Scottish Parliament Region: North East Scotland

Case 200501660: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; Medical care; Complaint handling

Overview

The complainant (Mrs C) complained about the care and treatment her sister (Mrs A) received at Ninewells Hospital, Dundee (the Hospital).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was an unreasonable delay in arranging an MRI scan following Mrs A's admission to the Hospital in November 2003 (*upheld*);

(b) the delay caused Mrs A's condition to worsen and become irreparable leaving her in constant and severe pain *(not upheld*);

(c) there was a failure by the Hospital's Pain Clinic to monitor or arrange appropriate follow-up in relation to the medication prescribed for Mrs A *(not upheld*); and

(d) there was an unreasonable delay by Tayside NHS Board (the Board) in the handling of the complaint (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) issue Mrs A with a full formal apology for the failures identified in part (a) of the complaint. The apology is to be in accordance with the Ombudsman's guidance note on 'apology' which sets out what is meant by and what is required for a meaningful apology; and

(ii) provide evidence to the Ombudsman of the steps taken to prevent a reoccurrence of the failures identified in paragraphs 21 to 23 of the report.

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

Main Investigation Report

Introduction

1. On 30 September 2005, the Ombudsman received a complaint from Mrs C, on behalf of her sister, Mrs A. Mrs C complained about the care and treatment provided for Mrs A following her admission to Ninewells Hospital, Dundee (the Hospital) in November 2003. Mrs C complained there was an unreasonable delay in arranging an MRI scan following Mrs A's admission to the Hospital. Although Tayside Health Board (the Board) had apologised for the anxiety caused, Mrs C complained that the Board did not acknowledge the delay caused Mrs A's condition to worsen and become irreparable leaving her in constant and severe pain. In addition, Mrs C further complained about the subsequent failure by the Hospital's Pain Clinic to monitor or arrange appropriate follow-up for Mrs A in relation to the medication prescribed following her discharge.

2. On 31 October 2005 Mrs C also complained to this office about delay by the Board in dealing with her complaint.

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

(a) there was an unreasonable delay in arranging an MRI scan following Mrs A's admission to the Hospital in November 2003;

(b) the delay caused Mrs A's condition to worsen and become irreparable leaving her in constant and severe pain;

(c) there was a failure by the Hospital's Pain Clinic to monitor or arrange appropriate follow-up in relation to the medication prescribed for Mrs A; and

(d) there was an unreasonable delay by the Board in the handling of the complaint.

Investigation

4. The investigation of this complaint involved reading all the documentation supplied by Mrs C, Mrs A's clinical records and the Board's complaint file. I was assisted in my investigation by two of the Ombudsman's professional advisers, a hospital adviser (Adviser 1) and a surgical adviser (Adviser 2). In addition, advice in respect of part (b) of the complaint was obtained from an external medical adviser, a consultant in Pain Management (Adviser 3). They advised me on the clinical issues of the complaint. I have set out my findings of fact and conclusions for each part of Mrs C's complaint. An explanation of abbreviations

and glossary of medical terms used in this report are at Annex 1 and 2 of the report.

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

Background

6. The clinical advice I have received from Adviser 1 concerning Mrs A's clinical history, based on her medical notes, is as follows:

7. Mrs A has a long history of severe and complex medical problems. She has been under the care of various departments of the Hospital including rheumatology, orthopaedics, the Endocrine Clinic and the Pain Clinic.

8. Mrs A has Addison's Disease. She was diagnosed in 1979 since which time she has been cared for at the Hospital's Endocrine Clinic and by her general practitioners. Addison's Disease is not common; it is a life threatening disorder resulting from complete or partial failure of the cortex of the adrenal gland due to an auto-immune process, infection, haemorrhage or neoplasia. Patients affected by Addison's Disease suffer from multiple symptoms related to steroid deficiency and need to be managed by appropriate hormone replacement therapy which according to Mrs A's clinical notes, she is receiving.

9. Mrs A also has arthritis and suffers pain in various sites including the lower back, the lower limbs and feet. She is also hypertensive and has an underactive thyroid gland. Her hypertension and arthritic problems are not related to the Addison's Disease or its management, but the hypothyroidism may be. Arthritis is not uncommon in some one of Mrs A's age, 55 at the time of the complaint. Arthritis of any type may be progressive and require management by various types of medication as well as surgery in some cases. The medication in Mrs A's case has included pain relieving drugs as well as anti-inflammatory agents and she has also had spinal surgery. Her pain has been so severe as to necessitate the use of opiate analgesia.

10. Of necessity, Mrs A takes multiple drugs. Management of her condition must pose multiple problems. Not only is there a risk of the various drugs she is taking producing side effects but there is also a risk of drug interactions which can of course be dangerous.

11. In Adviser 1's opinion, Mrs A's case is extremely complex. The management of such patients, as Mrs A, is always going to be difficult as her chronic conditions are basically not curable and the best medical care can hope to achieve is palliative support, in particular in her case by means of appropriate chronic pain management.

(a) There was an unreasonable delay in arranging an MRI scan following Mrs A's admission to the Hospital in November 2003

12. On 21 November 2003 Mrs A, because she was suffering from sciatica, had a consultation on a private basis with Consultant 1, an Orthopaedic Surgeon, at his clinic at an independent Hospital (the Private Hospital). Consultant 1 also worked as an NHS Orthopaedic Surgeon at the Hospital.

13. Consultant 1 recommended an MRI scan. However, Mrs A could not afford to be admitted to the Private Hospital to have the scan, which would have been performed the following day. She said that Consultant 1, therefore, told her to go to the Hospital's Casualty Department. On doing so, Mrs A was admitted to the Hospital.

14. Mrs C said that during her sister's stay in the Hospital, where she was an in-patient for a week, Consultant 1 did not order an MRI scan. Mrs C considers that because of this Consultant 1 failed in his duties towards Mrs A. She said that there was an unreasonably long delay before her sister eventually had an MRI scan. Mrs C believes that this delay caused her sister's condition to worsen and become irreparable leaving her in constant and severe pain.

15. Ms D, Director of Nursing and Patient Services, replied to Mrs C's complaint, on behalf of the Board, on 15 August 2005. She said that Consultant 1 had confirmed that Mrs A was seen by him at a private consultation on 21 November 2003. Consultant 1 recommended Mrs A should go to the Accident and Emergency Department at the Hospital after it was clear that admission to the Private Hospital was not possible due to lack of private health insurance or finance to cover her stay.

16. Ms D said that Consultant 1 was not on receiving duties or present at the Hospital for several days after Mrs A's admission. He only became aware of Mrs A's admission to the Hospital and that she had been admitted under his care when he returned to duty. He considered that Mrs A should not have been

admitted under his care. Ms D said that it appeared that there had been a lack of communication about this issue which had since been discussed with the relevant staff to prevent it happening in the future.

17. Consultant 1 recalled completing an MRI scan request in November 2003 for Mrs A. Unfortunately the waiting list for this procedure at that time was considerable. The plan was for Consultant 1 to see Mrs A following the MRI scan to discuss treatment options. However, it appeared that the MRI scan request form was never received by the relevant department which led to Mrs A not being put onto the waiting list. The Board apologised for the failure of the transfer of information and for any anxiety caused to Mrs A.

18. Consultant 1 has stated that after he found out that Mrs A was a patient in the Hospital he 'distinctly' recalls completing an MRI scan request form for her. I am unable to establish the exact date when an MRI request form was completed because a copy of the request form is not in the records supplied to me. However, I have no reason to doubt Consultant 1's evidence that he did complete the request form whilst Mrs A was an in-patient in the Hospital in November 2003.

19. Consultant 1 said that he was not alerted to the fact that Mrs A had not had her MRI scan because the waiting time for MRI scans was 'very extensive' at that time and he had 'become used' to not receiving results back for a prolonged period of time. The result of Mrs A's MRI scan eventually came through in July 2004, approximately seven months after her admission to the Hospital.

20. The clinical advice given to me by Adviser 1 is that, as Mrs A could not afford to have the MRI scan carried out on a private basis, it would be usual for the scan to be arranged under the NHS, which may of necessity incur delay due to a waiting list for this particular investigation. This appeared to be the situation at the Hospital where the waiting list for an MRI scan at the time of Mrs A's admission was 'considerable'. According to Adviser 2 there were very long waiting lists for an MRI scan in many parts of the United Kingdom in 2003, although the situation has now improved.

21. The clinical advice I have received from Adviser 2 is that Mrs A's admission to the Hospital was on an acute basis. Consultant 1 had made a diagnosis of root entrapment, possibly due to a prolapsed disc of relatively

recent onset. She was clearly in severe pain because she required intravenous morphine. Mrs A's condition, therefore, demanded reasonable speed of action and she should have had her MRI scan, even in 2003, much more quickly than she did. The severity of Mrs A's pain was an indication to expedite the MRI scan. However, this did not happen. Mrs A waited until June 2004 for an MRI scan to be carried out. In the opinion of Adviser 2, Mrs A's problems have been handled, unfortunately, in a poor way.

22. Adviser 2 also commented on Consultant 1's response to the Board, following Mrs C's complaint to them. In his response, Consultant 1 stated that he only became aware of Mrs A's admission to an orthopaedic ward under his care, when he returned to the Hospital several days later. In Adviser 2's view the letter written by Consultant 1 to the Hospital's Accident and Emergency Department on 21 November 2003 stating that Mrs A would need a scan and possible surgery was the equivalent of saying she needed to get into a hospital bed straight away. The fact that Mrs A was admitted by the Hospital under Consultant 1's care when he was not going to be present in the Hospital for several days after her admission implies that the system of handover of responsibility for patients between doctors was incomplete at that time.

23. In the view of Adviser 2, there does not appear to have been provision made or recorded for keeping Mrs A under review after her admission to the Hospital, which was on an acute basis for severe pain. There do not appear to be any follow-up notes from Mrs A's admission brought about by Consultant 1's letter or a Discharge Letter or Management Plan regarding Mrs A's treatment which might have indicated that she would be followed up in the Out-patient Department before or after an MRI scan. If a patient is admitted to hospital with an acute condition, it is quite common, if not routine, to give them a follow-up out-patient appointment on discharge. This does not seem to have happened as part of the management of Mrs A's care. If such an out-patient appointment had been made in Mrs A's case, there would have been the opportunity for somebody to realise that the MRI scan request form had been completed and to check when the scan was going to be performed.

(a) Conclusion

24. As I have identified above, there were significant delays in Mrs A having an MRI scan, particularly given her medical condition. They were clearly the result of system failures in the management of Mrs A's care. Therefore, I uphold this part of the complaint.

25. I accept that the Board say that the circumstances giving rise to Mrs A being admitted under the care of Consultant 1, in his absence, have been discussed with the relevant staff to prevent it happening in the future. I also recognise that the Board has apologised in writing to Mrs C for the failure of the MRI request form to reach the relevant department and for any anxiety caused to Mrs A by this.

26. Nevertheless, I consider the apology issued by the Board to be a limited apology because it does not take account of the failings identified in paragraphs 21 to 23 of this report which, in my view, led to the unacceptable delay before Mrs A received her MRI scan. I, therefore, consider that the Board should issue a personal apology direct to Mrs A for those failings and explain the steps taken to prevent a re-occurrence of those failures.

(a) Recommendation

27. The specific recommendations the Ombudsman is making resulting from the investigation of this part of the complaint is that the Board should:

(i) issue Mrs A with a full formal apology for the failures identified in this part of the complaint. The apology is to be in accordance with the Ombudsman's guidance note on 'apology' which sets out what is meant by and what is required for a meaningful apology; and

(ii) provide evidence to the Ombudsman of the steps taken to prevent a reoccurrence of the failures identified in paragraphs 21 to 23 of the report.

(b) The delay caused Mrs A's condition to worsen and become irreparable leaving her in constant and severe pain

28. The Board, in their response to Mrs C following her complaint, did not accept that the delay in arranging an MRI scan caused Mrs A's condition to worsen and become irreparable leaving her in constant and severe pain.

29. Mrs A waited ten months for her spine surgery. From her time of discharge from the Hospital on 28 November 2003 she waited until 5 July 2004 for the MRI scan to be reported when the Rheumatology Department then referred her to the Neurosurgery Department. She waited until 7 September 2004 for neurosurgical assessment and until 20 September 2004 for surgery.

30. The MRI scan showed evidence of disc prolapse causing some spinal

stenosis and also a nerve root impingement consistent with Mrs A's symptoms. Following the scan, Mrs A was referred to a consultant neurosurgeon at the Hospital. She was admitted on 19 September 2004 for a lamanectomy and a right-sided microdiscectomy which took place on 20 September 2004. According to a letter of 10 January 2005 from the consultant neurosurgeon to Mrs A's GP it was 'unlikely that further surgery will help [Mrs A]'.

31. In Adviser 1's opinion it is impossible to say whether or not the delay in arranging an MRI scan made any difference to the outcome of Mrs A's joint problems, which are of a chronic nature, or if the damage to her joints became irreparable as a result of the delays in investigation.

32. In the opinion of Adviser 2 it is unlikely that Mrs A did get worse because of the delay. Further, 95% of all acute disc prolapses get better with conservative treatment.

(b) Conclusion

33. In view of the clinical advice I have received from Advisers 1 and 2 on this part of the complaint, I am unable to conclude that the delay caused Mrs A's condition to worsen and become irreparable. Therefore, I do not uphold this part of the complaint.

(b) Recommendation

34. The Ombudsman has no recommendation to make.

(c) There was a failure by the Hospital's Pain Clinic to monitor or arrange appropriate follow-up in relation to the medication prescribed for Mrs A

35. In her complaint to the Board Mrs C complained that there was a failure by the Hospital's Pain Clinic to monitor or arrange appropriate follow-up in relation to the medication prescribed for Mrs A. In response to the complaint, Consultant 2, a consultant in anaesthesia and pain management stated that he had referred Mrs A to the nurse-led TENS clinic where TENS would have been fully explained and best possible trials conducted. This was in addition to a nurse-led follow-up of her consultant/registrar Pain Clinic appointment. He stated that the Pain Clinic did not monitor all drugs it recommends as the normal practice is to recommend a therapy to the GP who then prescribes and monitors it in conjunction with other medicines the patient is receiving at the time. Consultant 2 also stated that 'it [was] simply not possible to bring every

patient back for medication review because the clinic would become unworkable with waiting times running into years'.

36. In his view, a registrar who had seen Mrs A at the Pain Clinic on 30 March 2005, fully understood Mrs A's desire to reduce her medication. The registrar had stated that as a way of trying to improve Mrs A's pain control, it was elected to use TENS along with Baclonfen as a muscle relaxant and then move to acupuncture. If this was successful then the plan was to reduce Mrs A's morphine. If the morphine was reduced or removed without substituting it with an alternative this may have led to a withdrawal syndrome and significantly increased pain for Mrs A.

37. Often patients referred to the Pain Clinic had already seen a large number of doctors who had, unfortunately, been unable to alleviate their problems. In such cases doctors involved in the patients' earlier treatment often remained involved after the referral to the Pain Clinic. Where multiple specialists, along with GPs, were involved it was often difficult to keep track of what was happening with medication and other therapies which could lead to confusion about what drugs should be continued, reduced, increased or stopped.

38. Consultant 2 further added that the Pain Clinic asks patients to fill in a questionnaire. The questionnaires are primarily used to triage patients who need to be seen urgently. Mrs A had provided a six page document in addition to the questionnaire she had completed. In his view, to have gone through Mrs A's six page document would have required a significant amount of time and would have reduced the amount of time left for consultation, examination and discussion.

39. The clinical advice I have received from Adviser 1 it is that it is certainly the case that Pain Clinics are a last resort for a lot of patients with multiple medical disorders which have provided insurmountable problems for many other departments. Such patients will frequently be on multiple drugs which cannot always be reduced in number. Although many specialists were involved in Mrs A's care, the view of Adviser 1 is that the evidence from her clinical case records points to good communication between the various departments and the general practitioners rather than the converse.

40. The clinical advice I have received from Adviser 3 is as follows:

41. When a patient is admitted to hospital he/she remains under the care of the admitting clinician or is transferred to the care of another specialist within the hospital. Although pain relief services may advise on symptoms control, they do not assume the responsibility for the patient's stay in hospital, their time of discharge or the routine follow-up arrangements.

42. Hospitals vary in their responsibility of their acute pain team. Chronic pain teams (Pain Clinics) also vary between hospitals and their involvement with in-patients ranges from the absence of formal input to a close working relationship with an acute pain service. It may not be assumed that if the acute pain team has been involved, then the patient will automatically be sent to the Pain Clinic for follow-up after discharge.

43. The reason that Pain Clinic follow-up is not automatic is because only a minority of patients admitted to hospital might be seen as appropriate for referral to a Pain Clinic. The admitting speciality will determine what further investigations and follow-up arrangements are made which may include a plan for interval surgical intervention. When the acute and chronic pain teams work closely together, it is to be hoped that there is agreement with the primary speciality that discharge arrangements will include a Pain Clinic follow-up. However, these processes leave a small number of patients feeling unsatisfied at the lack of progress towards a solution that takes their pain away.

44. Mrs A was involved in a process of ongoing investigation and treatment for left foot pain and for low back pain. It is likely that everyone's focus – including Mrs A's - was on the treatment that could control the pain and make her pain free. These treatments took place first on her left foot and then on her spine.

45. It is clear that the therapeutic relationship between Mrs A and the Pain Clinic had deteriorated. Matters might have gone differently if the consultant treating Mrs A had recognised or been alerted to a need for extra input, for example, by booking a joint consultation with the Clinical Nurse Specialist to which Mrs A would be explicitly invited. It may then have been possible to clarify some of the misunderstandings and to hatch a therapeutic plan in which Mrs A had greater confidence. Mrs A has had the misfortune to have separate painful pathologies involving feet and her lumbar spine. While different specialities concentrated on competent treatment of these disease processes, the pain management issues did not receive optimal attention. However, there is no evidence that Mrs A's treatment, particularly at the Pain Clinic, could be

criticised.

(c) Conclusion

46. I accept that, on the basis of the advice I have received, there is no evidence of clinical failings in Mrs A's treatment by the Pain Clinic. Therefore, I do not uphold this part of Mrs C's complaint. Nevertheless, it does appear to me that if the various Hospital departments treating Mrs A had consulted with each other and jointly worked together, then this may have been beneficial to Mrs A in the management of her pain relief.

47. I fully recognise that my decision will come as a disappointment to both Mrs C and Mrs A. I understand that Mrs A continues to suffer severe pain. While I sympathise with Mrs A's ongoing health problems, I have based my decision on the clinical advice of two consultants, one a chronic pain specialist.

(c) Recommendation

48. The Ombudsman has no recommendation to make.

(d) There was an unreasonable delay by Tayside NHS Board in the handling of the complaint

49. On 31 October 2005 Mrs C complained to the Ombudsman that there had been an unreasonable delay by the Board in the handling of her complaint. In particular, that after waiting for 14 weeks, the response to her complaint had been sent by Ms D, the Director of Nursing and Patient Services, Acute Services Division rather than the Board's Chief Executive or his deputy, as she had expected. Her letter of complaint was addressed to the Chief Executive and she expected him to have the courtesy to reply to her.

50. Mrs C's initial letter dated 18 May 2005 expressing her concerns about her sister's care and treatment was addressed to the Board's Chief Executive. On 27 May 2005 a reply was sent by , the Board's Complaints and Advice Co-ordinator. In this letter she explained an investigation into Mrs C's concerns was currently taking place and she would receive a written response from the Chief Executive or his deputy within four weeks. However, if this was not possible she would be advised of the reason for the delay. On 17 June 2005 Ms E sent a further letter explaining that all of the information required to provide Mrs C with a detailed response to her concerns was not yet available. I note that the Board apologised for the delay in the letter.

51. On 14 July 2005 Ms E wrote again informing Mrs C that she 'was still not in a position to offer a written response from the Board's Chief Executive or his deputy due to delays in receiving all the information required for a full and detailed response. She again apologised for the delay.

52. On 15 August 2005 a detailed three page letter in response to Mrs C's initial letter of complaint was sent to her. The letter was signed by Ms D. She explained she had signed the letter because of the Chief Executive's absence that week and to avoid any further delay. She also informed Mrs C of her right to complain to the Ombudsman's office if she was dissatisfied with the response.

53. I note from the Board's complaint file that on 27 May 2005, the Board asked the various consultants who were concerned with Mrs A's care to comment on the complaint. Following responses from the consultants, a draft of the response to be sent to Mrs C was sent to them for comment on 12 July 2005. Final approval of the draft response letter was requested of and received from the consultants on 15 August 2005. The final response letter was sent to Mrs C on the same day. From notes on the complaint file, which I am satisfied were written at the time, it is noted that some members of staff were on annual leave up until 15 August 2005.

54. The target reply date for responding to Mrs C's complaint was 26 June 2005. However, given staff were on annual leave, the complexity of the complaint and as the Board had kept Mrs C regularly updated by letter on the progress of their investigation, I do not consider the delay was unreasonable.

55. The Board have accepted there was delay in responding to Mrs C's complaint for which they apologised on a number of occasions, in particular in the letter of 15 August 2005. In addition, in this letter, Ms D also apologised if Consultant 3, a consultant endocrinologist, at the Endocrine Clinic did not make Mrs A aware of the name or position of the registrar who was also present at the consultation and apologised for this lack of communication on his part. He also apologised if he had caused offence to Mrs A concerning comments he had made about her medication. I note that Consultant 3 had also written directly to Mrs A on 20 May 2005 in response to the complaint about him.

56. Mrs C's also complained that the letter of 15 August 2005 was not signed

by the Chief Executive or his deputy. However, the Board have explained the reason for this. I do not consider the Board treated Mrs C's complaint any less importantly because the letter was signed by Ms D rather the Chief Executive or his Deputy.

57. I appreciate that on 17 August 2005, despite the letter of 15 August 2005 having already been sent, a letter was sent by Ms E to Mrs C stating that the Board was still not in a position to offer her a written response from the Board's Chief Executive or his Deputy. The letter also explained that as the complaint exceeded the specified time limit laid down in the NHS Complaints Procedure, she could approach the Ombudsman's office with her complaint. Although unfortunate, I accept the sending of this letter was an administrative error.

(d) Conclusion

58. In view of my findings above, I do not uphold this part of the complaint.

(d) Recommendation

59. The Ombudsman has no recommendation to make.

60. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

21 November 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mrs A	The sister of the complainant, Mrs C and the subject of the compliant
The Hospital	Ninewells Hospital, Dundee
The Board	Tayside NHS Board
Adviser 1	Ombudsman's hospital adviser
Adviser 2	Ombudsman's surgical adviser
Adviser 3	External professional adviser to the Ombudsman and a consultant in Pain Management
Consultant 1	A consultant Orthopaedic Surgeon at the Hospital and the Private Hospital
The Private Hospital	An independent hospital
Ms D	Director of Nursing and Patient Services
Consultant 2	A Consultant in Anaesthesia and Pain Management at the Hospital
Ms E	The Board's Complaints and Advice Co-ordinator
Consultant 3	A Consultant Endocrinologist at the Endocrine Clinic at the Hospital

Annex 2

Glossary of terms

Baclonfen	An oral medication that relaxes skeletal muscles
Lamanectomy	A surgical procedure most often performed to treat leg pain related to herniated discs, spinal stenosis, and other related conditions. Stenosis occurs as people age and the ligaments of the spine thicken and harden, discs bulge, bones and joints enlarge, and bone spurs form
Microdiscectomy	The surgical removal of an injured or herniated disc from the spine
MRI Scan	A magnetic resonance imaging scan is a radiology technique that uses magnetism, radio waves, and a computer to produce images of body structures
TENS	A Transcutaneous Electrical Nerve Stimulation machine used in pain relief