Scottish Parliament Region: Lothian

Case 200601244: Lothian NHS Board

Summary of Investigation

Category
Health: Hospital; Care of the elderly, orthopaedics

Overview
The complainants (Mrs C and Mrs D) raised a number of concerns about the care and treatment of their late mother (Mrs A) at St Johns Hospital at Howden (the Hospital) between 19 December 2005 and 2 February 2006.

Specific complaints and conclusions
The complaints which have been investigated are that Lothian NHS Board (the Board):
(a) failed to provide adequate care and treatment to Mrs A (*partially upheld*); and
(b) failed to properly plan for Mrs A's discharge (*upheld*).

Redress and recommendations
The Ombudsman recommends that the Board:
(i) ensure that discussions take place within the clinical team on Ward 9 of the Hospital to agree the appropriate standard of practice with regards to the importance of a) thorough examination of a patient prior to discharge, with particular reference to patients with pre-existing medical problems and multiple medications, and b) recording of medical examination findings and the rational behind any changes to medications;
(ii) consider the use of fully unified records, i.e. including therapy follow-up records with the joint medical/nursing records;
(iii) consider regular (at least weekly) multi-disciplinary team meetings where discharge planning for complex cases, particularly for elderly patients, can be discussed, coordinated and recorded;
(iv) consider that where family conflicts or carer anxieties are raised, case conference meetings are organised when the key disciplines and family and carers can meet to exchange information and plan discharges and that all family meetings are adequately recorded; and

(v) consider whether current occupational therapist staffing levels in this area are sufficient to avoid the delays experienced by Mrs A.

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

Main Investigation Report

Introduction

1. On 18 August 2006 the Ombudsman received a complaint (Mrs C and Mrs D) about the care and treatment of their late mother (Mrs A). Mrs A was admitted to St Johns Hospital at Howden (the Hospital) on 19 December 2005 following a fall at home where she had sustained broken ribs. She was discharged on 2 February 2006 but re-admitted the following day. Mrs A had had another fall at home and later complained of nausea and chest pain which caused her to be readmitted. On readmission she was found to have DVT (deep vein thrombosis) and pleural effusion. Mrs C and Mrs D first complained in writing to Lothian NHS Board (the Board) on 15 February 2006 (after Mrs A's second fall at home) and received a response in May 2006. A meeting was arranged but Mrs C felt that the appropriate staff were not present throughout and it did not resolve matters. Mrs C and Mrs D remained dissatisfied and brought their complaint to this office.

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

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

(b) failed to properly plan for Mrs A's discharge.

Investigation

3. Investigation of this complaint included obtaining and reviewing Mrs A's clinical records and the Board's complaint file. I have also obtained the views of a medical (Adviser 1) and nursing adviser (Adviser 2) to the Ombudsman. I met with Mrs C and Mrs D. Adviser 2 and I met with representatives of the Board. 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 D and the Board were given an opportunity to comment on a draft of this report.

Medical Background

4. Mrs A had a medical history of stroke and colonic cancer and was receiving medication to regulate her blood pressure. Mrs A was admitted to the Hospital on 19 December 2005 with broken ribs following a fall at home. Mrs A was transferred from the Observation Ward to await medical review in the morning. Her care was taken over by a consultant (the Consultant) on 20 December 2005. There was a verbal handover to a staff nurse in Ward 9 on 21 December 2005 although; it is not absolutely clear from the clinical records

when the transfer to Ward 9 took place. Mrs A was discharged home from Ward 9 on 2 February 2006. Unfortunately, Mrs A fell again at home and was re-admitted to the Hospital (Ward 15) on 3 February 2006 under the care of another consultant. Mrs A was found to have rib fractures, DVT in her left leg and extensive right-sided pleural effusion (fluid in the space between the lung and chest wall). This latter condition ultimately required surgery to the rib on 17 February 2006 at another hospital (to evacuate blood clots and fluids). Mrs A returned to the Hospital on 20 February 2006 and was discharged to a nursing home on 10 March 2006 and subsequently returned home on 25 March 2006 where she sadly died on 26 March 2006.

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

5. Mrs C complained that the Consultant had failed to note and respond to Mrs A's DVT, fractured ribs and stroke. Mrs C noted that she and Mrs D had both met with the Consultant on 13 January 2006 and specifically raised concerns about Mrs A's symptoms of breathlessness, oedema in her legs and confusion. Mrs C complained that the Consultant dismissed her concerns which prevented him diagnosing Mrs A's DVT, pleural effusion and possible stroke as well as heart failure which was noted as a cause of death on her mother's death certificate. Mrs C considered that Mrs A was not in fact clinically fit for discharge on 2 February 2006.

6. In response to Mrs C's original complaint to the Board, the Consultant noted his disagreement with Mrs C's recollection of the discussion at the meeting on 13 January 2006. I met with Mrs C and Mrs D, both of whom met with the Consultant on 13 January 2006, and they repeated their view that the Consultant had not acknowledged their concerns but had dismissed them as attributable to Mrs A's age and weight. It is unfortunate that the meeting on 13 January 2006 is not as fully recorded by the Consultant as it could have been and that this difference of view cannot accordingly be resolved.

7. On 11 January 2006 Mrs C is noted in the medical records as calling twice to raise concerns about Mrs A's deteriorating condition; specifically that she had become very vague, was suffering shortness of breath, had swollen legs and would need an increased package of care before she could be discharged.

8. Adviser 1 and Adviser 2 both noted that the telephone calls on 11 January 2006 should have alerted the ward staff that Mrs C was unhappy generally about Mrs A's current medical condition and her possible discharge

and a formal discussion should have been held with her and the multi-disciplinary team in order to reassure her and to allow her to participate in the decisions about Mrs A's current and future health, support and care needs.

9. Adviser 1 also made specific comments on the issues raised by Mrs C and Mrs D at their later meeting with the Consultant on 13 January 2006 and their significance (or otherwise) to Mrs A's later diagnoses of DVT, fractured ribs and pleural effusion. With respect to DVT Adviser 1 told me that the nurses recorded that Mrs A had swollen legs on 8 January 2006 and that her legs were elevated onto a stool. Mrs A was noted to be complaining of increased breathlessness and wheezing but her recorded observations did not show anything significant but a doctor was informed. The doctor who reviewed Mrs A later that day found no breathlessness and noted she appeared to be comfortable and pain free. In particular he found no sign of pitting leg oedema over her lower shins but thought that she had some slight swelling around her knees. Adviser 1 noted that if Mrs A had been developing a DVT then she would have had discomfort in one leg or other and that leg would be noticeably swollen and tender below the knees compared with the other. He also noted that there was no evidence of pulmonary embolism on CT scanning of the lungs following Mrs A's re-admission on 3 February 2006 and that had a DVT persisted over such a period of time this would have been visible on such a scan. With respect to the fractured ribs and plural effusion, Adviser 1 told me that the second fall at home may have caused further fractures, or dislodged the fractured ends of Mrs A's ribs leading to lung perforation and bleeding with effusion and that this could also explain the breathlessness at the time of re-admission.

10. Mrs C told me that her mother's legs were in fact severely swollen and her left leg very sore to the touch but that none of this had been noted or recorded by staff despite the fact that Mrs C and Mrs D had mentioned it to them.

11. Mrs C had also expressed concerns about Mrs A's confusion since her admission on 19 December 2005 and questioned whether Mrs A had had a stroke. Mrs C complained that the Consultant should have arranged a brain CT scan. Adviser 1 noted that he considered it would have been unreasonable to perform a brain CT scan on the basis of what Mrs C told the doctors on Ward 9. He noted that a scan was performed after Mrs A's re-admission but that in his view this did not show any evidence of recent stroke or other evidence that would explain any mental deterioration in Mrs A.

12. At my meeting with Mrs C and Mrs D, they expressed concern that the clinical records for Ward 9 did not reflect their recollection of events or Mrs A's symptoms. They noted that heart failure was one of the causes of death listed on Mrs A's death certificate and noted that the Consultant had not acted on their expressed concerns about Mrs A's breathlessness and oedema both of which might be signs of heart failure. They also told me that Mrs A's legs had become so swollen that she could not be dressed in her normal clothes. Adviser 1 reviewed the medical records again in light of this concern and noted that Mrs A was taking a number of medications for blood pressure on her admission to the Hospital on 19 December 2005 which could also be used to treat heart failure. He noted a number of changes were made to Mrs A's drug therapy during both her first and second admissions but that there was very little recorded in the clinical records about her lungs, heart or her legs which made it impossible for him to say with any certainty whether Mrs A's was experiencing a degree of heart failure, whether this possibility was considered by the doctors caring for her or what the rational for drug changes was.

13. Adviser 1 concluded that on the whole, Mrs A received reasonable care and treatment on Ward 9. He noted that while there is no evidence in the medical records to suggest that Mrs A was exhibiting adverse physical signs before her discharge there is no evidence either that she had been thoroughly examined immediately before being sent home. It was clinically quite plausible that her second fall at home caused the severe bleeding and effusion with which she was re-admitted. The onset of the DVT possibly could have occurred simultaneously but might have been present before discharge. The DVT must, however, have been of recent onset, as there was no evidence of lung embolism on the CT scan performed shortly after Mrs A's re-admission on 3 February 2006. He noted, however, that there was a lack of evidence of any management and review of her cardiovascular system, which preclude him being able to reassure Mrs C or confirm her concerns about Mrs A's breathlessness and swollen legs being related to a heart condition.

(a) Conclusion

14. The medical advice I have received is that Mrs A received reasonable care and treatment for her known problems but that there were insufficient records relating to the medical review and management of her condition and her potential symptoms to reach a conclusion on her overall clinical management. I, therefore, partially uphold this aspect of the complaint.

(a) Recommendation

15. The Ombudsman recommends that the Board ensure that discussions take place within the clinical team on Ward 9 to agree the appropriate standard of practice with regards to the importance of a) thorough examination of a patient prior to discharge with particular reference to patients with pre-existing medical problems and multiple medications and b) recording of medical examination findings and the rational behind any changes to medications. The recommendations following complaint (b) are also of relevance to this aspect of the complaint.

(b) The Board failed to properly plan for Mrs A's discharge

16. Mrs C complained that she had made it known to staff that the family would require 48 hours notice to make arrangements for Mrs A's discharge but that on a number of occasions they were told Mrs A was to be discharged imminently. Mrs C also complained that they had requested a home assessment for Mrs A before she was discharged to ensure it was safe for her to return but that this did not happen until 23 January 2006 and again she was advised Mrs A was ready for discharge on a number of occasions before then. Mrs A was not felt to be ready for discharge by the OT (occupational therapist) until 2 February 2006 at which point she was still unable to get herself in or out of bed on her own.

17. An entry in the medical notes by a registrar on 4 January 2006 states 'Much Better … Wanting home … IF FAMILY HAPPY – if not, to stay'. A later nursing note records '(Discussed) with daughter. She doesn't feel she is ready for home yet'. An entry later that date by the registrar notes 'Not for home yet' and that Mrs A was to be referred to an OT. The first record in the nursing notes of Mrs C requesting 48 hours notice prior to discharge is on 11 January 2006. A number of further entries in the medical record make it clear that Mrs A was considered to be medically fit for discharge from early January 2006 and that discharge was mentioned on a number of occasions prior to the OT assessment being carried out. There is confusion in the nursing records which indicate an OT assessment was first requested on 5 January 2006 and again on 11 January 2006 but there is no record of such a request being received until 12 January 2006. Mrs C told me that the Consultant had specifically said there would be no point in an OT assessment of Mrs A at home during their meeting on 13 January 2006. The Consultant

disagreed with this account of the conversation and the contemporaneous notes contain no reference to this.

18. Adviser 1 noted there was an inordinate delay in getting an OT assessment. Adviser 2 noted that there are a number of entries from the date of Mrs A's first admission which refer to the need for OT input prior to discharge and two specific references in early January 2006 to a referral being made. Adviser 2 also noted that there is a medical entry in the record that states 'OT assessment would be desirable but length of wait could jeopardise [Mrs A]'s wellbeing'. Adviser 1 noted that in fact the OT first assessed Mrs A on 18 January 2006 and recorded Mrs A was unable to get in and out of bed unassisted and that this alone would have been a factor against a discharge before then. Adviser 1 noted that he would have expected an OT assessment well before 4 January 2006 when discharge was being first discussed. As mentioned above, a nurse noted that an OT referral was to be made on that date but nothing seems to have been arranged. The physiotherapist recorded on admission on 19 December 2005 concerns being expressed by Mrs A's family that she was coping less well at home prior to admission. The physiotherapist also recorded Mrs A's very poor standing and mobility. Adviser 1 stated that:

> 'It would appear that neither nursing nor medical staff read the physiotherapist's notes which were separately filed from the medical/nursing notes. This may have acted as a barrier for collaborative working and co-ordinated planning between disciplines and is the main argument for unified records being a requisite for older people with complex problems admitted to hospital. The main reason why [Mrs A]'s discharge was not as well organised as it should have been was that there was poor inter-disciplinary co-ordination. There was no evidence of any multi-disciplinary meetings, for instance. It is also unfortunate that [Mrs A] was not able to be assessed by the continence service in the fortnight before her discharge.'

19. Adviser 1 concluded that there is evidence that the discharge planning for Mrs A was fragmentary and there was poor inter-disciplinary coordination, possibly as a result of no multi-disciplinary meetings taking place. There were, however, considerable and unexplained delays in the assessments by OT and the continence service.

(b) Conclusion

20. I noted in paragraph 8 above, Adviser 1's view that the telephone calls on 11 January 2006 from Mrs C to nursing staff should have alerted the ward staff that Mrs C was unhappy generally about Mrs A's discharge and a formal discussion should have been held with her by the consultant, physiotherapist and OT in order to reassure her. It is clear that there were a number of occasions where Mrs C and Mrs D were given to believe that Mrs A was to be discharged imminently without their being consulted on this before hand. The lack of any clear evidence or a formal plan for Mrs A's discharge gave rise to considerable confusion and caused distress for the family. Again a multi-disciplinary meeting involving the family would have permitted an exchange of information and sharing of knowledge as well as ensuring proper planning for and management of Mrs A's discharge. The lack of a clear discharge plan and effective multi-disciplinary communication gave rise to a poorly managed discharge process over a number of weeks. An apparent lack of OT services also contributed to the delay and confusion. I uphold this aspect of the complaint.

(b) Recommendation

21. The Ombudsman recommends that the Board consider:

- the use of fully unified records, i.e. including therapy follow-up records with the joint medical/nursing records;
- regular (at least weekly) multi-disciplinary team meetings where discharge planning for complex cases, particularly for elderly patients, can be discussed, coordinated and recorded;
- that where family conflicts or carer anxieties are raised, case conference meetings are organised when the key disciplines and family and carers can meet to exchange information and plan discharges and that all family meetings are adequately recorded; and
- whether the current OT staffing levels in this area are sufficient to avoid the delays experienced by Mrs A.

22. 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 – Mrs A's daughter
Mrs D	The complainant – Mrs A's daughter
Mrs A	The aggrieved
The Hospital	St Johns Hospital
DVT	Deep vein thrombosis
The Board	Lothian NHS Board
Adviser 1	A medical adviser to the Ombudsman
Adviser 2	A nursing adviser to the Ombudsman
The Consultant	The consultant responsible for Mrs A's care from 20 December 2005
OT	Occupational therapist

Annex 2

Glossary of terms

CT scan	A computerised three dimensional image of the body
Pleural effusion	Fluid in the space between the lung and chest wall