Scottish Parliament Region: North East Scotland

Case 200702838: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Ms C) complained about some aspects of care and treatment and communication with the family in respect of her mother, aged 80, who had been admitted to Aberdeen Royal Infirmary (the Hospital), a hospital in the area of Grampian NHS Board (the Board) in October 2007. She had been badly injured in a road traffic accident and, most sadly, never properly recovered full consciousness, dying in the Hospital about a fortnight later.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) some aspects of the care and treatment were inadequate (*upheld*); and

(b) communication with the family was inadequate (*no finding*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise direct to Ms C for the shortcomings identified in this report;

(ii) reflect on the medical lessons to be learnt from this case and consider appropriate action;

(iii) ensure that, in future, they are able to evidence patients' fluid levels, by retaining, for example, a record of daily fluid totals for a year after the event, in case needed;

(iv) consider how to improve the record-keeping, including notes of discussions with patients and families, of medical staff in the ward in question, and take action accordingly;

(v) consider any need for a wider audit of medical record-keeping; and

(vi) reflect on the criticisms about complaint handling and consider appropriate action.

Main Investigation Report

Introduction

1. The complainant (Ms C) complained about some aspects of care and treatment and communication with the family in respect of her mother (Mrs A), aged 80, who had been admitted to Aberdeen Royal Infirmary (the Hospital), a hospital in the area of Grampian NHS Board (the Board) in October 2007. She had been badly injured in a road traffic accident and, most sadly, never recovered full consciousness, dying in the Hospital about a fortnight later. A reminder of the abbreviations used is in the annex.

2. The complaints from Ms C which I have investigated are that:
(a) some aspects of the care and treatment were inadequate; and
(b) communication with the family was inadequate.

Investigation

3. I was assisted in the investigation by clinical advisers (the Advisers), a consultant physician and senior nurse, whose role was to explain to me, and provide an unbiased comment on, aspects of the complaint. We examined the papers provided by Ms C (which included her complaint correspondence with the Board and her opinions about what had happened) and information from the Board (which included Mrs A's clinical hospital records and their replies to my enquiries). In line with the practice of the Ombudsman's office, the standard by which the events were judged was whether they were reasonable. By that, I mean whether the decisions and actions taken were within a range of what would have been considered to be acceptable professional practice at the time in question. The purpose of the investigation was to use the information from Ms C and the Board to try to establish what happened (ie the relevant facts) and then to consider whether what happened fell within this range of reasonable practice. I should also explain that we do not judge decisions and actions by using hindsight. In other words, our conclusions are not based on how things later turn out for a patient. Our approach is to consider what (for example) evidence and information were available to clinicians at the time in question and to consider whether their actions were reasonably based on that information. This is because that is the only information on which the clinicians could have based their decisions at the time.

4. I have not included in this report every detail investigated. In particular, I have not recorded details which are known to Ms C and the Board, are not in

dispute or do not have any particular relevance to my conclusions. I am satisfied that no matter of significance has been overlooked in the investigation. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) Some aspects of the care and treatment were inadequate

5. I turn now to the events of the complaint. Mrs A was admitted to the Hospital on 17 October 2007 because of a road traffic accident. She was aged 80, and her existing medical conditions included hypertension, which is abnormally high blood pressure and for which she was taking anti-hypertensive medication.

6. Amongst other things, a scan of Mrs A's head was done on 17 October 2007, which showed severe head injury and from which a consultant neurosurgeon (the Consultant) considered that surgery or management in an intensive care unit would not be appropriate. He considered that, although she was very likely to die, there was a remote possibility of survival, and Mrs A was, therefore, simply to be nursed to see whether she was able to make any improvement. From the Hospital's accident and emergency department, Mrs A was, therefore, admitted to a neurosurgery ward for nursing. Her level of consciousness fluctuated but remained very poor. Another scan was done on 24 October 2007 to establish whether anything could be done to encourage some recovery, but in some respects it showed a worse position than on 17 October 2007. Mrs A developed cold sores and a probable chest infection, which were treated with drugs, and her situation was observed through monitoring. Her condition, although poor, remained fairly stable. However, sadly, she died on 30 October 2007 without ever having properly regained full consciousness.

7. Because of the shortcomings, this report focuses on the Advisers' criticisms and the actions the Ombudsman wants the Board to take, rather than on the detail of Mrs A's condition. Firstly, however, I should emphasise that the Advisers are clear that the Consultant's opinion and his plan, as set out in the previous paragraph, were entirely appropriate and that, overall, Mrs A received a standard of nursing care which was well within the range described at paragraph 3. In particular: great attention was paid to ensure that Mrs A did not develop pressure sores from lying too long in one position on an inappropriate mattress (which is a common occurrence in hospitals – and a common complaint to the Ombudsman); and attention was given to her hygiene

and comfort (bed baths, cream on her skin etc). Additionally, the nursing records were detailed and well written.

8. Here, then, are the main criticisms of the Advisers, together with an indication of the Board's reaction:

> 'There were many gaps in the monitoring of Mrs A's blood pressure, including gaps of 12 hours and more, which we consider to be poor. We note that the Board now accept that more frequent monitoring should have been done. The Ombudsman's Investigator expressed disappointment to the Board that they had earlier told her that blood pressure was monitored 'frequently and regularly' throughout the admission; it is disappointing that the Board made no comment in response to that.
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> When the Investigator told the Board that we did not consider they had adequately acknowledged the various lapses in monitoring, the Board did acknowledge the lapses and expressed regret. That is welcome. However, they added that, however frequent the monitoring, this would not have prompted any change to Mrs A's treatment. This is apparently given by the Board as an argument in their defence, which is disappointing. The point is that monitoring should have been more frequent, whatever the outcome later turned out to be: to say that it would not have changed anything is to apply hindsight and is simply not relevant.
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> On the morning of 29 October 2007, Mrs A's blood pressure was found to be very low, yet nothing was done about this. It should have prompted, for example, more frequent blood pressure monitoring and a review of Mrs A to consider the cause and any need to change her medication. We note that the Board now acknowledge the unacceptability of noting, yet taking no action, on such a drop in blood pressure.
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> The cause of the low blood pressure on 29 October 2007 was not clear, but infection had almost certainly been present for some days, judging by blood test results. In a letter to Ms C, the Board said one possible reason was chest infection and that active treatment with antibiotics was being given. The antibiotic was flucloxacillin. In a letter to the Investigator, the Board said that the medical team's best guess was a chest infection. Nowhere in the clinical records is there any entry about a possible chest infection. It is disappointing that, when the Investigator put this to the Board, they made no comment. We also note that, when the Investigator

commented to the Board that flucloxacillin was not an adequate antibiotic for chest infection, they commented that it had been given in addition to another drug because of cold sores, which were thought to be secondarily infected. Our criticism of the flucloxacillin remains: although cold sores are referred to in the medical records, there is no mention of any secondary infection. The Investigator also commented to the Board that, if a chest infection was present, or suspected, monitoring of oxygen levels should have continued, and it is disappointing that the Board's response included no comment about this. The nursing records and charts make no reference to any such monitoring from 25 October 2007 onwards, although the physiotherapy records for 29 October indicate that oxygen levels were monitored at least once on that day. We must conclude that there was inadequate oxygen monitoring. Additionally, if, as is most likely, the terminal events in Mrs A's life were associated with infection, there should have been clear, detailed, entries about all these issues in the records.

There was evidence of dehydration, but, again, the records present an unclear picture. There is no evidence to support the Board's statement to the Investigator that Mrs A's fluid intake and output were monitored continuously. The Board quoted one of their procedures manuals, which allowed for the destruction of fluid balance charts. We acknowledge that such destruction is Board policy. However, we consider that the Board need to be able to evidence that adequate fluid monitoring has taken place - for example, by retaining a record of patients' daily totals, in case fluid information is needed during the following year or so by an Ombudsman investigation or fatal accident inquiry etc. We note that the nutrition being fed (through a nose tube) was changed to a low-salt feed because Mrs A's blood salt level was found to be raised. However, that rise was another feature suggestive of dehydration, and this should have been thought about by the medical team. There is no evidence in the records of this. In fact, on 24 October 2007, the records show the dietician as recommending the blood salt level to be monitored, yet no consequent blood tests are shown as being taken until five days later – on 29 October 2007. The Investigator commented to the Board that, despite the evidence of dehydration, the drug to increase Mrs A's urine output was not stopped, and it is disappointing that the Board made no comment in reply.

Another instance of unclear records is in relation to the various descriptions of Mrs A's level of consciousness. The opinions were made

using a recognised scoring system, but the records give a confusing picture. For example, a medical record for 17 October 2007 says that Mrs A was not communicating at all, yet part of the score shows her as 'orientated in person, space and time'. There may be a simple explanation for this, but the point is that the records should not need explaining to this extent.

The Board told the Investigator that the chemicals in Mrs A's blood were 'very closely observed'. However, we note that no blood samples were taken after 24 October until 29 October 2007. We would not describe this as 'very closely observed'. The result of the blood test on 29 October 2007, which almost certainly indicated dehydration, was not seen until the next day. Had blood samples been taken more regularly, they may well have indicated developing dehydration and, probably, infection at an earlier point, which means that both might have been attended to at an earlier point. We do not consider that the Board's response to the Investigator about this at all adequately addressed this point, and, therefore, it remains a concern.

In short, there were various lapses in medical and nursing care, oxygenation and blood taking and inadequate recording in the doctors' notes about clinical situations. Note: there is no criticism of the nursing notes [see paragraph 7].

The Investigator invited the Board to explain any action they had taken in respect of any shortcomings, and it is disappointing that it took a further letter from the Investigator to prompt a response on this, from which we quote below:

> 'Other actions have since been initiated to try to prevent other shortcomings identified by [Ms C]'s complaint. These have included two separate meetings with all the senior staff nurses advising them of the concerns relating to night time monitoring and reminding them of their responsibility in ensuring 24 hour monitoring of seriously ill patients … I do indeed wish to apologise to the family for any omissions in the care of their mother that caused them any unnecessary distress or anxiety. I would also seek to reassure [Ms C] that her concerns have been taken very seriously and that action has been taken to prevent any such omissions in the future'.

This is welcome'.

(a) Conclusion

9. As stated at paragraph 3, I was assisted in this investigation by the Advisers, whose role was to explain and comment on Mrs A's care. I accept their advice, and it follows that I accept their criticisms of the Board. The action that the Board told me they had taken is very welcome. However, the Ombudsman is clear that it needs to go further. For example, by focusing on nursing issues, the Board's actions do not take account of the medical issues, ie those involving the doctors. The Ombudsman also considers good record-keeping to be important, and this complaint has shown that, without clear, detailed, records, it is difficult to get a clear picture - not just a picture of what was done or not done but a picture of the reasons. I also cover record-keeping under complaint (b). In respect of complaint handling, I have to say that phrases such as '[Mrs A]'s vital signs were monitored regularly until the time of her death' in correspondence with Ms C were unacceptably inaccurate. And paragraph 8 outlines areas where the Board did not respond to points in my correspondence and where they made statements that were unsupported by evidence. As well as inaccuracies, parts of the Board's complaint correspondence came across as rather defensive and evasive. The Ombudsman has, therefore, also included recommendations about record-keeping and complaint handling. In all the circumstances, I uphold complaint (a).

(a) Recommendations

10. The Ombudsman recommends that the Board:

(vii) apologise direct to Ms C for the shortcomings identified in this report;

(i) reflect on the medical lessons to be learnt from this case and consider appropriate action;

(ii) ensure that, in future, they are able to evidence patients' fluid levels, by retaining, for example, a record of daily fluid totals for a year after the event, in case needed;

(iii) consider how to improve the record-keeping, including notes of discussions with patients and families, of medical staff in the ward in question, and take action accordingly;

(iv) consider any need for a wider audit of medical record-keeping; and

(v) reflect on the criticisms about complaint handling and consider appropriate action.

(b) Communication with the family was inadequate

11. Ms C had concerns about doctors' communication with the family, which included concerns that: on many occasions, the family asked nursing staff if they could see a doctor, but nothing happened; they were not told of changes in Mrs A's condition, such as low blood pressure; and, although a junior doctor said that Mrs A would not survive, the Consultant phrased the prognosis as a 'wait and see' situation, rather than a 'likely to die' situation, and such conflicting advice was distressing. The Board gave a different account of the communication issues. For example, they said that the Consultant had advised the family that Mrs A was likely to die. I note here that the Consultant said he had not spoken with Ms C herself, only with other family members. The Board also explained that, beyond the initial discussion with the Consultant, the family had not been told of changes in Mrs A's condition because it was, by and large, stable, and added that there was no record of any request by the family to discuss Mrs A's condition with a senior doctor.

12. The Board told Ms C that it was clear that communication had not been of a standard which the family considered satisfactory and that the Consultant and his team would try to improve this. In a letter to me, the Board said that the Consultant had undertaken to reflect on the case and make every effort to improve communication and that, at recent study days for staff nurses, a session on communication with families following head injury had been included.

13. I note that there are virtually no references to the family in the clinical records and that those which are there are extremely brief – for example, one on 17 October 2007, saying, '[patient] seen with son'.

(b) Conclusion

14. I have to say that it is simply not possible to know what discussions were held with Ms C's family. I note that the Consultant said he spoke with other family members, rather than Ms C. I have no reason to doubt this, but the point is that no discussions are documented in the records. Ms C and the Board have given conflicting accounts about the communication, and there is simply no evidence to show what did happen. It is welcome that the Board have acknowledged that there was room for improvement and identified appropriate action by medical and nursing staff. That is a constructive and satisfactory outcome to complaint (b). However, as I have said in the conclusion for complaint (a), the Ombudsman takes record-keeping seriously. This includes

the documenting of discussions with families. Therefore, although my conclusion on complaint (b) has to be that I can make no finding about the standard of communication, the Ombudsman has made recommendations (see paragraph 10) about record-keeping in relation to such discussions.

15. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mrs A	The complainant's mother
The Hospital	Aberdeen Royal Infirmary
The Board	Grampian NHS Board
The Advisers	Clinical advisers to the Ombudsman
The Consultant	The consultant neurosurgeon