SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
Bridgeside House
99 McDonald Road
Edinburgh
EH7 4NS

Tel **0800 377 7330**
Web **www.spso.org.uk**

Scottish Parliament Region: Highlands and Islands

Case ref: 201901343, Highland NHS Board

Sector: Health

Subject: Hospitals / Clinical treatment / diagnosis

Ms C complained about the care and treatment her late father (Mr A) received at Raigmore Hospital after he died unexpectedly following elective knee surgery. Ms C also complained about Highland NHS Board's investigation of her complaint.

The Board's investigation of Ms C's complaint did not identify any failings in Mr A's care. We took independent advice from a consultant trauma and orthopaedic surgeon. We found that Mr A's symptoms prior to discharge were not appropriately acted on. Had they been, there is a possibility that other specialities could have been called in to assess and assist. However, we could not say whether this would have affected Mr A's outcome. We concluded that Mr A's postoperative care and treatment was of an unreasonable standard and upheld the complaint.

In terms of the consent process for Mr A's surgery, we were also critical that there was no record to demonstrate that all the specific recognised risks of a total knee replacement surgery were covered sufficiently during a clinic consultation. We concluded that this is contrary to national guidance on consent and was unreasonable.

We also found that the Board's investigation and response to Ms C's complaint contained inaccurate information; did not reasonably address all the concerns Ms C raised; and did not reasonably identify and address the failings in Mr A's care. The letter concentrated mainly on the opinion as to the cause of Mr A's death rather than systematically addressing the points Ms C had written in her complaints form. We concluded that the response to Ms C's complaint was not compliant with the NHS Complaints Handling Procedure (NHS CHP) because the investigation and response should have been more comprehensive, clearer and easier to understand. We upheld the complaint.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Ms C:

Complaint number	What we found	What the organisation should do	What we need to see
(a)	• There was an unreasonable failure to act upon Mr A's acute kidney injury and episodes of vomiting; • there was an unreasonable failure to demonstrate that all the recognised risks of total knee replacement surgery were covered sufficiently during the consultation on 30 January 2018; and • the Board's investigation and response to Ms C's complaint contained inaccurate information; did not reasonably address all the concerns Ms C raised; and did not reasonably identify and address the failings in Mr A's care	Apologise to Ms C and the family for failing to: • act upon Mr A's acute kidney injury and episodes of vomiting; • demonstrate that all the recognised risks of total knee replacement surgery had been fully explained to Mr A; and • provide accurate information in their complaint response to Ms C, address all the concerns Ms C raised, and identify and address the failings in Mr A's care	A copy or record of the apology. By: 16 September 2020

We are asking the Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	• The fluid balance chart was discontinued despite there being a significant fluid imbalance and an acute kidney injury having been identified; • the acute kidney injury was not acted upon (no intravenous infusion was given and no repeat blood testing carried out); and • no physical examination was performed prior to discharge	• Patients with acute kidney injury should have their symptoms acted on and managed in line with relevant standards and guidance, where appropriate	Evidence that: • these findings have been shared with all relevant staff involved in Mr A's care in a supportive manner that encourages learning (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions); and • there is a standard operating procedure for the management of acute kidney injury and ensure it is included in junior doctor induction. By: 11 November 2020

(a)	The orthopaedic team did not seek assistance regarding the acute kidney injury from other specialities	Patients should receive appropriate medical review for their symptoms	Evidence to: • demonstrate that these findings have been shared with the surgical staff involved in Mr A's care in a supportive manner that encourages learning (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions); and • demonstrate how junior doctors are supported on the surgical ward. By: 11 November 2020

(a)	There was an unreasonable failure to demonstrate that all the recognised risks of total knee replacement surgery were covered sufficiently during the consultation on 30 January 2018	Patients should be fully advised of all material risks of total knee replacement surgery and the discussion should be clearly recorded, in accordance with the Royal College of Surgeons standard	Evidence that: • surgical staff undertaking total knee replacement surgery have been reminded of the requirement to obtain informed consent in line with relevant standards and guidance; and • the consent form has been reviewed to ensure there is a section on the template to clearly capture material risks of the proposed procedure. The SPSO thematic report on informed consent may assist in encouraging learning for staff in this area: https://www.spso.org.uk/thematic-reports By: 11 November 2020

We are asking the Board to **improve their complaints handling**:

Complaint number	What we found	Outcome needed	What we need to see
(b)	The Board's investigation and response to Ms C's complaint contained inaccurate information; did not reasonably address all the concerns Ms C raised; and did not reasonably identify and address the failings in Mr A's care	The Board's complaint handling and governance systems should ensure that complaints are investigated and responded to in accordance with the NHS CHP. They should ensure that failings (and good practice) are identified; and that learning from complaints is used to drive service development and improvement	Evidence that: • these findings have been shared with complaint handling staff (both clinical and non-clinical) in a supportive manner that encourages learning (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions); and • the Board have reviewed why its own investigation into the complaint did not identify or acknowledge all the failings highlighted here and any learning they have identified. By: 11 November 2020

Feedback

Points to note

As well as the recommendation above to ensure there is a standard operating procedure for the management of acute kidney injury and to include this in junior doctor induction, the Board may wish to consider the placement of ward posters informing others about the issue.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to me about the care her late father (Mr A) received in July 2018 at Raigmore Hospital for elective total knee replacement surgery. Ms C's complaint concerned the period of care following Mr A's total knee replacement up to his unexpected death two days later. Ms C had complained to Highland NHS Board (the Board) but remained dissatisfied with their investigation of her complaint because she felt their response did not fully address the issues she raised.

2. The complaints from Ms C I have investigated are that:

(a) the postoperative care and treatment was of an unreasonable standard (upheld); and

(b) the Board's handling of the complaint was unreasonable (upheld).

Investigation

3. In order to investigate Ms C's complaint, I and my complaints reviewer considered all the information provided from both Ms C and the Board. This included copies of the complaint correspondence and Mr A's medical records relevant to the complaint. We also sought independent professional advice from a consultant trauma and orthopaedic surgeon (the Adviser).

4. I appreciate that at this time, the NHS is under considerable pressure due to the impact of COVID-19. Like others I recognise, appreciate and respect the huge contribution everyone in the NHS (and public services) is making. However, much as I recognise this, I also recognise that patient safety, personal redress, and learning from complaints are as relevant as ever and it is important that we do not miss opportunities to learn for the future.

5. In this case, I have decided to issue a public report on Ms C's complaint because of the significant failings my investigation has identified and the personal injustice to Ms C and her family. I am particularly concerned that these failings were not identified or addressed by the Board during their investigation of the complaint, especially as I consider there may be wider learning from this case for the Board and other NHS Board clinicians and complaint handling teams.

6. This report includes the information that is required for me to explain the reasons for my decisions on this case. Please note, I have not included every detail of the information considered.

7. Ms C and the Board were given an opportunity to comment on a draft of this report.

Background

8. On 30 January 2018, Mr A was reviewed in clinic by a consultant orthopaedic surgeon (Doctor 1) and listed for knee replacement surgery. He then attended a nursing pre-assessment on 21 February 2018. On 11 July 2018, Mr A underwent an uncomplicated left total knee replacement. At 17:00, on 12 July 2018, a junior doctor (Doctor 2) noted that Mr A's blood test results showed a slight acute kidney injury (AKI; a sudden episode of kidney failure or kidney damage that happens within a few hours or a few days). At 19:25 nursing staff noted that Mr A had a low blood pressure reading and oral fluids were encouraged. At 23:30, it was noted that Mr A had two episodes of vomiting earlier at 21:40. On 13 July 2018, Mr A was reviewed by a registrar (middle grade doctor) (Doctor 3), and was deemed medically fit for discharge.

9. At 11:20, Mr A was found collapsed in the shower room. Cardiopulmonary resuscitation (CPR) was undertaken without success and Mr A died shortly thereafter.

10. On 16 July 2018, a post mortem examination was carried out following instruction from the Scottish Fatalities Investigation Unit (SFIU) to determine the cause of death. This showed a paralytic ileus of the bowel (lack of movement somewhere in the intestines that leads to a build-up and potential blockage). The report indicated that there was no evidence of a recent ischaemic event (inadequate blood flow to an organ) and no evidence of pulmonary thromboembolism (a blockage in one of the pulmonary arteries in the lung). Mr A's pre-existing ischaemic heart disease was considered to be a contributory factor.

11. On 4 October 2018, a Morbidity and Mortality meeting amongst Board staff took place to discuss Mr A's case and a report was compiled on 8 October 2018. The case was subsequently discussed at the Board's Quality and Patient Safety Sub-Group on 8 November 2018. At this time, it was noted that there were no plans for further review into Mr A's case.

12. On 20 February 2019, Ms C complained to the Board about Mr A's care and treatment. Ms C felt there was a chance Mr A's death could have been avoided.

13. On 9 April 2019, the Board responded to Ms C's complaint and provided Ms C with a copy of the Morbidity and Mortality Report, about which they apologised for not providing sooner. The Board's investigation of Ms C's complaint did not identify any

failings in Mr A's care and they concluded that there were no features to suggest paralytic ileus (which did not correspond with the post mortem findings). The Board was of the view that a sudden cardiac event was the most likely cause of Mr A's death. Ms C remained dissatisfied and escalated her concerns to my office in May 2019.

14. In June 2019, the SFIU discussed the case with the Board in order to reconcile the findings of the post mortem examination with the Board's Morbidity and Mortality Report. A number of points were covered, including that the cause of death was most likely to be cardiac dysrhythmia (an abnormal heart rate or rhythm) secondary to underlying ischaemic heart disease and subclinical (an early stage of a disease having no noticeable clinical symptoms) paralytic ileus.

(a) The postoperative care and treatment was of an unreasonable standard

Ms C's position

15. Ms C told us the reasons she considered the Board had failed to provide Mr A with appropriate care and treatment as follows:

i. following surgery on 11 July 2018, Mr A was noted to have vomited twice on 12 July 2018 and once on 13 July 2018. He was also noted to be tachycardic (an abnormally fast heart rate) and unwell. However, Mr A was deemed medically fit for discharge with no apparent medical examination or further investigations; and

ii. there was a lack of consideration given to the possible complication of paralytic ileus following knee replacement surgery.

The Board's position

16. As noted above, the Board's written reply to Ms C's complaint on 9 April 2019 enclosed a copy of the Morbidity and Mortality Report of 8 October 2018. The main points of the Morbidity and Mortality Report included information that:

- the increased risks associated with Mr A's ischemic disease, previous myocardial infarction (heart attack) and stenting (a surgical procedure for inserting a small tube to help blood flow more easily) were discussed with him as part of the consent procedure for surgery;

- Mr A was prescribed anti-emetic medication (medication to prevent or relieve nausea and vomiting) and was never sufficiently uncomfortable or distended for nasogastric suction (the removal of solids, liquids, or gasses from the stomach

or small intestine by inserting a tube through the nose and suctioning the material through the tube) to be considered appropriate;

- in terms of whether there were any additional features that could have suggested development of paralytic ileus, other than the two episodes of vomiting at separate times nine hours apart, there were no additional features. In particular, Mr A maintained a healthy oral fluid intake, was not noted to have abdominal distension prior to CPR, did not complain of abdominal pain, and was walking around the ward minutes before his collapse. This was felt to be atypical for someone with paralytic ileus. Vomiting by itself is common in postoperative patients on opiate analgesia, despite anti-emetics;

- Mr A was encouraged to maintain a good oral intake which he managed without the need for intravenous infusion. Transient rise in urea and creatinine (indicators of kidney function) in postoperative major cases is almost universal; and

- there were no indicators of deterioration prior to Mr A's collapse.

17. The Board stated in their letter of 9 April 2019 to Ms C that the clinical opinion was that there were no indicators of a significant gastrointestinal problem during Mr A's postoperative period and in particular there were no features to suggest paralytic ileus. The Board went on to say that, clearly this did not correspond with the findings at post mortem but the findings needed to be interpreted alongside the postoperative clinical picture. The Board concluded that a sudden cardiac event such as an arrhythmia was the most likely cause of death.

18. In response to our enquiries, the Board further commented that Doctor 1 was at a peripheral clinic outwith the hospital on the morning Mr A collapsed but had seen Mr A the previous morning when his condition gave no cause for concern.

Medical advice

19. Prior to the knee replacement surgery going ahead, the Adviser noted from Mr A's medical records that, on 30 January 2018, Mr A was reviewed by Doctor 1 in clinic and listed for knee replacement surgery. Doctor 1 documented in a letter to Mr A's GP the discussion that took place with Mr A that the procedure of knee replacement surgery was covered 'in some detail' and that Mr A was made aware of 'the risk of significant complications'. Mr A signed a consent form at this time agreeing to the proposed surgery. However, the Adviser was critical that no specific complications were noted or documented on either the clinic letter to the GP or the consent form.

20. The Adviser referred to the British Orthopaedic Association (BOA) guidance on consent for total knee replacement which lists the recognised risks and complications as: pain; dissatisfaction; bleeding/vessel injury; nerve injury; early revision and failure (within three years); peri-operative fracture; knee stiffness; infection; deep vein thrombosis/pulmonary embolism; and death.

21. The Adviser also referred to guidance issued by the Royal College of Surgeons on consent. Section 4 sets out that surgeons must ensure that the patient is provided with the information they need to make an informed decision about treatment, such as the material risks inherent in the procedure. It also states that, in addition to completing the consent form, surgeons should maintain a written decision-making record (which can be in the form of a letter to the patient and their GP/referring doctor) that contains a contemporaneous documentation of the key points of the consent discussion. Any written information given to the patient should also be recorded and copies should be included in the patient's notes.

22. The Adviser, therefore, considered that in Mr A's case, it was unreasonable that there were no recognised risks and complications of the procedure documented in order to evidence that informed consent had been obtained from Mr A before proceeding with the surgery.

23. The Adviser went on to say that on 11 July 2018, Mr A underwent an uncomplicated left total knee replacement. At 12:05, nursing staff noted that Mr A was alert and oriented with a National Early Warning Score (NEWS) of 2. At 15:20 Doctor 2 noted that Mr A was well and had not passed urine. At 21:05 nursing staff noted that Mr A had low blood pressure and a temperature with a NEWS of 2. It was also noted that he had passed urine. However, the fluid balance chart noted that Mr A's fluid input for 11 July 2018 was 3,325mls and output was 460mls, which the Adviser said represented significant imbalance.

24. On 12 July 2018, nursing staff noted that Mr A's NEWS was 0 at 06:30 and at 14:50. At 17:00 Doctor 2 noted Mr A's blood test results showed a 'slight AKI' as the blood creatinine (a measure of kidney function) was raised at 122. The Adviser explained that AKI is defined by the National Institute for Health and Care Excellence as a raise in serum creatinine of 26 within 48 hours. Prior to the operation, Mr A's creatinine was noted to be 90 at his nursing pre-assessment on 21 February 2018. Therefore, the Adviser said that Mr A had an AKI. The Adviser explained that this was mild to moderate; is not common and is not 'almost universal in postoperative major cases' as noted in the Board's Morbidity and Mortality Report.

25. The Adviser said that rises in creatinine of not greater than 25 are common. Furthermore, in 2018, the Scottish average was 2% for an AKI in post-operative knee

arthroplasty operations; and in Mr A's case AKI would be unusual as he was a reasonable anaesthetic and surgical candidate prior to surgery.

26. The Adviser was critical that this abnormal blood creatinine result (identified by Doctor 2 at 17:00 on 12 July 2018) was not acted upon (that is, encourage fluids, put up an intravenous infusion and repeat bloods). The Adviser noted that Mr A's fluid balance chart was discontinued on 12 July 2018 despite an AKI being present. In the Adviser's opinion, it was unreasonable for the fluid balance chart to be discontinued on 12 July 2018 when an AKI had been diagnosed.

27. The Adviser commented that the nursing staff encouraged Mr A to take oral fluids at 19:25 on 12 July 2018 when they noted he had low blood pressure. At 23:30, it was documented that Mr A had two episodes of vomiting at 21:40 and that anti-emetic medication was not required. At 04:15 on 13 July 2018, nursing staff noted that Mr A had passed 197mls of urine which the Adviser said was a small amount. At 06:20 it was documented that Mr A had had a further episode of vomiting.

28. Mr A was reviewed at 06:30 by Doctor 3 who noted that an x-ray of his knee was good and that Mr A was medically fit for discharge. In the Adviser's opinion, there was no evidence to suggest that Mr A was fit for discharge.

29. The Adviser considered it was unreasonable that a physical examination (including abdominal) was not performed on Mr A prior to his discharge with a history of vomiting and a deteriorating kidney function. The Adviser further considered that given the AKI, the orthopaedic team should have sought assistance from other specialities to investigate and treat. In the Adviser's opinion, it was unreasonable that this did not happen.

30. The Adviser was asked to comment on whether or not there was an unreasonable lack of consideration given to the possible complication of paralytic ileus following the surgery. The Adviser said that paralytic ileus is an uncommon complication following knee replacement surgery. The Adviser noted that the pathologist had noted a 4% risk. The Adviser said that literature reveals the risk to be between 0.3 to 2%. The Adviser also said that paralytic ileus is not on the list of complications noted in the BOA's best practice guidance. Therefore, the Adviser considered there was not an unreasonable lack of consideration given to this but reiterated that it was unreasonable that a physical examination was not performed prior to discharge.

31. The Adviser concluded that, as the postoperative AKI was not acted upon and as Mr A was not examined despite the AKI and the vomiting, the postoperative care

and treatment was not of a reasonable standard. The Adviser also commented that, if the AKI was acted upon and an examination performed, it would have been reasonable practice to call other specialities to assess and assist.

(a) Decision

32. In making my decision on whether or not Mr A's postoperative care and treatment was of an unreasonable standard, I have given careful consideration to the complaint correspondence between both parties; copies of Mr A's medical records relevant to the complaint; and the independent professional advice obtained.

33. It is clear from the advice I have received, that, following Mr A's total knee replacement surgery, he developed an AKI and episodes of vomiting that warranted further clinical intervention. From the evidence available, I accept the advice I have received that the postoperative care and treatment Mr A received was not of a reasonable standard due to the following reasons:

- the fluid balance chart was discontinued despite there being a significant fluid imbalance and an AKI having been identified;
- the AKI was not acted upon (no intravenous infusion was given and no repeat blood testing carried out);
- the orthopaedic team did not seek assistance regarding the AKI from other specialities; and
- no physical examination was performed prior to discharge.

34. It is also clear that Mr A's symptoms prior to discharge were not appropriately acted on. Had they been, there is a possibility that other specialities could have been called in to assess and assist. I cannot say whether this would have affected the outcome, however, Ms C could have been assured that Mr A had received reasonable care and treatment prior to his death.

35. In terms of the consent process for surgery, I am deeply concerned that there was no record, on either the clinic letter to the GP or the consent form Mr A signed, to demonstrate that all the specific recognised risks of a total knee replacement surgery were covered sufficiently during the consultation on 30 January 2018. This is contrary to national guidance on consent and was unreasonable.

36. In view of my findings, I conclude that Mr A's postoperative care and treatment was not of a reasonable standard. I uphold this complaint.

37. I am also very concerned that the Board's Morbidity and Mortality Report did not identify and address these failings. I consider this in more detail under part (b) of the complaint.

38. My recommendations for action by the Board are set out at the end of this report.

(b) The Board's handling of the complaint was unreasonable

Ms C's position

39. In Ms C's complaint to the Board on 20 February 2019 she raised concerns that Mr A's observations and symptoms should have raised the possibility of paralytic ileus and prompted further investigations and potentially lifesaving treatment. Ms C referred to concerns she had about Mr A having had signs of AKI, fever, low blood pressure, three episodes of vomiting and feeling unwell, despite being deemed medically fit for discharge.

40. Ms C told us the reasons she considered the Board had not handled her complaint of 20 February 2019 properly were as follows:

i. the Board's letter of response to the complaint dated 9 April 2019 mainly consisted of a copy of the Morbidity and Mortality Report of 8 October 2018;

ii. the letter failed to address the issues she raised about the orthopaedic doctors having questioned and provided an opinion on the pathologist's post mortem findings without the pathologist being present at the meeting; and

iii. the Morbidity and Mortality Report only referred to two episodes of vomiting instead of three episodes.

The Board's position

41. The main points of the Board's response to Ms C's complaint are set out in paragraphs 12 and 13 above.

42. In response to our enquiries the Board said that several offers had been made to meet with Ms C and the family both in the days following Mr A's death and after the Board's response to the SFIU.

Medical advice

43. In the Adviser's opinion it was unreasonable:

- for the orthopaedic specialist to question the pathologist's findings without the pathologist being present at the Morbidity and Mortality meeting;
- for the Morbidity and Mortality Report to only refer to two episodes of vomiting instead of three episodes;
- not to discuss the management/lack of management of the AKI that Mr A suffered postoperatively; and
- to note that AKI is almost universal (as referred to in paragraph 24).

NHS Scotland Complaints Handling Procedure

44. In terms of NHS organisations responding to complaints that have been investigated at stage 2 of the process, the NHS CHP states that:

'The quality of the report is very important and in terms of best practice should:

- *be clear and easy to understand, written in a way that is person-centred and non-confrontational;*
- *avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided;*
- *address all the issues raised and demonstrate that each element has been fully and fairly investigated;*
- *include an apology where things have gone wrong;*
- *highlight any area of disagreement and explain why no further action can be taken…'*.

(b) Decision

45. In making a decision about whether or not the Board's handling of Ms C's complaint was of a reasonable standard, I have examined and considered the complaint correspondence between both parties, the Morbidity and Mortality Report of 8 October 2018, the independent professional advice obtained, and the NHS CHP.

46. Whilst I note that a number of matters were covered within the Morbidity and Mortality Report of 8 October 2018, particularly regarding paralytic ileus, I consider that not all of the points raised in Ms C's complaint form of 20 February 2019 were sufficiently addressed in the Board's response letter of 9 April 2019. The letter concentrated mainly on the opinion as to the cause of Mr A's death rather than

systematically addressing the points Ms C had written in her complaints form. In particular, Ms C's concerns regarding Mr A being deemed medically fit for discharge despite signs of AKI, fever, low blood pressure, three episodes of vomiting and feeling unwell.

47. I consider, therefore, that the response to Ms C's complaint was not compliant with the NHS CHP because the investigation and response should have been more comprehensive, clearer and easier to understand.

48. I noted that Ms C's complaint form to the Board did not refer to the concerns she had about the orthopaedic doctors having questioned and provided an opinion on the pathologist's findings without the pathologist being present at the meeting. In that respect, I accept the advice I have received that it was unreasonable that:

- the orthopaedic doctors had questioned and provided an opinion on the pathologist's findings without the pathologist present at the meeting on 4 October 2018. As stated in paragraph 14, I note that action has since been taken to address this in June 2019.

49. I also accept it was unreasonable that:

- the Morbidity and Mortality Report/response to Ms C's complaint did not refer to all three episodes of vomiting as recorded in the medical records;

- there was no discussion at the Morbidity and Mortality meeting/no mention in the response to Ms C's complaint about the management/lack of management of Mr A's AKI; and

- the Morbidity and Mortality Report/response to Ms C's complaint noted that AKI is almost universal taking into account the advice I have received on this point.

50. As noted above, when responding to Ms C's complaint the Board referred largely to the Morbidity and Mortality Report. The NHS CHP seeks to ensure that complaints are thoroughly investigated, clear reasons given for findings and conclusions, and that areas for learning and improvement are identified and actioned. I am extremely concerned that this has not been the case with Ms C's complaint.

51. In view of these findings, I conclude that the Board's handling of Ms C's complaint was not of a reasonable standard. I uphold this complaint.

52. Members of the public should have confidence that any complaint made to the Board under their CHP will be properly investigated and a full, reasoned, response provided. This is vitally important to ensure openness and accountability, and to

build and reinforce trust in the NHS. My feedback and recommendations for action by the Board are set out at the end of this report. The Board has accepted the recommendations and I will follow this up.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for Ms C:

Complaint number	What we found	What the organisation should do	What we need to see
(a)	• There was an unreasonable failure to act upon Mr A's acute kidney injury and episodes of vomiting; • there was an unreasonable failure to demonstrate that all the recognised risks of total knee replacement surgery were covered sufficiently during the consultation on 30 January 2018; and • the Board's investigation and response to Ms C's complaint contained inaccurate information;	Apologise to Ms C and the family for failing to: • act upon Mr A's acute kidney injury and episodes of vomiting; • demonstrate that all the recognised risks of total knee replacement surgery had been fully explained to Mr A; and • provide accurate information in their complaint response to Ms C, address all the concerns Ms C	A copy or record of the apology. By: 16 September 2020

Complaint number	What we found	What the organisation should do	What we need to see
	did not reasonably address all the concerns Ms C raised; and did not reasonably identify and address the failings in Mr A's care	raised, and identify and address the failings in Mr A's care	

We are asking the Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	• The fluid balance chart was discontinued despite there being a significant fluid imbalance and an acute kidney injury having been identified; • the acute kidney injury was not acted upon (no intravenous infusion was given and no repeat blood testing carried out); and	Patients with acute kidney injury should have their symptoms acted on and managed in line with relevant standards and guidance, where appropriate	Evidence that: • these findings have been shared with all relevant staff involved in Mr A's care in a supportive manner that encourages learning (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions); and • there is a standard operating procedure for the management of acute kidney injury and ensure it

	• no physical examination was performed prior to discharge		is included in junior doctor induction. By: 11 November 2020
(a)	The orthopaedic team did not seek assistance regarding the acute kidney injury from other specialities	Patients should receive appropriate medical review for their symptoms	Evidence to: • demonstrate that these findings have been shared with the surgical staff involved in Mr A's care in a supportive manner that encourages learning (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions); and • demonstrate how junior doctors are supported on the surgical ward. By: 11 November 2020

(a)	There was an unreasonable failure to demonstrate that all the recognised risks of total knee replacement surgery were covered sufficiently during the consultation on 30 January 2018	Patients should be fully advised of all material risks of total knee replacement surgery and the discussion should be clearly recorded, in accordance with the Royal College of Surgeons standard	Evidence that: • surgical staff undertaking total knee replacement surgery have been reminded of the requirement to obtain informed consent in line with relevant standards and guidance; and • the consent form has been reviewed to ensure there is a section on the template to clearly capture material risks of the proposed procedure. The SPSO thematic report on informed consent may assist in encouraging learning for staff in this area: https://www.spso.org.uk/thematic-reports By: 11 November 2020

We are asking the Board to **improve their complaints handling**:

Complaint number	What we found	Outcome needed	What we need to see
(b)	The Board's investigation and response to Ms C's complaint contained inaccurate information; did not reasonably address all the concerns Ms C raised; and did not reasonably identify and address the failings in Mr A's care	The Board's complaint handling and governance systems should ensure that complaints are investigated and responded to in accordance with the NHS CHP. They should ensure that failings (and good practice) are identified; and that learning from complaints is used to drive service development and improvement	Evidence that: • these findings have been shared with complaint handling staff (both clinical and non-clinical) in a supportive manner that encourages learning (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions); and • the Board have reviewed why its own investigation into the complaint did not identify or acknowledge all the failings highlighted here and any learning they have identified. By: 11 November 2020

Feedback

Points to note

As well as the recommendation above to ensure there is a standard operating procedure for the management of acute kidney injury and to include this in junior doctor induction, the Board may wish to consider the placement of ward posters informing others about the issue.

Terms used in the report **Annex 1**

AKI	acute kidney injury – early kidney failure
anti-emetic	medication to prevent or relieve nausea and vomiting
cardiopulmonary resuscitation	the manual application of chest compressions and ventilations to patients in cardiac arrest
Doctor 1	a consultant orthopaedic surgeon - a specialist in the treatment of diseases and injuries of the musculoskeletal system
Doctor 2	an FY1 doctor (a junior doctor in the first year of a two-year programme for doctors who have just graduated from medical school)
Doctor 3	a registrar (middle grade doctor)
ischaemic heart disease	reduced blood supply to the heart due to a build-up of fatty substances in the coronary arteries
Mr A	the patient
Ms C	the complainant and daughter of Mr A
NEWS	national early warning score – a standardised assessment tool designed to quickly determine the degree of illness of a patient and prompt intervention
paralytic ileus	lack of movement somewhere in the intestines that leads to a build-up and potential blockage
pulmonary thromboembolism	the blockage of a lung artery due to a blood clot that was dislodged from somewhere else in the body, usually the legs

SFIU	Scottish Fatalities Investigation Unit – a specialist unit of the Crown Office and Procurator Fiscal Service
stenting	a surgical procedure or operation for inserting a stent (a small tube made of metal mesh to help blood flow more easily) into an anatomical vessel
the Adviser	a consultant trauma and orthopaedic surgeon
the Board	Highland NHS Board
urea and creatinine	chemical waste products which are eliminated from the body by the kidneys, in the form of urine. Urea and Creatinine levels in the blood can be measured to determine kidney function

List of legislation and policies considered **Annex 2**

Acute Kidney Injury National Institute for Health and Care Excellence (April 2018)

Best Practice Consent Total Knee Replacement British Orthopaedics Association

NHS Scotland Complaints Handling Procedure (1 April 2017)

Royal College of Surgeons *Consent Supported Decision Making – a guide to good practice (November 2016)*

SPSO thematic report on informed consent (March 2017)