Ombudsman Ombwdsmon

PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

The investigation of a complaint by Mrs D against Abertawe Bro Morgannwg University Health Board

A report by the Public Services Ombudsman for Wales

Case: 201200939

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 D.

Summary

Mrs D complained about the care and treatment her mother, the late Mrs M, received when she was admitted to the Accident and Emergency Department at the Princess of Wales Hospital on July 2010. Mrs D said that the triage nurse had not administered the treatment that her mother's condition required. There were also concerns about her subsequent treatment and in particular how discussions about the requirement to resuscitate, should that prove necessary, were managed.

Mrs D held the view that her mother was initially being allowed to die without appropriate medical intervention and that the lack of intervention had led to her death some days later.

The Ombudsman's clinical advisers were highly critical of the failure of staff to deal with Mrs M's condition on arrival appropriately. They could not find any evidence of appropriate intervention as required by procedures such as nursing staff calling a doctor. There were also delays in cannulating Mrs M and in administering medication appropriate to her health needs. They could not however point to evidence that the failures in early intervention had contributed to Mrs M's death.

The Ombudsman recommended that the Board should apologise to the family for the failings in the report, make a payment of £1,000 and review its procedures and the professional competence and training of the nursing staff involved in the admission of Mrs M. The Board accepted the recommendations.

The complaint

1. Mrs D complained about the care and treatment that her late mother Mrs M received when she was admitted to the Accident and Emergency ["A&E"] department of the Princess of Wales Hospital in Bridgend on 30 July 2010.

Investigation

2. I obtained a copy of the medical records for Mrs M from the Abertawe Bro Morgannwg University Health Board ["the Board"] and considered those in conjunction with the evidence provided by Mrs D. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

3. Both Mrs D and the Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

4. I am issuing this report under the authority delegated to me by the Ombudsman under paragraph 13(1) of schedule 1 of the Public Services Ombudsman (Wales) Act 2005.

The background events

Background

5. Mrs M was eighty two years of age and lived in a care home. She was referred to hospital by her GP and was an expected medical admission for attention due to general deterioration in her health, diarrhoea and low blood potassium levels. She was admitted to A&E in the early hours of 30 July 2010. Mrs M was extremely unwell on admission but after her condition was made more stable, she was transferred to other departments and wards within the hospital and was cared for until, sadly, she died on 4 August 2010.

Mrs D's evidence

6. Mrs D complained about the quality of care and treatment that her late mother had received in A&E. She said that she had been present from the time the ambulance picked her mother up from the care home and that she arrived at the hospital just after her mother. She said that at the time, she had raised concerns with staff in A&E that her mother was dying and that she was not being given appropriate treatment. She told them that her mother's extremities were blue, that she appeared to be having trouble in breathing and was going into shock. Mrs D said she had thought the blueness was the result of a lack of oxygen, a condition known as cyanosis[1], but the nurse had said her mother was cold.

7. Mrs D said that she told staff that her mother needed to be seen by a doctor urgently. She said that there were people she took to be doctors in the area close to her mother but they did not come to see her mother. She said that it took too long for a doctor to see her mother and that her coldness should have been addressed more quickly. She said that she thought the efforts made to cannulate[2] Mrs M were inadequate. She said that her sister and father were also present for most of the time, had seen what had happened and were also very concerned at the lack of response from nursing staff.

8. Mrs D believed that her mother was being allowed to die and this impression was reinforced when she said a doctor later advised her that her mother could not be accepted into the high dependency unit ["HDU"] because of her general state of health. She recalled that on the previous admission to the hospital, a doctor had asked her what the family wanted them to do if Mrs M had a further crisis and she had been concerned by this as she expected hospital staff to attempt to preserve her mother's life. She wondered if there was a hidden agenda in relation to older patients that could have adversely affected the quality of care that her mother received.

[1] Cyanosis is the appearance of a blue or purple colouration of the skin or mucous membranes due to the tissues near the skin's surface being low in oxygen.
[2] A tube inserted into the tissues of the body for the delivery of fluid, medication or other substances.

9. Mrs D said that she had worked in the ambulance service and that her sister was a police officer. They believed that the response of the nursing staff was not appropriate given Mrs M's condition on admission and were concerned that this may have contributed to her death some days later. They pursued a formal complaint with the Board but had not received a satisfactory response to their concerns.

The Board's evidence

10. The Board advised that a localised system of triage was in place known as BRATZ which stood for Bridgend Rapid Assessment and Treatment Zone. It said that this would not have been in operation at the time Mrs M was admitted in the early hours of the morning as it operated between 9am and 9pm. It said that outside those times the system was that a registered nurse would assess a patient on arrival.

11. The Board provided the clinical records for Mrs M, the MEWS[3] chart for her admission and a one page MEWS action plan for the Emergency Department. This indicated that the following steps should be taken:-

(a) "If any one parameter except temperature or urine scores 3:-
"Move patient to resuscitation room.
Inform ED senior doctor (and specialty doctor where necessary) and nurse in charge immediately.
Attach to cardiac monitor, give high flow oxygen and gain IV access
15 minutes vital signs.

(b) If any one parameter scores 2 or above:-
"Move patient to trolley bay.
Inform doctor and nurse in charge.
Cardiac monitor, high flow oxygen, IV access.
Perform vital signs half hourly.

[3] Modified Early Warning Score – a matrix used to quickly determine the degree of illness of a patient.

(c) A score of 1 or below:-

> Hourly observations.
> Inform nurse in charge."

The action plan concludes with the following:-

> "Please note. If you are concerned about the patient's condition at any time inform a senior member of staff. MEWS score must be documented before patient is transferred to the ward and a clear management plan including how often the observations should be recorded must be in place by the doctor."

12. The Board advised that Mrs D had a high MEWS score of 11 on admission but that a rapid response call was not needed as there was a 24 hour emergency presence in the Emergency Department. There was no explanation provided as to why a doctor was not called to see Mrs M immediately her condition was recognised.

Meeting 9 January 2013

13. The investigator met relevant clinical staff at the hospital on 9 January 2012. At this meeting staff said that they have relevant procedures and guidance in place but said that staff experience and clinical judgement is paramount in dealing with patients. They said that a patient may be more well or less ill than a MEWS reading alone might suggest. Hospital-wide MEWS action warning posters have been taken down from the Emergency Department and have been replaced with Emergency Department MEWS action posters.

14. The staff said they thought that Mrs M's initial blood pressure reading may have been wrong, as the reading improved without intervention soon after she arrived in A&E. With regard to the family questioning whether Mrs M's oxygen saturation reading of 100% could have been wrong, staff said

that they had no reason to doubt the accuracy of that reading, given that Mrs M did not have any clinical symptoms to suggest toxic ingestions or other reasons which could affect the oxygen levels in the blood.

15. They also said that having subsequently reviewed Mrs M's treatment, they regarded it as appropriate, although the interruptions of the family on the night were inevitably distracting for staff. They did not believe that the initial treatment had any long term effect as Mrs M was unwell. Staff said that Mrs M was stabilised after admission and lived for another five days.

16. With regard to the attempts at cannulation, the staff said that an A&E nurse can be better at cannulating a patient than a doctor as they are required to do this more frequently.

17. In response to a query posed by the Ombudsman's physician adviser, the staff said that the hospital has no absolute contra-indication level for INR[4] in regard to central line access. Much depends on the experience of the doctor involved and it is a matter of clinical judgement. They said that the presence of Clostridium Difficile[5], which Mrs M had, can be a factor which needs to be considered before attempting femoral access and that an anaesthetist would probably be needed to perform it.

18. Staff said that Mrs M was waiting to see a doctor but there were cardiac arrests in the medical wards that stopped a doctor from seeing Mrs M sooner in A&E.

19. Staff said that there are two junior doctors on duty in the hospital's A&E at night and an on-call team for GP referred medical patients such as Mrs M.

20. Having reviewed the case, the staff did not believe that the handling of a case like Mrs M's would be any different today and their procedures have not changed in the interim period.

[4] International Normalised Ratio, which measures the time it takes for blood to clot and compares it with an average.
[5] A bacterial infection that can affect the digestive system. Symptoms include diarrhoea, high temperature and painful abdominal cramps.

21. The staff drew the investigator's attention to the fact that the resuscitation room, HDU and A&E are in close proximity and said there had been no delays in transferring Mrs M between them or in her treatment, given the resources available on the night.

22. According to the records, the family came into the bed bay area of A&E and were disruptive, shouting close to the staff station and other patients. As a result a staff nurse was called to deal with them. If that situation arose again, staff said they would probably ask a disruptive family to leave or call Security.

23. They also pointed out that staffing arrangements of the A&E service can be different in different geographical locations according to need and the resources available.

Professional advice

Nursing Advice

24. The Ombudsman's nursing adviser on this case, Rona McKay, is a senior nurse with extensive experience in emergency and acute care.

25. In summary, Ms McKay identified a number of failings in the initial care and treatment of Mrs M. The adviser said that Mrs M's grossly abnormal readings on admission were such that a doctor should have been called immediately and the failure of the nurses to do so was a failure in care. Mrs M's initial MEWS score was 11 and information obtained from the Board said that a score of 7 or above should trigger an emergency call for a doctor to attend the patient. The adviser said it was unclear from Mrs M's records whether this had occurred.

26. The adviser said that there was no evidence that Mrs M was given a triage category, although the first nurse who saw her appeared to recognise the severity of her condition and moved her to the resuscitation area, but a doctor should have been asked to see her at this time.

27. The adviser said that a staff member had recorded that there had been seven attempts to site a cannula for Mrs M in the hour and a half following her admission. She said that there were two gaps in the records of the monitoring of Mrs M's oxygen saturation levels and temperature during this time.

28. The adviser said that the records showed that Mrs M had a low body temperature with cold extremities on arrival in A&E and that warming techniques should have been applied within a short time, but this did not take place until nearly three hours later.

29. With regard to the nursing care in the Clinical Decisions Unit and subsequent wards, the adviser thought that the care was of a reasonable standard. She said from this point the notes showed that Mrs M had at various times refused some of the measures that were suggested by staff such as a naso-gastric tube for feeding and did not always agree to be repositioned when staff thought it appropriate to do so for pressure relief.

30. She commented that the nursing records showed that there had been a high level of conflict with the relatives at the time of admission, which is noted as being due to previous issues with their mother's care. The adviser said this could also have been due to the fact that they were trying to get prompt medical attention for their mother.

General Physician's advice

31. The Ombudsman's adviser, Dr Richard McGonigle, is a general consultant and renal physician of over 20 years' experience.

32. Dr McGonigle said that the notes showed that Mrs M had been admitted to A&E at 1.35am on 30 July 2010. She was admitted due to diarrhoea, general deterioration in her health and low blood potassium levels (hypokalaemia). The GP was treating Mrs M for atrial fibrillation[6] and had also diagnosed that she had Clostridium Difficile.

[6] An abnormal heart rhythm.

33. He said that on admission Mrs M had a rapid heart rate related to atrial fibrillation, low blood pressure, and rapid respiratory rate and was hypothermic with cold extremities. She was triaged at 1.45am and was moved to the resuscitation room. Difficulties were encountered getting a cannula into her arm because her arms were oedematous[7]. She was dehydrated and had an INR reading that required urgent attention. Mrs M's chest was given an X-ray which was clear. After treatment with a saline drip and magnesium infusion, she was reported by a doctor at 7.30am as being warmer and brighter, with a better colour.

34. After transfer to the Clinical Decisions Unit, there was an assessment by consultants, who agreed that Mrs M had poor quality of life and was not suitable for admission to intensive care. On 2 August, a consultant physician noted improvements in Mrs M's symptoms from the previous day. He made a three page medical entry on the position. It was noted that Mrs M's resuscitation had been discussed in front of her and with the daughter and husband present. It was concluded that she would not be given cardio pulmonary resuscitation in the event of cardiac arrest but otherwise, would be actively treated. She was further assessed on 3 August when it was found that her condition had deteriorated to the extent that a palliative care approach was agreed. Mrs M refused a naso-gastric feeding tube. Sadly, she died early on 4 August.

35. The adviser made a number of criticisms of the care and treatment Mrs M received; saying that a doctor should have been called immediately to attend Mrs M but she did not receive a medical review until 4.30am, some three hours after her arrival.

36. The adviser also said that more senior staff should have been called to attend to Mrs M after two attempts at cannulation had failed. He pointed out that she had worryingly low blood pressure and that hypovolaemia[8] and

[7] The excessive build-up of fluid in the tissues of the body.
[8] A state of decreased blood volume, specifically a decrease in blood plasma, which may be caused by haemorrhaging or dehydration.

dehydration were considered to be the cause of this, therefore intravenous fluid replacement would be critically important. He added that low potassium levels were associated with potentially dangerous cardiac arrhythmias[9].

37. The adviser said it was not clear why a tourniquet was not used to assist in the insertion of a cannula, which would have been standard practice. He added that although a pink Venflon[10] had been inserted at one point, he believed that given Mrs M's condition, a cannula with a wider bore would have been essential. He said it was unclear from the medical notes why more urgent measures were not taken to correct Mrs M's INR result and to insert a large bore line either at the elbow, neck or groin via a femoral vein. More senior medical advice would have been needed on this but the notes indicated that such intervention had been requested of the HDU by a doctor on 2 August and it was unclear why this support had not been provided. He said this requirement should have been addressed on the day of admission. He also noted that there had a failure to record all of the cannulation attempts claimed.

38. The adviser also said that discussions had taken place on the "Do Not Attempt Resuscitation"[11] situation which were not compliant with national guidance, as clinical staff had been contacted at home for input. It would be expected that staff present at the time should have all the relevant information to enable an informed discussion to take place. He also said that although there was no record of approaches to the family about DNAR prior to the meeting of 2 August, if these had taken place as claimed by the family, they were inappropriately managed. He was also critical of the HDU's failure to advise on or assist with Mrs M's cannulation being linked by the clinicians with her prospects of admission into HDU.

[9] A condition in which the normal rhythm of the heart is disrupted.
[10] A needle inserted into the body to enable direct administration of medication.
[11] Do Not Attempt Resuscitation - A written and agreed statement as to whether or not a patient will receive cardio pulmonary resuscitation in the event of a collapse.

39. The adviser also commented that there were a number of shortfalls in record keeping, with the names and seniority of staff who attended Mrs D being unclear or omitted and there were also gaps as to the times of day that she had been seen. The adviser said that there had been some retrospective changes to records but did not think that these had any significance in terms of the care or treatment delivered.

40. The adviser said that he could find no evidence that the delays in the initial treatment of Mrs M had contributed to her death.

41. The adviser said that it was unclear from the notes what system was in place to assess and prioritise patients admitted to A&E. He said that there were a number of issues that the Board needed to address resulting from its handling of this case and should be asked to explain its position with regard to gaining central line access. The latter point has been addressed in paragraph 17 of this report.

42. The adviser's report lists the guidance that should have been followed during Mrs M's admission and subsequent care.

Adviser in Emergency Medicine

43. The Ombudsman's adviser, Dr R J Evans, is a consultant in emergency medicine who works in the Emergency Department of a teaching hospital in Wales. He has many years experience of dealing with complaints, legal cases and has provided expert evidence in coroner's cases. He has been the chairman of the resuscitation committee of a teaching hospital.

44. Dr Evans said that the records showed that Mrs M presented with a rapid pulse rate, low blood pressure and a high respiratory rate. She had a MEWS reading of 11, which is considered to be high and of concern.

45. He said that the hospital's MEWS action plan said that in the event of any one physiological parameter reaching a score of 3, staff should move the patient to resuscitation room, inform the senior Emergency Department doctor and specialty doctor where necessary and nurse in charge immediately. Staff should also attach the patient to a cardiac monitor, give high flow oxygen and gain IV access. Vital signs should be measured at 15 minute intervals.

46. The adviser said that the triage nurse had failed to fully implement the MEWS action plan. Although she had transferred the patient to the resuscitation room and notified a senior nurse, she had not called a doctor immediately or attached a cardiac monitor, or given high flow oxygen, or achieved IV access.

47. The adviser said that Mrs M was in shock on admission, as she had low blood pressure and an elevated heart rate. He quoted from the British Thoracic Society Guidelines 2007 as follows:-

> "Supplementary oxygen therapy is required for all acutely hypoxaemic[12] patients and for many other patients who are at risk of hypoxaemia, including patients with major trauma and shock.
>
> All patients with shock, major trauma, sepsis or other critical illness should initially be managed with high concentration oxygen therapy from a reservoir mask."

48. The adviser also said there were failures to monitor Mrs M's vital signs at 15 minute intervals as required by the MEWS action plan, as there were gaps in the records.

[12] Hypoxaemia is a deficiency of oxygen in arterial blood.

49. He found that the records with regard to obtaining IV access were sparse. His view was that a doctor should have been called to assess Mrs M urgently and to attempt to gain IV access. If that doctor had failed, the requirement for cannulation should have been escalated to more specialist and senior staff.

50. From the time that IV access was obtained at 3.30am, the adviser said that the rate of infusion was poor, given Mrs M's low blood pressure and that he would expect a fluid bolus[13] of 250ml to have been given and the response monitored.

51. The adviser said that the records showed that Mrs M was on long standing steroid treatment. This, coupled with her extremely poor condition, placed her at risk of adrenal crisis[14]. He criticised the staff for not recognising this situation, for which he would expect hydrocortisone to have been administered in a more timely manner. It was not given until 3.30am.

52. The adviser concluded that, from the emergency medicine perspective, the care and treatment given to Mrs M fell below a reasonable standard.

Responses to draft report

The Complainant

53. Mrs D welcomed the report and said that it had provided her with information that had not been supplied during her dealings with the Board. She felt reassured by the fact that the Ombudsman had found failings in the care of her late mother. Mrs D said she remained of the view that these failings had contributed to her mother's death. She said that she and her family were still distressed by the events they had witnessed that night and

[13] The administration, intravenously or by injection, of a medication, drug or other compound to raise its concentration in blood to an effective level.
[14] Acute adrenal crisis is a life threatening condition that occurs when there is not enough cortisol, a hormone produced by the adrenal glands.

by the lack of response and compassion on the part of the nursing staff in A&E. Mrs D denied behaving in the manner alleged by hospital staff and was simply trying to get appropriate attention for her mother.

54. Mrs D was sceptical about the staff's claim that there had been seven attempts to cannulate Mrs M; saying that she had seen no attempts at cannulation and had seen no needles or other relevant equipment in the room. She said there were no indications on her mother's arms of such attempts.

55. Mrs D said she had not been able to come to terms, even after nearly three years, with the absence of even the most basic and obvious clinical responses to her mother's condition on arrival at the hospital. She believed that without her presence, her mother would not have received any intervention in A&E.

The Board's response to the draft report

56. The Board said that it had engaged in a number of processes with Mrs M's family which were aimed at addressing their concerns. There had been a POVA[15] investigation conducted with input from the family and the formal complaints process of the Board had been exhausted. These processes had included an independent review of the case by an independent A&E professional and some failings had been identified.

57. The Board apologised for the statement made by its staff at the informal meeting (paragraph 20) that nothing had changed since the case of Mrs M in 2010 and that a similar case would be handled the same way today. It said that a number of clinical improvements and procedural changes had in fact been made; these included implementing the National Early Warning Score (NEWS) system which is an improved and updated system to replace MEWS. Staff had been trained on this and NEWS action posters were in place

[15] Protection of Vulnerable Adults.

in A&E. It had also introduced the Peripheral Cannula Bundle to improve the management of cannulation, with each attempt being recorded and also that NICE Guideline 50[16] was in place. The Board held the view that a tourniquet would have been used in the attempts to cannulate Mrs M.

58. The Board responded positively to the draft report accepting the comments made regarding the failures within A&E. Having conducted a review of the case, it now agreed its handling of Mrs M's admission had fallen below a reasonable standard of care and that it would be addressing these matters with the staff involved. It provided information about what it said were higher priority cases on the medical wards at the time but concluded that in the circumstances of Mrs M's admission, a doctor should have been called to attend her and if that was not possible, an A&E doctor should have been summoned. It said that in the event, she had been attended by the A&E sister, two staff nurses and the out of hours nurse practitioner.

59. The Board accepted the criticism that record keeping had fallen below standard in this case and that this matter would be addressed.

60. In summary the Board agreed that:-

- Mrs M should have been immediately attended by a doctor as soon as the MEWS score of 11 was identified.
- There was an unacceptable delay in the appropriate cannulation and intravenous fluid replacement of Mrs M that should have been dealt with urgently by a senior doctor.
- There was an unacceptable delay in applying warming techniques to Mrs M that should have been applied within a short time of arrival at the hospital.
- Since Mrs M could have been in shock on admission, she should have been given a reservoir mask for high flow oxygen, even though her oxygen reading was 100%.

[16] National Institute for Health and Clinical Excellence – Guidelines on Management of Acutely Ill Patients.

- Given her MEWS score of 11, Mrs M's vital signs should have been monitored at fifteen minute intervals.
- Given that Mrs M was on long term steroid treatment she should have been urgently administered hydrocortisone treatment.

61. The Board said it concludes and accepts that there were a number of elements of Mrs M's treatment and clinical care that did not meet the Boards' standards or expectations. It said that it would develop an action plan to address these matters and that this would be audited to ensure that the failings in Mrs M's case were addressed so that a similar admission in 2013 would receive treatment and care to the high standard expected. It accepted all of the recommendations made in the report and said it would consider making a higher financial award than had been recommended.

Analysis and conclusions

Escalation to medical staff

62. My advisers have all expressed concern about the condition of Mrs M on her initial admission to A&E and the response of the nurse who initially received and assessed her. Mrs M had a high MEWS score which meant that a doctor should have been called immediately. There is no evidence in the records of a doctor having been called to see her at this time.

63. Staff have said that Mrs M was placed on oxygen and that a staff nurse was called, however, it has also said that both of these actions were taken in response to the difficulties staff experienced in dealing with the family, rather than a response to Mrs M's readings. These were serious failures to follow the protocol for dealing with a seriously ill patient.

64. It is apparent that the nursing staff failed to treat Mrs M properly and it is unsurprising that the family was distressed by what they saw and asked repeatedly for a doctor to be called. The Board submitted records to show that a number of high priority cases were being managed on the medical

wards at the time. However, it has also now acknowledged that a doctor should have been called from the A&E department if none was available from the medical wards. However the outcome on the night was that a doctor did not attend Mrs M for some three and a half hours when the hospital's procedures require an immediate call for a doctor. This was service failure.

65. There are gaps in the monitoring and recording of Mrs M's oxygen levels and the relevant guidelines for administration of oxygen to patients in shock were not followed immediately. These were service failures.

66. Mrs M needed to be cannulated immediately, not only by virtue of her condition on admission but because it was also required by the hospital's MEWS action plan. She should have been cannulated immediately and specialist staff should have been called when difficulties were experienced in achieving this. A more senior staff member should have been called after two failed cannulation attempts. That this did not occur was service failure.

67. Mrs M was at risk of potentially fatal adrenal failure on admission due to being on steroids and being extremely unwell but this was not addressed for nearly four hours, when she was seen by a doctor and was cannulated. Even when cannulation was achieved it was not a sufficient flow to address her symptoms speedily. A doctor appears to have recognised this and it is documented that he asked for advice and assistance from HDU. It is not documented why this assistance was not provided and the failure of HDU to provide such advice and assistance was a service failure.

68. There are therefore some failings identified in the subsequent care given after the admission itself and criticisms are also made of the handling of DNAR discussions, which should have been focused on staff who were present at the time.

69. Mrs M was clearly very unwell on admission, and although her condition stabilised eventually, this could have been achieved more speedily by immediate medical intervention to address her potentially life threatening conditions so that both she and the family could have been spared considerable distress and concern. However, no evidence has been found to suggest that the early failings in her treatment contributed to her death, which may be of some consolation to her family.

Procedures

70. I am obliged to the Board for now having clarified that process improvements have been made in the intervening period and for supplying the procedures that have been introduced since the time of Mrs M's admission. It has now confirmed that it operates NEWS, NICE 50 and an improved process for the management of cannulation. It has also supplied a copy of a handbook for staff in the emergency department which has been place since April 2013. I am therefore now satisfied the Board has appropriate procedures in place, which, if followed, should make the failings in this case less likely to re-occur.

71. I look to the Board to consider whether its responses to the investigation could have been more comprehensive and timely. It is not until a late stage in the investigation that its operating procedures and service improvements have been clarified to my satisfaction.

Record keeping

72. There are numerous failings in record keeping and a worrying lack of appropriate detail about the staff who attended Mrs M and what they did. I find that there was service failure in terms of record keeping, particularly illustrated by the failure to record all of the claimed seven cannulation attempts, the failures to record all of the vital signs checks and failure to record the full details of staff attending and involved with Mrs M's care.

73. In conclusion, I am satisfied that the number of failings in the initial treatment of Mrs M in A&E and their life threatening nature are such that the complaint should be upheld. Her initial care fell below a reasonable standard. Additionally, there are also some significant failings in her subsequent care and failures to follow national guidelines.

Recommendations

74. Therefore it follows from the above that I recommend that within three months of the date of the final report, the Board should provide evidence of the following actions:-

a) An apology to the family for the failings identified in this report and a payment to them in the sum of £750 for the distress of witnessing their late mother's unsatisfactory care in A&E and a further £250 for their time and trouble in pursuing a complaint over a lengthy period of time without obtaining a satisfactory response.

b) That it should bring this report to the attention of the nursing staff who first dealt with Mrs M in A&E and formally satisfy itself as to the professional competence of these staff.

c) That the Board should review its guidance to staff on record keeping and should conduct regular audits of clinical records to demonstrate that this guidance is being followed.

d) That the Board should follow national guidance in relation to "Do Not Resuscitate" decisions.

e) Provide detailed evidence of the actions taken to train and retrain staff in the guidelines referenced throughout this report and in the advisers' reports.

75. I am pleased to note that in commenting on the draft of this report the Abertawe Bro Morgannwg University Health Board has agreed to implement these recommendations.

Peter Tyndall 18 July 2013
Ombudsman

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 01656 641150
Fax: 01656 641199
E-mail: ask@ombudsman-wales.org.uk
Follow us on Twitter: @OmbudsmanWales