Scottish Parliament Region: Lothian

Case 200601149: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Premature Discharge, failure to provide timely treatment; failure to maintain proper records

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment of her late husband (Mr C) and the handling of his complaint about that care and treatment by Lothian NHS Board (the Board).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C was prematurely discharged from the Royal Infirmary of Edinburgh (Hospital 1) on 16 September 2005 (*upheld*);

(b) the Board failed to provide Mr C with appropriate and timely care and treatment between 27 September 2005 and 6 October 2005 (*upheld*); and

(c) the Board failed to make an adequate response to Mrs C's complaint (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) inform her of progress towards achieving the objectives set out in paragraph 16 of this Report; and

(ii) make a written apology to Mrs C for the failure to maintain proper records and the additional distress this has caused to Mr C's family in pursuing this matter.

The Board have accepted the recommendations and agreed to act on them accordingly.

Main Investigation Report

Introduction

1. On 12 July 2006 the Ombudsman received a complaint from Mrs C (supported by her son, Mr B) concerning the care and treatment provided to her late husband (Mr C) by Lothian NHS Board (the Board) between 15 September 2005 and 6 October 2005 at the Royal Infirmary of Edinburgh (Hospital 1) and the Western General, Edinburgh (Hospital 2). Mr C died in Hospital 1 on 19 October 2005. Mrs C complained to the Board on 20 November 2005 and received a response on 8 February 2006. Mrs C was unhappy with the response and was concerned that it failed to answer a number of her concerns because the Board claimed that significant amounts of Mr C's clinical records were missing. Mrs C, therefore, also complained that the response she had received from the Board to her complaint was inadequate.

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

(a) Mr C was prematurely discharged from Hospital 1 on 16 September 2005;

(b) the Board failed to provide Mr C with appropriate and timely care and treatment between 27 September 2005 and 6 October 2005; and

(c) the Board failed to make an adequate response to Mrs C's complaint.

Investigation

3. Investigation of this complaint has involved obtaining and reviewing the available clinical records and NHS complaint file. I have spoken with Mr B and also sought clinical advice from medical (Adviser 1) and clinical (Adviser 2) advisers to the Ombudsman. I have sought further comments and action from the Board particularly in relation to the quality and quantity of clinical records available in this case. Investigation of this complaint has been severely hampered by the loss of relevant records and the poor record-keeping demonstrated in those available.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C, Mr B and the Board were given an opportunity to comment on a draft of this report.

5. I have set out each of the heads of complaint individually but drawn together my conclusions and the Ombudsman's recommendations as both are applicable to all three heads of complaint.

(a) Mr C was prematurely discharged from Hospital 1 on 16 September 2005

6. Mr C had a history of vascular disease and chronic renal impairment. He was admitted to Hospital 1 on 11 August 2005 with a fractured right hip and had an operation for this on 13 August 2005. On 15 September 2005 Mr C had a fall in Hospital 1 and sustained some bruising to his left hip. He was discharged on 16 September 2005. Mr C complained of pain and was reviewed at home by a physiotherapist on 21 September 2005 but no clinical signs of a fracture were noted. A further review took place on 27 September 2005 after which Mr C was referred to his GP for review for a possible deep vein thrombosis. Mr C was admitted to Hospital 2 by the locum GP who reviewed him that day.

7. Mr B told me that although Mr C was otherwise well when he was discharged on 16 September 2005 he was experiencing pain in his left hip and nothing appeared to have been done to ascertain whether he had damaged his hip in the fall. Mrs C was concerned that it was only when Mr C was admitted to Hospital 2, 11 days later and subsequently x-rayed after another six days, that Mr C's fractured left hip was diagnosed.

8. In their response the Board noted that there was no reference to a fall in Mr C's nursing notes for the 15 September 2005 although the occupational therapy (OT) notes did indicate such a fall. The OT note on 16 September 2005 recorded that there was 'no residual effect from the fall yesterday'. The Board indicated that the ward physiotherapist had been interviewed and did recall the fall and talking to Mr C afterwards. The ward physiotherapist also advised the Board that she believed a staff nurse was going to complete an Incident Form to report the fall but could not recall which nurse this was. The Board advised that they had interviewed the nurses responsible for the ward at the time but neither could recall the fall. No Incident Form can be traced. The Board concluded that the Incident Form which should have been filled out and actioned had not been completed and apologised to Mrs C for this advising her that staff had been reminded of the importance of completing these forms and examining patients after a fall. The Board also noted that the medical, physiotherapy and OT staff had not noted any changes in Mr C's mobility after his fall and prior to his discharge.

(b) The Board failed to provide Mr C with appropriate and timely care and treatment between 27 September 2005 and 6 October 2005

9. Mr C was admitted to Hospital 2 on 27 September 2005 and transferred to an acute medical ward the next day. A consultant (the Consultant) first reviewed and examined Mr C on 30 September 2005 and requested a left hip and pelvis x-ray be done that day to determine whether Mr C had sustained a fracture to his left hip. The x-ray did not in fact occur until 3 October 2005 when a fracture was confirmed. On the same day there was a marked change in Mr C's blood test results suggesting that he may be experiencing problems with his kidney function. His blood clotting levels were also shown to have diminished and his warfarin was stopped. Mr C's condition was noted to be worse on 4 October 2005 and further tests including a CT scan, chest x-ray and ECG were performed. On 5 October 2005 Mr C's condition continued to deteriorate and a renal Specialist Registrar was contacted for advice on Mr C's on-going treatment. Advice was sought again on 6 October 2005 and it was decided that Mr C would be transferred to specialist care in Hospital 1.

10. Mr B told me that he had visited Mr C over the weekend on 1 and 2 October 2005. He told me that he noted a big change in Mr C's condition and that he had brought this to the attention of staff at the time but nothing appeared to have been done to investigate this or arrange the x-ray until the Consultant returned to work on 3 October 2005.

11. In their response the Board stated that, unfortunately, no trace could be found of Mr C's clinical records for this time and that they could not, therefore, comment on Mr C's condition at this time. The Board advised Mrs C that they had investigated why the x-ray had not occurred on 30 September 2005 as ordered by the Consultant. They concluded that there had been an oversight by a member of the radiology department who had failed to properly prioritise the x-ray. The Board apologised for this error and also noted that the Consultant had reminded his staff that they should also have followed up on the x-ray request. The Board stated that on 4 October 2005 the Consultant felt it was important to stabilise Mr C before considering a transfer to Hospital 1 for the left hip operation.

12. In response to my request the Board conducted a further search for the missing records and undertook a review of the records that were available. They concluded that the records remained missing but that review of the available records had highlighted a number of record-keeping concerns. The

Board provided me with a report from the clinician (not connected with any of these events), who had reviewed the available records, which highlighted a number of concerns about the record-keeping. The Board apologised that the records could not be found and that there were a number of omissions in the records available that made reconstructing events difficult and sometimes impossible.

13. Adviser 1 reviewed the available notes for me and stated that he found great difficulty in making any meaningful comment on any of the events of this complaint because he considered that the standard exhibited in relation to health records fell woefully short of what was to be expected. Adviser 1 noted that while a considerable volume of the medical records were known to be missing the remaining records often allowed for multi-disciplinary input but this was also lacking in most instances.

14. In relation to the reason for Mr C's admission on 27 September 2005 Adviser 1 noted that there was no evidence of medical assessment and any suspicion at that point of a fracture nor any evidence of investigation of suspected venous thrombosis (the reason for admission). Action was only taken following an assessment by a physiotherapist and the Consultant on 30 September 2005. Adviser 1 noted that the Board had apologised for a number of failings identified, such as the delay in the x-ray once ordered, but that there were other potential failings which the lack of records prevented him reaching a conclusion about.

(c) The Board failed to make an adequate response to Mr C's complaint

15. Mrs C complained to me that she was concerned that the Board's response was overly reliant on missing or incomplete records and failed to answer the substance of his concerns because of this. Mr B expressed a concern that while nothing could now be done for Mr C his family were concerned that they had not been reassured that other elderly and vulnerable patients were not also affected by possible failures in care and treatment.

16. In response to my request the Board conducted another search for the missing records but these could not be found. I asked the Board to conduct an audit of a sample of patient records which involved similar transfers between both hospitals and specialities and consider the implications of the results of this for future practice. The Board agreed to this and conducted the audit in May 2007. The Board reported the results of the audit to me and also provided

me with a statement of the actions to be taken as a consequence of the findings of the audit (which identified a number of errors and concerns along-side incidences of good practice). These actions are:

- Developing a template for regular healthcare record audits (to be developed by clinical governance and clinical effectiveness staff)
- Providing feed-back to the Clinical Management Teams and making healthcare records management a regular item in Clinical Quality Improvement Programmes
- Providing feed-back on the audit to the Clinical Documentation and Healthcare Governance Groups (and having healthcare records management as a regular agenda item for both these groups)
- Setting-up a regular programme of independent healthcare records audit

(a),(b) and (c) Conclusions

17. There are two types of recognised failures in this case. Firstly records are missing and secondly, on more than one occasion, staff failed to take the appropriate action which caused, at the very least, a delay in Mr C receiving the appropriate treatment. The missing records have led to the further difficulties experienced by the Board and Adviser 1 in responding to this complaint and Mr C's family not being given the reassurance that he received appropriate care.

18. I have discussed the audit, its findings and the action proposed by the Board with Adviser 2 who has said that the audit identified a number of issues which are sadly not untypical of those regularly found in this office's review of clinical records but that the Board's response was an appropriate way forward to try and address these problems. I would note that the Board have co-operated fully with my investigation and acted very promptly on any request for further searches and audit of records. I consider it would have been helpful to the resolution of this complaint if such an audit had been conducted before this office became involved as this would have given Mr C's family more confidence that the Board considered missing records to be unacceptable rather than unfortunate.

19. I am unable to conclude with any certainty on whether Mr C's fracture should have been detected prior to his discharge on 16 September 2005 or whether staff in Hospital 2 failed to react appropriately and speedily to his readmission on 27 September 2005 and his subsequent deterioration. I cannot do this because of a lack of records. There is evidence of failings in practice in

relation to the reporting of falls and obtaining the x-rays which, quite understandably, has caused Mrs C to be concerned about what else may have gone wrong. The quality of record-keeping fails to meet a reasonable standard and the Board are accordingly unable to demonstrate that reasonable care and treatment was provided to Mr C. Based on the acknowledged failings in care and the Board's inability to provide adequate evidence of appropriate care and treatment I uphold all aspects of this complaint.

(a),(b) and (c) Recommendations

20. The Ombudsman recognises and commends the apologies and actions already under-taken by the Board and asks that they inform her of progress towards achieving the objectives set out in paragraph 16. The Ombudsman recommends that the Board make a written apology to Mrs C for the failure to maintain proper records and the additional distress this has caused to Mr C's family in pursuing this matter.

21. The Board have accepted the recommendations and agreed to act on them accordingly.

24 October 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	Mrs C's husband, the aggrieved
Mr B	Mr and Mrs C's son
The Board	Lothian NHS Board
Hospital 1	The Royal Infirmary of Edinburgh
Hospital 2	The Western General, Edinburgh
Adviser 1	A medical adviser to the Ombudsman
Adviser 2	A clinical adviser to the Ombudsman
OT	Occupational Therapy
The Consultant	The Consultant who reviewed Mr C on 30 September 2005

Annex 2

Glossary of terms

Chronic renal impairment	Slow progressive loss of kidney function
CT scan	A three dimensional image scan
Deep vein thrombosis/ venous thrombosis	The formation of a blood clot in a deep vein
ECG	A recording of the electrical activity of the heart over time
Vascular Disease	Hardening of the arteries of around he body leading to a decreased blood supply
Warfarin	An anti-coagulant