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The investigation of a complaint by Mrs J against Cwm Taf Local Health Board

A report by the Public Services Ombudsman for Wales

Case: 201101484

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 J who is the daughter of the patient concerned, Mrs Y. Sadly Mrs Y died on 16 May 2010.

Summary

Mrs J, the daughter of the late Mrs Y, complained to Cwm Taf Health Board about the clinical investigations and treatment provided to her mother when she attended the Accident & Emergency Department on 13 May, and the Medical Day Unit at Royal Glamorgan Hospital on 14 May 2010. Sadly, Mrs Y died following her discharge on 16 May 2010. Pulmonary thromboembolism was recorded as the principal cause of death.

Mrs J complained that the clinicians treating her mother failed to take timely and appropriate action in response to a blood test result which indicated thrombosis. Mrs J considers that had prompt action been taken when the result was available on 14 May 2010, her mother's death may have been prevented.

The Ombudsman's investigation found that the test was viewed by a nurse before Mrs Y's discharge on 14 May. Mrs Y's blood result was positive. A positive result can indicate thrombosis. The test result does not appear to have been appropriately considered, if at all, by the doctor who made the decision to discharge Mrs Y or by the Consultant with overall responsibility for her care before her discharge.

The Ombudsman concluded that the failure to consider and act upon the positive blood test result before making the decision to send Mrs Y home fell below an acceptable standard of care. This failing gave rise to a missed opportunity to make the correct diagnosis and to treat Mrs Y appropriately. The treatment that should have been given might have prevented her death. The investigation also identified a number of additional failings on the part of the Health Board.

The Ombudsman upheld the complaint and recommended that the Health Board should provide explanations and an apology to Mrs J and her family in addition to a redress payment of £ 5,000.

The complaint

1. Mrs J the daughter of the late Mrs Y complained to Cwm Taf Health Board ("HB") about the clinical investigations and treatment provided to her mother when she attended the Accident & Emergency Department ("A&E") on 13 May and the Medical Day Unit ("MDU")[1] at Royal Glamorgan Hospital on 14 May 2010. Sadly Mrs Y died on 16 May 2010. Pulmonary thromboembolism[2] was recorded as the principal cause of death.

2. In particular Mrs J complained that the clinicians treating her mother failed to take appropriate action when a D-dimer test result[3] was available on 14 May. She also complained that she had not received any explanation as to what action, if any, was taken over the weekend of 14 -16 May in respect of it. Mrs J considers that had prompt action been taken when the result was available, her mother's death might have been prevented.

Investigation

3. The investigation started on 17 March 2012. My investigator obtained comments and copies of relevant documents from the HB. I considered those in conjunction with the evidence provided by Mrs J. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

4. Professional advice was also taken from two of my clinical advisers. My advisor Dr Charles Turton, is a Consultant in Respiratory and General Internal Medicine ("the Respiratory Adviser") with many years of experience of management of the condition referred to in this report and Dr Rupert Evans, who is an experienced Consultant in Emergency Medicine ("the A&E Adviser").

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[1] Medical Day Unit is an ambulatory care unit open Monday to Friday from 8am to 4:30pm.
[2] A clot on the lung.
[3] A screening test for venous thrombosis. A negative result practically rules out thrombosis, a positive result can indicate thrombosis, but does not rule out other potential causes.

5. A summary of the available guidance considered to be relevant to the complaint is attached at **Appendix 1.**

6. When investigating complaints relating to clinical matters, I (and my advisers) am obliged to consider what would be a reasonable standard of care at the time events took place. I cannot assess events with the benefit of hindsight. Where there is a conflict in evidence (such as differences in verbal accounts) I am unable to resolve such matters.

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

The background events

8. On Thursday 13 May at 10:33 Mrs Y (aged 62) arrived at the A&E department by ambulance. She said that she had become severely breathless when walking to the bathroom that morning and was gasping for breath. Routine observations were taken at 10:35. Mrs Y was noted to have reduced oxygen saturations at 92%,[4] a low peak flow and an elevated pulse at 104 bpm.[5]

9. Mrs Y was then reviewed by the A&E doctor who recorded a past medical history of asthma, arthritis and depression. The doctor also recorded that Mrs Y had been suffering from an ongoing chest infection for two weeks, that she had seen her GP and was taking steroids and antibiotics. She was noted to have been "chesty throughout, coughing and bringing up phlegm". The records state that she said she had not had any chest pain and did not experience pain on deep inspiration.

[4] Level of oxygen within the blood - normal range is 94-98%
[5] A normal heart rate should be between 60 and 100 beats per minute (bpm) when resting

10. The A&E doctor performed a chest examination and recorded that she had bilateral air entry with no added sounds. He also recorded that she had bilateral pedal edema[6] up to the knee with cellulitis[7] of the right leg. The doctor requested routine blood tests, an ECG[8] and a chest x-ray.

11. The chest x-ray was reviewed by a radiologist who recorded "normal heart and medostatin. Background changes of COPD. No focal consolidation."

12. The doctor discussed Mrs Y's case with an Advanced Nurse Practitioner ("ANP") from the MDU, the doctor recorded that Mrs Y would be reviewed in the MDU. Mrs Y was prescribed antibiotics and steroids, released from A&E and advised to return to the MDU the following day (14 May). A referral document was completed and sent to the acute medicine department by the A&E doctor.

13. Mrs Y attended the MDU on Friday 14 May. The presenting complaint recorded in the admission note was "*worsening SOB x months*". Additional points recorded in the history section were that she was a non smoker and had increased day time sleepiness. Observations showed normal temperature, blood pressures, pulse, respirations and oxygen saturations. Physical findings included weight 141kgs (body mass index of 62), right lower leg circumference of 5cms more than the left, rash on right leg, and clear chest.

14. Mrs Y was initially seen by a medical registrar who arranged for the repeat of routine blood tests. The results of which were satisfactory with the exception of a high white cell count. Arterial blood gases breathing air showed low oxygen tension and normal

[6] Bilateral pedal edema is the accumulation of fluids in both lower extremities (feet, lower legs).
[7] Cellulitis is a localized or diffuse inflammation of connective tissue with severe inflammation of dermal and subcutaneous layers of the skin
[8] Electrocardiogram (ECG) - The electrocardiogram is commonly used to detect abnormal heart rhythms and to investigate the cause of chest pains

carbon monoxide tension and pH. D-dimer and CRP tests were taken also. The doctor noted a Wells score[9] of 1-0. The notes contain the following reference "consider clexane.[10] Not dictated as pt [patient] coming back to MDU next week".

15. Mrs Y's case was reviewed by a Consultant Acute Physician that day ("the Consultant") at 15:30. Possible diagnoses considered were a cardiac component to the breathlessness and obstructive sleep apnoea. Arrangements were made for Mrs Y to attend at the clinic the following week (21 May) for review and further investigation. Mrs Y was given an anti-obesity drug and was sent home.

16. Mrs Y's D-dimer test result was recorded as 2.51 ug/ml.[11] The pathology report within the patient records indicates that the "Cut off for exclusion of VTE is 0.5 ug/ml". The results were recorded on the electronic system used by the HB and authorised as complete at 15:32.

17. The patient records demonstrate that the Consultant reviewed Mrs Y's case on the morning of Monday 17 May. Arrangements were to be made for her urgent return to the MDU for a CT scan to investigate possible PE and for treatment with clexane. A phone call established that, tragically, she had collapsed and died at home on Sunday 16 May 2010. The causes of death recorded in the post mortem report were pulmonary thromboembolism and obesity.

[9] Wells PE Risk Score is an assessment tool used to assess the clinical probability of venous thromboembolism. It is recommended by the British Thoracic Society for use by junior doctors. A low score is generally interpreted as representing a low probability of PE.
[10] Clexane is a brand name for the drug enoxaparin which is often used for prophylaxis and treatment for venous thrombosis.
[11] Micrograms per millilitre. A result of greater than 2.0 ug/ml is considered to be a high reading. A positive D-dimer indicates the presence of an abnormally high level of cross-linked fibrin degradation products in the body. A positive result suggests that there has been significant clot (thrombus) formation and breakdown in the body, but it does not identify the location or cause.

18. Mrs J wrote to the HB on 7 July 2010 to complain about the treatment received by Mrs Y in the days leading to her death. Mrs J initially expressed concern about the care provided within the A&E department when Mrs Y presented with extreme breathing difficulties. She questioned why PE was not at least considered as a possibility by the department. Mrs J expressed the view that a simple D-dimer test could have been done by the A&E department to assess the possibility. Mrs J said that her mother's symptoms of breathlessness, swollen right leg and low oxygen levels in her blood were misdiagnosed.

19. Mrs J questioned the information provided to her by the A&E doctor concerning her mother's chest x-ray which she said was later contradicted by the MDU staff.

20. Mrs J also raised concerns about the treatment provided to her mother in the MDU on 14 May. She said that a further chest x-ray was not performed and that much was made of the fact that her mother was significantly overweight. She said that despite presenting with significant symptoms and in a state of distress on two occasions she was released without a diagnosis having been made.

21. Finally, Mrs J expressed deep frustration that the MDU staff contacted her by telephone on the morning of 17 May, to ask Mrs Y to attend the hospital that day for further tests. Mrs J considered that these actions were indicative of the fact that a glaring opportunity to save her mother's life had been missed.

22. On 23 August 2010 the HB provided a response to Mrs J. The HB confirmed the sequence of events as recorded in the medical records. In response to the specific issues raised it stated that the chest x-ray carried out in A&E appeared normal, and was reviewed the following day in MDU.

23. The HB confirmed that the Consultant did discuss Mrs Y's weight with her and that her respiratory problem was possibly being exacerbated by her size. It commented that Mrs Y did not appear to show any offence at having discussed this. However, the HB apologised if this was not the case.

24. The HB said that Mrs Y's high white blood cell count and low blood oxygen levels were noted on 14 May. However, the white blood cell count could be accounted for by the infection or steroid use and that although there was a low oxygen level, Mrs Y's pH and carbon dioxide were both normal. In view of these factors and her six month medical history, the Consultant considered that "there was something going on" with Mrs Y's chest which required further investigation. As a consequence the Consultant was arranging for further tests to be performed the following week and for an urgent respiratory consultation.

25. The HB commented that Mrs Y walked slowly but comfortably from the MDU and appeared satisfied that she would be reviewed and investigated further the following week.

26. The HB advised that Mrs Y's test results including the D-dimer test result was reviewed by the Consultant on 17 May, who decided that a CT scan should be undertaken that day and further blood gases obtained. The Consultant said that both would have helped to exclude PE and to consider another diagnosis.

27. On 18 November 2010 Mrs J, together with her sister Mrs G, attended a meeting with the HB's Lead Consultant in Emergency Medicine and Head of Nursing for Acute Medicine to discuss the complaint further.

28. The representatives of the HB confirmed that it was not uncommon for patients to be discharged from A&E to attend the MDU the following day. Further, they explained that admission was not normally required for a PE.

29. The issue of the D-dimer was discussed. Mrs J was advised that results are generally available electronically and when they are unfavourable, they are brought to the attention of the medical team and arrangements can then be made to admit the patient immediately onto the Acute Medical Unit ("AMU") where necessary. The representatives of the HB were unable to confirm neither who saw Mrs Y's D-dimer result nor when it was available to be viewed. The HB advised that the Consultant saw all the test results on the morning of 17 May.

30. Mrs J was advised that the D-dimer result was not considered necessary for the initial investigations in view of her mother's six month medical history, a PE was not considered likely at the time (14 May). The representatives of the HB concluded that the clinicians would not look at just one factor, they would look at all factors when making a clinical decision.

31. Mrs J indicated during the meeting that she remained dissatisfied with the explanation of events and felt that her mother had the PE on her initial attendance at the hospital on 13 May. The meeting concluded and a representative of the HB stated that she would provide the family with additional information concerning the availability of the D-dimer test result; the national guidelines in relation to PE and to confirm the exact cause of Mrs Y's death.

32. Mrs J sought further explanation of her mother's cause of death from HB's Cellular Pathology Department in February 2011. A consultant histopathologist responded to these concerns.

Mrs J's evidence

33. Mrs J said that she believes that the HB's staff failed to take appropriate action when the D-dimer test result was available. She explained that she was informed during the meeting that the test results only take a few hours to be returned, and considers that no explanation was given to her as to when they were available and viewed. Mrs J said that the HB has not explained what action, if any, was taken over the weekend in response to the result. Mrs J clearly expressed the view that had appropriate action been taken in response to the D-dimer result over the weekend then her mother's death may have been prevented.

The Health Board's evidence

34. The HB did not make any further comment on the issues raised in the complaint, it is therefore assumed that the responses previously provided to Mrs J are reflective of its position.

35. As part of the investigative process my investigator made additional enquiries with the HB in relation to the specific issues raised in the complaint. In response the HB said that pathology test results, including D-dimer results are available to be viewed on the HB's electronic web browser. According to the system Mrs Y's sample for the D-dimer test was taken on 14 May 2010 at 14:45, received by the laboratory at 14:55 and authorised as complete at 15:32. The result would have been available at that time. However, the HB's records indicate that the result was actually viewed by a nurse at 15:15, before Mrs Y's discharge.

36. The HB state that the test result was accessed on the electronic system only by the nurse on 14 May and that it was not viewed by the Consultant before Mrs Y went home. However, the nurse who looked at the result said that whilst she cannot recall the patient or the circumstances she is of the view that she would have made a doctor aware of the result. The HB believes that the nurse may have

informed the medical registrar who had seen Mrs Y earlier that day. The HB has been unsuccessful in its attempts to locate this doctor.

37. The Consultant commented that considering all the factors, which include the use of a non specific test in a lady with a six month history of chest problems, she would not have done anything differently even if she had seen the test result. She added that it was only after that weekend that she could have expedited matters by carrying out a computerized tomography – pulmonary angiogram ("CT-PA")[12], which may have helped her come to some other diagnosis for Mrs Y before she was seen by the respiratory physician.

38. It said that it was the Consultant's clinical opinion that Mrs Y did not need to be admitted to the AMU[13] on 13 or 14 May as an outpatient and was suitable to attend the MDU on both 14 and 21 May.

39. Following consideration of the draft report the HB provided an email from a retired Senior Nurse Practitioner who was involved in Mrs Y's care on 14 May. The Nurse Practitioner retired some time ago but recently returned to the hospital as a bank nurse. She was able to recall the events of 14 May. She said that Mrs Y who was complaining of shortness of breath, was initially examined by the registrar and was later reviewed by the Consultant. She said that she was present during the examination and recalls that the Consultant thought that she was suffering from an infective episode and said that she would review Mrs Y in a few days after medication to ensure her symptoms had settled.

[12] CT pulmonary angiogram (CTPA) is a medical diagnostic test that employs computed tomography to obtain an image of the pulmonary arteries. Its main use is to diagnose pulmonary embolism (PE).
[13] AMU – Acute Medical Unit assessment unit. It is open 24 hours, 7 days a week.

40. The Nurse Practitioner said that the registrar asked if clexane should be administered until review as the D-dimer test result was outstanding. She said that the Consultant said that she would not have requested a D-dimer test as it was, in her view, an infective episode and would stand by her diagnosis even if the D-dimer result was raised. She said that they were given the D-dimer test result whilst they were still with the patient. She said that the Consultant asked to see Mrs Y's legs and all present agreed that there was no redness, they were not particularly hot and that there was no obvious swelling or pitting oedema. She said that the Consultant discharged Mrs Y with an appointment for the following week.

41. The Consultant has also commented on the draft report. She refers to paragraph 14 of the report and believes that the entry in the patient record is that the patient discharge summary was not "dictated" rather than being an explanation as to why clexane was not given. She said it is normal practice for discharge summaries to be dictated after review. She also said that it had always been the HB's policy if PE/DVT is considered, which she said it was not in this case, that clexane is given until it is excluded. She said that PE was not part of the differential diagnosis.

42. The Consultant said that there are differences in the recollection of the events of 14 May between her and the Nurse Practitioner and is upset by the potential confusion.

Professional advice

What the A& E adviser had to say

43. Dr Evans was satisfied that the initial assessments[14] undertaken in A&E on 13 May were of an appropriate and reasonable

[14] Triage assessments – which included routine observations of temperature, pulse, respiratory rate, blood pressure, oxygen saturations, and Glasgow coma scale and peak respiratory flow.

standard. However, he is of the opinion that Mrs Y's recorded history of an acute onset of severe shortness of breath, the recording of low oxygen saturations and the finding of a swollen calf, meant that a PE should have been considered in the differential diagnosis by the A&E doctor.

44. Dr Evans acknowledges that the Wells PE risk score used by the HB, would have revealed that Mrs Y had a low probability of PE and DVT. Having said that, he considers that the correct management would then have been to arrange a D-dimer blood test. Dr Evans expressed the view that on balance the result of a D-dimer on 13 May would have been elevated (given that it was elevated on 14 May). However, he has commented that the decision taken by the A&E doctor in conjunction with the ANP to refer Mrs Y to the MDU for further investigation was reasonable in the circumstances.

What the respiratory adviser had to say

45. Dr Turton explained that doctors reach diagnostic decisions by weighing the relative importance and putting together a very large number of points of information. He commented that if we were to highlight only the episode of severe SOB and Mrs Y's swollen leg then PE certainly should have been strongly considered and investigated. However, Mrs Y's case was more complicated in that there were a number of factors including her morbid obesity which commonly cause breathlessness.

46. Dr Turton was satisfied that there was a reasonable clinical assessment of Mrs Y at the MDU on 14 May 2010. Having said that, he was critical that no conclusion appears to have been reached in respect of the swelling of the right leg. Dr Turton questioned why a Doppler scan[15] was not undertaken to investigate the possibility of

[15] A Doppler ultrasound test uses reflected sound waves to evaluate blood as it flows through a blood vessel.

DVT. Although he acknowledges that the post mortem did not identify a DVT (it is therefore likely that any Doppler scan would have been negative in any event). However, the failure to identify the cause of the swelling and cellulitis by further investigation represents a serious failing in his view.

47. Further, Dr Turton notes the comments within the clinical records considering the use of clexane prophylaxis referred to in paragraph 14 above. He does not consider that Mrs Y's planned return the following week was sufficient justification for withholding prophylaxis if it was indicated on the grounds of her reduced mobility, general ill-health and possible cellulitis. Although he did comment that prophylaxis is not usually given to patients at home.

48. Dr Turton has confirmed that PE should have been considered as part of the differential diagnosis of unexplained breathlessness, even if the clinicians considered an alternative diagnosis was more likely. The clinical records do not mention PE specifically; however the request for a D-dimer is some evidence that it was considered.

49. Dr Turton commented that even if the diagnosis of PE was considered to be unlikely by those treating Mrs Y, which would not have been unreasonable in the overall circumstances, PEs are frequently missed, potentially fatal and readily treated. For this reason he does not consider that it would have been unreasonable for the clinicians in MDU to delay Mrs Y's release pending receipt and review of the result of the D-dimer test, if this was not available prior to her leaving the unit.

50. I specifically asked Dr Turton to comment upon the evidence received from the HB relating to the initial viewing of the D-dimer test result.

51. Dr Turton confirmed that the responsibility for considering and acting upon the D-dimer test result lay with the doctor receiving the result. He added that overall the responsibility for deciding on medical fitness for discharge lay with the most senior member of the medical team or whoever they had delegated it to on that day.

52. He said that if the nurse failed to inform the doctor then there was a serious communication failure within the clinical team. If however the doctor was informed then his/her failure to take necessary action in response to it was a serious omission.

53. Dr Turton considers that the positive D-dimer result substantially raised the probability of PE. He states that treatment (as opposed to prophylactic doses) doses of clexane should have been started pending a CTPA to confirm or refute the diagnosis. He said that with good care it is more likely than not that Mrs Y would have survived. In the event that Mrs Y had left the unit before the result was available to or brought to the attention of the doctor then she should have been recalled urgently.

54. Dr Turton said the HB's treatment of Mrs Y in failing to take account of all available information fell substantially below a level to be expected. He said that the decision and circumstances of Mrs Y's discharge were not reasonable in light of the D-dimer test result. Whilst he noted that there were confounding factors of asthma and severe morbid obesity which made Mrs Y's case very difficult, there were clear shortcomings in the care provided to Mrs Y and a missed opportunity to make the correct diagnosis and treat her.

55. I have also asked Dr Turton to comment on the additional information received from the HB in response to the draft report. He said that the additional evidence does not change his advice that PE should have been considered as a possible diagnosis for the clinical features which included a severe episode of breathlessness the

previous day, the documented increase in the circumference of the right leg (5cms) and the blood gas result of hypoxia. He said that notwithstanding the confounding factors referred to above, he remains of the view that the finding of a positive D-dimer test should have led to immediate treatment with treatment doses of clexane pending further investigation into possible venous thromboembolism. In his view the discharge from the unit was not safe given the D-dimer test result and he considers that with good care it is more likely than not that Mrs Y would have survived.

Analysis and conclusions

56. Mrs J's complaints concerning her mother's treatment in the A&E department on 13 May 2010 have in part been addressed by the HB through of the complaints process. I have however considered whether the department should have arranged for a D-dimer test to be taken on 13 May 2010.

57. The result of the D-dimer test was positive on 14 May 2010 and on the basis of the advice from Dr Evans it is likely that it would have been on 13 May also. However, he has confirmed that whilst the test may have helped the A&E staff to make a correct diagnosis for Mrs Y on 13 May, he considers that the decision to refer her to the specialist MDU was appropriate and reasonable. It is regrettable that a D-dimer test sample was not taken from Mrs Y on 13 May as this may at the very least have prompted the clinicians in the MDU on 14 May 2010 to make a diagnosis of Mrs Y's condition or indeed undertake further investigations that day. However, having said that the decision to refer to a specialist unit for further investigation in effect transferred the responsibility for diagnosis to the MDU and does appear to have been reasonable in the circumstances. I am therefore satisfied that the standard of care afforded to Mrs Y in A&E on this occasion was of an acceptable standard.

58. I now turn my attention to Mrs Y's attendance at the MDU on 14 May.

59. Both of my advisers have clearly stated that PE should have been considered as part of the differential diagnosis in view of Mrs Y's presentation. Whilst, the Consultant appears to take a contrary view I am guided by the advice received. The guidance on PEs highlights that they are frequently missed and easily treated. The fact that the D-dimer test sample was taken is evidence that it was at the very least considered by the medical registrar but I am saddened that Mrs Y was discharged without full consideration of all test results, which we now know were available before her discharge. There appears to be little purpose in conducting a test if the result was not going to be considered as part of any clinical diagnosis. I also consider that when making a decision to discharge a doctor should take into account all relevant factors included the result of any tests undertaken.

60. Overall I agree with the advice received that the failure to consider the D-dimer test result led to a missed opportunity to make a diagnosis and treat Mrs Y. This was a significant factor in her death. Proper consideration of the test result and prompt treatment may well have led to her survival. The consequences of this failure have had a devastating effect for Mrs Y and her family. I also agree with the adviser that the failing to reach a conclusion as to the cause of the swelling in Mrs Y's leg by further investigation represents an additional failing. I am satisfied that the care provided to Mrs Y when she attended at the MDU on 14 May was far below an acceptable standard. I therefore fully **uphold** Mrs J's complaint.

61. The information provided by the HB in relation to the availability of the D-dimer test result is in serious conflict. The information contained within the complaints file and confirmed by that provided to Mrs J previously, is that the D-dimer test result was not viewed by

anyone before Mrs Y's discharge, until the Consultant did so on the morning of 17 May. The information subsequently received during my investigation contradicts this account.

62. We are now aware that the result was accessed by a nurse at 15:15 that day the nurse concerned asserts that she would have made the doctor aware of it, although I note that she does not specifically recall Mrs Y, the circumstances of the case or the conversation with a doctor. The nurse practitioner is now suggesting that the test result was shared with and discounted by the Consultant whilst with the patient, although there is no entry within the patient records to reflect this. I also note that no reference is made to the result in the document prepared following Mrs Y's review by the Consultant at 15:30. I would at the very least have expected an entry to have been made in the records to justify the dismissal of an abnormal test result.

63. During the meeting on 18 November 2010 the HB advised Mrs J that "results are available electronically ... if the results were unfavourable, they would be brought to the attention of the medical team and arrangements would be made to admit the patient immediately onto the acute medical ward". This clearly did not occur the result was clearly unfavourable but no action appears to have been taken in respect of it before the morning of 17 May.

64. The principles of good record keeping issued by the NMC[16] state that nurses have a duty to communicate fully and effectively with colleagues, ensuring that they have all the information they need about the people in their care and should also use their professional judgement to decide what should be recorded in the patient records. There is no reference to the test result in the patient records to

[16] NMC Record Keeping Guidelines 2009 - Appendix 1

suggest that any member of staff was aware of the result before 17 May. It is of great concern that sight of a diagnostic test result was not recorded within the patient records, particularly in view of the clear indication that it was positive. Further, the lack of a record casts doubt on the nurse and nurse practitioner's accounts, in the absence of a reference to a discussion with a doctor within the patient records, I can only conclude that a discussion did not occur. The lack of reference to the result in the patient notes is wholly unsatisfactory and represents a further significant failing.

65. Enquiries have ascertained that the test was requested by the medical registrar and the decision to send Mrs Y home was taken by the Consultant. Mrs Y was not admitted and no treatment was offered. I must therefore assume that the test result was not taken into account when the decision to discharge was made. For the reasons set out above I do not consider that the decision to send Mrs Y home in these circumstances was reasonable. This issue gives rise to two possible scenarios that the Consultant was not made aware of the result by the nurse and made a decision without full consideration of all test results and factors to discharge Mrs Y or that she failed to take appropriate action when presented with the result. I am mindful of Dr Turton's comments in relation to the responsibility of the clinical staff to consider and act upon the result when it was available and that the overall responsibility for the patient's care lay with the Consultant. If Mrs Y had already left the unit when the result became known then she should have been recalled urgently for treatment, the Consultant appears to have adopted this approach on review of the case on the Monday morning.

66. The Consultant's view that even if she had seen the result on the Friday prior to discharge that she would not have done anything differently before the weekend is of great concern. I am mindful of the view expressed by Dr Turton, that the positive test result substantially raised the probability of PE and that treatment should have started

immediately pending further investigation. In view of this advice I do not consider that it would have been reasonable in any circumstances for the result to be discounted or for the delay of Mrs Y's treatment over the weekend. The MDU is an ambulatory unit open Monday to Friday 8am to 4.30pm. I am however advised by the HB that the Consultant would have had the opportunity to admit Mrs Y to the Acute Medical Unit had she considered it necessary to do so. I cannot therefore see any justifiable reason why the Consultant took this view if presented with the test result as claimed by the nursing staff. It is also worthy of note that the Consultant appears to have taken a contrary view and changed her position entirely on the morning of Monday 17 May. The entry within the patient records suggests that following her review of the case she made a decision to call Mrs Y in urgently and planned to start treatment pending further investigation to exclude PE.

67. An additional failing is in my view demonstrated in the communication, or as it would appear lack of, between the clinical staff at the MDU on 14 May. I have been unable to ascertain with certainty who, if anyone, was informed of the positive test result, and whether this was brought to the attention of the medical registrar or the Consultant who then discounted its relevance to the diagnosis. I am inclined to accept the account offered by the Consultant that she was not aware of the result until the morning of 17 May. This is supported by the information contained in the patient records and complaints documentation. I am satisfied that the apparent breakdown in communication represents a further serious failing.

68. I have also considered the manner in which the HB investigated Mrs J's complaint and the explanations provided to her. It is clear to me that the HB's own investigation was superficial and failed to identify a number of serious shortcomings in its performance. There is also evidence of service failure in the way in which the HB has dealt with Mrs J's complaint. The staff at the meeting agreed to

provide further information concerning the availability of the test result and who accessed them and when they were accessed. The HB did not do this. Enquiries made during this investigation have established when the results were available and when they were viewed for the first time before Mrs Y's discharge. I therefore **uphold** this aspect of the complaint.

69. I have concluded that the HB failed to consider and act upon Mrs Y's D-dimer test result before her discharge from the MDU, this failing gave rise to a missed opportunity to make a diagnosis, conduct further investigations and treat her condition. While accepting that there is rarely certainty in such matters, on balance such action may have prevented her sad death. I have no doubt that this uncertainty will always prey on the minds of Mrs Y's close family and to me constitutes an enduring injustice to them. I have also identified a failing in respect of the HB's handling of Mrs J's complaint. I consider this to be a further injustice to Mrs J and her family.

70. Finally, I am concerned that the HB did not consider whether the circumstances of the complaint warranted further investigation as a patient safety incident in accordance with its responsibilities under the complaint handling guidance. I have not seen any evidence to suggest that this case was assessed for this purpose or that any governance issues arose as a consequence. Given the serious nature of the failings identified in this report I would expect the HB to have considered whether this case did identify any safety issues.

Recommendations

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

a. Provides a written apology to "Mrs Y's family" from the Chief Executive, which recognises and acknowledges the distress to Mrs J

and others due to the circumstances of Mrs Y's discharge and for not adequately investigating her concerns previously.

b. Pays Mrs J £5,000 as an acknowledgement of the cumulative effect of the injustices to her and her family identified in this report.

c. Conduct an analysis of the care provided, including a consideration of what lessons might be learned and how those learning points will be addressed for the future. Evidence of this analysis, any action points and the outcome of the same should be provided to this office and Mrs J within six months of the date of this report.

d. Reviews its arrangements for communication within the MDU clinical team. Evidence of this analysis, any action points and the outcome of the same should be provided to this office and Mrs J within six months of the date of this report also.

e. 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.

f. Provide retraining to the Consultant and all staff in MDU in respect of investigation, diagnosis and treatment of Venous Thromboembolism.

g. Within two months, carry out an audit of nursing record keeping in the MDU and take appropriate action to remedy any shortcomings that are apparent. Evidence of this audit, any action points and the outcome of the same should be provided to this office and Mrs J within six months of the date of this report. Nursing staff should also be reminded of the responsibilities for record keeping in line with NMC Record Keeping Guidelines 2009.

h. Obtains the Consultant's agreement to place a copy of this report on her personal employment file for a 5 year period.

72. 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.

Elizabeth Thomas
Director of Investigations 15 November 2012

Signed for and on behalf of Peter Tyndall, Ombudsman.

Appendix 1

Relevant national clinical guidance and standards

The following are the relevant professional guidance documents that I and the Advisers considered relevant to this complaint, and were taken into account:

- British Thoracic Society ("BTS") guideline for the management of suspected pulmonary embolism ("PE"), Thorax 2003: 58: 470 – 484.

The BTS guidance states that all patients with possible PE should have clinical probability assessed and documented. It also states that an alternative clinical explanation should always be considered at presentation and sought when PE is excluded. The guidance sets out a number of risk factors for venous thromboembolism ("VTE"). Obesity and COPD[17] are listed as minor risk factors.

The guidance states that the overall mortality of PE untreated is 30%. The hospital mortality varies from 6 -15%, but that includes some patients not diagnosed in life or untreated before death. The mortality in PE treated is 5%, and the treatment takes effect rapidly.

The guidance states that blood D-dimer assay should only be considered following assessment of clinical probability and that a negative D-dimer test reliably excludes PE in patients with low or intermediate clinical probability; such patients do not require imaging for VTE.

- NICE Clinical Guidance 92 Venous thromboembolism: reducing the risk, January 2010.

[17] COPD - chronic obstructive pulmonary disease. It is the name used to describe a number of conditions, including chronic bronchitis and emphysema, where people have difficulty breathing because of long-term damage to their lungs.

- The NICE clinical guidance states that VTE is a condition in which a blood clot (a thrombus) forms in a vein. The thrombus may dislodge from its site of origin to travel in the blood. VTE encompasses a range of clinical presentations, venous thrombosis is often asymptomatic; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. Symptomatic venous thrombosis carries a considerable burden of morbidity. Sometimes over a long term because of chronic venous insufficiency. This is in turn can cause venous ulceration and development of a post-thrombotic limb (characterised by chronic pain, swelling and skin changes). The risk of developing VTE depends on the condition and/or procedure for which the patient is admitted and on any predisposing risk factors (such as age, obesity and related conditions).

The guidance states that all patients should be assessed on admission to identify those who are at increased risk of VTE. Those patients should be regarded as being at risk of VTE if they are expected to have ongoing reduced mobility relative to their normal state and have one or more of the risk factors identified in the guidance (which include obesity). It goes on to state that general medical patients assessed to be at increased risk of VTE should be offered pharmacological VTE prophylaxis. However, all patients should be assessed for risk of bleeding before offering pharmacological VTE prophylaxis.

- GMC duties of a doctor and good medical practice (November 2006).

The GMC's function is to ensure proper standards in the practice of medicine by doctors. Its guidance on good practice guidance includes a section on record keeping by doctors, stating that records

need to be clear, accurate, and report the decisions made and information given to patients.

- NMC Guidelines - Record keeping guidance for nurses and midwives 2009

Principles of good record keeping:

> "6. You should use your professional judgement to decide what is relevant and what should be recorded.
>
> 7. You should record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment.
>
> 8. Records should identify any risks or problems that have arisen and show the action taken to deal with them.
>
> 9. You have a duty to communicate fully and effectively with your colleagues, ensuring that they have all the information they need about the people in your care."

- Complaints in the NHS. The Guide to good complaint handling in Wales (April 2003).

The guide to good complaint handing in Wales[18] [pre April 2011] provided that all NHS Bodies should have separate policies and procedures in place for management and investigation of patient related adverse incidents. The overarching aim was to ensure that lessons were learnt.

[18] http://www.wales.nhs.uk/sites3/docopen.cfm?orgid=932&id=162729&90F51B39-08AD-DAE4-9785D7ED39E90459