Scottish Parliament Region: Lothian

Case 200401824: Lothian NHS Board

A complaints investigator with the delegated authority of the Scottish Public Services Ombudsman has conducted this investigation.

Summary

1. On 11 January 2005 the Ombudsman received a complaint from a man (referred to in this report as Mr C) that the treatment and care his 81 year-old mother (Mrs C) received in the Edinburgh Royal Infirmary (ERI) in November and December 2003 was inadequate and contributed to her death on 26 December 2003. My investigation did not uphold Mr C's central complaint but found that there were shortcomings in communication with Mrs C's family and significant deficiencies in her clinical records. In the light of these findings the Ombudsman recommends that the Board review their communication standards and the effectiveness of their medical records.

Background

2. Mrs C was admitted to the ERI on 31 July 2003 with severe pain and spasms in her right leg. She was transferred to the Astley Ainslie Hospital on 15 August 2003 and returned to the ERI on 5 November 2003 for a total hip replacement. She suffered a stroke on 7 December 2003 and died on 26 December 2003.

Complaint as put to the Ombudsman

3. Mr C complained of:

(a) incorrect clinical practice in giving his mother a total hip replacement;

(b) failure to communicate with the family;

(c) failure to keep Mrs C's family informed about aspects of her condition;

(d) failure to take account of the family's wishes with respect to Mrs C's treatment;

(e) failure to provide appropriate treatment for Mrs C's pneumonia;

(f) failure to provide sufficient nursing care to Mrs C, causing her hip to dislocate on two occasions;

(g) failure to provide a complete or timely response to his complaint;

(h) failure by the independent review convener to consider his complaint properly or adequately.

Investigation and findings of fact

4. In the course of the investigation of this complaint, I have read all the documentation supplied by Mr C, Mrs C's medical records and the complaint files. Advice has been obtained from both the medical and the nursing advisers to the Ombudsman. Several written enquires have been made to the University Hospitals' Division of Lothian NHS Board (the Board). I now set out, for each of the eight heads of Mr C's complaint, my findings of fact and conclusions. The investigation has identified concerns about the standard of hospital records and I deal with these in paragraphs 48-57. Where appropriate, recommendations are set out at the end of the sections dealing with individual heads of complaint. A summary of recommendations is in paragraph 58. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked. Mr C and the Board have been given an opportunity to comment on a draft of this report.

(a) Total hip replacement

5. Mr C complained that his mother was not fit for the operation. He said that, as she had suffered a stroke following a previous hip operation, she should not have been considered suitable for such treatment. He also complained that the family were not properly informed of the nature of the operation Mrs C was to be given at

the ERI. They believed it was a minor operation to remove some floating bones. He was unhappy that the hospital had only consulted Mrs C and her husband, whom Mr C believed to be too vulnerable to make such decisions alone and who may not have fully understood what was being discussed with them. Mr C believed that the possible complication of deep vein thrombosis, leading to stroke, was never explained to Mrs C or her husband. Mr C said that, at the time of Mrs C's first hip operation in 2002, her family had been fully consulted before agreeing to the operation.

6. During the local resolution stage of the NHS complaints procedure, the Board commented that the consultant had discussed the matter with Mrs C and her husband in some detail and that they had both welcomed the operation, as it would relieve Mrs C's pain. They also stated that the consultant had considered Mrs C's medical history and current condition, but had concluded that, on balance, it was better to proceed with the operation. The Board have pointed out that Mrs C's husband was her next-of-kin and as such would be their principal contact.

7. The medical adviser commented that the medical notes did not indicate that anyone sat down with the family to discuss the complications of any surgery that was to be carried out, at any stage. However, the medical adviser also said that it was unthinkable that any surgeon would not have discussed this with a patient. He said that, while there was no recording in the notes, medical staff must have felt that the only way to help Mrs C was to try to rid her of pain. The only option for doing this was a total hip replacement, despite the potential risk of dislocation. Accordingly, he did not believe the decision to undertake surgery was wrong.

8. Two medical advisers commented on the consent form used by NHS Lothian. They both felt that the forms used were not helpful in that they did not record if any risks were discussed with the patient. Both advisers said that such an entry is now standard practice in England and Wales and I am aware that other NHS bodies in Scotland have made such changes.

9. In response to their review of the draft of this report, the Board advised me that they had already introduced a revised consent form. I reviewed the new form and was satisfied that it included sufficient reference to the discussion of possible risks.

Total hip replacement: conclusions

10. Based on the advice I have received, I am satisfied that the decision to operate was clinically appropriate and I, therefore, do not uphold this aspect of Mr C's complaint. I am pleased to note that the Board have revised their consent form. (Please also note the Ombudsman's recommendation at paragraph 58).

(b) Communication with the family

11. Mr C complained that the family always had to proactively seek information and that the answers they did get were often vague and unhelpful. This left them with the impression that their mother was being 'written off' by those who were supposed to be there to help her.

12. The first record in the nursing notes of discussions with the family was a note on 7 December 2003 that the family were informed of the situation, although it does not say by whom. On 10 December 2003, the nursing notes reported that the consultant had spoken to the family but there was no record in the medical notes of any such conversation or what was said.

13. The nursing adviser commented that poor communications between professionals and families were at the heart of many complaints. She said that, in this case, the documentation was very poor regarding what had been discussed with the family and, although the Board have commented that staff spoke with the family, nothing was written to that effect.

14. The medical adviser commented that there were no records in the medical notes of what had been communicated to relatives by doctors.

15. In response to enquiries, the Board provided a copy of the *NHS Lothian Standard for Communicating with Patients and Relatives* (the Standard). Included in the Standard are the following statements:

‘There is to be a clear written record of what the patient and their relatives have been told at all stages of the illness.’

‘Sufficient time is to be made available to the patient/relative to discuss the diagnosis, treatment and prognosis.’

The Standard also refers to the methods to be used to audit compliance with the Standards.

Communication with the family: conclusions

16. Due to the lack of detail in the written records, I am not able to reach any firm conclusion regarding the quality and quantity of general communication with the patient or her family. Based on the advice I have been given and the evidence I have reviewed, I am concerned that the level of communication may not have been adequate and is clearly not evidenced by the hospital record as required by the Standard. The Ombudsman recommends that the Board review the audit procedures, as set out in the Standard, to ensure that the Standard is being properly applied. The Ombudsman requests that the Board provide evidence of their actions to ensure compliance with the Standard, by supplying her with copies of the results of the latest audits and surveys of communications with patients (as provided for in the Standard) and details of action being taken to address any shortfalls identified.

17. The Ombudsman’s recommendations at paragraph 58 are also relevant to this aspect of the complaint.

(c) Information to Mrs C’s family about aspects of her condition

18. Mr C complained that he only discovered his mother had MRSA when he read her file at the Astley Ainslie Hospital. At that time, the family were told that there was nothing to worry about. They subsequently came to believe that there was in fact a serious MRSA infection, which led to her contracting pneumonia, blood poisoning and a bladder infection. They believed that they should have been notified of the infection and its severity. Mr C also complained that his mother

should not have been given the hip operation while suffering from MRSA. Mr C commented that the medical record indicated that the infection was in her blood stream (systemic).

19. During local resolution, the Board commented to Mr C that a routine swab from Mrs C's throat was reported positive for MRSA on 20 August 2003. However, there was no indication that she had a systemic infection and it was considered reasonable to proceed with her operation. They also advised Mr C that the bacterial infection found to be in her blood stream in November was not MRSA but another infection, which was treated with the necessary antibiotics.

20. The medical adviser said that he considered that the treatment provided to Mrs C in this regard was reasonable. He commented that Mrs C did not die from organisms in her blood. He also commented that the organisms that she did have in her blood were not those of MRSA.

21. Mr C also complained that, during the second operation to relocate his mother's hip, she was given an abductor tenotomy (a cutting of the tendon muscle). However, the family were not asked about this or advised that it had happened, and only discovered that it had happened after her death.

22. During local resolution, the Board commented that it was necessary to perform the abductor tenotomy because Mrs C had a pre-existing muscle rigidity in that leg. The Board apologised if this had not been clearly explained to the family at the time.

23. The medical adviser commented that, after a hip reduction operation (the operation to re-site a dislocated hip), it is sometimes very evident that the muscles are tight, especially in someone who has had previous strokes. In these rare circumstances, a surgeon may sometimes feel that it is better to go ahead and do this very small operation to release the muscles in the hope that this will help prevent the hip re-dislocating.

Information to Mrs C's family about aspects of her condition: conclusions

24. I am satisfied, based on the advice I have been given, that the family were given adequate information with respect to Mrs C's blood infection and that it was reasonable (although not ideal) for them not to be given information regarding the abductor tenotomy procedure. I do not uphold this aspect of the complaint.

(d) Family's wishes with respect to Mrs C's treatment

25. Mr C said that the family had discussed the removal of his mother's antibiotics with medical staff but were assured that the saline drip would not be removed. However, the next day it was removed and it was only after a confrontation between Mr C's brother and a member of nursing staff that it was replaced. Mr C maintains that the nurse on duty that day (20 December 2003) refused to replace the drip, despite this having been previously agreed. Mr C is also unhappy that the family were told that no member of medical staff was available at the time.

26. During local resolution, the Board commented that the saline drip had 'tissued' – that is, it had stopped working. It was then necessary to resite it and this proved very difficult. The saline infusion was eventually restarted by using subcutaneous (under the skin) access. The Board also commented that, due to sickness absences, there were no junior doctors available on the ward at the time.

27. The nursing adviser commented on the absence of entries in the care plan with respect to this change of treatment. The nursing notes did say that there was no intravenous infusion (IVI) access. Accordingly it may not have been possible to resite the IVI. However, there was no documentary evidence that an attempt had been made to do so.

28. The nursing adviser said that it was entirely reasonable for a junior charge nurse to have been the most senior person on duty on the ward and indeed staff nurses are often in charge of wards.

29. In response to enquiries, the Board said that there were medical staff shortages on 20 December 2003 and it is possible that the medical staff on duty were busy elsewhere, for example in surgery. They also said that there had been

a change in cover arrangements since the time at which the events in this report took place, which has resulted in additional medical support to the ward.

Family's wishes with respect to Mrs C's treatment: conclusions

30. Based on the advice I have been given, I am satisfied that the removal of the drip was necessary and that the agreed treatment had to be provided in another way. There was no refusal to provide Mrs C with the agreed treatment. So I do not uphold this aspect of the complaint. However, I am concerned that there was no evidence in support of this change within the medical records. The Ombudsman's recommendation at paragraph 58 are also relevant to this aspect of the complaint.

(e) Treatment for Mrs C's pneumonia

31. Mr C said that a doctor had informed him that Mrs C probably had pneumonia for some time and certainly before she contracted chemical pneumonia. He was unhappy that nothing was done about this problem earlier.

32. Pneumonia is usually caused by a bacteria or virus in the lungs. In chemical pneumonia, lung tissue is inflamed – this can be caused by chemicals or by breathing in acid from the stomach while vomiting.

33. The medical adviser commented that the initial diagnosis of pneumonia can be very difficult with an elderly patient. Mrs C's stroke would have made swallowing much more difficult and increased the chance of even ordinary saliva going down the wrong channel into the lungs. This can start an infection in the lungs, which the body's immune system cannot always fight off. Mrs C's various symptoms of stroke would all have made a diagnosis of pneumonia difficult and thus caused a delay in diagnosis.

Treatment for Mrs C's pneumonia: conclusions

34. I am satisfied that there was no major delay in diagnosing or subsequently treating Mrs C's serious pneumonia, once it became apparent. I do not, therefore, uphold this aspect of the complaint.

(f) Nursing care

35. Mrs C had her full hip replacement operation on 11 November 2003. This dislocated and she returned to theatre on 14 November 2003 to have a reduction (repositioning of the dislocation). It was dislocated again with another reduction being performed on 19 November 2003.

36. Mr C complained that there was negligence in allowing his mother's hip to dislocate twice, despite the precautions which were apparently put in place after the first dislocation. He also believed the added strain of two additional operations under general anaesthetic contributed to his mother's vulnerability to stroke.

37. The medical adviser commented that, on 14 November 2003, the records indicated that Mrs C had had an operation because her total hip replacement had dislocated. There was nothing in the medical notes or in the nursing notes that indicated when the dislocation had occurred. He has also advised that dislocation is a more common problem in patients who have had previous strokes.

38. The medical adviser said that following the second episode of dislocation, an abduction pillow was used, which is a usual way to try to prevent further dislocations. It was not clear from the records what was done the first time, if anything, to prevent a re-dislocation. The medical adviser said that he believed they probably mobilised the patient on the basis that dislocation was unlikely to recur.

39. Both the medical and nursing advisers commented on the lack of any reference in the notes to the possible causes or other information regarding the dislocations. The nursing adviser expressed concern at the absence of any plan, or revised plan, within the care plans following either dislocation.

40. In response to enquiries, the Board said that a pathway document for use following reduction of a dislocated hip has been introduced since these events. I have reviewed this document. It is stated in the document that, in general, specialist pillows are not used to keep the hip abducted (facing outwards) after a reduction. The nursing adviser reviewed this document and was satisfied that the

Board have adequate procedures for the prevention of hip dislocation. The nursing adviser again expressed concern that there was no evidence of these procedures in Mrs C's records.

Nursing care: conclusions

41. Based on the evidence available to me, I am unable to reach a clear conclusion on the measures taken to prevent Mrs C's hip dislocating on either occasion. However, the advice I have been given by the medical adviser indicates that there was a reasonable chance of this happening whatever precautions had been taken. Therefore, the fact that dislocation occurred cannot necessarily be attributed to poor practice. I do not, therefore, uphold this aspect of the complaint. Once again I note the difficulties caused by a lack of written evidence in the hospital records.

(g) Response to Mr C's complaint

42. Mr C complained that the answers provided by the Board to his complaint were inadequate and did not address all the points he raised. He was also unhappy that it took the Board three months to respond to his original query and another two months to respond to his further points. He considered that these were deliberate delaying tactics to dissuade him from complaining further.

Response to Mr C's complaint: conclusions

43. While I agree with Mr C, that the Board did not respond to all the issues raised in his complaint, I consider that they did make reasonable attempts to answer his concerns. It would have been helpful if the Board had sought to ensure that all the points raised were given a specific answer. The Ombudsman strongly commends this approach be adopted in future responses, particularly to such complex complaints. The Board did exceed the NHS timescales for complaint handling. However, I am satisfied that this was due to the complex nature of the complaint response required and that the Board made reasonable attempts to notify Mr C of these delays. I do not uphold this aspect of Mr C's complaint to the Ombudsman.

(h) Independent review convener's consideration of Mr C's complaint

44. Mr C complained that the level of response provided by the independent review convener was extremely basic and that he was potentially biased.

45. Both advisers commented on the unsatisfactory nature of the convener's response. The medical adviser commented that the convener's response seems to have been almost negligible, with what appeared to be an attempt to resolve a number of issues by recourse to further local resolution.

46. It is important to note that there has recently been a major change to the NHS complaints procedure. Since 1 April 2005, the independent review stage of the NHS complaints procedure has been removed, and complainants are able to approach the Ombudsman immediately on completion of local resolution.

Independent review convener's consideration of Mr C's complaint: conclusions

47. In light of the changes to the NHS complaints procedure, there would be no purpose served in making any specific recommendation on this aspect of the complaint. I consider that it would have been more helpful to Mr C to provide him with a more detailed response and that the referral for further local resolution did not seek to provide a response to all the outstanding points raised by Mr C. To that extent, I uphold this aspect of Mr C's complaint to the Ombudsman.

Standard of hospital records

48. As outlined above, hospital documentation for the ERI used a combination of unitary patient record (UPR), which allowed for multidisciplinary input to the record, and pre-printed care plans, which covered specific aspects of care, for example dietary needs.

49. As this investigation progressed, it became apparent that a number of the issues raised by Mr C revealed an underlying problem with the quality and the quantity of hospital documentation. I note above several instances where the hospital record did not document conversations with Mrs C's family or actions taken by staff.

50. The nursing adviser expressed considerable concern that the hospital records, as a whole, were particularly sparse. The completion of care plans was especially poor.

51. The nursing adviser also expressed concern that, given the complexity of Mrs C's condition and her previous medical history, there appeared to be no comprehensive care plans, detailing individual problems, what the goals were for nursing staff in treating problems, how they evaluated their care and how they were assessing the situation for new problems. She regarded the care planning for Mrs C to be extremely poor and the risk assessment non-existent. She found no evidence of a comprehensive plan of care for a patient who had complex and changing care needs and who was at risk from a number of problems. Mrs C's daily progress reports suggested that she was getting an acceptable level of nursing care, although the nursing adviser believed this would have been greatly enhanced had adequate care plans been in place. The nursing adviser also expressed concerns that the system of care plans, running alongside the records, with numbered codes used to complete pre-printed care plans, may have been serving to make the process a tick-box exercise rather than a comprehensive patient assessment.

52. I would also comment that the Board have not been able to supply all the relevant x-rays from the theatre, following the two reductions, as these were not contained in the relevant x-ray envelope.

53. Following my initial enquiry, the medical adviser was concerned by the gaps in recording in the medical record and I sought confirmation from the Board that I had all the records. The Board then supplied the missing records. This initial omission highlights one of the difficulties with the current method of record-keeping, in that records can very easily be mislaid or misfiled.

54. The Board commented on the draft of this report that they have now amended the specific integrated care pathway regarding hip fractures to address the deficiencies raised in this case. In addition, there is now an integrated care

pathway for hip dislocations. A review of all the trauma integrated care pathways is also about to be undertaken.

55. The current guidelines for record-keeping, issued by the Nursing and Midwifery Council (the organisation set up to protect the public by ensuring that nurses and midwives provide high standards of care to their patients and clients), states that records should:

- be factual, consistent and accurate;
- be written as soon as possible after an event has occurred, providing current information on the care and condition of the patient or client;
- be accurately dated, timed and signed, with the signature printed alongside the record;
- be consecutive;
- identify problems that have arisen and the action taken to rectify them;
- provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.

Nursing and Midwifery Council Guidelines for records and record-keeping January 2005.

Standard of hospital records: conclusions

56. The lack of evidence and clarity in the hospital record gave rise to a number of concerns in this complaint and prevented me from reaching clear conclusions on some issues. It is also apparent that, based on the advice I have received, there has been a failure to ensure record-keeping meets the NMC guidelines. These are matters of concern. I consider they indicate a need for the Board to review the scope of the UPR and responsibilities for documenting in that record; provide further training for staff with regard to care plans, establish an ongoing framework

for evaluating nursing care; and consider the comments about record-keeping detailed in this report.

57. I am aware that these are major pieces of work. I am also aware that an independent panel has been set up to advise NHS Lothian on the care of older patients with the aim of bringing an objective view on best practice in looking after patients' personal and emotional needs, as well as providing high-quality medical treatment. I will ensure that the independent panel receives a copy of this report.

Summary of recommendations

58. Following the investigation of all aspects of this complaint, the Ombudsman recommends that the Board:

i. provide evidence of their actions to ensure compliance with the Standard, by providing her with copies of the results of the latest audits and surveys of communications with patients (as provided for in the Standard) and details of action being taken to address any shortfalls identified;

ii. review the scope of the UPR and nursing responsibilities for documenting in this record;

iii. provide further training for staff in relation to maximising the benefits of care plans - in particular specific issues for each patient;

iv. establish an ongoing framework for evaluating nursing care to include auditing of documentation and of the overall patient experience;

v. consider the comments about record-keeping alongside any recommendations made by the independent panel on the care of older patients.

Further Action

59. As noted in paragraph 4, the Board have been given an opportunity to comment on the draft of this report. They have said that they accept the

recommendations and will act on them accordingly. The Ombudsman asks the Board to notify her when and how the recommendations are implemented.

20 December 2005

Appendix 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	Mr C's mother who died
ERI	Edinburgh Royal Infirmary
The Board	Lothian NHS Board

Appendix 2

Glossary of medical terms

MRSA	Methicillin resistant staphylococcus aureus, a bacterial infection that is drug resistant
Abductor tenotomy	Cutting of the tendon muscle
Hip reduction operation	The operation to re-site a dislocated hip
IVI	Intravenous infusion
UPR	Unitary patient record