Scottish Parliament Region: Highlands and Islands and Lothian

Cases 200601436 & 200800094: Shetland NHS Board and Scottish Ambulance Service

Summary of Investigation

Category

Health: Hospital; Accident and Emergency department and patient transport

Overview

The complainant (Mr C) complained about the transport arrangements for his wife (Mrs C) after her feeding tube blocked and she required hospital treatment to unblock it. He also complained about the care and treatment she received at Gilbert Bain Hospital, Shetland (Hospital 1).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was a delay in the arrival of the ambulance and when it arrived it could not take Mrs C in a powered wheelchair (upheld to the extent that the ambulance could have been dispatched more quickly and the delay avoided had the crew been advised when the request for the ambulance arrived);

(b) no arrangements were made to take Mrs C home after her attendance at Accident and Emergency at Hospital 1 (*upheld*);

(c) Mrs C had no nutrition or fluids for 20 hours (*upheld*);

(d) Mrs C was sent to the wrong address in a taxi (*upheld*); and

(e) the initial travel arrangements made for Mrs C to attend a hospital outwith the Shetland NHS Board area were unreasonable (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Scottish Ambulance Service:

(i) apologise to Mr C for the failings identified in this paragraphs 5 to 12 of this report; and

(ii) demonstrate that, through providing more tailored options for requesting physicians, the response and appropriateness of that response has improved.

The Ombudsman recommends that Shetland NHS Board:

(iii) apologise to Mr C for the failings identified in paragraphs 18 to 29 of this report;
(iv) send him a copy of the results of the audit of record-keeping in the Accident and Emergency department and any action taken to improve practice; and
(v) audit the Patient Travel Service to ensure that they are now requesting sufficient information to allow them to make appropriate arrangements for all patients in the Board area who require to travel.

Both the Scottish Ambulance Service and Shetland NHS Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. Mrs C had suffered a severe stroke in 2004, which left her paralysed and unable to speak or swallow. She required to be fed through a feeding (PEG) tube. Mrs C lived in a care home. At approximately midnight on 28 June 2006 the night staff at the care home tried to give Mrs C some water but were unable to do so because the feeding tube had become blocked. The staff could not unblock the tube using the prescribed method and neither could the two district nurses who attended the following morning. The duty GP at the local health centre was contacted and she faxed a referral letter to Gilbert Bain Hospital, Shetland (Hospital 1). The GP also asked the health centre receptionist to call an ambulance to take Mrs C to the Accident and Emergency department of Hospital 1. Mrs C's husband (Mr C) complained about the delay in the arrival of the ambulance and the further delay caused by having to transfer Mrs C to a stretcher, as the ambulance could not take her powered chair. Mr C also complained that no arrangements were made to take his wife home after her attendance at Accident and Emergency and, by the time she arrived back home, she had had no nutrition or fluids for 20 hours. A few days later Mrs C required similar treatment to have her tube unblocked again. Mr C said that, on that occasion, he was told Mrs C would be kept in Hospital 1 for observation. Mr C returned to the care home to collect overnight clothes for his wife. During his absence, his wife was discharged and sent home in a taxi, which took her to the wrong address. Mr C said this caused her to become distressed as she could not speak. Subsequently, arrangements were made for Mrs C to attend another hospital (Hospital 2) outwith Shetland NHS Board (the Board) area to have the tube replaced. Mr C complained that the initial travel arrangements made for Mrs C were unreasonable.

2. Mr C made several complaints to the Board, who contacted the Scottish Ambulance Service (the Service) and responded to his complaints, but he remained dissatisfied and he complained to the Ombudsman. Mr C submitted this complaint to the Ombudsman on 15 August 2006 and I very much regret that, for a variety of reasons, our consideration of this complaint has taken longer than it should have. For that I apologise sincerely to Mr C, the Service and the Board.

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

(a) there was a delay in the arrival of the ambulance and when it arrived it could not take Mrs C in a powered wheelchair;
(b) no arrangements were made to take Mrs C home after her attendance at Accident and Emergency at Hospital 1;
(c) Mrs C had no nutrition or fluids for 20 hours;
(d) Mrs C was sent to the wrong address in a taxi; and
(e) the initial travel arrangements made for Mrs C to attend Hospital 2 were unreasonable.

Investigation

4. In order to investigate this complaint I have had access to Mrs C's clinical records for the period in question and the complaint correspondence. I have obtained clinical advice from an adviser to the Ombudsman who is a hospital consultant (the Adviser). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C, the Service and the Board were given an opportunity to comment on a draft of this report.

(a) There was a delay in the arrival of the ambulance and when it arrived it could not take Mrs C in a powered wheelchair

5. Mr C complained that there was a delay in the ambulance's arrival at the care home on 29 June 2006 and that when it arrived the crew informed him that they had only been requested to attend a few minutes previously. Mr C said that there was a further delay caused by having to transfer Mrs C to a stretcher because the ambulance could not take her powered wheelchair.

6. On 31 July 2006 the Chief Executive of the Board responded to Mr C's complaint. She said that a routine ambulance (within four hours) had been requested at 12:50 by the health centre to take Mrs C to Hospital 1. The health centre receptionist had telephoned at 12:50 to arrange this. The Service's Medical Dispatch Centre (EMDC) had logged the call as having come in at 13:00 but did not contact the local ambulance station until 16:41. She had asked the Service for an explanation, although the time taken had technically been within the four hour target time.

7. On 21 September 2006 the Service's Regional Manager explained to the Chief Executive that when an ambulance was requested for Mrs C there had been a 40 minute window immediately following the request, when the task could have been allocated and completed. For some reason, the dispatcher

had held on to the job and then other, higher priority jobs, had come in. The job was allocated approximately three and a half hours after the initial call. Staff had been made aware of the need to allocate jobs quickly following this incident.

8. The Chief Executive said that the Lerwick Team Leader for the Service had told her that, due to difficulties with manual handling, local ambulance crews were not expected to transport patients in powered wheelchairs, although ambulances were equipped to transport patients in manual wheelchairs. Although the crew were not informed by the health centre that Mrs C was in a powered wheelchair, normal practice in circumstances where the patient was expected to be looked after on a bed when they arrived at hospital was to transfer the patient to a stretcher for transport to the hospital and that is what had happened in this case. The Chief Executive understood that local care homes and doctors were to be made aware of this procedure.

9. In response to my written enquiries of the Service, they advised me that there was nothing further they could add to the comments they had submitted to the Board.

10. The Adviser noted that the Service recorded the request for a routine ambulance at 13:00. The Adviser said that Mr C may not have been aware of the low priority given to the request by the GP. The ambulance crew who attended were not called until 16:10 and recorded the time of arrival at hospital as 16:56. The Adviser said that the delay by the ambulance staff in not letting the crew know of the task until the four hours was almost up was not acceptable in the circumstances. The Adviser said that neither the staff of the health centre nor the staff of the care home appeared to be aware of the fact that ambulances were not equipped to take powered wheelchairs. However, he has advised that would not have delayed the transport significantly in that although Mrs C would have needed to be hoisted from her chair to the stretcher this should not have caused undue delay.

11. In response to my enquiries the Chief Executive wrote, on 14 December 2007, that the Board's Medical Director had now communicated with Shetland GPs, recommending that if a feeding tube blockage is unresolved after eight hours in an otherwise nil by mouth patient any subsequent request for ambulance transport becomes a category B (serious) call rather than a category C (routine) request.

(a) Conclusion

12. It is understandable that Mr C was very worried about the delay in taking his wife to hospital that day but he may not have realised that the ambulance was summoned to transport his wife to hospital within four hours. Technically, that target was just met and, when the ambulance crew were alerted by ambulance staff, they attended within 50 minutes of receiving the callout. However, it has been confirmed by the Service that there was a 40 minute window of opportunity immediately following the request for the ambulance to be dispatched. It is clear that the ambulance could have been dispatched more quickly and the delay avoided had the ambulance crew been advised when the request for the ambulance was received. The Adviser has confirmed that while the health centre and care home had not been aware of the fact that ambulances are not equipped to take patients on a powered wheelchair this would not have added substantially to the delay. In these circumstances, I have decided to uphold this complaint to the extent that the ambulance could have been dispatched more quickly and the delay avoided had the crew been advised when the request for the ambulance arrived. I note that the Board have now taken steps to advise GPs that such requests should be allocated higher priority in future. I also note that ambulance staff have been made aware of the need to allocate tasks quickly and also that local doctors and care staff have been informed of the position with regard to powered wheelchairs. Since issuing the draft report the Service have told me that they have changed the way that GPs can call for an ambulance. GPs can now make more tailored requests for an ambulance to attend within one, two, three or four hours. However, the Ombudsman has the following recommendation.

(a) Recommendations

13. The Ombudsman recommends that the Service;

(i) apologise to Mr C for the failings identified in paragraphs 5 to 12 of this report; and

(ii) demonstrate that, through providing more tailored options for requesting physicians, the response and appropriateness of that response has improved.

(b) No arrangements were made to take Mrs C home after her attendance at Accident and Emergency at Hospital 1

14. Mr C said that a consultant surgeon unblocked Mrs C's tube at the Accident and Emergency department of Hospital 1, following which Mrs C was

discharged from Hospital 1 but no transport was available to take Mrs C back to the care home. Mr C complained that he had to find a specially adapted taxi which could take the manual wheelchair in which the hospital discharged Mrs C in order to take her back to the care home.

15. The Chief Executive wrote to Mr C on 31 July 2006. She said that Mrs C had been discharged after 17:00, when the non-emergency patient transport stopped. Under the circumstances, and given Mrs C's level of disability, the Chief Executive would have expected Hospital 1 to have arranged and paid for Mrs C's transport home. Unfortunately that had not happened and the Chief Executive apologised for the inconvenience. The Chief Executive offered to refund the taxi fare and said that she would arrange for the issue to be addressed with staff to avoid similar inconvenience in the future. Mr C said that he was not seeking refunds or retribution. He wanted the Board to sort out the problem.

16. In response to my enquiries the Chief Executive said that, following Mr C's complaint, the Board had negotiated enhancements to the service levels provided by the Service in Shetland. Between 09:00 and 18:00 each weekday there is now a dedicated patient transport vehicle and crew on duty and between 07:00 on Tuesday and 17:00 on Saturday there is duty cover from the emergency service vehicle and crew. Outside these times there is a standby service. There is a local understanding with emergency crews that if they are not attending an emergency call they will be available for the type of journey required by patients such as Mrs C. Should a profoundly disabled patient require ambulance transport during the times covered by the standby service the local clinicians will in future consider short-term admission to hospital rather than requesting taxi transport.

(b) Conclusion

17. The Chief Executive said that, in the circumstances and given Mrs C's level of disability, she would have expected Hospital 1 to have arranged and paid for her transport back to the care home. In this case that did not happen and I, therefore, uphold this complaint. I note, however, that the Board have apologised to Mr C and have now taken steps to ensure that this situation will not arise in the future. In these circumstances, the Ombudsman has no recommendations to make.

(c) Mrs C had no nutrition or fluids for 20 hours

18. Mr C said that by the time his wife returned to her care home it was approximately 19:30 and 20 hours had passed, during which time his wife had had no food or water and she was becoming dehydrated.

19. In response to my enquiries on this point, the Chief Executive wrote to me referring to the advice given by the Board's Medical Director regarding the priority to be given to ambulance requests in future if a feeding tube blockage is unresolved after eight hours in an otherwise nil by mouth patient (see paragraph 11).

20. The Adviser said that in addition to the delays in transporting Mrs C to Hospital 1, Mrs C was not seen by the consultant surgeon until 18:35, when he successfully unblocked the tube. (Mrs C had arrived at the Hospital at 16:56, see paragraph 10.) The Adviser said that the delays which Mrs C experienced throughout the day, however, were no reason why she should not have received alternative methods of hydration, if necessary by intravenous (IV) drip, if not nutrition. The Adviser said that there would have been time for this to be done while Mrs C was waiting for the consultant surgeon and the fact that it was not considered suggests a poor assessment by staff at the time of Mrs C's admission to Accident and Emergency.

21. In response to my further enquiries the Chief Executive wrote to me on 25 April 2008, noting the Adviser's opinion. She said that the Director of Nursing said the usual practice was to ask about the last time a patient ate or drank but, if discharge was imminent, staff were unlikely to do further formal assessment and documentation unless there were clinical indications. She went on to advise that someone due to be admitted or waiting in the Accident and Emergency department for an extended period would be additionally assessed regarding their care needs. In this case, Mrs C's pulse and blood pressure were recorded and did not give rise to concern which would warrant further intervention. The staff involved did not recall this particular case but said that they would have weighed up the invasiveness and potential complications of introducing IV fluids, as opposed to waiting until the tube was unblocked. The Chief Executive said that, nevertheless, she would have expected assessment of last food and fluids taken to be done in the Accident and Emergency department by the nursing staff and to be recorded and she would wish to apologise to Mr and Mrs C that this was not done on this occasion. The Chief Executive said that staff in the Accident and Emergency department had

been reminded of the importance of assessing and recording these aspects of care, particularly in patients who are unable to communicate for themselves. The Chief Executive also arranged to include the Accident and Emergency department in their next audit of record-keeping.

(c) Conclusion

22. There is no indication in the records that staff were aware that by the time Mrs C was admitted to Accident and Emergency at approximately 17:00 she had already been without fluid or nutrition since the night before. Mrs C still had to wait a further two and a half hours before she was returned to her care home. The Adviser said that Mrs C's nutritional needs should have been assessed by staff while she was in the Accident and Emergency department. I, therefore, uphold this complaint. I note the change in procedure regarding the ambulance request, which should improve the speed with which the patient is transported to hospital. I also note the Chief Executive's apology and the steps taken to include the Accident and Emergency department in the next audit of record-keeping.

(c) Recommendation

23. The Ombudsman recommends that the Board send him a copy of the results of the audit of record-keeping in the Accident and Emergency department and any action taken to improve practice.

(d) Mrs C was sent to the wrong address in a taxi

24. Mr C said that his wife's feeding tube blocked again on 12 July 2006 and she again required to be taken to the Accident and Emergency department to have it unblocked. On that occasion, Mr C understood that it might be necessary for his wife to be admitted and had returned to her care home to collect some overnight clothes for her. During his absence, Mrs C was discharged in a taxi to the wrong address, which had caused her considerable distress as she was unable to speak. Mr C wrote to the Board to complain about this.

25. In the Chief Executive's reply to Mr C she said that it was not acceptable for a patient to be taken to the wrong address and she would look into how this had happened. The Chief Executive also said that she would put measures in place to minimise the possibility of a discharged patient being taken to the wrong address in future.

26. In response to my enquiries, the Chief Executive said that the changes in the Service's provision (see paragraph 16) will help to prevent any recurrence of this most unfortunate mistake. All patient transport bookings are now handled by the Service professional call handlers, who are very used to dealing with this type of request.

27. The Chief Executive wrote to me again on 25 April 2008. She said that they had not been able to establish why Mrs C was sent to the wrong address. Their usual practice was to record the home address on the Accident and Emergency record and she could confirm that the care home address was correctly recorded in Mrs C's record. When a taxi was ordered to take a patient home there were two ways of notifying the driver of the address: firstly, the taxi company was told when the taxi was ordered by the hospital reception staff from information provided by the staff of the Accident and Emergency department; and, secondly, when the taxi driver arrived to collect the patient, if the patient needed assistance, the member of staff assisting the patient confirmed the address with the driver. Staff involved in Mrs C's care could not recall what had happened. In terms of minimising the possibility of this happening again, the Chief Executive said that feedback on this case has reminded staff of the importance of being accurate and clear in passing on information and particularly of involving a relative or carer when a patient has difficulty in communicating themselves, as in this case. The Chief Executive said that there was clearly a lack of communication between staff, in not waiting for Mr C to return before sending Mrs C in a taxi, and the Chief Executive said that she would like to apologise to Mr and Mrs C for the lack of communication. The Chief Executive also said that she had reinforced with Accident and Emergency staff the procedure for arranging taxis and the alternative of overnight admission to hospital and ambulance transport the next day if that seems a better option for the patient. (This has been superseded by the new travel arrangements and procedures now in place – see paragraph 16)

(d) Conclusion

28. It must have been frightening for an elderly person, unable to move or speak, to be taken to the wrong place. The Board have not been able to explain how this happened although they agree it was unacceptable. It is unlikely that further investigation would shed any more light on the matter. I uphold this complaint.

(d) Recommendation

29. In view of the changes in procedures put in place by the Board to prevent a recurrence, the Ombudsman has no recommendations to make.

(e) The initial travel arrangements made for Mrs C to Hospital 2 were unreasonable

30. Mr C said that when it became necessary for his wife to go to Hospital 2 to have her feeding tube replaced (on 30 August 2006), the Patient Travel Service decided to send her alone on a normal domestic flight. She was expected to make her own way to the airport. It was only after Mr C had spoken to a GP at the health centre that the arrangements were changed to an air ambulance flight and Mr C was permitted to go with his wife as her escort and claim travel expenses for the trip to the airport.

31. On 10 October 2006 the Chief Executive wrote to Mr C. She said that she had reviewed procedures within the Patient Travel Service to understand how the decision was made to send Mrs C on a domestic flight with no escort. She said that bookings were normally made relying on whatever information was received from the patient, carer or health care worker. The Patient Travel Service did not request clinical information regarding whether or not a patient needed more assistance but relied on the person making the booking to let them know. It was felt that making enquiries could be considered intrusive and could potentially compromise a patient's confidentiality rights. She said that in this case the request for travel had come from the care home where Mrs C was living and the Patient Travel Service staff did not ask for more information on Mrs C's needs for the journey, instead they relied on the staff requesting the booking to let them know if additional support was needed. The Chief Executive had asked for the matter to be considered further by relevant staff to see if a way could be found to ensure patient needs were met without compromising confidentiality.

32. The Chief Executive wrote to me again on 25 April 2008. She said that she had taken action to ensure that, in future, the Patient Travel Service would automatically ask about a patient's care needs if the patient is resident in a care home. The Chief Executive said that the current practice was now to for the Patient Travel Service to ask about care needs before making arrangements for transport. The Chief Executive said that care home staff had also been reminded of the need to inform the Patient Travel Service of the care needs of a patient requiring transport.

(e) Conclusion

33. Mrs C was clearly unable to travel unaccompanied on a domestic flight. While I appreciate that the request came from the care home where Mrs C was living, there is no evidence that the Patient Travel Service who made the booking took steps to ensure that the arrangements they were making were appropriate for Mrs C's needs. The proposed arrangements were not adequate and, although Mr C succeeded in ensuring that more suitable arrangements were made prior to the date of travel, I, nevertheless, uphold this complaint as the initial arrangements were clearly unsuitable. I am pleased to note the action taken in relation to Patient Travel Service staff asking about care needs.

(e) Recommendation

34. The Ombudsman recommends that the Board audit the Patient Travel Service to ensure that they are now requesting sufficient information to allow them to make appropriate arrangements for all patients in the Board area who require to travel; and

General recommendation

35. The Ombudsman recommends that in view of the failings identified in paragraphs 18 to 29 of this report the Board apologise to Mr C.

36. Both the Service and the Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that they notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	The complainant's wife
The Board	Shetland NHS Board
The Service	The Scottish Ambulance Service
Hospital 1	Gilbert Bain Hospital, Shetland
Hospital 2	A hospital outwith the Board area
The Adviser	The Ombudsman's professional medical adviser
EMDC	The Scottish Ambulance Service Medical Dispatch Centre
IV	Intravenous

Annex 2

Glossary of terms

PEG	Percutaneous endoscopic gastronomy feeding tube