The investigation of a complaint by Ms R against Hywel Dda Local Health Board

A report by the Public Services Ombudsman for Wales

Case: 201100456

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 Ms R.

Summary
Ms R complained about Hywel Dda Health Board ("the HB"). Her complaint related to treatment that her late father received at Bronglais Hospital ("the Hospital") in December 2008 and subsequent events. Ms R said that her father was admitted to Hospital after becoming unwell aged 80 years. Among other matters, Ms R complained that the Hospital failed to record important information about his diabetic regime and did not monitor his blood sugar properly. She added that there was evidence to suggest that nursing staff amended the records of her father's blood sugar monitoring to hide their failures. Ms R explained that sadly her father had a hypoglycaemic attack during the period of poor monitoring, which she believed contributed to a cardiac arrest. Her father died a few months later. Ms R added that the response to her complaint by the predecessor body to the HB and later the HB, was not robust.

The Ombudsman upheld Ms R's complaint. He concluded that the Hospital did not record and therefore act upon, important details about her father's diabetic regime and failed to monitor his blood sugar levels properly. The Ombudsman found that the hypoglycaemic attack, to which the Hospital's failings contributed, had an unspecific causal effect on the patient's subsequent cardiac arrest and deterioration. The Ombudsman also concluded that there appeared to be a deliberate attempt to cover up the lack of blood sugar monitoring. He found the internal complaint investigations, that took place before his involvement, were inadequate.

The Ombudsman made a number of recommendations to the HB. These included paying Ms R and the family a total of £1700 as an acknowledgement of the uncertainty and distress over how the failings might have contributed to her father's demise and the extensive time that they had spent pursuing the complaint. He also recommended various systemic reviews, audits and training. The HB undertook to implement his recommendations.

The complaint

1. With the help of the Community Health Council ("the CHC"), Ms R complained about the former Hywel Dda NHS Trust ("the Trust"). She said that she took that role on behalf of the family of her late father, Mr T, most notably her siblings and Mrs T, Mr T's widow. In October 2009, the newly formed Hywel Dda Health Board ("the HB") took over the Trust's responsibilities as part of NHS re-organisation in Wales.

2. Ms R's complaint concerned treatment that her father received at Bronglais Hospital ("the Hospital") in December 2008. Ms R said that the Hospital admitted Mr T in the early hours of 22 December 2008 after he visited A & E. Ms R outlined the critical events as follows. Mr T, who was 80 years old at the time, presented with general feelings of illness and left sided weakness. On the acute Ward, Mr T started receiving antibiotics for an infection. In the early hours of 23 December, Mr T, who suffered from insulin-controlled diabetes, became hypoglycaemic. This means that the sugar levels in his blood dropped too low. As a result of this episode, Mr T vomited. He aspirated his vomit (inhaled it into his lungs) and suffered a respiratory and cardiac arrest. This left him severely debilitated. Thereafter, he required 24 hour nursing care. In April 2009, the Hospital discharged him to a nursing home. Mr T sadly died there a few days later, aged 81.

3. Mr T's family complained about his care to the Trust. They have been through extensive local resolution and an independent review. However, they remained dissatisfied with the explanations that they received from the Trust/HB and the actions that resulted. Their central concern is that trained nurses, in an acute setting, allowed Mr T's blood sugar levels to fall to a dangerously low level. Ms R outlined a number of misgivings that she regarded as unresolved. She asserted that these were contributory factors to the central failing. She set these out as follows:

- Lack of staff access to Mr T's medical records on admission.
- Inaccurate and incomplete admission documents.

- A recorded, but inappropriate, diagnosis of dementia, which may have contributed to staff misinterpreting early signs of hypoglycaemia.
- Staff shortages, which meant that Mr T's blood sugar was not monitored properly.
- Absence of food charts for vulnerable diabetic patients.
- Failure to recognise individual requirements of patients, which do not fit with an institutionalised regime (in Mr T's case, the unmet need for a late evening snack).

4. In addition to the above, Ms R stated that there was evidence of tampering with the records to cover up nursing failures. She said that the clinical records indicated that a staff member had completed an entry in a chart relating to Mr T's blood sugar levels, later than was apparent, with false information. Ms R stated that the HB had lost the original version of this chart.

5. Ms R maintained that the Trust/HB had not fully acknowledged its failures. Therefore, it had not taken sufficient remedial action or allowed the family to find closure. Ms R said that Mr T died because of his poor care in the Hospital and had a miserable last few months. She said that the effect on the family was "catastrophic".

Investigation

6. The investigation started on 23 June 2011. My Investigator obtained comments and copies of relevant documents from the HB. I considered those in conjunction with the evidence provided by Ms R. I have taken due account of the advice of two of my professional advisers: a Medical Adviser and a Nursing Adviser. My Medical Adviser is a Consultant Physician with many years experience working in an acute setting. His name is John Dawson. My Nursing Adviser is a Senior Nurse with extensive experience in acute care at a senior level. Her name is Lindsey Etherington. Both Ms R and the HB have had an opportunity to comment on a draft version of this report.

7. I have not included every detail investigated in this report. However, I am satisfied that nothing of significance has been overlooked.

Hypoglycaemia

8. Hypoglycaemia is the medical word for when a person's level of sugar in their blood falls too low. This means the body lacks the energy to perform effectively. Causes are often unknown. Generally, it occurs when the level of insulin is too high in relation to the food that is consumed. A blood sugar level of less than four percent glucose (sugar) is regarded as hypoglycaemia. A hypoglycaemic episode usually has symptoms such as vomiting, dizziness, confusion, sweating and trembling. Immediate treatment can include taking glucose. If untreated it can cause a person to have a seizure or lose consciousness.

The background events

9. At 00.47am on 22 December **2008**, Mr T was taken by ambulance to the Hospital's A & E unit. Mr T's wife and his daughter, Ms R, accompanied him. Records indicated that Mr T's blood sugar had dropped low before he was taken ill at home. His wife had fed him with a sandwich and a drink to deal with this. However, the records show that it was concerns about Mr T's left sided weakness that prompted his family to seek medical help. Whilst in A & E, staff assessed him. They found that he had a raised temperature. However, he was fully aware of his surroundings, had stable blood sugar at 6.2 and was not demonstrating signs of a stroke. Other physiological observations were within normal limits.

10. At 3.20am, Mr T was transferred to the Ward. The medical records indicate that Mr T was possibly suffering from a urinary tract infection. The planned treatment was intravenous antibiotics.

11. According to the blood sugar monitoring chart that the family supplied to me, Mr T's blood sugar was 10.7 at 4.30am on 22 December. A reading of 11.7 at 6.55am followed.

12. Untimed entries in the nursing and medical records indicated that the Hospital's Diabetes Consultant ("the Consultant") decided to continue with antibiotics. The entries also showed that insulin was to be given but she instructed that nurses should reduce the dose if Mr T became hypoglycaemic. The Consultant requested four hourly monitoring of Mr T's blood sugar levels. She arranged for a urine

sample to be tested in the laboratory. A later untimed entry (which seems to be in relation to the late evening of 22 December) said that Mr T was “confused” and “uncoordinated”.

13. Further blood sugar measurements for 22 and 23 December were included on the chart as follows.

12.30pm	5.1
5.20pm	6.6
11.00pm	9.3
1.30am	1.5
2.00am	1.3

The 11.00pm entry was overwritten and is difficult to read. It was the only unsigned entry on that chart. The chart includes a graph to illustrate the rise and fall of the patient’s blood sugar levels. It is clear that the 5.20pm and 1.30am entries on the graph link together as if the latter was the next reading after the former. The 11.00pm entry does not link up with anything on the graph.

14. After the 1.30am entry, nursing staff gave Mr T glucose by mouth. After the 2.00am entry, staff provided glucose to Mr T intravenously. An entry on the chart for 2.30am showed Mr T’s blood sugar level at 10.7.

15. According to the nursing records, Mr T collapsed with a cardiac arrest at 4.10am on 23 December, whilst being examined by a doctor. The medical records stated that prior to the cardiac arrest, Mr T was short of breath and agitated. They also said that Mr T vomited before becoming unresponsive. Hospital staff resuscitated him. However, after this episode, his general physical and mental condition deteriorated significantly. He sadly died on 5 April 2009 soon after the Hospital discharged him to a nursing home.

16. On 26 January **2009**, Ms R wrote to the Consultant. The letter referred to a meeting between the two, a few days earlier. The letter said that the family visited Mr T on 22 December. It stated that Mr T was “alert, chatty and complaining about the food”. It added that early on the

morning of 23 December, her mother had taken a telephone call from the Hospital. Ms R said that a nurse had informed her mother that Mr T became hypoglycaemic and when laid flat to re-fit a cannula (a tube used for feeding or drawing fluids) "he had vomited, aspirated and suffered a respiratory and cardiac arrest". Ms R outlined the deterioration that Mr T had exhibited since, resulting in severe cognitive impairment and the need for 24 hour nursing care. Ms R compared this to the morning of 21 December when Mr T had showered and dressed himself, had breakfast, walked his dog and undertaken a long telephone conversation. She added:

> "My father was a highly intelligent Cambridge graduate who could converse and debate any subject fluently and cogently. After 24 hours as an inpatient he is now immobile, dysphasic [unable to communicate] and brain-damaged."

Ms R said that she believed that Mr T received appropriate doses of insulin in Hospital but not enough to eat. She stated that the family had been told that nurses did not record his intake and did not give him a late snack. Ms R raised a number of questions about her father's care, which she said required answers. These related mainly to the hypoglycaemic episode. The letter said that the NHS had "let our father down badly". It asked for a swift response.

17. On 3 February, the Complaints Administrator for the Trust wrote to Ms R. She acknowledged Ms R's letter of 26 January to the Consultant. The letter said that the Trust would deal with the matters raised in line with the complaints procedure.

18. On 16 February, the relevant Ward Sister sent an email to the Nurse Manager. The latter was investigating aspects of the complaint. The Ward Sister had worked on the late shift on 22 December but was not on the Ward in the night. The email said that there was no record of what Mr T ate on 22 December 2008. She added that keeping such details was not "normal practice" unless there was a dietary problem. She confirmed that Mr T did not have a bedtime snack, as the family had not made staff aware of the need for this. The email stated that the

Senior Nurse in charge of the Ward on the night in question was off sick and therefore, her evidence was unavailable at the time.

19. The Consultant provided an undated internal response to the complaint to inform the reply to Ms R. The document summarised the issues from the Consultant's point of view. The Consultant said that Mr T's insulin intake was appropriate as he was eating well. She set out the blood sugar readings including the 9.3 result noted for 11.00pm. She said that the records indicated that Mr T's diagnosis after his attacks in the early hours of 23 December 2008, were aspiration due to vomiting leading to respiratory arrest and probable stroke. The document summarised the deterioration in Mr T subsequent to the events of 23 December. This part of the Consultant's submission ended by stating that Mr T was "fully dependent for activities of daily living and will need nursing home care". The document referred to the meeting with family members on 23 January 2009. It added in that context:

> "I understand and empathise with their distress at the neurological deterioration of [Mr T]. I explained that the deterioration would be due to a combination of several factors namely infection, hypoglycaemia, cardiac arrest, cerebrovascular disease and age."

20. On 5 March, the Trust's Deputy Chief Executive responded by letter to Ms R's complaint. The main points included were as follows:

- Mr T had his usual dose of insulin on 22 December 2008 and this was fine as he was eating well.
- There was no food chart for that day.
- Food charts are not normally completed in the absence of a dietary issue.
- Mr T ate some supper based on the memory of the Ward Sister
- The blood sugar readings were set out.
- Based on the information available, the Consultant believed that Mr T was hypoglycaemic for 1-1.5 hours.
- There was no record to show that Mr T was laid flat whilst the tube was fitted.

21. On 31 March, Ms R wrote to the Complaints Administrator. She referred to the recent letter from the Deputy Chief Executive. She said that Mr T's insulin regime on 22 December was too inflexible. She added that the Trust could not claim, as it had done, that her father was eating well due to the lack of food charts. Ms R argued that food charts were essential and should be the "default position". Ms R maintained that Mr T's hypoglycaemia was the main factor in his "deterioration, aspiration and cardiac arrest". Ms R confirmed that the family had been told that Mr T vomited whilst laid flat. The letter ended by requesting an independent review of the complaint.

22. On 1 October, the new HB came into being.

23. On 12 October 2009, there was a local resolution meeting held to discuss the complaint. The HB had arranged the meeting prior to the independent review with the family's agreement. The participants were Ms R and other family members, the CHC advocate, the Nurse Manager, the Ward Sister, the Consultant and a Diabetic Nurse Specialist. The meeting notes were 14 pages long. The meeting covered many issues in detail including the areas of complaint that Ms R has raised in her complaint to me. Of particular note was the family's concern that an entry in the blood sugar monitoring chart had been changed or added later. On pages 13 and 14, a number of points were listed under the heading of "actions" for the HB to carry out as follows:

- Incident forms to be reviewed to check whether Mr T aspirating was recorded as an incident.
- Consideration to be given to whether aspiration should be labelled an incident routinely.
- Discussions were necessary regarding whether Mr T lying on his back may have facilitated aspiration.
- Nurses and junior doctors to be reviewed by the Nurse Manager and the Consultant respectively, about the apparent non-recording of information on admission – possibly leading to a wider audit regarding diabetic patients.
- Review of standard paperwork regarding information collected on admission.

- Review of the routine diabetic care plan documentation to see whether more subjective information could be included.
- Training for nursing staff in accurate chart completion for diabetic patients.

It is worth noting that the last action on this list resulted from a discussion about the reliability of the 11.00pm reading, about which family and NHS participants at the meeting had raised concerns. The Nurse Manager was cited as having used the word "fraud" in the meeting in that context.

24. On 27 January **2010**, the Nurse Manager wrote to Ms R. The letter updated Ms R on the HB's action plan arising from the complaint. The letter acknowledged that Mr T aspirating should have been recorded as an incident. The writer apologised for this. She said that nursing staff were able to decide if a patient should be laid on their back, as this was a matter of clinical judgement. The Nurse Manager said that she and the Consultant had "investigated" concerns about recording of information on admission. She confirmed that relevant staff had been reminded of the importance of capturing important information. The Nurse Manager explained that the HB was piloting a new checklist regarding diabetic care plans. She added that training regarding blood sugar monitoring had begun.

25. On 26 July, the independent review reported to Ms R after the family had decided to take the complaint through that process. The outcome was that the Lay Reviewer recommended to the HB that it set up a further local resolution meeting with the family to discuss, among other matters:

- The "poorly recorded" discussions with the family on Mr T's admission.
- The "failure to acknowledge" that Mr T's routine was to have a bedtime snack and that this "may have been critical" to his hypoglycaemia.
- Recording of blood sugar measurements.
- Whether a diabetic care plan was in place and if not, should it have been.

- An explanation of appropriate staffing levels on the Ward, which the nursing assessor for the independent review had concluded were “one registered nurse short”.

26. On 15 November, a further local resolution meeting took place. The participants were family members of Mr T including Ms R, the CHC Advocate, the Consultant, the County Head of Nursing (“the Head of Nursing”), the Hospital Manager, the Diabetic Nurse Specialist and the Complaints Administrator. The main points relevant to this complaint, as set out in the notes, were discussed as follows:

- With regard to the recording of patient information provided by family members on admission, HB staff explained that new documentation, better administrative systems and audits were being introduced.
- The Diabetic Nurse Specialist explained that with newer types of insulin, patients would not normally have evening snacks. However, some patients were on older forms and if that meant an evening snack was necessary, it should be possible. She added that there was ongoing work to remind nurses that each patient had individual needs.
- The Hospital Manager acknowledged that previous action plans in response to the complaints had been “inadequate”. The Head of Nursing apologised that the family had felt the need to chase the Trust/HB for updates.
- The family did not consider that the HB had introduced an adequate system for monitoring food consumption by diabetic patients.
- The family raised the issue of the apparent discrepancy in the blood sugar chart relating to the 11.00pm entry. They noted that the action plans had not provided an update about this matter. The Hospital Manager said that this was “potentially a criminal and a professional offence”. It was agreed that the Hospital Manager and the Head of Nursing would investigate the issue.
- The family again asserted that too much was made of Mr T suffering from dementia and that this might have affected his care negatively.

- The family maintained that due to staff shortages, Mr T's blood sugar was not monitored every four hours.
- The Hospital Manager said that she considered that "the whole case" should be reviewed "afresh".
- Participants agreed that 15 January would be the deadline for a detailed update to be available for the family.

27. On 18 February **2011**, the Head of Nursing sent a copy of the updated action plan to Ms R and promised a further update in April.

28. On 23 May, my office received Ms R's complaint via the CHC.

29. On 22 June, the Head of Nursing sent a copy of the updated action plan to the family. The plan addressed various issues. Of relevance to this report, it provided a response to the issues of record keeping on admission, individual patient routines, incident reporting and diabetic charts. It also dealt with other issues of note. It stated that staffing levels for the early hours of 22 December 2008 were normal but pressure was high. It also promised further investigation concerning "irregularities" in the blood sugar chart and the events surrounding Mr T's aspiration.

30. On 4 August, the Hospital Manager and the Acute Services Manager, met with the two Senior Nurses who had been on duty overnight on 22 and 23 December 2008. A representative of the Royal College of Nurses accompanied the Senior Nurses. First, the meeting discussed the blood sugar monitoring chart. The Senior Nurses said that they remembered the night in question as it was busy and a member of staff was off sick. One of the Senior Nurses recalled that an incident form was completed about the situation on the Ward that night. The notes of the meeting added that the incident form was not retrievable. The Acute Services Manager provided a copy of the blood sugar chart to both Senior Nurses. The Hospital Manager asked both Senior Nurses to explain the various anomalies. Neither could do so. The notes of this meeting recorded the following:

> "[The Hospital Manager] suggested that due to the anomalies in the [11.00pm] entry, the following could be assumed – the [blood

sugar reading] had last been undertaken at [5.20pm] and when it was taken again at 1.30am it had dropped dramatically to 1.5. On looking at the chart it appeared that a retrospective entry had been made as the plotted mark was inconsistent with the marks either side."

31. On 6 October, senior HB staff interviewed a Heath Care Support Worker ("the HCSW") who was on duty at 11.00pm on 22 December 2008. A Senior Nurse accompanied the HCSW. She worked on the Ward but has not featured above. The HCSW said that the nursing compliment was down by one qualified and one unqualified nurse on the night in question. The HCSW said that six hourly blood sugar monitoring is carried out on the Ward even when the request is for four hourly checks. The senior nurse who was present apparently confirmed this. The HCSW could not explain the 11.00pm entry on the blood sugar monitoring chart.

Ms R's evidence

32. Ms R supported her specific concerns as outlined in paragraph 3 above, with a general analysis of what the family believed happened to Mr T. She said that staff on the Ward failed to record vital information that the family provided. Key in that regard was that:

- Mr T required a bedtime snack to help regulate his blood sugar levels appropriately.
- Mr T was relatively asymptomatic when suffering from hypoglycaemia.
- Mr T had an acceptable blood sugar level of about 10.

With regard to the bedtime snack, Ms R said that her mother told Ward staff the above information during the afternoon of 22 December 2008 and again later that evening. On the latter occasion, Ms R was a witness to the conversations. She also said that her mother told an A & E nurse and an A & E doctor.

33. Ms R believed that Mr T did not eat much dinner, presumably around 5.00-6.00pm on 22 December, as he later complained about the food to the family. Moreover, staff did not give him a bedtime snack. Ms

R stated that the combination of lack of food and having a full dose of insulin would have led to a hypoglycaemic attack. She made the point that the Ward did not use any food intake charts for diabetic patients, which she considered were vital. Therefore, Mr T's consumption was not monitored. Ms R maintained that Mr T's blood sugar levels were not monitored properly.

34. As a result of this evidence, Ms R commented that Mr T probably was hypoglycaemic for many hours. She believed that his confused state in the late evening of 22 December, as she saw written in the nursing records, might have been evidence of this but was missed as nurses may have relied on the over emphasised diagnosis of dementia.

35. Ms R stated that the hypoglycaemic episode probably led to Mr T vomiting when his tube was re-fitted, which caused him to aspirate during that procedure. The aspiration in turn led to respiratory and cardiac arrest from which Mr T never fully recovered.

36. Ms R stated that the Trust let her father down in the first few days of his admission to the Hospital. Although she said his care thereafter was excellent, Ms R's analysis of events led the family to believe that Mr T would most likely be alive today if the failures in his care had not occurred.

37. Ms R said that a formal written response from the Trust, two local resolution meetings and independent review, had not led to a full recognition on behalf of the HB about what went wrong and what consequences it had. However, she stated that the action plans had gradually improved and taken on board some of the points that the family had raised. Notwithstanding this, Ms R said that having a full and unreserved apology for the poor care that Mr T received and recognition of what it caused would mean a great deal to her mother and the rest of the family.

The Health Board's evidence

38. The HB supplied Mr T's medical records, complaint and investigation information and its comments on all aspects of the complaint. It confirmed that the main participants in the case, as

mentioned in the chronology of events above, have had an opportunity to contribute to its response to my Investigator.

39. The HB acknowledged that not being able to locate Mr T's medical records on admission was "not satisfactory". However, it stated that it has acted to rectify the problem as follows:

- Patient records are "tracked" on the relevant computer system.
- Training has been provided to staff on using the system.
- An incident report is created when patient care is deemed compromised by failure to access records promptly.
- Correspondence is uploaded so medical staff have access to information in advance of obtaining the full records.

40. The HB explained that it had introduced a diabetic checklist for patients who attend A & E and an "Adult Insulin Administration record". The latter includes an area for recording special instructions. It also stated that the A & E documentation has been reviewed again in response to my investigation. The HB said:

> "The notes taken by the A & E nurse …are extremely comprehensive and demonstrate that a detailed history of the patient was taken. [HB] staff maintain that, on balance, had the nurse been informed about [Mr T's] bedtime snack requirements that she would have added this to her already detailed notes."

41. The HB said that it did note that Mr T had a history of dementia, "but this was not a working diagnosis". It stated that the management plan for Mr T was not treatment for dementia.

42. The HB discussed the issue of staffing on the night of 22/23 December 2008. Initially when responding to the investigation, the HB claimed that staffing levels were "normal" but that the nursing staff were particularly busy. It later provided information gathered at interviews with Senior Nurses on 4 August 2011. This implied that the nursing compliment was down by one. The HB then confirmed, after the investigation had posed further questions, that the matter had been reviewed again. It said:

> "…the Ward staffing on [22/23 December 2008] was not adequate despite our initial report indicating that it was."

43. The HB stated that the action that should follow from notice of short staffing was (and is) as follows:

> "Staff are required to complete [an electronic incident form] to log the problem and ensure that cover is requested formally – firstly via the…pool of bank nurses and if this fails then senior staff will try to arrange agency cover and/or bring in staff from another, less busy area.
>
> If all options have been exhausted and cover has still not been found for the area in question then senior staff will explore the possibility of moving patients to another area or look at closing a Ward…"

44. The HB explained that there are now additional "escalation procedures" in place to ensure a ward is safely managed. These include risk assessments on patients before admission to wards, new incident reporting mechanisms and an on-call system when immediate action is required.

45. The HB said that, because of my investigation, it had "reviewed the case in detail." With regard to staffing levels, the HB concluded that at the time of the original complaint, the Trust had not given adequate attention to the matter. That being the case, the Trust and then the HB had worked on the wrong assumption that staffing was adequate. In that context, the HB apologised to Ms R through its response to my Investigator. The HB said that staff did not notice the independent review's mention of the staffing problem because they were not the original people involved in the complaint responses.

46. The HB submitted its views on the problematic blood sugar monitoring chart. It clarified that it had misplaced the chart between the two local resolution meetings and that it had to obtain a copy from the complainant. The HB initially reported that it was aware of a

discrepancy in the chart relating to the 11.00pm entry on 22 December. It later supplied notes from the 4 August 2011 interviews with the Senior Nurses who were on duty in the night of 22/23 December. The Senior Nurses could not explain the apparent problems with the blood sugar monitoring chart. The HB drew the conclusion that the 11.00pm entry on the blood sugar monitoring chart for 22 December 2008 was "not reliable".

47. The HB accepted that the Trust's and its investigations into the blood sugar monitoring chart's discrepancies went wrong. It made the following points in that regard:

- The original investigation should have involved the relevant manager of the Ward in question.
- The immediate response to the family questioning the chart at the local resolution meeting of 12 October 2009, was not robust enough generally.
- The initial response to the family's queries should have involved interviews with the Senior Nurses.
- There was "an unacceptably long delay" in interviewing the Senior Nurses after the local resolution meeting of 15 November 2010.
- Staff on duty on the night of 22/23 December 2008, other than Senior Nurses, should also have been interviewed more promptly.

The HB apologised for its failures. It explained that investigations are, "far more robust in the present day". It outlined a range of measures that it had taken to ensure that this is the case. It also explained new systems for keeping records safer during investigations.

48. Until late in this investigation, the HB failed to produce some other records relating to Mr T during 22 and 23 December 2008. However, it eventually supplied them, having had to request them from the papers collected during the independent review. These papers included physiological observations. Vital in this regard were the oxygen saturation levels (which measures the amount of oxygen in red blood cells). These recordings show that Mr T's oxygen saturation level was 94% at 2.10am on 23 December, a fall from the previous two entries

where it was recorded as 96-99%. By 4.10, it was 87%, by which time Mr T had collapsed.

49. The HB reported comments made by two of the participants in the case in response to aspects of the investigation's enquiries. The Nurse Manager clarified that when she mentioned fraud at the first local resolution meeting, she was referring to her view that if the blood sugar monitoring chart had been amended, it would amount to "a fraudulent act". The Consultant stated that she recalled seeing the 11.00pm entry in the blood sugar monitoring chart after Ms R's complaint was submitted to the Trust and she asked the Ward Sister to make enquiries.

50. The HB provided a copy of a letter that it had sent to every nurse employed by it. The letter reminded nurses of the obligations under the Nursing and Midwifery Council for "adhering to documentation procedures at all times".[1] Nurses based in the Ceredigion County area have had an additional letter, which reminded them of codes of conduct and record keeping.[2]

51. The HB discussed Ms R's complaint about the absence of food charts for diabetic patients. It explained:

> "…all patients now undergo a nutritional assessment on admission and if this highlights a cause for concern the patient is commenced on a food chart. A…system is also in full operation which works by easily identifying vulnerable patients who require support at mealtimes".

52. The HB said that it has addressed Ms R's concerns about individual facets of patients being ignored, by the introduction of Diabetic Patient Passports. However, it explained that the passports were not compulsory and are patient led.

53. The HB outlined its position with regard to Mr T's deterioration from 23 December 2008. It accepted that he had a hypoglycaemic episode. It added:

[1] Nursing & Midwifery Council (2009). Record Keeping.
[2] Nursing & Midwifery Council (2007). Professional Code of Conduct.

> "We can advise however that we are unable to ascertain the exact order of events surrounding the respiratory arrest and aspiration episode…We can advise that hypoglycaemia would not normally cause respiratory arrest, though it would be reasonable to conclude that it could be contributory to his subsequent clinical deterioration."

Professional advice

54. My Medical Adviser assessed Mr T's general health on admission from his interpretation of the records. He said that Mr T was taking a drug for "mild to moderate dementia". He added that Mr T presumably had some history of heart problems as he was having drugs to that end. My Medical Adviser stated that Mr T was recorded as "self-caring". He was admitted due to left sided weakness. He said that the clinical impression was that Mr T had an infection. My Medical Adviser did not identify any acute cardiovascular problem from his reading of the medical records.

55. My Medical Adviser made the following points of note about Mr T's clinical care:

- There was "clear evidence" that Mr T had a history of dementia but no evidence that staff ascribed his problems to that condition.
- His presenting condition was "appropriately treated".
- In the light of the available evidence, "there was no record [of blood sugar monitoring] between 5.20pm on 22 December 2008 to 1.30am on 23 December.
- Blood sugar monitoring should have occurred at around 10.00pm on 22 December.
- Mr T may have been hypoglycaemic for up to eight hours.

56. My Medical Adviser discussed Mr T's clinical deterioration in the early hours of 23 December 2008. He said that Mr T's clinical records are "sparse" for the night in question. My Medical Adviser stated that the exact cause of Mr T's cardiac arrest are not known. He added that it might have been an "acute cardiac event". However, he submitted the following analysis:

> "[As Mr T's blood sugar should have been monitored at 10.00pm], the Trust potentially failed to treat his hypoglycaemia for [three and a half hours]. This is a significant failing. Hypoglycaemia leads to depressed consciousness and seizures, both of which can lead to aspiration. It is also a significant stress which is relevant in relation to a patient with cardiovascular history…Both aspiration and stress can lead to acute cardiac problems which may lead to cardiac arrest."

My Medical Adviser concluded that there was, "a causal link" between the failure to monitor Mr T's blood sugar levels and his cardiac arrest. Furthermore, Mr T's clinical deterioration can be attributed, at least in part, to the cardiac arrest.

57. My Nursing Adviser made the general point that the nursing records were not clear enough in parts to the sequence of events in Mr T's case to accurately allow consideration. She referred to guidance from the Nursing and Midwifery Council, which is clear about the importance of adequate and accurate record keeping.

58. My Nursing Adviser, whilst accepting the importance of access to a patient's record on admission, made two points. First, she considered that the HB has responded appropriately to this problem and its systems should minimise the chances of a recurrence. Second, she did not believe that this shortcoming affected Mr T's initial care.

59. My Nursing Adviser said that it could not be determined with certainty what Mrs T told various staff members about Mr T's diabetic details and regime. However, she stated that she found Ms R's view "persuasive". She based this on the constant and consistent re-iteration of the point by Ms R. Moreover, my Nursing Adviser concluded that details of Mr T's normal eating and drinking pattern were not recorded adequately on admission to the Ward. She said that the relevant form included "good appetite" but no detail. She pointed out that guidance from the National Institute for Clinical Excellence supports her view. [3] She said:

[3] National Institute for Clinical Excellence guideline 32, Nutrition Support in Adults 2006

> "In summary and in line with relevant guidance, the question of [Mr T's] diabetic food intake and pattern should have been enquired about regardless of whether or not his family passed on the information".

60. My Nursing Adviser stated that Mr T's treatment in the Hospital was aimed at dealing with an infection not dementia. She did not criticise the Hospital for including dementia in Mr T's medical background details. She added that there is no evidence available to determine whether staff did allow that diagnosis to interfere with considerations when Mr T's condition might have appeared different.

61. My Nursing Adviser analysed issues surrounding Mr T's food consumption during the period in question. Her general view concerning food charts for diabetic patients was that these are not always necessary. She said some diabetic patients are not vulnerable. She suggested that:

> "The key issue is the quality of the nursing assessment, which should inform whether or not further action (such as the commencement of food charts) needs to be implemented.
>
> …
>
> The point is that a blanket rule for diabetic patients is not as meaningful as a patient-centred assessment, which informs planning and monitoring strategies".

In Mr T's case, my Nursing Adviser made the following points in this regard:

- As stated above, there was a lack of documentation on the Ward regarding Mr T's normal diabetic management.
- Food charts should have been put in place for Mr T because his needs may have differed "in the light of his sepsis".
- There was no documentary evidence of what food Mr T consumed during 22 December 2008. There was "no excuse" for this,

particularly for a diabetic patient with an acute illness. Mr T was on his full dose of insulin and had a hypoglycaemic attack at home recently. Recording his food intake was important in his case. This was not only a failure to meet established good practice but also professional standards regarding record keeping.

- Mr T may have benefited from an evening snack but this might not have prevented the subsequent events.
- There appears to be no fluid balance charts for 22 December (which show the difference between fluid taken and excreted). This was a failing in Mr T's case.

62. My Nursing Adviser added that the HB appeared to have introduced appropriate strategies via its action plans to address the assessment and monitoring of diabetic patients.

63. My Nursing Adviser reviewed Mr T's blood sugar monitoring for 22 and 23 December 2008. First, she made the point that even if the 11.00pm entry on 22 December is counted, staff did not monitor Mr T's blood sugar four hourly as instructed. She also expressed serious concern that the HCSW and a Senior Nurse on the Ward, recently said it was normal practice to monitor blood sugar six hourly, regardless of instructions to the contrary. She stated that this was an "astonishing statement". She added:

> "I have great concern about the knowledge and skills in relation to diabetic monitoring by nurses on an acute medical ward, especially as the statement was supported by a qualified nurse…"

64. My Nursing Adviser discussed the 11.00pm entry on the blood sugar monitoring chart. She said that her view was that it was added later. She considered that Ms R had raised a "very reasonable question", when challenging the validity of that entry. My Nursing Adviser said that she cannot be sure about exactly what happened but that tampering with medical records was "a very serious professional matter" and potentially "professional malpractice". She acknowledged that the length of time that had elapsed before a full investigation was undertaken, meant that the issue would never be fully resolved. My Nursing Adviser said that, because the 11.00pm reading can be

discounted, Mr T did not have his blood sugar monitored for eight hours. She described this as “unacceptable”.

65. My Nursing Adviser also raised concerns about the monitoring of Mr T’s blood oxygen levels. She said that Mr T’s level dropped to 94% at 2.10am on 23 December from 96-99% on previous readings. She was critical that the levels were not checked again until 4.10am, by which time Mr T had been taken ill and the oxygen blood level was 87%. She added that the lower 94% recording was not referred to in the nursing records. My Nursing Adviser referred to Guidance concerning the monitoring of acutely ill patients. It states:

> “Physiological observations should be recorded and acted upon by staff who had been trained to undertake these procedures and understand their critical relevance.
>
> …
>
> Staff caring for patients in acute hospital settings should have competencies in monitoring, measurement, interpretation and prompt response to the acutely ill patient appropriate to the level of care they are providing. Education and training should be provided to ensure staff have these competencies, and they should be assessed to ensure they can demonstrate them.
>
> …
>
> The frequency of monitoring should increase if abnormal physiology is detected”.[4]

She explained that the drop at 2.10am should have led to a repeat at 3.25am when other observations were recorded. She said however, that it was not possible to state that an earlier referral to medical staff would have resulted. Nevertheless, the episode implies that there may be “a, knowledge and skills gap”.

[4] National Institute for Clinical Excellence guideline 50, Acutely Ill Patients in Hospital 2007.

66. My Nursing Adviser pointed out the contradictions in the HB's evidence about the issue of staffing for the night of 22/23 December 2008. She said that whatever the exact situation it "imposed a risk to patients". She added that there was no information about what was done about it at the time.

67. My Nursing Adviser said that the HB has acknowledged some failings in Mr T's care and some of "the less significant" issues. In those areas, she considered that the HB has implemented appropriate remedial action. However, she did not consider that the HB had addressed the central aspects of the complaint.

Analysis and conclusions

68. The NHS let Mr T down. I conclude below that his care, in crucial aspects for a short period, was below an acceptable standard. The clinical failings contributed to the sudden and significant deterioration in his health. I have also criticised the HB for its role in related aspects of the case. I provide my analysis and conclusions in line with the chronological events that took place. In so doing, I have dealt with the main points that Ms R raised in her complaint to me. I summarise my findings thereafter, before discussing the injustice to Ms R and the family.

69. It was unsatisfactory that staff initially lacked access to Mr T's medical records on admission. Based on the analysis of both my Advisers and my reading of subsequent events, I do not believe that Mr T's care was influenced to a significant extent by this. Moreover, it appears that the HB has responded appropriately.

70. In terms of the information that the family imparted to staff on admission to the Ward and thereafter, I find Ms R's evidence compelling. As my Nursing Adviser has said, Ms R has been adamant and consistent – both during the local resolution process and in her evidence to my Investigator. The information that Ms R states was supplied (see paragraph 32) was important. I cannot envisage that this family failed to emphasise those points. I note that the independent review outcome on this issue included the phrase, "poorly recorded" in the context of the information that the family provided. I am surprised

that the HB does not accept this. It has told me that on balance, it considers that the thoroughness of the A & E notes shows that staff did record relevant information. However, it is on admission to the Ward, that the matter becomes crucial. By that time, the family realised that Mr T would require a stay in the Hospital and were fully aware of the significance of some of the details about Mr T's diabetic regime. My Nursing Adviser has commented that the Ward admission documents lacked detail in that respect. Even if the family were not capable of imparting useful information to staff without prompting (which is certainly not the case), that information should have been gathered. I would also point out that there is no evidence that the Trust or HB doubted the family's evidence about this matter, until its recent letter to my Investigator. Consistently through local resolution the Trust/HB has been reassuring about feedback to staff and improved systems and documentation. If the Trust/HB considered that there was no case to answer on this issue, it should have said so earlier. I believe that Mrs T provided vital information to Ward staff on admission and in the hours that followed. This was not recorded or acted upon. I will discuss the implications of this later.

71. Ms R raised another issue concerning information about Mr T during the admission process, concerning a previous diagnosis of dementia. I do not consider that it was wrong to record dementia as background information in Mr T's case. Moreover, there is no evidence to suggest that Ward staff ignored symptoms due to a mistaken belief that he was agitated or confused due to dementia. Both my Advisers have been reassuring on this point. Therefore, whilst I can understand Ms R's views in that regard, as Mr T did not appear to have severe dementia, I cannot agree with her.

72. Ms R raised the issue of short staffing in her complaint. She believed that it played a part in what she saw as a failure to monitor her father's blood sugar levels adequately. Although the Trust/HB's responses to her and my Investigator on this matter have been muddled, it has become clear that the Ward was short staffed on the night of 22/23 December 2008. My Nursing Adviser has said that this posed a danger to patients. I am not critical of the Trust/HB's systems for dealing with short staffing. Nor can I state with any certainty the effect of this during

that night. However, two points should be made. First, the systems for ensuring the safety of patients broke down, for reasons which we will never know. Second, the potential for poor care to patients was increased.

73. I now turn to Mr T's blood sugar monitoring on the night in question. It fell well below a reasonable standard. I note my Nursing Adviser's comments that even if the 11.00pm entry had been in order, Mr T's blood sugar monitoring was not completed every four hours, as it should have been. Moreover, the 11.00pm entry cannot be counted. Therefore, as my Medical Adviser has concluded, Mr T could have been hypoglycaemic for eight hours. His analysis, which is plausible, is that the Trust potentially failed to treat Mr T's hypoglycaemia for over three hours because staff should have recorded his blood sugar levels at about 10.00pm on 22 December but did not do so until 1.30am. This was unacceptable.

74. I am particularly concerned about the latest evidence gathered from Ward staff about blood sugar monitoring. The HCSW and a Senior Nurse said that blood sugar monitoring is carried out every six hours regardless of instructions from medical staff. This is unacceptable. It also undermines the claim that staff have undergone training regarding blood sugar monitoring. I cannot find any evidence that the HB has picked up on the HCSW's comments. I find this disappointing, especially in the context of this case.

75. I also note my Nursing Adviser's analysis, which outlines other failures of monitoring with regard to blood oxygen levels and fluid balance records. The former may also have played some part in the tragic events that followed.

76. I do not want to say a great deal about the problematic 11.00pm entry in the blood sugar monitoring charts. It is a matter for the HB to take appropriate action. However, it seems clear to me that the entry was written in retrospect and very likely reflects an attempt to alter the record to cover up poor monitoring. I take a very serious view of attempts to falsify clinical records. I have had reason to criticise the HB previously in that regard (see case ref: 200901551). If it had been more

obvious which nurses were to blame, I would have referred the matter to the Nursing and Midwifery Council. I expect the HB to take robust action in future in this context.

77. Ms R has strongly argued that food charts should be introduced for all diabetic patients. I have some sympathy with her view. However, I agree with my Nursing Adviser. A patient-centred approach is preferable to blanket policies. Despite this general view, she has criticised the Trust's treatment of Mr T in two related aspects. First, in his case, a food monitoring chart was indicated but did not happen. Second, there was no worthwhile record of what he ate on 22 December. I accept her analysis.

78. I do not accept Ms R's contention that the Trust would not cater for the individual needs of patients. I am reassured by the comments and actions that the HB has made and carried out in response to this. However, Mr T did not receive a bedtime snack. This was a failure of information recording. I assume that he would have been given the snack if the records had shown that he required it.

79. Before discussing the influence of the identified failures on Mr T's health, I will comment on the Trust/HB's investigations. In short, they were superficial and untimely. I find various aspects of the Trust/HB's response to the complaints during local resolution, to be nowhere near good enough. It is to the Trust/HB's credit that it admitted some errors and created gradually improving action plans. However, a good deal of this work was done under pressure from the family. They should take credit for much of the action that has resulted from their complaint. The Trust/HB has introduced sound new systems in response to Ms R's complaint. It has also been honest about the shortcomings in its complaint response. The HB appears committed to improving. Nevertheless, I remain unconvinced that the HB has fully and directly acknowledged that its staff failed to monitor Mr T's blood sugar appropriately. I am very surprised that it took well over two years to attempt a proper investigation of the apparent discrepancies in the blood sugar monitoring chart. Many Trust and HB staff would have seen that chart, at least until it was lost. Nevertheless, it was left to the family to

make an issue of it despite the obviously dubious nature of its completion. This reflects poorly on those involved.

80. To summarise, I find that the Trust/HB failed in the following crucial regards:

- Staff were not vigilant enough in recording information about Mr T's diabetic regime.
- There was an inadequate response to the problem of short staffing on the Ward during 22/23 December 2008.
- Mr T's blood sugar was not monitored properly.
- Other physiological measurements were not fully recorded.
- There appears to be a false blood sugar reading added retrospectively to the record.
- The response to the complaint was thin and protracted.

81. The lack of detail in some of the clinical records and the passage of time, make it more difficult than it might have been to estimate the effect that the failures in care had on Mr T's heath during the night of 22/23 December 2008. However, I think it is reasonable to say that the failings had a contributory effect on his deterioration and therefore, subsequent death. My Medical Adviser has drawn that conclusion (see paragraph 56). I find his analysis measured and plausible. I think it is fair to conclude that if Mr T had been given a bedtime snack and/or had his blood sugar checked at around 10.00pm on 22 December, there was a reasonable chance that he would not have had a cardiac arrest on 23 December. It is also possible that a further measure of Mr T's blood oxygen level, before he had the heart attack, might have led to an earlier medical review and therefore, altered events. None of this is certain. However, it is sufficient for me to say that poor care contributed to Mr T's demise. The uncertainty will never be resolved. This represents a major injustice to Ms R and the family. In addition, having been through the distress of observing Mr T's deterioration and subsequently losing him, they had to battle for well over three years in the hope of gaining some resolution. I uphold the complaint.

82. Diabetes is a fast growing disease. Increasing numbers of people will be admitted to hospital with acute conditions, whilst suffering from

diabetes. It is crucial that nursing staff operate a patient centred approach, follow medical direction, monitor patients carefully and have the knowledge to underpin the care they provide. Mr T did not receive such a service.

Recommendations

83. I recommend that, within one month of this report or later where specified the HB:

A. Provide a detailed written apology from its Chief Executive for the injustice that I have set out above. This should be addressed to "The Family" of the deceased and sent to Ms R.

B. Pay Ms R £1700. I regard £1200 of this as an acknowledgement of the additional distress the family has suffered through the knowledge that Mr T's care was poor and the uncertainty about the precise contribution it made to his deterioration and death. It is not compensation for his loss. £500 is for Ms R's time and trouble in raising this complaint, locally and for submitting it to me.

C. Satisfy itself that its systems and procedures for dealing with acute short staffing on its medical wards are working.

D. Instruct all the nurses in the Ward that it is unacceptable for there to be a blanket policy regarding the timings of blood sugar monitoring for diabetic patients in their care and those recordings should be as requested by medical staff or more frequently if needed in response to abnormal findings.

E. Satisfy itself that there is no such blanket policy for blood sugar monitoring in any of the other medical wards in the Hospital.

F. Within three months, carry out an in-depth review of the skills and knowledge of all nursing staff on medical wards in the Hospital regarding blood sugar monitoring and diabetic care and take appropriate action thereafter.

G. Within three months, provides training to all nurses in medical wards in the Hospital on the significance of oxygen blood levels.

H. Within two months, carry out an audit of nursing record keeping on the Ward and take appropriate action to remedy any shortcomings that are apparent.

I. Provide a copy of the final report of this investigation to all the staff that featured in the background events above and ask them to reflect on their role in the matter.

84. Finally, in light of the extent and gravity of the failings I have identified, I will be sending a copy of this report to Healthcare Inspectorate Wales for it to take account of my concerns in planning its inspections.

85. The HB has agreed to implement my recommendations.

Peter Tyndall
Ombudsman 4 April 2012