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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint by Dr A against Cardiff and Vale University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201401302

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 Dr A and his mother as Mrs A.

Summary

Dr A complained about the care given to his mother ("Mrs A") by Cardiff and Vale University Health Board ("the Health Board"). He said that, on 13 February 2014, Mrs A was admitted to the Medical Assessment Unit ("the MAU") of the University Hospital of Wales. She was later transferred to a surgical ward ("the Ward"). Dr A said Mrs A was triaged wrongly, the medical team were late in examining her and no treatment was given. He said the MAU misdiagnosed and mismanaged sepsis and failed to follow the "sepsis pathway". He also said:

- antibiotics were either administered late or not at all
- fluid balance monitoring was not done. His mother was septic and was unable to pass urine, but a catheter was not inserted;
- no paracetamol was given in the MAU and she remained feverish throughout her stay in the MAU;
- despite being on oxygen when she was in the MAU, she was not given oxygen during a transfer between the MAU and the Ward.

Dr A said the failings led to Mrs A suffering a cardiac arrest on 13 February. Mrs A remained in hospital until 8 March when, sadly, she died.

My investigation considered the relevant records along with comments from the Health Board and Dr A. I also obtained advice from two of my clinical advisers.

Sepsis is a common and potentially life-threatening condition triggered by an infection. If not treated quickly, it can eventually lead to multiple organ failure and death. Early symptoms of sepsis usually develop quickly and it can move from a mild illness to a serious one very quickly. Therefore, early intervention is key. If identified and treated quickly, sepsis is treatable. The Sepsis Six is a recognised set of interventions (including the giving of antibiotics) which, when delivered in the first hour, can increase the chance of survival.

My investigation found that Mrs A was suffering from sepsis. However, the Health Board failed to implement the Sepsis Six.

Mrs A should have been seen by a doctor within 10 minutes of triage; however she was not reviewed by the doctor for three and a half hours. There was a similar delay in the giving of paracetamol and, more seriously, a delay of over six hours in the giving of antibiotics.

My investigation also found that the Health Board failed to follow record keeping and complaint handling guidance.

In relation to Dr A's complaint that Mrs A was not given oxygen during a transfer between the MAU and the Ward, it is clear that Mrs A needed supplementary oxygen and this was given in the MAU. However, it was not clear from the records whether this was provided during the transfer to the Ward. If Mrs A was transferred without oxygen this would be a serious failing. The records indicated that she was peripherally cyanosed shortly after the transfer. This fits with the possibility that she was transferred without oxygen. She then suffered a cardiac arrest.

Unfortunately, as a result of poor record keeping, my investigation could not determine with any certainty whether Mrs A was, or was not, given oxygen during the transfer. Nor could it definitively identify what role the transfer played in her suffering a cardiac arrest. The poor record keeping therefore caused uncertainty which is an injustice.

I concluded that the care provided to Mrs A on 13 February was inadequate. Therefore, I **upheld** Dr A's complaint and recommended that the Health Board should:

a) Give Dr A an unequivocal written apology for the failures identified by this report.

b) Make a payment to Dr A of £4000 to reflect the:
   i. distress caused by the failings in Mrs A's care;
   ii. uncertainty caused by those failings;
   iii. failings in the Health Board's handling of his complaint;
   iv. provision of incorrect information during the complaint process.

c) So that appropriate lessons may be learned, share this report with the doctors, nurses and administrative staff involved in the case.

d) Formally remind the doctors and nurses involved in Mrs A's care to follow the relevant record keeping guidance. (If needed, and within four months of the date of this report, the Health Board should implement refresher training for staff, involved in the case, who indicate that they are not fully conversant with the relevant guidance).

e) Provide me with evidence of its current process which ensures that doctors and nurses who meet with complainants are familiar with the case and the patient's records.

f) Provide me with evidence of the existing monitoring and quality assurance mechanisms it has in place to prevent a recurrence of the failure of:

i. doctors to review a patient categorised as triage 2 within the timescales specified by the MTS.
ii. doctors and nurses to follow the sepsis pathway.
iii. doctors to ensure that the surgical review was performed by a doctor experienced enough to perform it.
iv. doctors and nurses to maintain appropriate records.
v. doctors, nurses and administrative staff to follow the Complaints Guidance.

(If the Health Board is not able to provide evidence to show that it has current suitable protocols for (e) and (f)(i) – (v) then, within four months, it should provide its plans to introduce such protocols).

g) Ensure that staff training in respect of recognising sepsis is up to date.

(If needed, and within six months of the date of this report, the Health Board should implement training for staff who indicate that they are not fully conversant with the relevant protocols).

The complaint

1. In May 2014, Dr A[1] complained about the care given to his mother ("Mrs A") by Cardiff and Vale University Health Board ("the Health Board"). He said that, on 13 February 2014, Mrs A was admitted to the Medical Assessment Unit ("the MAU") of the University Hospital of Wales ("the Hospital"). She was later transferred to a surgical ward ("the Ward").

2. Dr A said Mrs A was triaged wrongly, the medical team were late in examining her and no treatment was given. He said the MAU misdiagnosed and mismanaged sepsis and failed to follow the sepsis pathway. He also said:

- antibiotics were either administered late or not at all. The drug chart[2] showed no timing of the actual administration of the antibiotics;
- fluid balance monitoring was not done. His mother was septic and was unable to pass urine, but a catheter was not inserted;
- no paracetamol was given in the MAU and she remained feverish throughout her stay in the MAU;
- despite being on oxygen when she was in the MAU, she was not given oxygen during a transfer between the MAU and the Ward.

3. Dr A said the failings led to Mrs A suffering a cardiac arrest on 13 February. Mrs A remained in hospital until 8 March when, sadly, she died.

Investigation

4. Dr A complained only about the care provided by the Health Board on 13 February 2014. Therefore the investigation only considered this episode of care.

5. My investigator obtained comments and copies of relevant documents from the Health Board and I took advice from two of my Professional Advisers. Dr D Staples ("the Physician Adviser") is a consultant physician in acute internal medicine. Ms R McKay ("the Nursing Adviser") is a senior nurse with extensive experience in emergency and acute care.

[1] Dr A is a hospital doctor from another area.
[2] Also known as the MAR - Medication Administration Record.

6. The Advisers and I are obliged to consider what would have been a reasonable standard of care at the time events took place. My investigator and the Advisers reviewed the records and the evidence provided by Dr A. The Advisers responded to questions that my investigator put to them. Their advice, which I accept, is summarised below. However, the conclusions I have reached are my own.

7. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked. Both Dr A and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant legislation, guidance and protocols

8. During the investigation and my investigator and Advisers considered:

- Sepsis Screening Tool and the Sepsis Six (www.survivesepsis.org)[3]
- The "Surviving Sepsis Campaign: International Guidelines for Management of Severe Sepsis and Septic Shock" (2008 & 2012)
- Manchester Triage System – (Emergency Triage, Manchester Triage Group)[4] ("MTS")
- Guidance for records and record keeping (Nursing and Midwifery Council, 2009)
- A Clinician's Guide to Record Standards – Parts 1 and 2 (Royal College of Physicians)
- Good Medical Practice (General Medical Council, 2013)
- Clinical Standards for Emergency Departments, September 2013 (the College of Emergency Medicine)
- The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations") and Putting Things Right - Guidance on dealing with concerns about the NHS ("PTR").
- The Access to Health Records Act 1990 ("AHRA")

[3] Appendix 1.
[4] Appendix 1 - Triage is the process of prioritising sick or injured people for treatment according to the seriousness of the condition or injury.

- The Health Board's protocols on:
    a. Triage in the MAU.
    b. Treatment and management of sepsis.
    c. Catheterisation of patients.
    d. Record keeping.

The background events with comments from Dr A and the Health Board

9. Mrs A was 79 years old. She had a history of ischaemic heart disease, diet controlled diabetes, congestive cardiac failure and osteoarthritis. She had also previously suffered a stroke.

10. At around 7.00pm on 12 February 2014, Mrs A had a sudden onset of nausea, vomiting and abdominal pains. Later that evening, a GP referred her to the Hospital. Observations taken in the ambulance showed:

- a raised respiratory rate with low oxygen saturations
- a pulse of 81 beats per minutes
- blood pressure of 152/50
- blood sugar - 12
- she was fully alert.

11. On 13 February at 0.57am, she was triaged in the MAU and assessed as "category 2" (very urgent. i.e. requiring medical review within 10 minutes).[5] [6] She was started on oxygen (2L per minute) and her saturations[7] improved to 94%.

12. The records note that, at 4.30am, Mrs A was given paracetamol "as per PGD".[8]

[5] MTS '2' Very Urgent - Appendix 1.
[6] In its comments on the draft report, the Health Board said the triage system in the EU has changed since this date and all patients are triaged by the triage nurse.
[7] Oxygen saturation refers to the concentration of oxygen in the blood. In most cases, a normal reading is 95% or over.
[8] PGD - patient group directives allow specified health care professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The health care professional working within the PGD is responsible for assessing that the patient fits the criteria set out in the PGD.

13. At 4.40am, she was reviewed by two medical doctors ("the MAU Doctors"). As Mrs A did not speak English, they were only able to obtain limited information from her (Dr A was not with her at the time).[9] The records note:

- temperature of 39.1 degrees
- pulse of 89 or 110 beats per minute (both values are recorded on the same page)
- blood pressure of 111/60
- respiratory rate of 20 breaths per minute (on 4L litres per minute of oxygen)

14. The record also noted abdominal pain, tachycardia[10] and high temperature. A chest examination noted bilateral sounds and an ECG[11] showed signs consistent with the existing ischaemic heart disease. A chest X-ray and an abdominal X-ray were taken.[12] Blood results indicated an acute infection. The differential diagnosis[13] was "[impression] sepsis",[14] with diverticulitis[15] or other Gram negative[16]/urinary sepsis being the possible causes. The management plan included the need for a surgical review and the comment "Hold off diuretics in view of sepsis".

15. Dr A told me[17] that he did not trust the record of the 4.40am review. He believed that, at some point after the events, one of the MAU Doctors had changed the differential diagnosis to include sepsis.

16. At 5.30am, a surgeon ("the First Surgeon") reviewed Mrs A. The examination and observations recorded were identical to those already

[9] Dr A's complaint noted that he left the Hospital at 3.00am and returned at 8.00am.
[10] A heart rate that exceeds the normal range. In general, a resting heart rate over 100 beats per minute is accepted as tachycardia.
[11] An electrocardiogram (ECG) records the electrical activity of the heart.
[12] The results were not available until some days later.
[13] The consideration of which one of several conditions with similar symptoms is the condition that the patient has.
[14] Sepsis is a life-threatening illness. It is often referred to as septicaemia, although that term is not entirely accurate. Septicaemia refers to a bacterial infection of the blood. Sepsis is not just limited to the blood but can affect the whole body, including the organs. Sepsis can be caused by bacterial, viral or fungal infections.
[15] Diverticular disease and diverticulitis are digestive conditions that affect the large intestine (colon). In diverticular disease, small bulges or pockets develop in the lining of the intestine. Diverticulitis is when these pockets become inflamed or infected.
[16] Bacterial infection.
[17] 23 July 2014.

obtained. At a later (untimed) point, another surgeon ("the Second Surgeon") reviewed Mrs A.

17. At 7.30am, Mrs A was reviewed by a consultant physician ("the MAU Consultant"). The records note that Mrs A was "unwell" and "abdomen not acute". The likely diagnosis was acute diverticulitis or pyelonephritis.[18] The management plan was "continue antibiotics, give slow IV fluids, allow oral fluids as tolerated and check MSU".[19]

18. Dr A told me[20] that he did not trust the record of this review. He said he did not think the MAU Consultant examined Mrs A.

19. At 7.45am, Mrs A's care was transferred to the surgical team. The records noted: "patient for transfer to [the Ward] - handed over to receiving ward nursing staff".

20. The Health Board told[21] me that the "tracking system" showed that porters responded to the MAU request at 7.57am and the transfer was completed by 8.28am. It said a transfer would typically take 8 - 10 minutes (depending on lift availability).

21. The NEWS[22] Chart noted that, at 8.30am, Mrs A was receiving oxygen ("4L") and the NEWS score was '4'.[23] The Chart did not record an oxygen saturation level for that time. It also noted "transfer to [Ward]".

22. The Health Board's chronology[24] indicated that the 8.30am NEWS score should have been '5'[25] because the score had not included the oxygen being given.

23. In his complaint to the Health Board,[26] Dr A said when he returned to the MAU his mother had been moved to the Ward. When he then saw her,

[18] A kidney infection.
[19] Mid stream urine sample.
[20] 23 July 2014.
[21] 21 January 2014.
[22] The National Early Warning Score is a standardised chart. It is used to record the patient's clinical condition, thereby alerting the clinical team to any medical deterioration and triggering a timely clinical response.
[23] A NEWS score of 4 requires that physiological observations are taken a minimum of every 4 – 6 hours.
[24] Given with its formal comments on the complaint on 25 July 2014.
[25] A NEWS score of 5 requires that physiological observations are taken a minimum of every hour.
[26] 7 March 2014.

she was peripherally cyanosed.[27] In his complaint to this office, he said despite being on oxygen when she was in the MAU, he believed Mrs A was not given oxygen during the transfer between the MAU and the Ward.

24. A retrospective entry in the records noted that at 8.45am there was an emergency call to the Ward because Mrs A had gone into cardiac arrest. The records also note that she was peripherally cyanosed. Following the cardiac arrest Mrs A was transferred to the ICU[28] at 11.00am. The admission record noted the reason for admission as "sepsis". Mrs A remained in the ICU until 8 March when, very sadly, she died. The records note multi-organ failure and bronchopneumonia as the cause of death.

25. On 7 March, Dr A complained to the Health Board.[29] He said he was very distressed and concerned about the medical care that his mother had received in the MAU. He asked:

- for the details of the medical management plan "from the first minute of her admission"
- for the details of the nursing care that was required, and she was provided with, at that time
- why a 79 years old woman with acute medical problem ended up in a surgical ward peripherally cyanosed with no medical care at that time.

26. On 10 March, the Health Board acknowledged his e-mail.[30] The records show that the complaint was graded '5' ("catastrophic").[31]

27. On 17 March, in response to a request by Dr A, the Health Board told him that he could have a copy of his mother's medical records "...on completion of the investigation, free of charge...". Alternatively, he could make an AHRA[32] request, but, it said, there was normally a charge and a 40 day response time for such requests.

[27] Cyanosis is caused by a lack of oxygen in the blood. Peripheral cyanosis results from a lack of oxygen rich blood in the extremities. It appears as a blue tint in the fingers and extremities.
[28] Intensive Care Unit.
[29] By e-mail.
[30] PTR.
[31] The Health Board's grading framework for dealing with concerns – negligible '1', catastrophic '5'.
[32] Appendix 2 sets out the time allowed for a body to respond to an AHRA request.

28. On 27 March, Dr A met the Health Board's Clinical Director and the doctor who reviewed Mrs A in the MAU ("the MAU Doctor"). The notes of the meeting were very detailed. In summary, they discussed Mrs A's condition, the care she received in the MAU and the transfer to the Ward. Dr A said he wanted to know if there had been a mistake and, if so, how the Health Board would prevent this from happening again.

29. He questioned the time taken between triage and Mrs A being seen by a doctor. The Clinical Director said that the initial assessment did not indicate an urgent review, Mrs A was not septic or significantly hypotensive[33] so her case was not classed for urgent medical review. He also said the impression was that this was SIRS[34] rather than sepsis and while he acknowledged that there was a delay with the antibiotics, Mrs A was not septic or hypotensive. He said that the records did not indicate that Mrs A was tachycardic and the sepsis pathway was not triggered.

30. Dr A said he believed Mrs A was septic from the beginning and she was not managed well. He said he felt the nurses were incompetent.

31. He questioned why Mrs A was not given paracetamol and also not catheterised. The Clinical Director said that paracetamol was not given and this was "a clear mistake". He said that the catheter was not part of the management plan but, reasonably, this should have been done. He confirmed that Mrs A was given oxygen in the MAU.

32. The Clinical Director agreed that there had been a delay in giving antibiotics. The MAU Doctor said the antibiotics had been given sometime after the ward round at 7.30am.[35]

33. Dr A said when he saw his mother on the Ward she was feverish, unable to pass urine, septic and peripherally cyanosed. The nursing assistants did not realise that she was cyanosed. He told them to go and get help.

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[33] Low blood pressure.

[34] Systemic inflammatory response is indicated by a minimum of two of the following results - temperature above 38°C or below 36°C; heart rate over 90 beats per minute; respiratory rate over 20 breaths per minute (or Partial pressure of carbon dioxide less than 32 mm Hg); white blood cell count above 12,000 or less than 4000. For sepsis, in addition to the presence of SIRS markers, there would be a suspected or known source of infection.

[35] The MAU Consultant's review took place during the normal ward round.

34. The Clinical Director asked what Dr A expected as an outcome of his complaint. Dr A said he wanted a full review of the MAU. He felt that the management at the Hospital was not appropriate and "unimaginable mistakes" had been made. The Clinical Director said there were some issues that could be discussed with staff and the Health Board would always look at whether improvements could be made in the management of sepsis. He said it was difficult to know if the issues affected the outcome for Mrs A. He also said he could not see radical changes being made as a result of this case.

35. On 31 March, Dr A told the Health Board that he still wanted a full response and a copy of his mother's medical records.

36. On 25 April, the Health Board gave Dr A a copy of his mother's records.

37. On 23 May, the Health Board gave Dr A a formal response to his complaint. The response gave sincere condolences. It included the minutes of the March meeting (it apologised for the delay in providing these). The Health Board acknowledged there were the following "breaches in the duty of care":[36]

- delay with the administration of paracetamol;
- a lack of documented time that Augmentin[37] was administered;
- a urinary catheter should have been considered.

38. The Health Board asked Dr A to agree to a further review of the care given to Mrs A, by an independent expert. It also said that, if Dr A was unhappy with the Health Board's investigation, he could make a complaint to the Ombudsman.

39. On 30 May, Dr A complained to the Ombudsman.

[36] Appendix 2 sets out the duty of care.
[37] An antibiotic.

Professional advice

The Physician Adviser's comments

40. The Physician Adviser said Mrs A was correctly triaged as '2'. Therefore, he was concerned why it took doctors three hours to see Mrs A - this delayed the sepsis diagnosis.

41. He said that, based on the records, the MAU doctors recognised (at 4.40am) that Mrs A had sepsis and an appropriate investigation plan was formulated. However, it was not clear from the notes whether the MAU followed the sepsis pathway. He said the Sepsis Six[38] should have been implemented within an hour of the diagnosis.

42. The Physician Adviser said Mrs A did not receive an acceptable standard of care. She should have been seen by a competent clinical decision maker within the specified time frame for a Triage Category 2 patient (i.e. 10 minutes). This would have resulted in an earlier diagnosis of sepsis and earlier implementation of the Sepsis Six. He said early antibiotic therapy saves lives in septic patients but it is not clear when antibiotics were given to Mrs A.

43. The Physician Adviser said the records were not sufficient to determine, with certainty, whether blood cultures were taken or when antibiotics were given. However, this was not the same as saying the MAU did not follow the sepsis pathway, as some elements were followed:

- oxygen was given at 1.00am;
- IV fluids were given appropriately (starting at 5.00am);
- a serum lactate was taken at 1.18am (and noted as normal);

44. He said it was not possible to say whether antibiotics were given in a timely fashion because there was no time recorded on the MAR; it was noted as "the morning". The Physician Adviser said antibiotics were also not noted in the "stat"[39] dose section of the MAR. This implied that a dose was not given immediately. That suggested that the first dose was given in the morning, which, he said, is normally at around 8.00am. However, it could

[38] Appendix 1 explains the actions that form the Sepsis Six.
[39] Stat, from the Latin statim, meaning "immediately".

have been given shortly after being prescribed by the doctor, but this seemed less likely. He said that a septic patient should receive antibiotics within an hour of diagnosis. Therefore if the dose was not given until around 8.00am, this was a significant failing.

45. In relation to Dr A's belief that his mother should have been catheterised, the Physician Adviser said the records do not suggest that when she was admitted, she was not passing urine. He said apart from her respiratory parameters and high temperature, the observations were stable. Such observations would not necessarily prompt catheterisation. Mrs A's blood pressure was high enough to suspect no sepsis driven impairment of the kidneys and she had normal renal function.

46. He said the Sepsis Six guidelines suggest catheterisation of all patients with a diagnosis of sepsis, but in practice it is sometimes reasonable to defer this decision. The Physician Adviser said there has been a large drive to prevent unnecessary catheterisation of patients as this may cause infection. He said it was reasonable for the team to step outside of this guidance in this case. The lack of catheterisation had no impact on her condition and did not contribute to Mrs A's arrest.

47. The Physician Adviser said the records indicate that the First Surgeon (who reviewed Mrs A at 5.30am) was a first year GP trainee who would have had less experience than the MAU Doctor who made the referral. He said it was inappropriate to allow a junior doctor (the First Surgeon) to give a surgical opinion when asked to do so by a medical registrar (the MAU Doctor). The latter's experience far outweighed the former. Should a medical registrar require a surgical opinion this should be from an appropriately trained clinician (i.e. a surgical registrar or consultant).

48. He said the observations recorded by the First Surgeon were identical to those already obtained and could possibly have been copied from the observations chart. He said the reviews completed by the First and Second Surgeons[40] added nothing to Mrs A's treatment or care.

[40] Paragraph 16.

49. In relation to Dr A's belief that his mother did not have oxygen during the transfer between the MAU and the Ward, the Physician Adviser said the records did not cover the transfer process. He said doctors do not usually supervise inter-ward transfers; this would be the responsibility of nursing staff.

50. The Physician Adviser said Mrs A needed supplementary oxygen, but it was not clear that this was provided during the transfer. If the transfer time was very short, transferring her without oxygen may have made no difference. Otherwise, if oxygen was omitted this would have been "dangerous and detrimental" to her.

51. The Physician Adviser said that the cause of Mrs A's cardiac arrest had not been established. This could have been sepsis; but, at the time she arrested, elements of the Sepsis Six had been implemented and her observations did not show septic shock[41] so this seems unlikely. He said Mrs A was an elderly lady with multiple medical problems. He said it is not possible to say definitively whether earlier antibiotics might have altered the course of events or, if the transfer was made without oxygen, what impact that had.

The Nursing Adviser's comments

52. The Nursing Adviser confirmed that Mrs A was triaged as '2'; therefore she should have been seen urgently by a doctor.

53. She said that, as there were PGDs in place it, would have been established good practice for paracetamol be administered around the time of admission, not three and a half hours later.

54. The Nursing Adviser said the records do not indicate that Mrs A had trouble passing urine. She said that Mrs A was waiting to be reviewed by a doctor and there was no working diagnosis for her prior to that assessment (4.40am). IV fluids were started after the assessment and the fluid balance chart noted that she passed 60mls urine at 6.30am. The Nursing Adviser said that if Mrs A had been seen by a doctor sooner, it is more than likely that her fluid balance would have been monitored earlier.

[41] Low blood pressure due to sepsis.

55. The Nursing Adviser confirmed that the records did not cover the transfer process. She said there was no written transfer plan but this would be reasonable if there was an adequate verbal handover to appropriate registered nursing staff. Due to the lack of records, she could not say:

- whether oxygen was administered during the transfer
- whether a nurse accompanied Mrs A
- how the handover was completed.

56. The Nursing Adviser said that while in the MAU, Mrs A required oxygen and it would be reasonable to conclude that she would continue to need oxygen, and that a registered nurse would know to continue the oxygen. She said that the need for ongoing oxygen therapy is not referred to in any of the medical plans and it is not prescribed on the MAR but it would still be reasonable for staff to continue oxygen therapy.

57. The Nursing Adviser said that as part of Dr A's complaint to the Health Board was about nursing care she had some concerns that a senior nurse was not involved in the Health Board's consideration of the complaint.

The Health Board's comments on the draft report

58. On 14 April 2015, the Health Board gave comments on the draft of this report. It said this was an extremely sad case. It also said it was difficult to say whether earlier use of the Sepsis Pathway would have altered the outcome as Mrs A did not appear to fit the criteria for severe sepsis. The Health Board said SIRS was a reasonable provisional diagnosis at the time.

59. The Health Board said there appeared to be "an assumption that the patient was transferred to [the Ward] without oxygen because it is not documented that she was receiving oxygen". It said it "would argue that it is not documented that oxygen was disconnected for the transfer and the Observation chart at 8.30am completed on the Ward post transfer documents that Oxygen was in progress…". The Health Board said that if oxygen had been discontinued this would constitute a change in the support and care being provided and would, by its very nature, prompt documentation.

60. It also noted that Mrs A went into cardiac arrest 15 minutes after the 8.30am observations were taken.

61. The Health Board agreed that record keeping, for the transfer process, should have been better. It said that it has since introduced transfer documentation.

62. The Health Board said Dr A's complaint was initially graded '5' in error (paragraph 26) and it was later revised to '3'. It apologised for not explaining this sooner.

63. It said that, at the time (March 2014), it felt a meeting with the clinicians had been the best way forward (paragraph 28). It said it had identified and accepted there were some breaches in the duty of care and had intended to instruct an external expert, but, due to the Ombudsman's investigation, it had not done so.

64. The Health Board explained that the Clinical Director said Dr A had made many "absurd and unreasonable" allegations at the meeting. It said the Clinical Director's comment (that he could not see radical changes being made, paragraph 34) was taken out of context. It also said that following this meeting it audio records all meetings.

65. It said that if Dr A had been specific in his concerns about nursing care a senior nurse would have attended the meeting.

66. The Health Board said that it found the Physician Adviser's comments about the Sepsis Six (paragraph 46) "confusing". It also said it considered that the First Surgeon's review was comprehensive and thorough (paragraph 16). It questioned the Physician Adviser's comments about the value of the review (paragraph 48).

67. The Health Board said it believed the complaint should only be partly upheld, because Dr A's complaint that staff changed medical records had not been upheld.

68. On 20 May, the Health Board said it accepted some of the recommendations, but it was difficult to accept others.

69. It said it had discussed the case with the Critical Care Consultant who is Health Board's lead on sepsis ("the Critical Care Consultant").

70. The Health Board acknowledged that the records demonstrated that despite Mrs A being triaged at 00.57am, she was not seen by the medical team until 4.30am. It said that between those times the clinical observations suggested that she was "unwell, possibly with sepsis, but not critically ill at first".

71. The Critical Care Consultant said he would not expect to see SIRS recorded as a diagnosis as it was not a diagnosis, it was "more a screening tool". He said he would expect to see "? Sepsis" recorded.

72. The Health Board said that the MAU Doctor considered a diagnosis of sepsis, with the likely source being intra-abdominal. It said initial blood tests were also "highly suggestive of sepsis".

73. The Critical Care Consultant said "there was sufficient suspicion, clinically and from blood tests, for a diagnosis of sepsis to be considered but there was no suggestion of any shock or end-organ dysfunction at this time".

74. The Health Board acknowledged that there was no record of the sepsis screening tool being used. It also acknowledged that there was no clear record of when or where the first dose of antibiotic was given. It said that "it could be considered" that the antibiotic prescription was inadequate in terms of the possible source of infection and also in terms of not prescribing a first "stat" dose.

75. The Critical Care Consultant said that the Sepsis Six says that urine output should be measured, therefore it would have been sensible to have inserted a catheter early on in Mrs A's admission. However, there was no initial indication of acute kidney injury.

76. The Health Board said it was "difficult to say whether earlier use of the Sepsis Pathway would have altered the outcome". It acknowledged that several aspects of the care given to Mrs A "were not of a reasonable standard". It said:

- Triage was unacceptably delayed
- A stat dose of antibiotics should have been considered
- The sepsis screening tool should have been completed to demonstrate the rationale and decision making
- A more senior surgical review would have been preferable (but the review by the junior was comprehensive)
- Record keeping could have been improved

77. It said "there was no doubt that care could have been improved in several areas and that the Sepsis screening tool should have been completed" but it questioned "what would then have been done differently?"

78. The Health Board agreed that there were breaches (in the duty of care). However its view was that Mrs A "did not appear to fit the criteria for severe sepsis", therefore, even if it had been considered, the Sepsis Six would not have been implemented.

Further Professional advice

The Physician Adviser's further comments

79. Following the Health Board's comments on the draft report, the Physician Adviser gave additional comments.

80. The Physician Adviser said that a sepsis screening tool would be wisely applied when there is clinical suspicion that someone might have sepsis, or in unwell patients where the cause is not immediately apparent. He said the sepsis pathway should have been triggered at the point of initial assessment and an "impression sepsis" differential diagnosis should also have triggered treatment and investigation for sepsis.

81. He said the Health Board's comments about SIRS do not have any bearing on the case. It is now accepted by the Health Board that Mrs A was septic. He said the important question is why it took over three hours to assess a triage category 2 patient (thereby only then realising she had sepsis) and why appropriate treatment was not then instigated, even at that time.

82. The Physician Adviser said his advice about the decision, not to immediately catheterise Mrs A, was clear (paragraph 46). He said that one, justifiable, deviation from the treatment (the decision not to immediately catheterise her) did not mean that Mrs A was not septic. She was "clearly septic".

83. He also clarified his comments about the First Surgeon's review (paragraph 47). He said he was concerned that the Health Board still believed that it is appropriate to allow someone with a few months experience to "advise" someone with considerably more. He said it was not.

84. He said a more senior and experienced surgeon would have given consideration to the presence of a surgical pathology and its treatment. He said the MAU Doctor may have needed advice on whether there was an underlying surgical cause which the MAU had not identified, or whether Mrs A might be a candidate for surgery, should a surgical cause be present. However, the Junior Surgeon would not be able to do either of these things more effectively than the MAU Doctor. Further, the Physician Adviser said the MAU Doctor should not need to have been told to give antibiotics to someone who was septic; this was "utterly obvious".

85. The Physician Adviser said he remained very concerned that patients with potentially serious surgical problems were being reviewed by those without the necessary experience to add anything to their care. He said the Health Board should check whether there are other specialties who allow very junior doctors to review patients on behalf of that specialty.

86. Lastly, he also said there was no reason to suggest that Dr A (who is medically qualified) "made up" the allegation that his mother was transferred without oxygen. He said the fact that Mrs A was peripherally cyanosed fits with this omission.

Analysis and conclusions

The care provided to Mrs A

87. Based on the clear advice given by both Advisers I am satisfied that Mrs A was triaged correctly. I am also satisfied that the clinical decision, not to catheterise her, was appropriate. I do acknowledge however, that the

Health Board has subsequently said it would have been sensible to insert a catheter.

88. I am very concerned about the delay between triage and the MAU Doctors' examination. Mrs A was triaged as category '2'. The MTS indicates that category 2 patients should be seen within 10 minutes.[42] Mrs A was not seen for three and a half hours. That caused delays in diagnosis and treatment, including the administration of antibiotics.

89. I appreciate that the Health Board said the triage system has since changed and all patients are now triaged by a triage nurse. However, the Health Board has not given any evidence to show that, on 13 February 2014, when Mrs A was triaged to be seen within 10 minutes, that categorisation was inappropriate. Therefore, I am satisfied that, considering the triage system that was in place at the time (the MTS), Mrs A should have been seen within 10 minutes.

90. Dr A said Mrs A had sepsis which was misdiagnosed and mismanaged. The MAU Doctor's differential diagnosis noted sepsis as a possible cause. I have considered the issue very carefully. The evidence indicates that, whilst by the time Mrs A suffered a cardiac arrest at 8.45am, some treatments which form part of the Sepsis Six had been provided, the sepsis pathway was not followed. I have reached this conclusion because:

- The Health Board's Sepsis Screening Tool included a checklist.[43] The checklist was to be kept in the patient's notes. It was not present in Mrs A's notes.
- The Clinical Director told[44] Dr A that Mrs A had SIRS, not sepsis.
- The Health Board's letter to Dr A on 23 May said it wanted to ask an independent expert to advise if the sepsis pathway should have been considered and whether earlier treatment would have affected the outcome.
- The Health Board's comments on the draft report questioned whether the outcome would have been different if it had been followed. The

[42] Appendix 1 sets out the Manchester Triage System categories.
[43] A version was provided as evidence on 25 July 2014, a fuller version was provided with comments on the draft on 20 May 2015.
[44] During the meeting on 27 March.

comments also accepted that the Sepsis Screening Tool should have been completed.
- The Health Board's comments on the draft report also indicated that even if the sepsis protocol had been considered, the Sepsis Six would not have been implemented.

91. The records note that Mrs A was given antibiotics in "the morning", there was no time specified. The Physician Adviser said "the morning" normally meant around 8.00am. The MAU Doctor said[45] they were given after 7.30am. Mrs A should have been seen within 10 minutes of triage (i.e. at around 1.10am). Therefore, she could potentially have received antibiotics shortly after. On the balance of probabilities, there was a delay in the giving antibiotics of almost seven hours.

92. I am troubled by the Health Board's repeated comments, that this was SIRS not sepsis, as justification for not following the sepsis pathway. The Health Board's records do not support that view. The records note sepsis, not SIRS, throughout. There is no mention of SIRS until the complaint meeting on 27 March (paragraph 29). I acknowledge the Health Board's statement that SIRS would not be noted as a provisional, or other, diagnosis.

93. The Health Board belatedly acknowledged that the Sepsis Screening Tool should have been used (paragraphs 76 and 77). It also belatedly accepted that the MAU doctor suspected sepsis (paragraphs 72 and 73). However, it still believed that, because Mrs A did not have **severe** sepsis (my emphasis), the Sepsis Six would not have been implemented. That stance causes me concern - the Health Board's Sepsis Screening Tool clearly recommends implementation of the Sepsis Six in sepsis cases, not just in severe sepsis (Appendix 1).

94. The Physician Adviser said, in sepsis, early antibiotic therapy saves lives. I conclude that the failure to follow the sepsis pathway, the delays in Mrs A being seen by the MAU Doctors, and in being given antibiotics, were significant failings.

[45] During the meeting on 27 March.

95. Dr A also said that his mother was not given paracetamol in the MAU. The records show that she was given paracetamol at 4.30am. So, to that extent, I am satisfied that she was given the medication. However, the MAU operated PGDs. The Nursing Adviser said it would have been good practice for paracetamol to be administered around the time of admission. Therefore, Mrs A could also have been given this medication much sooner. I conclude that the delay in giving paracetamol was a failing.

96. Dr A said his mother was transferred without oxygen. The Health Board disputed the point but could not provide records for the transfer process. The Nursing Adviser said the lack of a written transfer plan would be reasonable if there was an adequate verbal handover to appropriate registered nursing staff. However, for a patient in Mrs A's condition, I do not consider the record of the verbal handover (paragraph 19) to be adequate. I am also concerned that the NEWS Chart entry, at 8.30am on 13 February, failed to record an oxygen saturation level and failed to account for any supplementary oxygen (paragraphs 21 and 22).

97. At some point between 7.57am and 8.28am, an approximate 10 minute transfer journey was completed by porters. The records note that at 8.30am, Mrs A was on the Ward and receiving oxygen. When Dr A then saw his mother, she was peripherally cyanosed (this is confirmed by the records) and, at 8.45am, she suffered a cardiac arrest.

98. The Physician Adviser said that if Mrs A was transferred without oxygen it would have been dangerous and detrimental. He also said there was no reason to suggest that Dr A (who is medically qualified) "made up" the allegation that his mother was transferred without oxygen. He said that the fact that Mrs A was peripherally cyanosed fits with this omission.

99. I conclude the lack of a transfer record and the NEWS Chart errors are a service failure (I discuss record keeping further below). Unfortunately, due to the poor records, we will never know definitively whether Mrs A received oxygen during the process, or whether the transfer was supervised by qualified staff. Consequently, the service failure (the poor records) has caused uncertainty, which is an injustice to Dr A.

Record keeping

100. Having said that the lack of a transfer record was a service failure, I now turn to Dr A's other comments on record keeping. He said the record of the MAU Doctors' assessment (paragraphs 13 and 14) had been altered after the event. He also said he did not trust the record of the MAU Consultant's review (paragraph 17), because he thought the MAU Consultant did not examine Mrs A.

101. I have reviewed the Health Board's original records; I have found no evidence to suggest that the records were altered after the event. Nor is there any evidence to confirm Dr A's view that the MAU Consultant did not examine Mrs A. Therefore, I have no reason to reach the same conclusion as Dr A.

The Health Board's consideration of Dr A's complaint

102. The Regulations and PTR set out specific actions which health boards must complete and specific timescales that they should comply with when considering complaints.

103. The evidence shows that the Health Board's consideration of Dr A's complaint failed to comply with the Regulations. I have found a number of failings.

104. Dr A asked for a copy of Mrs A's records. He was told that he could not have them until after the investigation had been completed unless he made an AHRA request. He was also told that an AHRA request would take 40 days. I am concerned that the information Dr A was given is incorrect. PTR[46] indicates that complainants should be given access to their medical records. It does not say that they must wait until the investigation is complete. Also, the AHRA says that if the record has been added to in the last 40 days (as was the case here) records should be provided within 21 days.

105. The Health Board graded the complaint as "5". This is the highest grade possible under the Regulations.[47] Later it said it was re-graded to "3".

[46] PTR 6.41.
[47] PTR 6.50.

PTR[48] says that the investigation of such complaints (grades 3 to 5) should potentially involve a multi-disciplinary approach, with the use of root cause analysis.[49] I would also expect to see statements from the staff responsible for Mrs A. Disappointingly, the Health Board has not provided evidence to demonstrate that it actually investigated the complaint. It has also not provided evidence to support its comment that the complaint was re-graded at any stage and it did not raise this until it commented on the draft report.

106. I am also concerned that a senior nurse was not involved in the Health Board's consideration of the complaint. In his complaint and during the March meeting, Dr A raised concerns about the nursing care.

107. However, the Health Board told me[50] that his concern was about medical care (i.e. doctors). It said that if, at the meeting, nursing issues had been raised these would have been investigated further. Later, it said that if Dr A had raised specific concerns about nursing, a senior nurse would have attended the meeting.

108. The Health Board's responses are disappointing, as the original complaint and the meeting minutes show that Dr A raised concerns about nursing care several times. Specifically, at the meeting, he said the nurses were "incompetent." Further, the Health Board's formal response (23 May) said the meeting focused on three main issues, one of which was nursing care. Disappointingly, even after the March meeting, there was no record of a senior nurse being involved in the Health Board's consideration of the complaint.

109. During the meeting, Dr A was also given inaccurate information by the Clinical Director, who said:

- The initial assessment did not indicate the need for an urgent review.
    - However, Mrs A was actually triaged as category "2" – MTS indicates she should therefore have been seen within 10 minutes.

[48] PTR 6.50 & 6.52.
[49] An analysis which looks to identify the prime reason(s) why an incident occurred. Removal of the identified root cause(s) will either prevent, or reduce the chances of a similar type of incident from happening in similar circumstances in the future.
[50] 21 January 2015.

- Mrs A had SIRS, not sepsis.
    - However, at 4.40am the diagnosis was sepsis and when she was transferred to the ICU at 11.00am the reason for admission was noted as sepsis.
- Mrs A was not tachycardic.
    - However, the records show that, when admitted, she was tachycardic. The records note that this later resolved.
- Mrs A was not given paracetamol.
    - However, Mrs A was given paracetamol at 4.30am.
- The plan was to move Mrs A to a general medicine ward, but she was moved to a surgical ward because (possibly) there were no medical beds available.
    - However, the transfer to a surgical ward was not due to a lack of medical beds. The records indicate that she was transferred to the surgical team because of the diverticulitis differential diagnosis.

110. The Clinical Director also said he could not see radical changes being made as a result of this case. I am disappointed with that view. On the face of it, it seems to discount opportunities to learn from concerns.[51] I am also concerned about the Clinical Director's view that Dr A made "absurd and unreasonable" allegations during the meeting. The notes of the meeting are exceptionally detailed; they do not support the Clinical Director's view. The Health Board should also bear in mind that, at that point (27 March 2014), Dr A was very recently bereaved.

111. The Health Board's response was issued under Regulation 26. However, the response did not comply with that Regulation. It did not include:[52]

- a description of the investigation undertaken so far;
- a description of why in the opinion of the Health Board there is or may be a qualifying liability;
- an explanation of how to access legal advice without charge;
- an explanation of the advocacy and support services which may be of assistance;
- an explanation of the process for considering liability and Redress;
- confirmation that the full investigation report would be made available to Dr A;

[51] Regulation 49, PTR section 11.
[52] PTR 6.82.

- an offer of an opportunity to discuss the contents of the interim report with the responsible officer or person acting on their behalf.

112. I conclude that the Health Board's consideration of the complaint fell well below the standard that is expected.

Decision

113. For the reasons outlined, and to the extent identified above, I **uphold** this complaint.

Recommendations

114. I recommend that, within one month of the date of this report, the Health Board should:

a) Give Dr A an unequivocal written apology for the failures identified by this report.
b) Make a payment to Dr A of £4,000 to reflect the:
    i. distress caused by the failings in Mrs A's care;
    ii. uncertainty caused by those failings;
    iii. failings in the Health Board's handling of his complaint
    iv. provision of incorrect information during the complaint process.
c) So that appropriate lessons may be learned, share this report with the doctors, nurses and administrative staff involved in the case.
d) Formally remind the doctors and nurses involved in Mrs A's care to follow the relevant record keeping guidance. (If needed, and within four months of the date of this report, the Health Board should implement refresher training for staff, involved in the case, who indicate that they are not fully conversant with the relevant guidance).
e) Provide me with evidence of its current process which ensures that doctors and nurses who meet with complainants are familiar with the case and the patient's records.
f) Provide me with evidence of the existing monitoring and quality assurance mechanisms it has in place to prevent a recurrence of the failure of:
    i. doctors to review a patient categorised as triage 2 within the timescales specified by the MTS.
    ii. doctors and nurses to follow the sepsis pathway.

iii. doctors to ensure that the surgical review was performed by a doctor experienced enough to perform it.
iv. doctors and nurses to maintain appropriate records.
v. doctors, nurses and administrative staff to follow the Complaints Guidance.

(If the Health Board is not able to provide evidence to show that it has current suitable protocols for (e) and (f)(i) – (v) then, within four months, it should provide its plans to introduce such protocols).

115. Within three months of the date of this report, the Health Board should ensure that staff training in respect of recognising sepsis is up to date. (If needed, and within six months of the date of this report, the Health Board should implement training for staff who indicate that they are not fully conversant with the relevant protocols).

116. I require evidence[53] that the Health Board has complied with the recommendations within one month of the due date for each.

117. I am pleased to note that in commenting on the draft of this report the Cardiff and Vale University Health Board has agreed to implement these recommendations.

Nick Bennett
Ombudsman 16 June 2015

[53] Suitable evidence is, for example, a copy of the apology letters, team meeting minutes, training material and attendance logs, an audit report, a revised protocol, a copy of the formal reminder to the relevant staff.

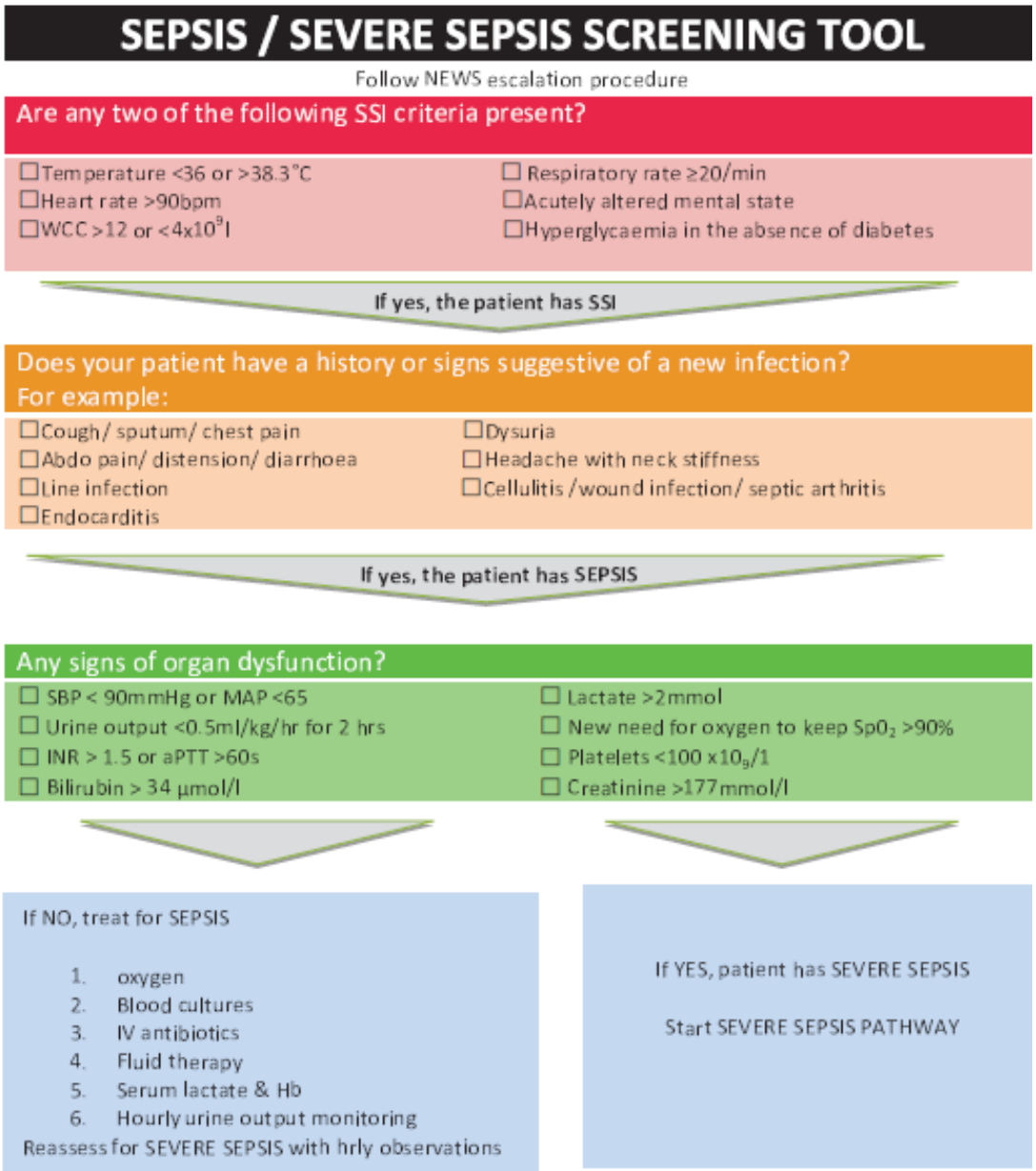
Appendix 1

The Sepsis Six

(taken from http://survivesepsis.org/the-sepsis-six)

1. Administer high flow oxygen
2. Take blood cultures
3. Give broad spectrum antibiotics
4. Give intravenous fluid
5. Measure serum lactate and haemoglobin
6. Measure accurate hourly urine output

An extract from the Health Board's Screening Tool



The Manchester Triage System

Category	Clinical Priority	Timescale
1	Immediate	0
2	Very Urgent	Within 10 minutes
3	Urgent	Within 1 hour
4	Standard	Within 2 hours
5	Non-Urgent	Within 4 hours

Appendix 2

The Duty of care and a Qualifying Liability

The Welsh Government issued statutory guidance on NHS complaint handling under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. This guidance is called: "Putting Things Right - Guidance on dealing with concerns about the NHS" (collectively referred to throughout as "The Complaints Guidance")

The Complaints Guidance sets out specific actions that health bodies should complete when considering complaints. The Complaints Guidance also covers the "duty of care" and "a qualifying liability in tort." It may be helpful to explain those terms:

Duty of care

The NHS owes a duty of care to the patient. A duty of care is both a professional and a legal obligation. It encompasses avoiding actions and omissions that are reasonably likely to cause harm to the patient. The legal test for a duty of care is:

> "You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour."

Qualifying liability in tort

For a qualifying liability in tort to exist, a Welsh NHS body must have **BOTH** (1) failed in its duty of care to a patient, **AND** the breach of duty of care must have been (2) causative of the harm that the person has suffered. It is only when both these tests are satisfied that financial compensation under the NHS Regulations would be considered.

The Access to Health Records Act 1990 (AHRA)

The AHRA provides certain individuals with a right of access to the health records of a deceased individual. Once the record holder has the relevant information and fee, they should comply with the request within 21 days where the record has been added to in the last 40 days, and within 40 days otherwise.

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