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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint by Mrs A against Abertawe Bro Morgannwg University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201205048

Contents

Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 ("the Act").

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 A.

Summary

Mrs A complained about the care provided for her late father, Mr B, by Abertawe Bro Morgannwg University Health Board ("the Health Board"), at Morriston Hospital ("the Hospital"). Her complaint concerned the diagnosis and investigation of his condition, his treatment in the Emergency Department ("ED"), his discharge from the Hospital, his spinal surgery, his ophthalmology input, his manual handling assessment and his personal care. Mr B had cancer.

The Acting Ombudsman upheld Mrs A's complaint. She considered that the Health Board had not investigated Mr B's condition appropriately, diagnosed it correctly soon enough, provided timely triage for him, managed his discharge, pain and handling-related needs effectively, or consistently given him a reasonable standard of personal care. She recommended that the Health Board should:

(a) **Apology** – Write to Mrs A to apologise for the failings identified.
(b) **Financial redress** – Pay Mrs A a nominal sum of £1500 in recognition of the significant distress that its failings caused.
(c) **Red Flags**[1] – Formally remind its clinicians of the importance of identifying and responding to Red Flags.
(d) **Triage arrangements** – Satisfy itself that its triage arrangements should avert any delay akin to that experienced by Mr B.
(e) **Pain policy** – Review its pain policy to ensure that it complies with the relevant pain management guideline.
(f) **Discharge-related training** – Arrange and provide discharge-related training for its nursing staff members.
(g) **Patient handling** – Formally remind its nursing staff members that they must ensure that their patient handling complies with the relevant best practice guidance.
(h) **Personal care** – Formally remind its nursing staff members that they must assess and review the personal care needs of their patients systematically and record the service provision associated with them consistently.

[1] Red flags are clinical indicators of possible serious underlying conditions that require urgent investigation.

(i) **Catheter care** - Formally remind its nursing staff members that they must ensure that their catheter care complies with the relevant best practice guidance.

(j) **Pain management training** – Arrange and provide pain management training for its nursing staff members.

(k) **Report sharing** – Share her investigation report with all relevant staff members and discuss it in an appropriate forum.

The Health Board agreed to comply with these recommendations.

The complaint

1. Mrs A complained about the care provided for her late father, Mr B, by Abertawe Bro Morgannwg University Health Board ("the Health Board"), at Morriston Hospital ("the First Hospital"), between 1 February and 16 March 2012. Her complaint concerned the diagnosis and investigation of his condition, his treatment in the Emergency Department ("ED"), his discharge from the First Hospital, his spinal surgery, his ophthalmology input, his manual handling assessment and his personal care.

Investigation

2. My Investigator obtained comments, Mr B's medical records for the relevant period and other information from the Health Board. She also obtained Mr B's GP records, documents, relating to him, from his local Council ("the Council") and information from Cardiff and Vale University Health Board. I considered this material in conjunction with the evidence provided by Mrs A. I also took advice from three of my Professional Advisers ("the Advisers"). The first of these Advisers, Dr Peta Longstaff, is a Consultant in Emergency Medicine ("the EM Adviser"), the second, Mr Michael Cass, is a Consultant Spinal and Orthopaedic Surgeon ("the Surgical Adviser") and the third, Ms Shelley McElvaney, is a Nurse Practitioner ("the Nursing Adviser"). I gave Mrs A and the Health Board the opportunity to see and comment on a draft version of this report before issuing it in its final form.

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

Background

Clinical history

4. On **1 February 2012** Mr B attended the ED at the First Hospital at 8.58pm. He was 59 years old at that time. He was complaining of lower back pain, pain in his right testicle, which was radiating down his right leg, and blurred vision. The First Triage Nurse noted that he had taken co-dydramol[2] but recorded that he was still in severe pain. The ED Consultant[3]

[2] Co-dydramol is used to treat mild to moderate pain.

noted that Mr B had been experiencing "severe progressing back pain" for four to five weeks. She recorded that he was tired all the time and that he had lost weight and his appetite. She noted that she had the impression that Mr B's back pain was "sinister". She recorded that his GP had "initiated all necessary investigations" and that s/he was due to see Mr B tomorrow (2 February). The Health Board discharged Mr B. Mrs A has reported[4] that it sent him home with ibuprofen[5] and co-codamol.[6]

5. The First GP referred Mr B to a Surgical Consultant, at the First Hospital, on 2 February. He noted that Mr B had had gastroenteritis[7] five weeks ago. He reported that his vomiting and diarrhoea had "settled" but said that his abdominal pain had persisted. He observed that this pain was "worsening" and noted that he was unable to determine its cause. He questioned whether Mr B had appendicitis. Mr B was admitted to the First Hospital. The Health Board completed X-rays of his chest and abdomen.

6. On 3 February the Consultant Colorectal Surgeon reviewed Mr B. He considered that degenerative changes[8] were causing Mr B's back pain. He planned to discharge him and refer him back to his GP. The First Junior Doctor noted that Mr B and Mrs A were concerned that Mr B's pain was "unbearable" and that he would "not cope", on his own, at home. S/he recorded that Mr B had been taking co-codamol and tramadol.[9] The Health Board transferred Mr B to Ward One "for pain control over the weekend."

7. The First Nurse recorded, on 6 February, that Mrs A was concerned about Mr B being discharged in the "same pain" that he had been in on admission.

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[3] The Health Board initially said that a junior doctor had seen Mr B on 1 February 2012. However, it pointed out, when commenting on a draft version of this report, that this was not the case and that the ED Consultant had seen him on that date. It apologised for this error.
[4] The Health Board's ED record does not record the provision of any discharge medication.
[5] Ibuprofen is used to treat pain and/or inflammation.
[6] Co-codamol is used to treat mild to moderate pain.
[7] Gastroenteritis is an infection of the stomach and bowel. Its symptoms include vomiting and diarrhoea.
[8] Such changes are associated with gradual wear and tear.
[9] Tramadol is used to treat moderate to severe pain.

8. The Consultant Colorectal Surgeon subsequently determined that Mr B's pain was "better controlled". He referred him to the Chronic Pain Service ("CPS")[10] and physiotherapists for pain management purposes. He requested their urgent input. He also asked the First Consultant Spinal Surgeon to see Mr B as an outpatient. The Health Board discharged Mr B on 8 February. Its Discharge Summary indicates that it gave him paracetamol,[11] tramadol, senna[12] and magnesium hydroxide,[13] to take home, at that point.

9. On 14 February Mrs A telephoned the Council's Social Services Department ("Social Services"). She indicated that Mr B's pain-relieving medication was not working and that he was unable to do any daily living tasks. Social Services referred Mr B to the Community Integrated Intermediate Care Service ("CIIS")[14] on the same day. The First CIIS Nurse assessed Mr B on 15 February. She recorded that she had informed the Second GP that Mr B had "threatened suicide" if his pain was not managed.

10. The Second CIIS Nurse visited Mr B on 16 February. She then contacted the Third GP. The Third GP referred Mr B to an Orthopaedic Consultant at the First Hospital. The Third GP noted that his back pain was "progressing" and that he had "gone from plain paracetamol to oxycodone[15] and naproxen[16] without relief". She reported that he was also falling. Mr B arrived at the ED between 5.05pm and 5.50pm;[17] the First Hospital was expecting him. The Second Triage Nurse recorded that Mr B was given Entonox[18] on arrival. Mrs A disputes this. The Second Triage Nurse noted that the Trauma and Orthopaedic ("T & O") Doctor was aware of Mr B's arrival at 6.20pm. S/he recorded that Mr B was in moderate pain. S/he noted that s/he gave him co-codamol at 7.20pm. S/he indicated that s/he completed triage assessments, in respect of Mr B, at 7.15pm and 8.15pm.

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[10] The CPS has a multidisciplinary team that includes a doctor, a physiotherapist, a clinical psychologist and a specialist pain nurse. It provides a range of services including specialised physiotherapy and a Pain Management Programme.
[11] Paracetamol is used to treat mild to moderate pain.
[12] Senna is used to treat occasional constipation.
[13] Magnesium hydroxide is used to treat occasional constipation and stomach problems like indigestion.
[14] CIIS is a health and social care service which provides short-term intervention "to promote independence" by preventing avoidable acute hospital admissions, facilitating early discharges from hospital and preventing and/or stopping a progressive deterioration in an individual's physical condition.
[15] Oxycodone is used to treat moderate to severe pain.
[16] Naproxen is used to treat moderate to severe pain.
[17] Mrs A maintains that Mr B arrived at the ED at 5.15pm, the Health Board's computerised records indicate that he arrived at 5.50pm and the Health Board's Investigation and Redress Manager has suggested, in his investigation report, that he arrived at 5.05pm.
[18] Entonox is an anaesthetic which is commonly known as gas and air.

A doctor reviewed Mr B at 9.40pm. S/he noted that Mr B's presenting complaint was back pain. S/he recorded that he was also complaining of associated flashes in his left eye. S/he referred him to the Ophthalmology Department at Singleton Hospital ("the Second Hospital"). He was admitted to Ward Two, at the First Hospital, at 11.45pm. The Health Board completed X-rays of the lumbar area of Mr B's spine. The Consultant Orthopaedic Surgeon identified a pathological L3 fracture.[19]

11. On 17 February the Health Board completed an MRI scan[20] of the lumbar and sacral areas of Mr B's spine. It identified probable tumours that were affecting L3 and L4 and nerve root compression at L4. It provisionally concluded that Mr B had "metastatic disease."[21] The Second Consultant Spinal Surgeon determined that Mr B required stabilisation and decompression surgery[22] ("spinal surgery"). A senior doctor contacted the University Hospital of Wales ("the Third Hospital")[23] because the Second Consultant Spinal Surgeon was concerned that she would not be able to perform the surgery required until 23 February, which was her next allocated theatre day.[24] Clinical records indicate that the Health Board fitted a brace around Mr B's back. The Health Board has explained that it did this "to allow mobilisation and rehabilitation of a stable L3 fracture, with a treatment aim of providing pain relief." Mrs A contends that the Health Board did not fit such a brace. The Second Consultant Spinal Surgeon recommended bed rest for Mr B. The Health Board completed a "Patient Moving and Handling Risk Assessment Form" ("the Handling Form").

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[19] The vertebrae and the discs between them create a canal that protects the spinal cord. The vertebrae are divided into three spinal areas, the cervical, thoracic and lumbar. Five vertebrae make up the lumbar spine, that is the lower part of the back. They are referred to as L1, L2 and so on. The lumbar vertebrae are larger than the vertebrae in other spinal areas because they carry more body weight. The third lumbar vertebra, L3, is located in the middle section of this spinal area. The spinal cord ends at L1 or L2. It divides into a bundle of nerve roots, which is known as the cauda equina, at that point. These nerves run into the lower body and extremities. A pathological fracture is a broken bone caused by disease.

[20] During an MRI (Magnetic Resonance Imaging) scan magnetic fields and radio waves produce detailed images of the body's interior.

[21] The term metastatic indicates that Mr B had cancer, which had spread to other parts of his body, from its primary site.

[22] This surgery aims to address persistent pain and other symptoms by stabilising and strengthening the spine and reducing the pressure on spinal nerves.

[23] Cardiff and Vale University Health Board is responsible for the management of the Third Hospital.

[24] The Health Board has reported that patients requiring non-urgent spinal surgery receive this during their Consultant's allocated theatre day. It has noted that the Second Consultant Spinal Surgeon's theatre day is Thursday. It has explained that it transfers patients, who require urgent spinal surgery, to the Third Hospital, if necessary.

12. The Health Board completed CT scans[25] of Mr B's abdomen and head on 20 February. It discovered tumours in his liver and left eye. The Consultant Orthopaedic Surgeon discussed Mr B's care with an Ophthalmologist. It was agreed that an urgent ophthalmology assessment was not required and that an outpatient assessment would be completed when Mr B was stable enough to be transferred to the Second Hospital. The Health Board performed an MRI scan of the cervical and thoracic areas of Mr B's spine. It discovered further tumours. It liaised with the Third Hospital again regarding Mr B's spinal surgery. The Third Hospital reportedly determined that it would not be appropriate for it to perform such surgery in Mr B's case.[26]

13. On 23 February the Health Board performed Mr B's spinal surgery at the First Hospital. It also obtained a biopsy specimen.

14. The Physiotherapist assessed Mr B on 28 February. S/he determined that he was able to mobilise with two sticks. S/he recorded that he was "unsteady without support" and that he would call nursing staff members when he needed the toilet.

15. Between 27 February and 7 March the Health Board completed immunohistochemistry ("IHC")[27] tests. It determined that Mr B had poorly differentiated carcinoma.[28]

16. On 10 March the Health Board inserted a urinary catheter for fluid monitoring purposes. Mr B's condition gradually deteriorated.

17. The Second Junior Doctor noted, on 11 March, that Mr B was unable to get out of bed. Bed rest was subsequently recommended for him. The Health Board determined that Mr B required palliative care.

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[25] A CT (Computerised Tomography) scan involves scanning the body with a series of X-rays. A computer then assembles the X-rays to produce detailed images of internal structures within the body, such as organs and blood vessels. Various conditions can affect the appearance of these structures.

[26] My Investigator asked Cardiff and Vale University Health Board for any records that it holds in respect of Mr B. It informed her that its Patient Information Management System does not contain any records relating to him.

[27] IHC tests, which are diagnostic, use staining to identify specific molecules, which act as disease markers. They can help a clinician to identify the primary site of a tumour.

[28] Carcinoma is the term used to refer to cancer that begins in the skin or tissues that line or cover internal organs. The phrase "poorly differentiated" indicates that the tissue, in Mr B's tumours, was very different to that of normal cells and tissues. Poorly differentiated tumours tend to spread at a faster rate than well differentiated tumours.

18. Sadly, on 16 March, Mr B died. The Health Board concluded that metastatic carcinoma had caused his death.

Complaint history

19. On **6 August 2012** Mrs A submitted a formal complaint to the Health Board. The Chief Operating Officer ("the Chief Officer") wrote to Mrs A, in response to her complaint, on 13 November. She also sent her a copy of the investigation report completed by the Investigation and Redress Manager ("the Manager"). This report contained comments made by the Lead Consultant in Emergency Care ("the Lead Consultant") and the Second Consultant Spinal Surgeon.

Mrs A's evidence

20. Mrs A said that the Health Board failed to diagnose Mr B's condition correctly on 1 and 2 February. She reported that it did not undertake appropriate investigations between 2 and 8 February. She said, in particular, that it did not complete an MRI or CT scan and that it did not examine his left eye further despite the fact that he was complaining about experiencing flashing lights. She also indicated that she was dissatisfied because it did not complete more IHC tests in an effort to establish the primary site of his cancer.

21. She told me that Mr B had to use a wheelchair, when she took him to the ED on 16 February, because he was "unable to walk". She said that he was left in the ED's waiting room for six hours, without being examined, on 16 February. She reported that he was in "absolute agony" during that period.

22. She said that the Health Board did not give Mr B advice, or arrange services for him, prior to his discharge on 8 February. She reported that it discharged him "with not much more than paracetamol" on that date. She said that he could not tolerate the pain that he was experiencing following this discharge.

23. She complained that the Health Board took too long to perform Mr B's spinal surgery. She noted that it did not treat the tumour in his left eye and implied that it should have done so. She said that it did not update Mr B's

Handling Form when the nature and severity of his condition became apparent. She suggested that he sustained another spinal fracture, on 14 March, because of this omission. She said that the Health Board's response to his personal care needs was also lacking. She argued that Mr B suffered unnecessarily and died sooner than might have been the case because of the Health Board's failings.

The Health Board's evidence

24. The Manager noted that Mr B's cancer "had been well established" prior to his admission on 2 February. He also acknowledged that an earlier diagnosis of his condition might have resulted in him having his spinal surgery approximately one week earlier and "eased his symptoms sooner". However, he indicated that he was satisfied that the Health Board had investigated Mr B's condition appropriately between 1 and 8 February. The Chief Officer also reported that the Health Board had "fully assessed" Mr B, between 2 and 8 February, and made "the appropriate referrals".

25. The Manager noted that Mr B's triage, on 16 February, was delayed. He also accepted that this delay "prevented" Mr B from "receiving pain relief sooner." The Lead Consultant suggested that this delay had occurred because the ED had "anticipated" that the Orthopaedic Team would assess Mr B "sooner than actually happened." He said that the ED had since improved its triage arrangements by increasing the availability of nurses and including pain scoring and observations in its triage assessments. The Manager indicated that the waiting time for triage, at the First Hospital's ED, had decreased as a result.

26. The Manager noted that the aims of Mr B's spinal surgery were pain control and quality of life improvement. He considered, given these aims and Mr B's poor prognosis, that the Third Hospital's decision not to perform this surgery was "correct". However, the Second Consultant Spinal Surgeon said that the delay, associated with Mr B's spinal surgery, was "unacceptable".

27. The Chief Officer said that the Health Board had had to postpone Mr B's ophthalmology appointments twice because he was "too ill" to be transferred to the Second Hospital. She noted that the Health Board had determined that his need for ophthalmology input was not urgent and that it had prioritised his other conditions on medical grounds. She indicated that an

ophthalmology appointment, at that time, would not have altered his treatment plan. She said that the Health Board was satisfied that it had not, due to its handling of Mr B, caused him further injury or affected the outcome for him.

28. The Chief Executive said, when commenting on a draft version of this report, that the Health Board had made "considerable changes" to the First Hospital's ED "in the last two years." He reported that the ED had increased "nurse staffing and capacity for triage". He noted that it had also secured funding for "a further increase" in triage nurses. He said that it had implemented a "new escalation process". He explained that this "empowers" the nursing staff "to chase" the Inpatient Teams if they have not seen their expected patients within an hour. He said that it had introduced the Manchester Triage System ("MTS").[29] He reported, with reference to the stocking of "opiate analgesia in pre-prepared syringes" and "a robotic pharmacy system", that ED staff members have "easier access to pain relief." He said that the Health Board plans to introduce a T & O assessment area, which "will allow all T & O GP expected patients to be seen in a dedicated area by specialist staff in a timely manner", later this year. He noted that it is also aiming to introduce a "new IT system", which will help it to "track" patients' progress "in real time", during September 2014. He also said that the Health Board had introduced "a robust nursing assurance process". He indicated that, as a consequence of this, compliance with manual handling and personal care-related standards, which includes compliance with all Care Bundles, is monitored, on a weekly basis, by the relevant Lead Nurse.

Professional advice

EM Adviser

29. The EM Adviser indicated that the Health Board, given the ongoing input of Mr B's GP, investigated Mr B's condition appropriately on 1 February. She noted that an MRI scan would have been helpful, at that stage, but noted that such a scan would not have been available to him at that time of the evening. She also observed that there was no evidence that Mr B had a neurological deficit and considered that "it would not have been deemed necessary to send him to a unit where there was 24-hour MRI availability" as

[29] MTS is a nationally recognised triage system.

a result. However, she indicated that its decision to discharge him on 1 February was questionable because it did not review his analgesia properly or ensure that his pain was controlled, prior to reaching it. She pointed out that the relevant guideline for the management of pain in adults[30] ("the Pain Guideline") stipulates that intravenous opiates should be administered for severe pain. She said that the Health Board should have given Mr B this medication and assessed its effectiveness. She noted that there is no evidence that it did so. She observed that it would have been reasonable for the Health Board to have discharged Mr B, on 1 February, "with suitable oral analgesia", if it had established that his pain was controlled. She said that she does not think that the outcome, for Mr B, would have been different if the Health Board had diagnosed his condition correctly on 1 February.

30. She noted that it is "unclear", given the timings recorded, when the Health Board actually triaged Mr B on 16 February. She observed that it does not appear to have completed a "full triage" until 8.15pm "despite the fact" that Mr B had required Entonox on arrival. She said that this was "an unacceptable wait". She noted that MTS gives patients with back pain and an inability to walk a yellow triage category, which means assessment within an hour. She said that the Health Board should have triaged Mr B, despite the fact that it described his pain as "moderate", by 6.50pm at the latest. She also questioned the appropriateness of this pain description, given Mr B's need for Entonox and Mrs A's description of events.

31. She considered that the Second Triage Nurse should have given Mr B "more potent pain relief", on 16 February, given that the Third GP had referred him to the First Hospital largely because of his pain. She noted that oxycodone and naproxen were not working. She said that "progression up the pain ladder to an intravenous opiate" would have been appropriate as a result. She observed that such a prescription "would have required medical input". She said that a doctor should have assessed Mr B earlier on 16 February given "his severe discomfort". She noted that if the Orthopaedic Team was unable to attend to him "it would have been reasonable to" have asked a member of the ED's medical staff to assess his pain and prescribe intravenous opiates for him. She said that it was "unacceptable" to leave Mr B in the waiting room given his pain.

[30] Guideline for the management of pain in adults. – Clinical Effectiveness Committee, The College of Emergency Medicine (June 2010).

Surgical Adviser

32. The Surgical Adviser said that the ED Consultant had identified a number of Red Flags, although she did not name them as such, when she assessed Mr B on 1 February. He noted that these Red Flags included Mr B's severe progressive back pain and his weight loss. He also observed that the ED Consultant had recorded that she had the impression that this pain was "sinister". He considered that the Health Board should have arranged, in the absence of a 24-hour MRI scanning facility, to perform an MRI scan, in respect of Mr B, on 2 February. He also suggested that, even in the absence of the Red Flags identified, it would have been prudent for the Health Board to have completed an MRI scan during Mr B's inpatient stay, that is between 2 and 8 February, given that this stay was prolonged for pain management purposes. He indicated, therefore, that the Health Board did not investigate Mr B's condition appropriately between 2 and 8 February.

33. He said that it is "more than reasonable to conclude" that the Health Board would have diagnosed Mr B's cancer, if it had done an MRI scan, on 2 February, because it "would almost certainly" have been "clearly evident" at that time. However, he considered, given the "aggressive" nature of his cancer, that the "marginally earlier" detection of it, would not have altered the outcome for him.

34. He stated that, in his opinion, completing more IHC tests would not have altered Mr B's treatment to a significant degree or changed the outcome for him. He also said that it is not always possible to identify the primary site of cancer akin to the type that Mr B had.

35. He indicated that the Health Board managed Mr B's discharge, on 8 February, reasonably in terms of medical service provision, given its diagnosis, albeit incorrect, at that time.

36. He agreed that the delay, associated with Mr B's spinal surgery, was "unacceptable" for compassionate reasons. However, he said that Mr B did not require urgent spinal surgery on medical grounds. He explained that this was because the vertebrae concerned were below the level at which the spinal cord ends and there was no evidence that they were at immediate risk

of collapse, which might have caused cauda equina syndrome ("CES").[31] He noted that he did not consider that Mr B's six-day wait for surgery was, given his spinal condition and resource constraints, clinically unreasonable. He indicated that this surgery could have reduced some of the pain that Mr B was experiencing. He said that performing it sooner would not have altered the outcome for him.

37. He said that Mr B's eye tumour was not causing him "significant symptoms" compared to his other tumours. He indicated that it was "reasonable" for the Health Board to defer his ophthalmology input pending the resolution of his other health issues, which were "significantly" more "threatening" to his health and life.

38. He said that there is no evidence to suggest that Mr B sustained another spinal fracture on 14 March. He observed, however, that there is evidence to suggest that the severity of the symptoms, which Mr B was experiencing due to the "advancing nature" of his disease, was increasing.

Nursing Adviser

39. The Nursing Adviser observed, with reference to the Handling Form completed on 17 February, that the Health Board determined that Mr B was independently mobile in all areas and that he was self-caring. She said that this was "inaccurate" because Mr B was on bed rest between 17 and 22 February. She observed that the Handling Form does not reflect Mr B's mobility change on 28 February or the Physiotherapist's assessment. She said that a lack of monitoring and review, in terms of patient handling, "represents a huge risk" because of the harm associated with falling. She indicated that these handling deficiencies were evident in Mr B's case.

40. She said that she would expect Mr B's personal care-related care plans to reflect the changes in his mobility by clearly outlining the level of support that he required to meet his personal care needs. She observed that the Health Board has not demonstrated that its nursing staff members assessed Mr B's personal care needs, or that they reviewed them as they changed,

[31] CES arises when pressure stops the nerves, carried by the cauda equina, from working. These nerves control various body parts, including the legs, bladder and bowel. CES can cause permanent nerve damage if the pressure is not treated quickly.

following his admission on 16 February. She also noted that there are no personal care-related care plans for Mr B. She observed that the nursing evaluation records refer to the provision of personal care but noted that these references are infrequent. She noted that there is a Care Log which indicates that Mr B received support with his personal care on 17 February but observed that this document contains no other entries. She also pointed out that the Health Board has not demonstrated, on the relevant Care Bundle,[32] that it completed any personal care specific to Mr B's catheter. She said that the Health Board failed to manage Mr B's personal care in accordance with relevant standards,[33] guidance[34] and "expected good practice."

41. She observed that bone pain, like that experienced by Mr B, can be "deep" and "aching". She said that due care and attention should have been taken to minimise his pain. She reported that this should have involved pain scoring at set intervals, a pain scoring review after the administration of analgesia and repositioning, if required and possible. She observed that the Health Board did not complete Mr B's lumbar pain care plan, which incorporated these pain control measures. She said that the Health Board's management of Mr B's pain, from a nursing perspective, "did not follow expected good practice" between 16 February and 16 March. However, she noted that she is unable to determine the impact that these failings, and those related to Mr B's handling and personal care, had upon him.

42. She noted that there is evidence that the pain suffered by Mr B during his inpatient stay, between 2 and 8 February, "impacted upon his ability to manage" the activities of daily living. She observed that the Health Board recognised that this pain was chronic and ongoing and that Mr B was reluctant to go home. She also noted that there are references to Mr B sleeping for long periods and spending most of a day resting on his bed. She said that the Health Board should have been concerned about Mr B's "motivation to mobilise" and his ability to manage his oral painkillers prior to discharging him. She observed that the CPS referral partly addressed the painkiller issue. However, she asserted that a referral to the CIIS, at the

[32] Short Term Urinary Catheter Documentation & Care Bundle. – Abertawe Bro Morgannwg University Health Board (Undated).
[33] The Code. Standards of conduct, performance and ethics for nurses and midwives. – Nursing and Midwifery Council (2008).
[34] Record keeping. Guidance for nurses and midwives. – Nursing and Midwifery Council (2009) / Catheter care. RCN guidance for nurses. – Royal College of Nursing (2008).

time of Mr B's discharge, was also indicated because he needed more support, within the community, at that stage. She indicated, with reference to relevant guidance,[35] that the Health Board did not, from a nursing perspective, manage Mr B's discharge appropriately because it failed to assess his discharge-related needs. She noted that the care that Mr B was receiving "stopped abruptly on discharge" as a result.

Analysis and conclusions

43. I have taken account of the advice provided by my Advisers when analysing this complaint and reaching my conclusions.

44. I do not consider that the Health Board investigated Mr B's condition appropriately, between 2 and 8 February, because of the Red Flags identified on 1 February and the ongoing nature of his pain. It seems to me that it should, at the very least, have completed an MRI scan during that admission. The Health Board's initial failure to investigate Mr B's condition properly delayed an accurate diagnosis and triggered his improper discharge. It seems to me that the suffering experienced by Mr B, between 8 and 16 February, and the distress caused to Mrs A, could have been reduced if this investigative failing had not occurred.

45. I understand why the remaining uncertainty about the primary site of Mr B's cancer concerns Mrs A. However, I am not persuaded that it was unreasonable for the Health Board not to complete more IHC tests given that the results of such tests would not have had a significant impact upon his treatment or altered the outcome for him. I also recognise that it is not always possible to identify a cancer's primary site.

46. I consider that the delays associated with Mr B's triage and the provision of effective pain relief, whilst he was in the ED on 16 February, were unacceptable given the nature of the Third GP's referral, Mr B's recent clinical history and the fact that the First Hospital was expecting him.

47. I am not satisfied that the Health Board managed Mr B's discharge, on 1 February, properly because it did not review his pain relief correctly or ensure that his pain was controlled prior to discharging him. I also consider

[35] Passing the Baton – A Practical Guide to Effective Discharge Planning. – National Leadership and Innovation Agency for Healthcare (2008).

that its management of his discharge on 8 February was poor. I recognise that the Consultant Colorectal Surgeon referred him to the CPS, physiotherapists and the First Consultant Spinal Surgeon. I also accept that these medical referrals would have been appropriate if Mr B had had a degenerative spinal condition. However, the Health Board failed to assess, in spite of the concerns that Mr B and Mrs A had expressed about Mr B's ability to cope at home, his community support-related needs before it discharged him. It seems to me that such an assessment would have led to a referral to the CIIS and possibly other support services. The inaccuracy of Mr B's diagnosis exacerbates the significance of these discharge-related deficiencies. I am also concerned that the pain relief given to Mr B, when he was discharged on 8 February, might not have been sufficient for him given the ongoing severity of his pain and his pain relief history.

48. I appreciate why, given the anticipated pain relief associated with Mr B's spinal surgery, Mrs A considers that he should have had it sooner. I also recognise that the Second Consultant Spinal Surgeon has, herself, said that the length of time taken to perform this surgery was "unacceptable". However, I am not persuaded that this surgical delay was, due to the nature of Mr B's spinal condition, clinically unacceptable. Nor do I consider that the Health Board's decision to defer the assessment and treatment of Mr B's eye tumour was, given the seriousness of his overall condition, unreasonable.

49. I am not satisfied that the Health Board managed the risks associated with handling Mr B appropriately. Its failure to accurately complete and update his Handling Form illustrates this. This failing, when caring for a patient with a spinal fracture, is indefensible. However, I cannot establish that Mr B sustained another spinal fracture on 14 March.

50. I am of the view, given the absence of personal care-related care plans and the incomplete Care Log and Care Bundle, that the Health Board's management of Mr B's personal care, between 16 February and 16 March, was lacking. I am also very concerned, given the inadequacy of the pain management-related documentation available, that the Health Board's response to Mr B's pain, during that period was deficient.

51. Regretfully, I have no doubt, based on the evidence before me, that Mr B suffered unnecessarily because of the Health Board's investigative, triage and discharge-related failings. I also consider that these failings

caused Mrs A, who had to witness Mr B's suffering, avoidable and considerable distress. However, I am not persuaded that these failings, or the others identified, caused Mr B to die sooner than might have been the case.

52. I **uphold** Mrs A's complaint because the Health Board did not investigate Mr B's condition appropriately between 2 and 8 February, diagnose it correctly at that time, provide timely triage for him on 16 February, manage his discharge, pain and handling-related needs effectively, or consistently give him a reasonable standard of personal care.

Recommendations

53. I recommend that the Health Board should:

(a) **Apology** – Write to Mrs A to apologise for the failings identified within this report.

(b) **Financial redress** – Pay Mrs A a nominal sum of £1500 in recognition of the significant distress that its failings caused.

(c) **Red Flags** – Formally remind its clinicians of the importance of identifying and responding to Red Flags.

(d) **Triage arrangements** – Revisit its triage arrangements, at the First Hospital's ED, and satisfy itself that they should avert any delay akin to that experienced by Mr B.

(e) **Pain policy** – Review its pain policy to ensure that it is in line with the Pain Guideline.

(f) **Discharge-related training** – Arrange and provide discharge-related training for its nursing staff members.

(g) **Patient handling** – Formally remind its nursing staff members that they must ensure that their patient handling complies with the relevant best practice guidance and that they complete the Handling Forms fully and consistently.

(h) **Personal care** – Formally remind its nursing staff members that they must assess and review the personal care needs of their patients systematically and record the service provision associated with them consistently.

(i) **Catheter care** - Formally remind its nursing staff members that they must ensure that their catheter care complies with the relevant best practice guidance and that they complete the Care Bundles fully and consistently.

(j) **Pain management training** – Arrange and provide pain management training for its nursing staff members.

(k) **Report sharing** – Share this report with all relevant clinicians and nursing staff members and discuss it in an appropriate forum.

54. I am pleased to note that the Health Board, when commenting on a draft version of this report, has agreed to implement these recommendations.

Prof Margaret Griffiths
Acting Ombudsman

27 May 2014

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