Scottish Parliament Region: Mid Scotland and Fife

Case 200602963: Forth Valley NHS Board

Summary of Investigation

Category

Health: Hospital; Orthopaedics

Overview

The complainants (Mr C and Mr D) raised a number of concerns about the care and treatment of their late mother (Mrs A) at Stirling Royal Infirmary (the Hospital) between 7 March and 21 March 2006.

Specific complaints and conclusions

The complaints which have been investigated are that Forth Valley NHS Board (the Board):

(a) failed to provide appropriate care and treatment to Mrs A (*upheld*); and

(b) failed to adequately investigate Mr C's original complaint (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) inform her of the progress of the recommendations in their Internal Review;

(ii) apologise to Mrs A's family for the failures identified in this report and their Internal Review and the additional distress caused by the failure of their original investigation to identify and address these failures; and

(iii) build more robust senior and independent review into the local resolution stage of the NHS Complaints Process to ensure complaints are addressed more comprehensively and review of complaints is built in to Clinical Governance to ensure lessons can be learned form complaints.

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

Main Investigation Report

Introduction

1. On 3 January 2006 the Ombudsman received a complaint from the complainant (Mr C), supported by his brother (Mr D), about the treatment and care of their mother (Mrs A) at Stirling Royal Infirmary (the Hospital) between 7 March and 21 March 2006. Mr C complained to Forth Valley NHS Board (the Board) on 26 March 2006 and received an initial response sent on 25 May 2006. A meeting was arranged on 19 June 2006 and a final response was sent on 14 September 2006. Mrs A died of colonic cancer on 23 August 2006.

2. The complaints from Mr C and Mr D which I have investigated are that the Board:

(a) failed to provide appropriate care and treatment to Mrs A; and

(b) failed to adequately investigate Mr C's original complaint.

Investigation

3. Investigation of this complaint involved obtaining and reviewing Mrs A's clinical records and the complaints file of the Board. I met with Mr C and Mr D and sought the views of a number of general and specialist clinical advisers to the Ombudsman. Our advisers raised a number of concerns about aspects of Mrs A's care and in June 2007 I asked the Board for further comments on these issues. In light of the serious nature of the concerns raised by our advisers the Board undertook their own Internal Review (the IR) of Mrs A's care and treatment. The IR reported on 19 October 2007 and concluded that there had been a number of significant failures and made eight recommendations for changes to future practice (see Annex 3) and produced an action plan for implementation of these (which actions were undertaken with immediate effect). I shared the IR report and action plan with a medical and nursing adviser to the Ombudsman (Adviser 1 and Adviser 2 respectively) and they were both satisfied that the IR had now addressed this office's previously identified concerns. I also shared the IR report and action plan with Mr C and Mr D who remain concerned that the problems had been allowed to happen and that their original letter of complaint had not caused the level of investigation and review which our intervention had.

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

Medical Background

5. Mrs A had a medical history of osteoarthritis (since 1996) and colonic cancer (1998). Mrs A attended the orthopaedic out-patient clinic at the Hospital on 7 March 2006 complaining of severe pain. The consultant (Consultant 1) had cancelled the clinic but Mrs A had not been notified of this but was reviewed by a Senior House Officer who admitted her for management of extreme pain. Mrs A was transferred between wards on several occasions before her final discharge on 21 March 2006. During that time she was reviewed by Consultant 1 who noted total hip-replacement would be needed and that Mrs A would be added to the waiting list for this procedure. An MRI scan was ordered but cancelled as Mrs A was claustrophobic. No alternative scans were considered. Mrs A was reviewed by the Pain Relief and Physiotherapy teams and discharged once her pain was considered by the team to be adequately managed.

6. Following her discharge Mrs A's family remained very concerned about her pain levels and general condition and on 24 March 2006 arranged for her to be seen privately by another consultant (Consultant 2) in a private hospital. Consultant 2 examined Mrs A on 3 April 2006 and arranged for an urgent x-ray which showed significant changes. Consultant 2 considered this was most likely to be caused by septic arthritis but that it could also be due to a spread of her previous cancer and accordingly he arranged an urgent bone scan. The CT scan and biopsy led to a definitive diagnosis of a spreading colonic carcinoma in the pelvis and a mass in the chest. Mrs A was readmitted to the Hospital on 4 April 2006 for removal of the hip and palliative care and treatment was arranged.

(a) The Board failed to provide appropriate care and treatment to Mrs A

7. Mr C and Mr D complained that Mrs A's true condition had not been detected during her admission to the Hospital despite repeated requests for a scan from the family and further noted that Consultant 2 had considered the possibility of cancer within a few minutes of examining Mrs A. Mr C and Mr D both told me that they understood that an earlier diagnosis would not necessarily have prolonged Mrs A's life but felt it would have allowed her to receive the appropriate, pain relieving treatment far sooner.

8. Adviser 1 told me that Mrs A's condition as finally diagnosed was a rare presentation (secondary cancer in the hip spreading from the colon) and not something he would have expected any doctor to immediately diagnosis but that the level of pain experienced by Mrs A was not consistent with the diagnosis of osteoarthritis and should have warranted further investigation which would (and indeed did) lead to the correct diagnosis.

9. Adviser 1 noted a number of areas of concern about the lack of effective communication between staff involved in Mrs A's care and between clinical specialisms which I raised with the Board in July 2007. The Board commissioned its own IR with independent consultant input which concluded that there were a number of failures and made eight recommendations. These can be found in Annex 3.

(a) Conclusion

10. In light of the concerns expressed by Adviser 1 and Adviser 2 and the failures recognised in the IR, I uphold this aspect of the complaint.

(a) Recommendation

11. The Ombudsman commends the Board for accepting the recommendations set out in Annex 3 and has no further recommendation to make with respect to the care and treatment afforded to Mrs A. The Ombudsman does request that the Board notify her of progress being made towards achieving all the recommendations of the IR.

(b) The Board failed to adequately investigate Mr C's original complaint

12. Mr C complained that the initial investigation of his complaints by the Board had been superficial and had simply accepted certain facts and opinions expressed by the clinicians involved at face value without confirming whether these were accurate or justified. As an illustration of this point he noted that the complaint response sent on 14 September 2006 had referred to Consultant 1's view that an x-ray of 6 March 2006 was consistent with his own diagnosis of osteoarthritis but that no such x-ray was ever taken.

13. I have checked the complaints file for the evidence supporting Consultant 1's view. There is an email on file from Consultant 1 expressing the view later translated to the complaint response letter. However, Mr C is correct that no x-ray was undertaken on 6 March 2006. There was an x-ray taken on

6 February 2006 which Consultant 1 also refers to in his email and I am of the view that the earlier reference to 6 March 2006 was a typographical error on his part which was not picked up by complaints staff and most unfortunately led to an error in the information provided to Mr C.

14. Mr C also noted that the response letter referred to Consultant 1's view that he had undertaken a thorough examination of Mrs A but that the IR had indicated that there was a 'lack of adequate documentation in the medical notes regarding the examination'. He expressed concern again that Consultant 1's views were accepted without question or evidence. I note that the IR comment referred to a broader concern about lack of evidence of examinations but that Adviser 1 and Adviser 2 had also noted a concern about the brevity of medical entries in the clinical records.

15. I note that the original investigation did uphold some aspects of Mr C's complaints with respect to the multiple ward transfers and action was taken to prevent this reoccurring. I also noted that the complaints file contains a number of statements from staff involved in Mrs A's care, including Consultant 1, who raised their own concerns about the system failures, a number of which were later included in the IR, but that these responses were used solely for the purposes of answering Mr C's complaints and there is no evidence that these were critically examined at a senior level to identify any further lessons that might be learned from this complaint.

(b) Conclusion

16. It is unfortunately not unusual in complaints to the Ombudsman's office that an error in the initial response adds to and exacerbates the complaint itself. That problem was compounded in this case by the failures which were missed by the Board's initial investigation. The errors in this complaint suggest that evidence was not confirmed to its original source and there is no evidence of critical, clinical oversight of the initial complaints response. There was, however, appropriate clinical input to the meeting with Mr C and Mr D although the original factual errors were still not clarified in the final response. In light of these problems I uphold this aspect of the complaint.

(b) Recommendation

17. The Ombudsman recommends that the Board:

(i) apologise to Mrs A's family for the failures identified in this report and the IR and the additional distress caused by the failure of their original investigation to identify and address these failures; and
(ii) build more robust senior and independent review into the local resolution stage of the NHS Complaints Process complaints system to ensure complaints are addressed more comprehensively and review of complaints is built in to Clinical Governance to ensure lessons can be learned form complaints.

18. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Council notify her when recommendations (ii) and (iii) have been implemented and provide the information update requested regarding recommendation (i)

Annex 1

Explanation of abbreviations used

Mr C	The complainant – Mrs A's son
Mr D	The complainant – Mrs A's son
Mrs A	The aggrieved
The Hospital	Stirling Royal Infirmary
The Board	Forth Valley NHS Board
The IR	The Board's Internal Review of Mrs A's care and treatment
Adviser 1	The medical adviser to the Ombudsman
Adviser 2	The nursing adviser to the Ombudsman
Consultant 1	The consultant responsible for Mrs A's care
Consultant 2	Another consultant at a private hospital who examined Mrs A

Annex 2

Glossary of terms

CT scan	x-ray pictures of the body using a computer to put them together
MRI scan	Scanner used to obtaining multiple cross-sectional pictures of parts of the body

Annex 3

NHS Forth Valley Acute Services Action Plan

Issue	Recommendation	Action	Identified Lead	Review Date
Out Patient Clinic Issues	Recommendation 1	Clear audit trail of the formal action required and positive feedback of action taken to rearrange, cancel the clinic or other directions to be evident and shown to be acted upon and communicated.	All Consultants/Unit Administrators'/Medical Secretaries/Health Records Manager	Immediate action with review at December 2007
Out Patient Clinic Issues	Recommendation 2	Clear guidelines for junior staff action should be formulated in instances where the responsible consultant is unavailable at clinic for whatever reason. The minimum action should be discussion with the consultant who is on-call for the day for appropriate advice.	Lead Clinician Orthopaedics Consultant Orthopaedic Surgeons	Immediate action with review at January 2008

Issue	Recommendation	Action	Identified Lead	Review Date
Emergency Admissions and Multiple Patient Transfers	Recommendation 3	Updated bed management system has guidelines for appropriate patient admission to emergency beds. Is now in place within Stirling Royal Infirmary. Daily capacity meeting reviews all patients placement in wards to ensure appropriate placement.	All Surgical and Medical Senior Nurses	Daily
Patient Location Outwith Speciality Wards	Recommendation 4	A system is in place now using appropriate information technology. Each consultant regardless of speciality receives on his 'home ward' a daily print out of all patients who are under his care regardless of ward. This daily print out allows consultants to ensure that they review each patient on a regular and appropriate basis	Unit Administrators/Health Records Manager	Daily

Issue	Recommendation	Action	Identified Lead	Review Date
Communication with Relatives	Recommendation 5	Clear feedback must be given to Consultant Orthopaedic Surgeon regarding the importance of patient and relative communication.	Orthopaedic Clinical Lead/ Surgical Clinical Governance Lead Clinician	Monthly at Surgical Clinical Governance meeting and Orthopaedic consultants meeting. Dec 2007
Management Plan / Medical Documentation	Recommendation 6	A process for review of orthopaedic systems and practice is already in hand. This will cover all the issues arising from Mrs A's care and issues generated by the staff themselves. The agenda for this review will be generated from the recommendations of this review and existing data from the complaints reports the Surgical Services already receives via the Surgical Services Clinical Governance Committee. This will include the reinforcement of good clinical and medical note taking and	Surgical Clinical Governance Lead/Associate Medical Director/Clinical Lead Orthopaedics	March 2008

Issue	Recommendation	Action	Identified Lead	Review Date
		recording by all in the orthopaedic team. This general point will be reinforced to all the medical teams within the orthopaedic service as a learning point. Organisational learning will be reinforced via the Clinical Governance structures.		
Management Plan / Medical Documentation	Recommendation 7	Absence of a management plan is significant and this issue will be managed appropriately, in conjunction with the Associate Medical Director.	Associate Medical Director	Immediate
Multi-disciplinary Reviews	Recommendation 8	The usefulness of MDR in complex cases will be reinforced via the orthopaedic department and clinicians via the Surgical Clinical Governance Committee.	Clinical Governance Lead Clinician	Immediate