter the lung which can alter the pressure in the lung. When this pressure changes because of excess air the lung may collapse again. There is also an added risk of infection being introduced into the chest cavity.

In view of the otherwise well documented episodes of care for this gentleman it is reasonable to expect documented evidence that the drainage system and patient had been checked by a qualified nurse with specific reference to the tubing being secure and working effectively as required for the assessment chart in use on the ward. It is also reasonable to expect an increase in frequency of clinical observations during the night in question to monitor for signs of deterioration.

Recommendations

That the Health Board review its policy and procedures for nurse management of chest drains, ensuring these are in line with best practice. It would also be beneficial to know what training nurses are given in the management of chest drains.

Conclusions

On the whole the nursing care and management of Mr W was reasonable and appropriate. On the issue of the chest drain management following the tubing being dislodged I am unable to categorically state that appropriate care was given due to the lack of documented evidence.

Nursing Advice **Appendix B2**
Cherilee Angland
Registered Nurse

Further to my original advice of 8 February I have reviewed the Health Board's letter dated 16 May.

Questions and responses

I note you are requesting further advice from Dr McGonigle and I further to our initial findings.

Having discussed the case with the Ombudsman's Investigator it was identified that a nursing response to question 4, concerns regarding Mr W's transfer to Broadgreen Hospital on 28 May, in regard to the appropriateness of escort on transfer from Ysbyty Gwynedd to Broadgreen Hospital was required.

The Health Board has stated in its letter of 16 May page 5 paragraph 3 that a trained escort was to accompany Mr W to Broadgreen Hospital and that this is reflected with the nursing documentation and on enquiry from the Welsh Ambulance Service NHS Trust (the WAST).

This is supported by the available documentation within the medical note dated 27 May at 14.25 as it states "will need trained staff to go over". The nursing notes dated 27 May states "for transfer with nurse escort in paramedic ambulance". The referral to the WAST received 28 May states that a trained nurse escort would be accompanying the patient. This is also confirmed by WAST as having taken place.

The use of a trained nurse escort to accompany Mr W in the paramedic ambulance is entirely appropriate and reflects good nursing care.

Conclusions

It was entirely appropriate and good practice for a trained nurse to escort Mr W to Broadgreen Hospital. No concerns on the nursing management have been identified in this area.