Scottish Parliament Region: Central Scotland

Case 200702704: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Miss C) raised a number of concerns regarding the treatment her late mother (Mrs A) received at Wishaw General Hospital (the Hospital). Miss C was unhappy with the level of nursing care which Mrs A received, specifically in relation to a fall she suffered in the early hours of the morning following her admission. Miss C also raised concerns regarding numerous cancellations of the proposed surgery to address damage suffered to Mrs A's femur during her fall.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the standard of nursing care provided was inadequate (*upheld*); and

(b) the decisions to cancel surgery were unreasonable (*not upheld*).

Redress and recommendations

The Ombudsman recommends that Lanarkshire NHS Board (the Board):

(i) undertake an urgent investigation into the nursing staff's failure to follow the correct procedure when administering a controlled substance;

(ii) implement an action to address the failure to assess Mrs A's pain, using the Modified Early Warning System tool;

(iii) implement a formal bed move policy which restricts any avoidable movement of vulnerable patients;

(iv) clarify their policy on nursing confused patients, providing a copy of a relevant risk assessment for patients' mental capacity, along with an appropriate nursing action plan, to be adopted following a diagnosis of confusion;

(v) remind staff of the importance of frequent vital observations, particularly after incidents where patients have sustained head injuries;

(vi) remind staff of the importance of fully completing all significant documentation, paying particular attention to the omissions identified in this report;

(vii) apologise to Miss C for the failings which have been identified in this report; and

(viii) ensure that a proper multi-disciplinary approach to patient care is in place and seen to be effective.

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

Main Investigation Report

Introduction

1. On 28 January 2008 the Ombudsman received a complaint from a woman (referred to in this report as Miss C) regarding the treatment her late mother (Mrs A) received at Wishaw General Hospital (the Hospital). Miss C is unhappy with aspects of the nursing care which Mrs A received, specifically in relation to a fall she suffered during the night of her admission. Miss C also raised concerns regarding numerous cancellations of proposed surgery to address damage suffered to Mrs A's femur during her fall. She complained to Lanarkshire NHS Board (the Board) but remained dissatisfied with the outcome and, subsequently, complained to the Ombudsman.

2. The complaints which have been investigated are that:

(a) the standard of nursing care provided was inadequate; and

(b) the decisions to cancel surgery were unreasonable.

Investigation

3. In writing this report I have had access to Mrs A's clinical records and the complaints correspondence with the Board. In addition, I obtained advice from one of the Ombudsman's professional nursing advisers (Adviser 1) and one of the Ombudsman's professional medical advisers (Adviser 2).

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of terms is at Annex 2. Miss C and the Board were given an opportunity to comment on a draft of this report.

Background

5. On 19 February 2007, Mrs A was admitted to the Emergency Care Unit (ECU) of the Hospital with a chest infection, however, in the early hours of 20 February 2007, she suffered a fall and sustained a fractured femur. As a result, surgery was planned to address this injury but, sadly, Mrs A's condition deteriorated during her stay and she passed away on 2 March 2007.

6. Miss C raised her concerns with staff immediately after Mrs A's fall and asked that an 'official enquiry' be carried out. The Board responded on 5 April 2007 and provided copies of statements made by nursing staff who were

on duty at the time of Mrs A's fall. On the basis of these statements, the Board concluded that the fall appeared to have been an unfortunate accident and they did not propose to take any further action. Following this, Miss C requested a meeting with senior staff to discuss her concerns, however, two proposed meetings had to be cancelled, initially by Miss C and latterly by the Board, and Miss C subsequently chose to put her concerns in writing in a letter dated 8 September 2007.

(a) The standard of nursing care provided was inadequate

7. In her letter, Miss C voiced her concerns over the standard of nursing care provided to Mrs A and she stated that Mrs A 'experienced stress, lack of what [Miss C] would deem as basic nursing care, and on her first night of her hospital stay she fell resulting in a broken femur'. She advised that Mrs A was 89 years old, and in a frail state at the time of her admission, and she did not feel that nursing staff provided her with the 'safe, comfortable and secure environment' she required.

8. In their response of 26 September 2007, the Board advised that, following her admission, Mrs A received a detailed assessment by both medical and nursing staff and a comprehensive management plan was commenced. They stated that this included a falls assessment which identified Mrs A as being at high risk and measures were, therefore, taken which included adjusting the height of Mrs A's bed, the cot sides being put in place, the call buzzer being placed beside her, and her bed being situated close to the nursing station for observation. The Board advised that an assessment by a falls nurse was carried out on 21 February 2007 and these measures, which had already been put in place, were recommended as a result.

9. The Board then noted that Mrs A had been restless, confused and agitated and that she had made several attempts to climb over the cot sides. They advised that she had been found sitting at the end of her bed at 04:20 on 20 February 2007 and was assisted back into bed, however, a noise was heard from the room at 04:30 and Mrs A was found lying on the floor. She was bleeding from a tear on her right arm and from two areas on her left forehead and an x-ray, organised by the on-call doctor, confirmed the fracture to her femur. The Board advised that, in line with normal hospital policy, a clinical incident form was completed and logged on their computer system and statements were collected from the staff on duty. They recognised Miss C's

concerns that the level of nursing care contributed to Mrs A's fall but they concluded that this did not appear to have been the case.

10. The Board also noted that, following Mrs A's fall, Miss C raised her concerns with both the Charge Nurse on ECU (the Charge Nurse) and the Consultant Physician responsible for Mrs A's care (the Consultant Physician) and full explanations of Mrs A's management of care were provided, along with apologies for the fall.

11. Miss C was not satisfied with the Board's response and, in a further letter dated 17 October 2007, she advised that Mrs A had extremely restricted physical movements and Miss C was, therefore, of the opinion that Mrs A would not have been able to climb over the cot sides. In addition, Miss C did not believe that Mrs A would have had the ability to use the call buzzer. Miss C expressed her family's disagreement with the Board's view that the fall had been an unfortunate accident and the family's view that Mrs A's care had fallen below acceptable standards. Miss C stated that she did not believe the information contained in the records reflected the actual circumstances and she did not consider that valid explanations had been provided.

12. In the Board's response of 12 November 2007, they advised that the nursing staff had recorded that Mrs A had climbed from the erected bed rails and that she had attempted to do so on several occasions on the night of her fall. They acknowledged Mrs A's frail and poor condition, but confirmed that the incidents had indeed taken place. They also agreed that Mrs A might have had difficulty using the buzzer, however, they advised that she was still undergoing an assessment following her recent admission and they had a duty to provide the nurse call system, which is used in conjunction with observations by nursing staff, to all patients. They expressed their regret that Miss C felt the incident was more than an unfortunate accident, however, they stated that there was no evidence available to suggest otherwise. Finally, the Board offered to rearrange the previously cancelled meeting and they noted that face-to-face meetings could be beneficial in such situations. Miss C did not take up the offer of a face-to-face meeting.

13. Miss C then raised her concerns with the Ombudsman in a letter dated 25 January 2008. She reiterated details of Mrs A's fall and stated that the injury she sustained had 'hugely impacted on her overall medical condition and necessitated a course of action much different from that which should have

ensued for the condition [with which] she was initially admitted'. She stated that the Board's investigation had left a number of unanswered questions.

14. I sought advice from Adviser 1 who noted that Mrs A had been admitted to the Hospital on the advice of her GP. She observed that Mrs A had lived alone and had a history of increasing frailty and confusion and that she had suffered a fall at home in which she sustained a cut to the front of her lower leg. Adviser 1 also noted Mrs A's fall following her admission, and advised that she had sustained a hip fracture, cuts to her left eyebrow and cheek and a cut to her right forearm. She advised that, during the following eight days, Mrs A was moved a further four times to different wards and that she, sadly, passed away on 2 March 2007. In commenting on the draft report, Miss C advised that the records were incorrect and that she has always lived with Mrs A.

15. After reviewing the notes, Adviser 1 observed that the multi-disciplinary record of patient assessment, completed at the time of admission, indicated that a Waterlow score (see Annex 2) was carried out and recorded as falling into the high risk area. Adviser 1 noted that fairly regular assessments of risk were carried out until 28 February 2007, however, Adviser 1 also commented that there was a poorer indication of what actions had been taken when risk areas were identified. Adviser 1 also noted that, upon admission to the ECU, a Modified Early Warning System (MEWS) chart was commenced with a record of vital signs, but that these were only recorded once, prior to the fall. In addition, a Patient Handling Assessment Mobility chart, which indicated a requirement for support for Mrs A's basic needs, was completed between 19 February 2007 and 28 February 2007.

16. Adviser 1 observed that Mrs A was being cared for with bed rails in position to prevent her from falling out of bed, however, she noted that there was no risk assessment carried out relating to the use of side rails and whether they were suitable for a confused patient. Adviser 1 advised that it was difficult to tell from the records how closely Mrs A was being visually monitored and she noted that the statements from the nursing staff had indicated that she had been restless and noisy. Adviser 1 then noted that the MEWS chart indicated that Mrs A was confused when observations were recorded between 19 February 2007 and 22 February 2007. Adviser 1 advised that a second chart had been commenced following the fall which recorded vital signs and neurological observations, however, she noted that these observations were carried out at four to six hourly intervals and she would have expected these to

have been carried out more frequently. After such a fall, Adviser 1 expected vital observations to have been rigorously carried out and recorded at least one hourly, for four hours, particularly given that Mrs A had suffered cuts to her head. Adviser 1 also noted that the observation chart showed a marked variation in blood pressure, particularly the pulse, from that recorded on admission, but no comment was made in the records relating to this.

17. Adviser 1 then raised her concerns regarding the administering of Morphine to Mrs A on the morning of 20 February 2007. Adviser 1 noted that both medical and nursing entries advised that Mrs A had been given 2.5mg of Morphine but she was unable to find the corresponding prescription for this medication. Adviser 1 did note that an 'as required' prescription for Morphine was included, however, the first dose was recorded as being given on the evening of 20 February 2007 and the morning dosage was not accounted for.

18. Further observations by Adviser 1 indicated that a falls risk assessment was completed on 20 February 2007 showing that Mrs A was at high risk from falls and a falls care plan was started on 21 February 2007 but no further evaluation was evident after this. In addition, there was no evidence of an incident form in the records or a note indicating that one had been completed. Adviser 1 stated that there appeared to have been a general absence of monitoring care while Mrs A was a patient on the Medical High Dependency Unit (MHDU), for example, a Patient Handling Assessment was not completed for this period. She did note that a Patient Handling Assessment: Mobility Chart had been commenced on 19 February 2007, and that this had been partially completed from then until 28 February 2007. She suggested that this may be related to the absence of completion of charts whilst Mrs A was a patient in MHDU. In this regard, Adviser 1 noted that the only care plans in the records in respect of Mrs A's time in MHDU had fairly limited information and no evaluation. In commenting on the draft report, the Board stated their view that incident reports did not form part of the clinical record, however, they acknowledged that staff should record in the clinical record the fact that an incident had taken place and an incident report form had been completed.

19. Adviser 1 noted that there was a record of management of pressure ulcers which provided a reasonable view of the treatment plan. This record began with assessments on 20 February 2007 and 28 February 2007, however, this was not continued after the latter date. Adviser 1 advised that the record showed indications of a weeping area on Mrs A's left elbow. She wondered whether this

was the site of an intravenous infusion (see Annex 2) and she noted that there was no chart to show observation of the infusion site on a regular basis. Adviser 1 also noted that intravenous infusion charts were in place, along with some records of oral intake and output, but that these were not regularly completed on a daily basis. In commenting on the draft report, Miss C stated that the weeping area was not near the site of the intravenous infusion.

20. Adviser 1 concluded that the Hospital had a great many excellent documents in place which, if used fully, would have given a much clearer picture of the regular care that was delivered. She suggested that an assessment of the need and safety in providing bed rails, a position where Mrs A could be safely monitored and closer observation of her vital signs on the night of 19 February 2007 may have gone some way to preventing the fall. Adviser 1 did acknowledge that there appeared to be some very good nursing entries but that there were also some very poor entries and many gaps, none of which contributed to reasonable or optimum patient care. She noted that risk assessments which should have been carried out on admission, such as a falls risk assessment, were not carried out until after the incident occurred and she expressed her disappointment with this. She also noted that there was a failure to document how the needs of a dying patient, and the emotional needs of the family, were being met.

21. After receiving and considering Adviser 1's comments, I asked the Board to provide some further information. With regards to their policy for risk assessing the use of bed rails, they advised that there was no such policy in place at the time of Mrs A's fall. However, they provided a copy of their Bedrail Policy which had been developed with the support of three acute hospital Falls Prevention Groups and was in the process of being implemented. They advised that these Falls Prevention Groups were each chaired by a Senior Nurse and that an audit of their Falls Risk Assessment Score for the Elderly (FRASE) tool had been carried out in May 2008 as part of their considerations. In addition, the Board advised that, in response to the results of the audit, wards would now be required to demonstrate that they have undertaken an audit of five patients per month in relation to falls assessments.

22. The Board advised that Mrs A was nursed in Room 6 in the ECU which was a six-bedded room next to the nurses' station and close to the reception area. They stated that this was the centre of the ward and the area with the greatest of observation.

23. With regards to the Morphine prescription on the morning of 20 February 2007, the Board advised that there was no separate prescription chart for this. However, they provided a copy of the controlled drugs register for the ECU which included an entry indicating that, at 05:00 on this date, two nurses documented taking the Morphine for Mrs A from the controlled drugs cupboard. They stated that the Morphine was prescribed but, in the absence of another prescription chart, they assumed that the nurses had given it but had not signed for having done so. They suggested that the prescription may have been authorised over the telephone, however, they acknowledged that this would also have required documentation. They advised that the Senior Nurse for Medicine was dealing with this with the Senior Charge Nurse. In addition, they noted, with disappointment, that there were no entries in the MEWS chart for a pain score during Mrs A's time in ECU and they advised that this was also being addressed by the Senior Nurses.

24. Finally, the Board advised that they did not have a policy in relation to the number of moves between wards for an elderly confused patient. They recognised that such moves could contribute to further confusion, however, they stated that moves were often dictated by the patient's clinical condition or other pressure on beds and there may be no alternative. In Mrs A's case, they advised that she was transferred from Accident and Emergency to ECU, where patients generally remain for a maximum of two days. After this, they advised that she would have been transferred to a medical specialty ward but her condition deteriorated and she was moved to MHDU as she required increased respiratory support. They further advised that Ward 4 was the step-down ward from MHDU (see Annex 2), primarily a cardiac ward, and, from there, Mrs A was transferred to Ward 7, a respiratory ward, to better meet her clinical needs. They stated that all wards in the Hospital were of the same layout and that remaining in the same ward for an extended period of time would not have meant that care would have been delivered by the same staff members due to turnaround and shift patterns.

25. I let Adviser 1 see the Board's comments. She commented positively on the Board's actions in relation to their new Bedrail Policy. She stated that it was a very well thought through, well referenced, policy developed by a senior group of nursing staff and she was pleased to note that it was being implemented across three hospitals. She also positively noted the Board's undertaking to

carry out five audits per month in relation to falls assessments and she stated that it was clear that the Board had taken this aspect of the complaint seriously.

26. Adviser 1 expressed disappointment that the Board had not used the opportunity to clarify their policy on nursing confused patients by providing a copy of the risk assessments the Hospital would use to assess a patient's mental capacity, or the actions that may be taken by nursing staff to care for a patient once a diagnosis of confusion had been made.

27. Adviser 1 also expressed disappointment that the Board had failed to provide a Bed Policy for the hospital, which included restricting the movement of vulnerable patients unless absolutely necessary. She acknowledged the Board's comments relating to clinical need and ward layout, however, she advised that it is generally the staff changes which can cause the most disruption to elderly patients, particularly those who are bed bound and confused. She suggested that, in instances such as Mrs A's, where there have been so many moves, it should have been well documented in the nursing record how this was managed for the patient and how this was communicated to the family.

28. Finally, Adviser 1 was very critical of the failures of nursing staff to follow the correct procedure when administering a controlled substance. She noted that an error was committed when the dose of Morphine was documented in the controlled drug register but not written up as a prescription on her treatment chart. She stated that, at no time, other than in an emergency situation, should controlled drugs be administered without being entered on a clearly written medical prescription chart. With regards to the Board's indication that the Senior Nurse for Medicine and the Senior Charge Nurse would be dealing with this, she stated that this was not appropriate action and she expressed disappointment that the Board had not taken further action to investigate this occurrence. In addition, she noted the Board's recognition of a failure to assess Mrs A's pain using the MEWS tool and she questioned whether the Board would be implementing an action to deal with this omission.

29. In criticising the recording of the administering of Morphine, Adviser 1 also criticised a failure to record the Morphine given to Mrs A on 22 February 2007 and 23 February 2007 on the controlled drug register. However, I checked this matter with the Board and they provided evidence that this had indeed been done. The Board explained that each ward had their own controlled drug

register and they had previously only sent me the register from ECU for 20 February 2007. As Mrs A had been transferred, separate registers were held from the wards in which she was being managed on the later dates, and the Board provided a copy of those registers.

(a) Conclusion

30. The professional advice which I have taken has identified failures in the standard of nursing care provided to Mrs A and I accept this advice. The advice received has also highlighted several failures in the recording of the care provided.

31. The major area of concern relates to the administering of controlled substances and the failure to write up an episode of Morphine provision on a medical prescription chart. The Board have acknowledged this failure, however, their response to this was non-specific and disappointing. Adviser 1 has also expressed disappointment at the Board's non-specific response to the acknowledged failure to assess Mrs A's pain, using the MEWS tool, and it would be appropriate for the Board to implement a more detailed action to address this omission.

32. A further area for concern was identified in relation to the number of bed moves Mrs A experienced during her time in the Hospital and the Board's lack of policy regarding the movement between wards of elderly/vulnerable patients. Adviser 1 has suggested that, where so many moves are absolutely necessary, the management of this and corresponding communication with the family should be well documented. Adviser 1 also raised further concern regarding the Board's failure to provide clarity on their procedure for nursing confused patients.

33. In addition, the decision was taken to care for Mrs A using bed rails, however, no risk assessment was carried out in this regard. My investigation identified that the Board did not have a process in place relating to this, however, they have since proposed a detailed Bedrail Policy for implementation and I would commend them for this.

34. Adviser 1 was also critical of the nursing staff's observation of Mrs A's vital signs. She has noted that vital signs were recorded in the MEWS chart only once prior to Mrs A's fall and that, following the fall, vital observations were not carried out with sufficient rigour. Additionally, Adviser 1 noted several failures to

properly document the care being provided, including the absence of records of monitoring care provided in MHDU, lack of comment relating to a variation in Mrs A's blood pressure and the failure to complete intravenous infusion charts and records of oral intake/output on a regular basis. She also noted the lack of evidence of a continued management plan for pressure ulcers as well as the omission from the records of an incident report relating to the fall. The advice concluded that, whilst the Board have many excellent documents in place, the failure to fully and properly complete these did not contribute to optimum patient care. Adviser 1 also noted a general failure to document how the needs of a dying patient, and the emotional needs of the family, were being met.

35. Taking all this into account, I accept the advice which I have been given and conclude that the standard of nursing care provided to Mrs A was inadequate. I, therefore, uphold this complaint.

(a) Recommendations

36. The Ombudsman recommends that the Board:

(i) undertake an urgent investigation into the nursing staff's failure to follow the correct procedure when administering a controlled substance;

(ii) implement an action to address the failure to assess Mrs A's pain, using the MEWS tool;

(iii) implement a formal bed move policy which restricts any avoidable movement of vulnerable patients;

(iv) clarify their policy on nursing confused patients, providing a copy of a relevant risk assessment for patients' mental capacity, along with an appropriate nursing action plan, to be adopted following a diagnosis of confusion;

(v) remind staff of the importance of frequent vital observations, particularly after incidents where patients have sustained head injuries;

(vi) remind staff of the importance of fully completing all significant documentation, paying particular attention to the omissions identified in this report;

(vii) apologise to Miss C for the failings which have been identified in this report.

(b) The decisions to cancel surgery were unreasonable

37. In her letter to the Board of 11 June 2007, Miss C voiced her concerns regarding the 'untimely cancellation of surgery on three occasions due to theatre having full schedule'. However, due to the meeting cancellations, this

concern was not addressed and Miss C did not raise this specific concern in her subsequent letters to the Board. The issue was next raised in Miss C's letter to the Ombudsman in which she advised that, during Mrs A's stay in hospital, she had been put on the theatre waiting list several times for surgery on her broken femur and on each occasion this had been cancelled. In their letter to the Ombudsman of 12 May 2008, the Board apologised for not realising that Miss C still required a response to her concerns regarding the cancellation of surgery. They confirmed that their letter of 26 September 2007 had focussed on responding to the issues raised in Miss C's letter of 8 September 2007.

38. The Board advised that Mrs A's surgery had initially been planned for 20 February 2007 but that this had subsequently been cancelled and they stated that they had regretfully been unable to establish the reason for this. They speculated that it was possible that she could not be taken within the time available as patients are taken according to clinical priority and they advised that this cancellation was within clinical guidelines which allow a 48 hour target. They then advised that the nursing notes indicated that Mrs A was to be fasted from midnight on 20 February 2007 for theatre the next morning, but this surgery was again cancelled, with no reason given. However, upon reviewing the medical notes, the Board stated that this appeared to have been as a result of her poor clinical condition.

39. The Board then noted that there was an entry in the medical notes which indicated that Mrs A was not fit for theatre on 22 February 2007, and a further orthopaedic review in relation to surgery on 23 February 2007, described her prognosis as 'poor' and 'guarded'. They then noted that she was deemed 'not fit for surgery' on 24 February 2007 and her condition had remained unchanged the following day. The Board advised that a decision was then taken to fast Mrs A for theatre from midnight on 27 February 2007, pending an anaesthetic review, which was carried out on 1 March 2007. This review deemed Mrs A unfit for theatre on that day and the Board advised that the decision had been discussed with Miss C's sister. Finally, the Board noted that Mrs A was reviewed by a Consultant Anaesthetist on 2 March 2007 and deemed unfit for theatre, which was discussed with Miss C. They advised that the medical records suggested there had been discussion between staff and Mrs A's family at various points, but they offered their apologies if the management plan was not adequately explained to the family.

40. I sought advice regarding this issue from Adviser 2 who examined the medical records and noted that Mrs A had a history of Chronic Obstructive Pulmonary Disease (see Annex 2). He advised that, upon admission, Mrs A had a slight fever and her blood oxygen saturation breathing air was below normal. In addition, she was considered to be dehydrated and there were abnormal sounds evident on listening to her lungs. Adviser 2 then noted that Mrs A was reviewed by an orthopaedic registrar following her fall, however, he observed that this assessment of Mrs A was inaccurate in that the registrar failed to spot that her oxygen levels on air were abnormal. In commenting on the subsequent cancellation of the proposed surgery, Adviser 2 noted that no clear reason was noted for this, however, he advised that it had been felt that Mrs A was suffering from pneumonia on top of her COPD and that she was confused. He advised that surgery, unless thought to be lifesaving, would have been extremely hazardous under those conditions and he believed that would have been the reason for the cancellation. He commented that, even if that was not the reason, the decision to cancel surgery was, in his view, the correct one.

41. Adviser 2 then noted that an x-ray on 21 February 2007 confirmed an infection in Mrs A's right upper lung and blood oxygenation remained below normal. He advised that Mrs A had also required some mechanical assistance with ventilation but she had not tolerated this well. He observed that those types of problems continued for the next few days and, in addition, it was thought that Mrs A had possibly developed heart failure on 24 February 2007. He stated that those problems would all have indicated against surgery.

42. The nursing notes for 26 February 2007 indicated that surgery was reconsidered and Adviser 2 noted that an anaesthetic review had been requested before a decision would be made and Miss C's brother was brought up-to-date. He then noted that, the following day, Mrs A was reviewed by an orthopaedic registrar who noted that she was still confused and that her oxygenation level remained low. Despite this, however, Adviser 2 noted that another provisional plan was made for surgery the next again day, pending anaesthetic review.

43. On 28 February 2007, Adviser 2 noted that Mrs A's chest x-ray showed some resolution of pneumonia but that her oxygen saturation remained low. He advised that there was another decision not to operate but also a repetition of the view that surgery could take place the following day depending on the anaesthetic review. He then noted that surgery was again decided against the

next day, but Mrs A was to continue to fast with surgery in mind. Adviser 2 observed that the notes from 2 March 2007 recorded a discussion with Miss C which indicated that she did not feel that her mother was fit for theatre.

44. Adviser 2 concluded that, from a medical point of view, it would have been inappropriate to have operated on a patient with pneumonia superimposed on chronic lung disease. He advised that nine days after admission the infection had not fully resolved and blood oxygenation had remained abnormal. He stated that this abnormality may have been due to the long-standing lung disease but that it may also have been worse than usual as a result of the new acute infection. In the circumstances, Adviser 2 believed the decision not to operate was correct, and he noted that there were also times when Mrs A's family were not in favour of surgery. He pointed out that, although Mrs A was fasted several times in preparation for potential surgery, she was maintained on intravenous fluids throughout her admission and dehydration was, therefore, avoided.

45. Despite his agreement with the decision not to operate, Adviser 2 was critical of the lack of clarity exhibited by, and between, the various teams dealing with Mrs A's care. He stated that the medical, surgical and anaesthetic teams should have made a much clearer decision at an earlier stage and that there should have been a clear statement for the reason for the initial surgery cancellation along with a plan for the future. He suggested that a clear statement could have been put in the notes indicating that surgery would be contemplated when Mrs A's medical condition allowed, depending on control of infection, the appearance of the chest x-ray and level of blood oxygenation. Adviser 2 considered that this type of instruction would have made it possible for the nursing and ward medical staff to be quite clear about whether and when surgery was possible, allowing them to provide Mrs A's family with a much clearer picture. Without such clarity concerning the parameters under which surgery could take place, Adviser 2 noted that an almost daily 'on-off' situation occurred regarding an operation, He stated that he did not believe this to have contributed to the sad outcome but that, nevertheless, it should have been avoided.

46. Adviser 2, therefore, recommended that the Board be asked to ensure that a proper multi-disciplinary approach to patient care is put in place and seen to be effective, particularly where there is an overlap between medical and surgical conditions. He suggested that this approach should translate into a

clear plan for a patient which should be known to all staff and be communicable to the patient and/or family.

(b) Conclusion

47. Again, I am guided with the advice which I have received and, given Adviser 2's opinion that it would not have been appropriate to operate on Mrs A, I conclude that the decisions to cancel surgery were appropriate. I, therefore, do not uphold this complaint.

48. However, notwithstanding this, the medical advice is critical of the lack of clarity displayed between the various teams responsible for Mrs A's care and treatment. This lack of clarity resulted in an ongoing confusion as to whether surgery would take place and I recognise that this would not have made things any easier for Mrs A's family. If more clarity had been displayed following the initial cancellation, and better note-keeping observed, a more definitive plan could have been put in place and outlined to Mrs A's family. I, therefore, recommend that the Board take steps to avoid a similar future recurrence.

(b) Recommendation

49. The Ombudsman recommends that the Board ensure that a proper multi-disciplinary approach to patient care is in place and seen to be effective, as per Adviser 2's comments in paragraph 46.

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

Annex 1

Explanation of abbreviations used

Miss C	The complainant
Mrs A	The complainant's late mother
The Hospital	Wishaw General Hospital
The Board	Lanarkshire NHS Board
Adviser 1	One of the Ombudsman's professional nursing advisers
Adviser 2	One of the Ombudsman's professional medical advisers
ECU	Emergency Care Unit
The Charge Nurse	The Charge Nurse on ECU
The Consultant Physician	The Consultant Physician responsible for Mrs A's care
MEWS	Modified Early Warning System
MHDU	Medical High Dependency Unit
FRASE	Falls Risk Assessment Score for the Elderly
COPD	Chronic Obstructive Pulmonary Disease

Annex 2

Glossary of terms

Pre-tibial laceration	Cut to the front of the lower leg
Waterlow score	A tool which helps determine the level of risk there is to a patient developing pressure sores
Intavenous Infusion	The provision of medication into a patients vein over a prolonged period of time
Chronic Obstructive Pulmonary Disease (COPD)	Term used to describe a variety of illnesses which damage the lungs and create breathing difficulties
Step-down ward	Transitional ward, prior to transfer to general ward, when patient requires less intensive care than provided in MHDU.