Scottish Parliament Region: South of Scotland

Case 200602508: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospitals; Care of the Elderly

Overview

The complainant (Mrs C) raised a number of concerns that her late father (Mr A) had not received adequate treatment from Ayrshire and Arran NHS Board (the Board) after being admitted to Ayr Hospital on 11 November 2005. Mr A was transferred to Ayrshire Central Hospital (Hospital 2) on 20 December 2005, but died there on 27 December 2005.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr A was catheterised without his consent (*upheld*);
(b) a consultant decided not to artificially hydrate Mr A (*upheld*);
(c) the Board inappropriately transferred Mr A to Hospital 2 (*upheld*); and
(d) the Board failed to communicate effectively with Mr A's family (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mrs C for the failure to record that verbal consent to insert the catheter had been obtained from Mr A and the failure to adhere to the General Medical Council's guidance regarding the decision not to artificially hydrate Mr A;
(ii) review the guidelines for catheterisation in order that they make explicit reference to recording that verbal consent has been obtained;
(iii) take steps to ensure that staff adhere to the General Medical Council's guidance when they consider withholding or withdrawing life-prolonging treatments, by involving the patient (or those close to the patient where the patient's wishes cannot be determined) in the decision making. Details of the decision taken should be clearly recorded in the medical records; and
(iv) review Mr A's case in order to establish if there are any lessons that can be learned regarding the transfer of patients to other hospitals.

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

Main Investigation Report

Introduction

1. On 13 November 2006, the Ombudsman received a complaint from the complainant (Mrs C) regarding the care her father (Mr A) had received from Ayrshire and Arran NHS Board (the Board) before his death. Mrs C had complained to the Board, but was not satisfied with the responses she received or that action had been taken to ensure that the problems did not recur.

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

(a) Mr A was catheterised without his consent;

(b) a consultant (the Consultant) decided not to artificially hydrate Mr A;

(c) the Board inappropriately transferred Mr A to Ayrshire Central Hospital (Hospital 2); and

(d) the Board failed to communicate effectively with Mr A's family.

Investigation

3. Investigation of the complaint involved reviewing Mr A's medical records relating to the events and the Board's complaints file. I also sought the views of a medical (Adviser 1) and a nursing (Adviser 2) adviser to the Ombudsman.

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

5. The broad facts of the case are not in dispute. Mr A was admitted to Ayr Hospital (Hospital 1) on 11 November 2005 because he had poor circulation and a gangrenous toe. Amputation of the toe was considered, but it was decided that this would not be appropriate. Mr A was transferred to Hospital 2 on 20 December 2005. Hospital 2 have stated that Mr A was very dehydrated on arrival. Although they commenced artificial hydration, his condition deteriorated and he died there on 27 December 2005.

6. Mrs C complained to the Board on 28 January 2006. The Board issued a response on 28 February 2006, but Mrs C complained again on 10 March 2006, 19 May 2006 and 24 August 2006. Mrs C was not satisfied with the responses she received and wrote to the Ombudsman on 10 November 2006.

(a) Mr A was catheterised without his consent

7. Mrs C said that Mr A had stated that he did not want to have a catheter inserted. The Board said that a member of the junior medical team in Hospital 1 made the decision to insert a catheter and that verbal consent for this should have been obtained from Mr A. The catheter was removed on the following day on the advice of a urology specialist.

8. Adviser 1 said that Mr A had a previous medical history of renal failure. He commented that it would be normal practice to catheterise a patient with renal failure in order to obtain an accurate measure of urine output to determine the appropriate amount of fluid intake. He said that this is an invasive procedure and that it is necessary to obtain patient consent, but that verbal consent is generally deemed to be sufficient. He said that for consent to be valid, it should be informed consent and he would expect this to be recorded in the written record of the procedure.

9. Adviser 2 said that it could be argued that the decision to catheterise Mr A was done in his best interests and with the best of intent by staff at the time. She agreed with Adviser 1 that a detailed verbal explanation is essential from the individual performing the procedure in order to ensure that the patient has all the information to understand the rationale behind the decision and, therefore, to consent to it. She said that it is good practice to indicate that this has taken place and that verbal consent has been obtained, particularly where the patient is vulnerable.

(a) Conclusion

10. In response to a draft copy of this report, the Board advised us that it was not routine practice to record in the notes that verbal consent for catheterisation had been obtained. They said that it was routine practice to obtain verbal consent and where this is refused, the procedure does not take place and the refusal is recorded in the notes. However, the NHS Quality Improvement Scotland Best Practice Statement on Urinary Catheterisation and Catheter Care states that informed patient consent must be obtained before catheterisation is carried out. It also states that health records must demonstrate the fact that the patient understands the process of catheterisation and the need for it and consents verbally to the procedure.

11. It is normal practice to catheterise patients with renal failure and in Mr A's case this appears to have been done with the best of intent at the time.

However, Mrs C has stated that Mr A said that he did not want to have a catheter inserted. Although this has not been documented, consent should have been obtained from Mr A before the catheter was inserted. I have been unable to find any documentary evidence that the Board obtained Mr A's consent to insert the catheter. In the absence of such documentation, it is not possible to state categorically that consent was given. I, therefore, uphold this aspect of the complaint.

(a) Recommendation

12. Although the Board's guidelines for catheterisation state that staff should explain the procedure to the patient and obtain consent for it to be performed, they do not state that this should be recorded in the health records. The Ombudsman recommends that the Board review their guidelines for catheterisation in order that they make explicit reference to recording that verbal consent has been obtained.

13. In addition, the Ombudsman recommends that the Board apologise to Mrs C for the failure to record that verbal consent to insert the catheter had been obtained from Mr A.

(b) The Consultant decided not to artificially hydrate Mr A

14. Mrs C complained that Mr A had chronic kidney failure when he was admitted to Hospital 1 on 11 November 2005, but the Consultant chose not to artificially hydrate him, which would have prolonged his life. Although Hospital 2 commenced artificial hydration when Mr A was admitted there on 20 December 2005, Mr A's condition deteriorated and he died on 27 December 2005.

15. The Board asked the Consultant for his comments on the matter and he said that there was no doubt that Mr A did become significantly dehydrated during the latter half of his stay in Hospital 1. The Consultant stated that staff were aware of this and although oral fluids were encouraged, they had elected not to give him intravenous or naso-gastric fluids. He considered that Mr A was reaching the end of his natural life and that artificial hydration would merely prolong the dying process, but not add to his quality of life. The Consultant said that he considered that it was better for Mr A to die a more peaceful and painless death from acute renal failure than to prolong his agony with artificial hydration and feeding. He also said that Mr A had not been denied access to drinks and was able to drink if he felt thirsty, but was not drinking enough to

prevent dehydration. Mrs C has stated that Mr A was aware how important it was to drink, but in the hospital, it was left to visitors to give him fluids, as he was visually impaired and his drinks were kept on a table at the bottom of his bed.

16. The General Medical Council's guidance on withholding and withdrawing life-prolonging treatments states that in some cases, treatment may only prolong the dying process and cause unnecessary distress to the patient. The guidance also indicates that doctors must offer those treatments where the possible benefits outweigh any burdens or risks associated with the treatment. It states that it is for the patient to judge what weight or priority to give to any benefits, burdens or risks, and to decide whether any of the options would be acceptable. The document also refers to artificial nutrition and hydration and states that:

> 'In deciding which of the options for providing artificial nutrition or hydration are appropriate in meeting a patient's assessed need, you must ensure that the patient (where able to decide), the health care team, and those close to the patient (where the patient's wishes cannot be determined), are fully involved in the decision making. You should take appropriate steps to help those participating in the decision making to understand your assessment of the patient's requirements for nutrition or hydration, and any uncertainties underlying the options you consider appropriate for meeting those needs.'

17. Adviser 1 commented that it was clear that Mr A had a degree of chronic renal failure on admission to Hospital 1. He also said that Mr A's high creatinine levels on his admission to Hospital 2 were indicative of increasing dehydration and 'acute on chronic' renal failure. He said that he had considered the Consultant's comments that hydration would merely prolong the dying process, but could not find any evidence of documentation of this decision or any evidence that it had been discussed with Mr A or his next of kin. Adviser 1 commented that Mr A was recorded as being confused at times and may, therefore, have lacked the capacity to make such a decision.

18. Adviser 1 said that Mr A had diabetes with common complications of mildly impaired kidney function, visual impairment and a gangrenous toe. He was surprised at the decision to withhold re-hydration since these, in themselves, would not normally be regarded as terminal diseases. He stated that there appeared to be no clear evidence in the clinical record that Mr A's condition was

terminal at that stage. He commented that it was clear that Mr A subsequently deteriorated, but it is suggested that this may have been due in part to opiate medication that had been prescribed for his painful toe. He also stated that it was clear that he was becoming progressively dehydrated. He stated that a decision was made to withhold life-saving treatment by intravenous fluids, but this decision was not compatible with his interpretation of the General Medical Council requirements in such circumstances.

19. Adviser 2 said that she believed that nursing staff had good regard for Mr A's well-being, the daily nursing progress records were of a high standard and there were clear evaluations recorded for most aspects of Mr A's care. However, she was concerned about the care provided to Mr A for nutrition and hydration. She also said that his status was underestimated and his risk factors were not sufficiently addressed. The monitoring records were insufficient to reassure her that robust observation was taking place.

(b) Conclusion

20. Although there were some problems with the monitoring process and records, the key issue in Mr A's treatment was the decision by the Consultant not to artificially hydrate him. The decision to withhold life-saving treatment is a momentous decision, which is why the General Medical Council expects the decision to be taken and recorded in an appropriate manner in accordance with its guidelines. In Mr A's case, the decision has not been documented. It is not clear when exactly it was made and it is not possible to make a definitive judgement on the appropriateness of the decision.

21. In addition, the General Medical Council's guidance on withholding and withdrawing life-prolonging treatments states that the patient, or those close to the patient where their wishes cannot be determined, must be involved in making the decision. The Board have told us that they have been advised that Mr A was not able to discuss the merits of treatment in any meaningful way at the time that the decision was made. The medical records indicate that Mr A showed some confusion from 10 December 2005 onwards and Mrs C has stated that this was caused by the drugs that Mr A was taking. However, there is no evidence that an assessment was carried out regarding whether Mr A had the capacity to make a decision about the withholding of treatment. Because of this and because I do not know when exactly the decision was taken, it is difficult for me to now comment on whether he was capable. However, if Mr A had been assessed as being capable, consent should have been obtained from

him. If the assessment showed that he was not capable, his family should have been fully involved in the decision making.

22. In response to a draft copy of this report, the Board advised us that the decision not to hydrate Mr A was made by the medical middle grade staff and that the Consultant did not change the decision, as he was in full agreement. The Board said that Mr A would not have survived an amputation, but without this, gangrene and infection would inevitably progress. They said that the decision required was how best to palliate Mr A's symptoms and manage his death. They also said that the Consultant took the decision and actions he believed were appropriate given that General Medical Council guidelines are not mandatory policy.

23. I can find no evidence, however, that the decision to withhold life-saving treatment was discussed with Mr A or those close to him. This clearly contravenes the General Medical Council's guidance. Should the Consultant have decided that it was not appropriate to adhere to the guidance when making such an important decision, this should have been clearly recorded. He failed to do so and I, therefore, uphold the aspect of the complaint.

(b) Recommendation

24. The Ombudsman recommends that the Board apologise to Mrs C for the failure to adhere to the General Medical Council's guidance regarding the decision not to artificially hydrate Mr A.

25. The Ombudsman also recommends that the Board take steps to ensure that staff adhere to the General Medical Council's guidance when they consider withholding or withdrawing life-prolonging treatments, by involving the patient (or those close to the patient where the patient's wishes cannot be determined) in the decision making. Details of the decision taken should be clearly recorded in the medical records.

(c) The Board inappropriately transferred Mr A to Hospital 2

26. The Board recorded in Mr A's medical notes on 9 December 2005 that he should be referred to Hospital 2 for rehabilitation. They then recorded on 15 December 2005 and on 19 December 2005 that they were awaiting a bed in Hospital 2. Mr A was transferred to Hospital 2 on 20 December 2005.

27. Mrs C complained to the Board about the transfer of Mr A to Hospital 2. She said that she was advised that Mr A was transferred for rehabilitation, but he could not have been rehabilitated because he was so ill. She said that the transfer to Hospital 2 only reduced her travelling by a few miles.

28. The Board asked the Consultant for his comments on the matter. He said that he was aware of the significant deterioration in Mr A's condition by the time of the transfer. He stated that he decided that Mr A should be transferred, because he was uncertain exactly how long he was likely to live for and he felt that it was preferable for Mr A to be closer to his family during his final days. He said that in retrospect, this was the wrong decision and he could only apologise to Mrs C for this. He also said that they did not communicate effectively with Hospital 2, who believed that they were getting a patient for rehabilitation, whereas Mr A was being transferred for terminal care. The Consultant stated that he erroneously thought that everyone was aware that Mr A was being transferred for terminal care and he did not feel the need to discuss this with Hospital 2.

29. In their responses to Mrs C, the Board said that there was a small possibility of rehabilitation when the original referral was made to Hospital 2 for a transfer. They said that it quickly became apparent, however, that rehabilitation would not be possible because his condition was so poor. They also said that the Consultant wished to apologise for not communicating that rehabilitation was not appropriate. They said that the Consultant had said that on reflection, Mr A should not have been moved to Hospital 2 and that they wished to apologise for this.

(c) Conclusion

30. The Board originally decided to transfer Mr A to Hospital 2, as there was a small chance of rehabilitation. However, Mr A's condition had deteriorated and, as his condition was terminal by the time of the transfer, rehabilitation was not possible. The Consultant has stated that they failed to communicate effectively with Hospital 2 and that on reflection, Mr A should not have been transferred there. I uphold this aspect of the complaint.

(c) Recommendation

31. The Ombudsman recommends that the Board review Mr A's case in order to establish if there are any lessons that can be learned regarding the transfer of patients to other hospitals.

(d) The Board failed to communicate effectively with Mr A's family

32. Mrs C has complained that she was never informed of Mr A's prognosis. The Consultant was asked for his comments on this and he said that he had stressed Mr A's poor condition and prognosis to Mrs C, but had tried to be optimistic about his short term outlook at the time when it seemed that Mr A might get home. He said that Mr A had deteriorated a little faster than he had anticipated, but the overall prognosis was always very poor, which was why they did not intervene.

33. As I have noted earlier in this report, the Consultant had made a decision that Mr A was not to be artificially hydrated. The General Medical Council's guidance regarding withholding and withdrawing life-prolonging treatments states that:

> 'Whatever decision is made, you must do your best to ensure that all those consulted, and especially those responsible for delivering care, are consistently informed of the decision and are clear about the goals and the agreed care plan. You should check that hand-over arrangements between professional and other carers include suitable arrangements for passing on the information.
>
> It is particularly important that where a patient's death is seen as an inevitable outcome of a decision to withhold or withdraw treatment, that everyone involved is clear about the arrangements for providing appropriate palliative or terminal care, and their roles. You should discuss what the role of the family or other carers will be; what religious, spiritual or other personal support the patient might need; and what support the patient and those close to the patient will receive from yourself or the healthcare team.
>
> You should bear in mind that, in circumstances where individuals may be under stress, any important information provided verbally might need to be reinforced in writing.'

34. There are six entries in the Relatives Information Communication Sheet in Mr A's medical records. There is no evidence in the first five of the entries that Mr A's relatives were advised of his prognosis. However, the last entry, dated 17 December 2005 states that a relative was informed that Mr A's condition had deteriorated and that a meeting was offered with the doctor. The relative said

that they would discuss the matter with another member of the family. Mrs C has stated that information should have been given to the next of kin.

(d) Conclusion

35. Effective communication with patients and their carers is an integral part of good healthcare. Although Hospital 1 advised a relative on 17 December 2005 that Mr A's condition had deteriorated, I have not seen any evidence that they effectively communicated Mr A's prognosis to his relatives prior to this or that the family were involved in the decision that artificial hydration was not to be provided to him. I have, therefore, concluded that the Board has failed to demonstrate that they communicated effectively with Mr A's family. I uphold this aspect of the complaint.

(d) Recommendation

36. The Board have accepted that there were failures with communication and have apologised for this. They also said that nurses would be reminded of their responsibilities regarding the importance of pro-active communication with relatives. In light of this and the previous recommendations in this report, the Ombudsman has no further recommendations to make regarding this aspect of the complaint.

37. 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.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	The aggrieved – Mrs C's father
The Board	Ayrshire and Arran NHS Board
The Consultant	The consultant at Hospital 1 who made the decision not to artificially hydrate Mr A
Hospital 2	Ayrshire Central Hospital
Adviser1	Medical adviser to the Ombudsman
Adviser 2	Nursing adviser to the Ombudsman
Hospital 1	Ayr Hospital

Annex 2

Glossary of terms

Artificial nutrition and hydration	The term is commonly used in medicine to refer to techniques such as the use of naso-gastric tubes, percutaneous endoscopic gastrostomy ('gastric PEG'), subcutaneous hydration, or intravenous cannula, to provide a patient with nutrition or hydration where they have a problem taking fluids or food orally. A distinction is generally made between such 'artificial' means and 'oral' nutrition and hydration where food or drink is given by mouth, the latter being regarded as part of nursing care
Catheter	A flexible tube passed into the bladder to drain it
Creatinine	A waste product of protein metabolism that is found in the urine
Renal failure	A decline in kidney function
Urology	A branch of medicine concerned with the diagnosis and treatment of diseases of the urinary tract and urogenital system

Annex 3

List of legislation and policies considered

NHS Quality Improvement Scotland: Best Practice Statement on Urinary Catheterisation and Catheter Care (June 2004)

General Medical Council: Withholding and withdrawing life-prolonging treatments: Good practice in decision-making