Health and Social Care Committee

Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction

DB 18 Amelia Bertram

My father was admitted to the Bronglais Hospital in the early hours of 22 December 2008. He was 80 years old at the time and was an insulin-controlled diabetic. He had a general feeling of illness and he was pyrexial. Once on the acute ward, he started receiving antibiotics for an infection. In the early hours of 23 December he became hypoglycaemic and his blood sugar was recorded at **1.3.** As a result of this episode, he vomited; he then aspirated his vomit and suffered a respiratory and cardiac arrest. This left him severely debilitated. Thereafter, he required 24 hour nursing care. In April 2009, the Hospital discharged him to a nursing home. He died there a few days later, aged 81.

We complained about his care to the Trust and followed an extensive and very lengthy process which included two rounds of local resolution and an independent review. However we remained dissatisfied with the explanations that we received from the Hywel Dda Health Board and the actions that resulted and we decided to take the complaint to the ombudsman. There appeared to be a lack of urgency to improve these areas to benefit other patients and a lack of improvements or sufficient evidence of remedial action to prevent such a situation occurring again. The ombudsman upheld our complaint and made a number of recommendations to the Health Board. Due to the gravity of his findings the ombudsman sent a copy of the report to the Healthcare Inspectorate for Wales. As a result of my father's case and subsequent contact we have had with HIW they now have put plans in place to assess and test the adequacy of Hywel Dda's arrangements for diabetic patients and review diabetes care in Wales. The inspectorate will then use the evidence gathered to report on how patients with diabetes are managed across inpatient services.

Our central concern was, and still is, that trained nurses working in an acute medical ward allowed my father's blood sugar levels to fall to a dangerously low level and aspirate on his own vomit. In addition we became aware that there had been other critical issues in his care including inaccurate and incomplete record taking, staff shortages, a failure to monitor him properly, the absence of food charts for a vulnerable diabetic patient, a failure to recognise the individual requirements of a patient which did not fit with an institutionalised regime (in my father's case the unmet need for a late evening snack) . We were critical of the failure to record vital information about my father and the management of his diabetes namely that the Hospital had failed to note that he required a bedtime snack to help regulate his blood sugar levels appropriately, was relatively asymptomatic when suffering from hypoglycaemia and he had an acceptable blood sugar level of about 10.

We believe that he did not eat well on the evening of the 22 December, and there was no food intake chart to record what he had eaten and we knew he had complained at visiting time about the food. Furthermore we learned that he was not offered a snack and we were later told that this facility was not available on the ward. The combination of a lack of food followed by his usual dose of insulin undoubtedly led to a hypoglycaemic attack. We had

noted that the ward did not use any food intake charts for diabetic patients. Subsequent meetings document the fact that the nursing staff in charge were unwilling to accept our suggestion that the use of a food chart for patient with sepsis would have been appropriate. The nursing adviser concluded that *'there was no documentary evidence of what food he consumed…there was 'no excuse' for this particularly for a diabetic patient with an acute illness.'*

When we examined my father's medical files we found that the blood sugar chart for the night in question had been tampered with. The ombudsman's nursing adviser discounted the reading meaning that my father did not have his blood sugar taken for **eight hours.** In the opinion of the nursing adviser, this was 'unacceptable'. The hospital could not locate the chart and the ombudsman's investigators relied on us to supply them with a copy. The chart provided evidence that the blood sugar readings were not taken in accordance with proper procedures and the medical team's instructions.

The medical evidence submitted to the ombudsman included the following
'In the light of the available evidence, there was no record [of blood sugar monitoring] between 5.20pm on 22 December 2008 to 1.30am on 23 December.
Blood sugar monitoring should have occurred at around 10.00pm on 22 December…
he may have been hypoglycaemic for up to eight hours' …. 'blood sugar should have been monitored at 10.00pm, the Trust potentially failed to treat his hypoglycaemia for [three and a half hours]. This is a significant failing. Hypoglycaemia leads to depressed consciousness and seizures, both of which can lead to aspiration. It is also a significant stress which is relevant in relation to a patient with cardiovascular history…Both aspiration and stress can lead to acute cardiac problems which may lead to cardiac arrest."
The Medical Adviser concluded that there was, "a causal link" between the failure to monitor my father's blood sugar levels and his cardiac arrest. Moreover, his clinical deterioration could be attributed, at least in part, to the cardiac arrest.

During the course of his enquiries the ombudsman discovered that nurses had adopted what was referred to in the report as a 'policy' of ignoring medical instructions to take blood sugars every four hours as instructed and instead chose to take them every six hours. The Nursing Adviser stated that this was an *'astonishing statement'*. She went on to say:
"I have great concern about the knowledge and skills in relation to diabetic monitoring by nurses on an acute medical ward, especially as the statement was supported by a qualified nurse…"

The nursing adviser also commented on other aspects of my father's care, specifically the monitoring of his blood oxygen levels which had not been carried out in accordance with correct procedures for monitoring acutely ill patients. It is worth noting that the events of the night of the 22nd of December were **not** recorded by the nursing staff as an incident.

Points for consideration arising from this case

- My father's care is not an 'isolated incident' which is how it was initially described to us by the CEO of the Hywel Dda in his letter of apology to my family. The recently

published National Diabetes Inpatient Audit 2011 illustrates 29.8% of patients in Wale experienced at least one medication error.

New: National Diabetes Inpatient Audit (NaDIA) National Report 2011 (pdf 730KB).

- Nurses did not understand the balance between insulin given and food intake or the importance of recording the details of the type of food consumed at a meal. 'Eaten well' is not an adequate record of complex carbohydrate intake. Worryingly nurses caring for my father did not demonstrate an understanding of the importance of following medical instruction regarding the frequency of blood sugar monitoring. Rather they followed their own procedures and monitored patients six hourly rather than four hourly as specified meaning that my father was left unmonitored for eight hours. Blood sugar monitoring should be carried out regularly and as specified by the consultant and more frequently if nurses become concerned about any change in the patient's condition. We found it deeply disturbing to learn from the diabetic specialist nurse present during our local resolution meetings that in her experience diabetics tend to "do better" at home than in hospital.

- We experienced a depth of ignorance about diabetes and diabetic care which is cause for concern and indicates that there could be gaps in some nurses understanding of the condition which will require a great deal of re-education.
- The Health Board hospital failed to provide the 'good quality consistent care' in line with the NSF for Diabetes. Unless measurable improvements are made to in-patient services across Wales more families will have similar experiences of poor care if their relatives are admitted to hospital.
- We urge the committee to consider improvements that could be made to in-patient Diabetic care in Wales in line with those suggested by Diabetes UK Wales. In particular the employment of a **part-time** National Clinical Director for Diabetes to oversee monitoring and evaluation of all diabetic services across Wales paying particular attention to the re-training of nursing staff, giving support to those Health Boards that have been shown to be failing in their duty to provide adequate care for diabetics and ensuring that consistent good quality care is provided throughout Wales.