Scottish Parliament Region: North East Scotland

Case 200802400: Tayside NHS Board

Summary of Investigation

Category
Health: Hospital; clinical treatment; pre-operative and post-operative care, people with learning difficulties

Overview
Mr C complained about the level of care provided to his daughter, Miss C, prior to her death in Ninewells Hospital, Dundee (the Hospital), on 1 April 2008. Miss C suffered from myotonic dystrophy, a condition in which generalised muscle weakness can be accompanied by a variety of other conditions, which in Miss C's case included learning difficulties. Miss C was admitted to the Hospital on 31 March 2008 for surgery on her parotid gland. Pre-operatively, she did not receive a formal assessment by a consultant anaesthetist. Post-operatively she was returned to the ward, where her initial observations included a period of low blood pressure. She was left to sleep overnight. Her vital signs were not recorded and she was not disturbed in the morning during a post-operative ward round. She was subsequently found to be unresponsive at around 10:30 and a cardiac arrest call was made at 10:58; however, it was not possible to resuscitate her. Her death was recorded at 11:17 that morning.

Specific complaints and conclusions
The complaints which have been investigated are that:
(a) Miss C was not properly assessed at a formal pre-operative clinic prior to her surgery (*upheld*);
(b) the care and treatment Miss C received post-operatively was inadequate (*upheld*); and
(c) communications with Miss C's family were not appropriate (*upheld*).

Redress and recommendations
The Ombudsman recommends that Tayside NHS Board (the Board):
(i) review the current interface arrangements in place between the ENT and Anaesthesia departments, to gain assurance that adequate communication, planning and multi team working arrangements are now in

place with regard to pre-operative admissions; and advise him of the outcome of this review;

(ii) provide a copy of the appropriate action plans which specifically contain details of how the Board will implement and meet the relevant policies, including:

- NHS QIS quality indicators for people with learning difficulties (NHS QIS report 'Learning Disabilities' Quality Indicators February 2004)
- NHS QIS report 'Tackling Indifference', (Healthcare Services for People with Learning Disabilities. National Overview Report. December 2009);

(iii) provide a copy of their education and training strategy, including the specific requirement relating to patients with learning disabilities;

(iv) review and evaluate the current arrangements for pre-operative admission for people with learning disabilities and provide him with a report of the findings;

(v) confirm the specific action taken to clarify the terms 'special nursing' and 'routine monitoring' to avoid ambiguity over what level of nursing support is required when caring for people with learning difficulties;

(vi) provide assurance that policies and procedures are in place to ensure that the *Nursing and Midwifery Council* Code of Conduct and in particular the 'Guidance for record keeping' (2009) is implemented so that communication with patients' families is clear and unambiguous; and

(vii) provide an explicit, unambiguous and meaningful apology to Miss C's family for all the failings identified in this report, detailing the steps they have put into place to ensure that a similar occurrence is not repeated.

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

Main Investigation Report

Introduction

1. Miss C was a young woman of 28 years who suffered from myotonic dystrophy; she also had learning difficulties. She was admitted to Ninewells Hospital, Dundee (the Hospital), on 31 March 2008 and underwent a sub-total removal of her left parotid gland. Having been admitted on the day of her operation, she was not formally assessed by a senior anaesthetist pre-operatively.

2. Post-operatively Miss C was returned to the ward, where her initial observations included a period of low blood pressure. Her blood pressure was last recorded at 21:15 on the evening of 31 March 2008; thereafter she was not subject to any further recorded observations. She was left to sleep overnight and on the morning of 1 April 2008, when a routine post-operative ward round took place, she was not disturbed. She was subsequently found to be unresponsive at around 10:30 and a cardiac arrest call was made, however, it was not possible to resuscitate her. Her death was recorded at 11:17 on 1 April 2008.

3. The Post Mortem Examination Report (the Report) found that death was 'attributed primarily to dystrophia myotonica' and went on to say that 'it is well recognised that surgical intervention and the post-surgical period place physical and psychological stress upon the heart muscle which, in this case, might have been more vulnerable to the development of cardiac arrhythmias in the conduction system'.

4. In bringing his complaint to the Ombudsman in December 2008, Miss C's father (Mr C) raised concerns over several aspects of Miss C's care and treatment. He also raised a general concern regarding the care and treatment given to people with learning difficulties. He said 'all I know is that if she had not been in for what was a minor operation she would still be with us today'.

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

(a) Miss C was not properly assessed at a formal pre-operative clinic prior to her surgery;

(b) the care and treatment Miss C received post-operatively was inadequate; and

(c) communications with Miss C's family were not appropriate.

Investigation

6. In order to investigate this complaint, I reviewed all correspondence between Mr C and Tayside NHS Board (the Board), together with internal correspondence provided by the Board. I also considered Miss C's clinical records. Professional advice about the care and treatment provided to Miss C was obtained from the Ombudsman's independent medical adviser (Adviser 1) and independent nursing adviser (Adviser 2) and, where appropriate, has been reflected in the report. In addition, I considered the MENCAP report 'Death by Indifference'; the report 'Six lives: the provision of public services to people with learning difficulties' produced jointly by the Local Government Ombudsman (LGO) and the Parliamentary and Health Service Ombudsman (PHSO); and the NHS Quality Improvement Scotland (NHS QIS) report 'Tackling Indifference', (Healthcare Services for People with Learning Disabilities. National Overview Report December 2009). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on the factual accuracy of a draft of this report.

(a) Miss C was not properly assessed at a formal pre-operative clinic prior to her surgery

7. Mr C's complaint to the Ombudsman expressed concern about the Board's arrangements for Miss C to have a formal pre-operative anaesthetic assessment prior to her surgery.

8. In considering the events leading up to Miss C's operation, I found that she first attended the Ear, Nose and Throat (ENT) out-patients department on 22 January 2008 in connection with a 'left neck lump' which had been painful for some four months. It was noted that Miss C was frightened of doctors (except for her General Practitioner) and required reassurance from her family to allow herself to be examined.

9. Miss C was seen again a week later (on 30 January 2008) by the ENT surgeon (the Consultant Surgeon) who would subsequently operate on her. His clinical impression was that of a parotid lump, however, he noted that he was not able to examine Miss C's facial nerve function satisfactorily as she was not fully cooperative. He organised an urgent ultrasound investigation of the lump with a guided needle aspiration, however, this proved to be insufficient for diagnostic purposes.

10. On 29 February 2008 the Consultant Surgeon met with Miss C and her stepfather (Mr B). During the course of that consultation the Consultant Surgeon suggested that he should also meet with Miss C's mother (Mrs B) to discuss further management options, one of which was the surgical removal of the lump.

11. The Consultant Surgeon then met with Mrs B, Mr B and the Community Psychiatric Nurse for People with Learning Difficulties on 3 March 2008. Miss C's lump had become bigger and she was complaining of pain, especially after food. The Consultant Surgeon was informed that the family considered that surgery was appropriate and noted that this was what Miss C wanted. He, therefore, arranged for surgery to be completed on 31 March 2008.

12. In taking account of Miss C's fear of doctors, the Consultant Surgeon made special arrangements for her to be admitted to the Hospital on the day of her operation, as opposed to the day prior to her operation as would normally have been arranged. He did not, however, notify the anaesthesia service of this decision and, as a consequence, anaesthesia and perioperative care planning was adversely impacted; I will expand on this further in paragraph 16. Miss C was, therefore, admitted to the Hospital on 31 March 2008 at 10:00 for surgery planned for 12:30.

13. In the following paragraphs I will document my examination of the evidence in relation to the actions and comments of the key stakeholders involved in providing pre-operative care and treatment to Miss C, together with the advice received from Adviser 1.

The Consultant Anaesthetist

14. In responding to the Board on an internal request for information regarding Mr C's complaint, the anaesthetist with responsibility for Miss C (the Consultant Anaesthetist) said that patients with myotonia may have cardiac and respiratory problems. In Miss C's case, he said that the day of surgery admission did not allow assessment of these in detail; in particular, the opportunity for pre-operative assessment tests such as measures of respiratory function and electrocardiogram (ECG). He considered, however, that these tests may not have been feasible for Miss C, given her marked anxiety and likely distress.

15. The Consultant Anaesthetist had not received prior notification of Miss C's planned admission to the Hospital. He was working in the operating theatre all morning on the day of Miss C's admission, therefore, the pre-operative assessment was completed by a senior trainee anaesthetist. The Consultant Anaesthetist said that Miss C's myotonia and learning difficulties had been identified by the trainee anaesthetist.

16. The Consultant Anaesthetist acknowledged that there were deficiencies in the care provided to Miss C. In particular, while there was detailed surgical assessment and planning for Miss C, anaesthesia and perioperative care planning was limited, because she was admitted to the Hospital on the day of surgery and without prior anaesthesia notification and involvement. He said that the complexities of Miss C's combined myotonia and special needs would have benefited from a pre-operative referral and multi-disciplinary planning for her hospital stay.

17. He also noted, however, that in his opinion the way Miss C responded to surgery and anaesthesia did not indicate obvious cardiac or respiratory problems. There was no cardiovascular depression during surgery and she awoke and breathed clearly and without compromise at the end of her anaesthetic.

The Board's response to the complaint

18. Taking account of the Consultant Anaesthetist's comments, the Board responded to Mr C's complaint by explaining that Miss C did not have a full pre-operative anaesthetic assessment prior to surgery because she was admitted to the Hospital on the day of her operation and this did not allow a detailed assessment to take place.

19. The Board also said that that it was possible that some of the necessary tests may not have been feasible for Miss C, as they had caused her marked anxiety and distress in the past. However, the Board also acknowledged 'In retrospect, full assessment before surgery by all specialities would have been desirable'.

Adviser 1

20. I asked Adviser 1 to consider the Board's response to Mr C. He said that it was unacceptable that a patient with myotonia was not properly assessed by a

senior anaesthetist at a formal pre-operative clinic prior to elective surgery. He considered this to be a serious failing on behalf of the medical team.

21. I shared Adviser 1's response with the Board and asked for their comments. The Board acknowledged that Miss C should have received a formal pre-operative assessment by a consultant anaesthetist. They went on to say:

> 'It remains the case that preoperative anaesthetic assessment facilities are not available in Tayside, however would be desirable. In this particular case admission on the day of surgery did not allow sufficient time for adequate assessment and planning. However, [Miss C] did receive a detailed surgical assessment and decision making with regard to the surgery. Staff were fully aware of her anxiety and the desire on behalf of the family to limit the time she spent in [the Hospital], and for these reasons admission was delayed for as long as possible.'

22. In response to the Board's comments, Adviser 1 said that, where a patient with special needs required a pre-operative anaesthetic review, specific measures should be in place to ensure that this happened.

23. The Board subsequently explained that following the events of this case 'a Pre-operative Working Group, within the ENT speciality, has reviewed and identified documentation that will support pre-assessment management'. I was provided with copies of a new 'Anaesthetic Referral Form' and pathway guidance to help medical staff identify patients who require review by an anaesthetist. I was encouraged to note that this new guidance makes specific reference to patients with myotonia and learning difficulties.

(a) Conclusion

24. Normal practice would have been for Miss C to be admitted to the Hospital on the day before her operation, to allow for a formal pre-operative assessment to be completed. However, acting to mitigate Miss C's fear of doctors, the Consultant Surgeon arranged for her to be admitted to the Hospital on the day of her operation. Crucially, however, he failed to properly notify anaesthesia of Miss C's planned admission.

25. Unfortunately, with no provision being made for prior anaesthesia notification and involvement, the Consultant Anaesthetist, who was involved in surgery all morning on the day of Miss C's admission, was not available for the

pre-operative assessment which was, therefore, completed by a senior trainee anaesthetist.

26. Adviser 1 considered it to be unacceptable that Miss C was not properly assessed by a senior anaesthetist at a formal pre-operative clinic prior to surgery; indeed he said that this was a serious failing. The Board have subsequently acknowledged that Miss C should have received a formal pre-operative assessment by a consultant anaesthetist.

27. A further concern is the Consultant Anaesthetist's acknowledgement that Miss C's combined myotonia and special needs would have benefited from multi-disciplinary planning for her hospital stay; however, I found no evidence to suggest that any consideration was given to rescheduling or postponing Miss C's planned operation to allow for this coordinated planning to happen.

28. While Miss C's initial response to surgery and anaesthesia may not have indicated obvious cardiac or respiratory problems, I have noted that the Consultant Anaesthetist recognised that patients with myotonia may have cardiac and respiratory problems (see paragraph 14) and I have taken account of the Report which reflected that it is well known that surgical intervention and the post surgical period place physical and psychological stress upon the heart muscle. It remains unknown if a formal assessment by a senior anaesthetist at a pre-operative clinic prior to elective surgery would have resulted in a different outcome for Miss C.

29. The fact that Miss C was admitted to the Hospital on the day of her operation did not preclude a formal pre-operative assessment by a senior anaesthetist. Rather, it was the absence of any prior notification to the Consultant Anaesthetist, which did not allow for the proper anaesthesia planning required to meet Miss C's needs. I consider this breakdown in communication to be a significant contributory factor and I agree with Adviser 1's comment that a patient with myotonia not being properly assessed by a senior anaesthetist at a formal pre-operative assessment is a serious failing.

30. I conclude that process failures in terms of communication (by the Consultant Surgeon), cross team working and planning, leading to failings on the part of the Consultant Anaesthetist who was responsible and accountable for Miss C's formal pre-operative anaesthetic assessment, contributed to Miss C

not being properly assessed at a formal pre-operative clinic prior to her surgery. I therefore uphold this complaint.

(a) Recommendation

31. I have noted arrangements put in place by the Board as a result of this case, to support medical staff identifying patients who require review by an anaesthetist. In particular, I note that the guidance makes particular reference to patients with myotonia and learning difficulties.

32. The Ombudsman, therefore, recommends that the Board review the current interface arrangements in place between the ENT and Anaesthesia departments to gain assurance that adequate communication, planning and multi team working arrangements are now in place with regard to pre-operative admissions; and advise him of the outcome of this review.

(b) The care and treatment Miss C received post-operatively was inadequate

33. Mr C specifically raised the issue of inadequate post-operative care provided to Miss C in his complaint to the Board. In particular, he expressed concern that Miss C's blood pressure was not recorded throughout the night, despite her blood pressure having been recorded as low earlier in the evening. He also questioned why Miss C did not have a heart monitor post-operatively (as she had had for previous operations) and suggested that the Consultant Surgeon had sanctioned Miss C's discharge without actually speaking to her first.

34. In addition, Mr C said that another point of concern for the family was the decision to place Miss C in a side room following her operation, as opposed to being in the open ward. Mr C said 'we all feel that if she had been in view and had been monitored properly, she would still be with us today'.

35. I found that following her operation, and between 17:00 and 20:00 on 31 March 2008, Miss C's blood pressure was recorded on five occasions, with each observation being low. At 21:15 her blood pressure was again recorded and found to be normal.

36. The nursing records confirmed that her blood pressure was not checked again. I found that, although the 02:00 and 06:00 observations were scheduled, the chart contained no entries. The nursing records had an entry at 20:50

(31 March 2008) with no subsequent entry until 06:00 (1 April 2008). There was no explanation for the failure to complete the 02:00 observations, however, the 06:00 entry confirmed that blood pressure was not checked as Miss C was asleep.

37. In the following paragraphs I will document the evidence examined in relation to the actions and comments of the key stakeholders involved in providing post-operative care and treatment to Miss C, together with the advice received from Adviser 1 and Adviser 2.

The Consultant Surgeon

38. The Consultant Surgeon said:

> 'I requested that [Miss C] be placed in a side room and that she be "specially nursed". [Miss C]'s mother and stepfather [Mrs B and Mr B] informed me that [Miss C] did not like being in hospital and did not trust medical people she did not know. It is my usual practice to admit patients the day before the surgery however the family felt that this would not be ideal with [Miss C] due to her anxieties with hospitals and hence admission was organised for the morning of the operation. I felt placing her in a side room would help allay her anxieties and provide her family with the opportunity to stay with her as required.'

39. He went on to say:

> '[Mrs B and Mr B] also felt that [Miss C] could possibly be more disruptive, were they to stay the night with her. Hence I felt that in her case one to one nursing through the night in a side room would be appropriate. I requested that [Miss C] have "special nursing" through the night and I was assured that this would be done. I had made it clear in my instructions that the reason for this was to ensure that the nurses on the ward that night were not torn between [Miss C]'s unpredictable behavioural requirements and their other ward duties.'

40. In referring to his post-operative instructions, the Consultant Surgeon said 'I wrote and dictated an operative note. It is my usual practice to include the required post-operative instructions. In retrospect I can see that my note did not include the required post-operative observation instructions on this occasion and I apologise for this omission'. My examination of the medical records confirmed that neither the handwritten nor the dictated operative notes included the required post-operative observation instructions.

41. The Consultant Surgeon saw Miss C shortly after her operation. He informed her that the operation had gone well and that he would return the following morning to see her. He said that he was not contacted regarding any concerns with respect to Miss C thereafter or overnight. The following morning he was advised of her low blood pressure of the previous evening but that the last recording was normal. He was also told Miss C had had a late night, eventually settling at 01:30.

42. He confirmed that he saw Miss C at about 09:00 (on 1 April 2008). Having noted that he had met her on several occasions previously, he did not consider her to be more pale than usual. He said she was breathing and her wound site was healthy. He, therefore, made a clinical decision that all was fine, based on the nursing report of a late night, and considered that Miss C should be left to sleep a little longer. He said 'I was aware that the blood pressure had not been done at 02:00 and 06:00. However given the continued activity till the early hours of the morning and the fact that she was fine in my clinical judgement that morning I did not wake her up'.

43. He went on to say:

> 'no entry is made of my ward round for the morning of 1 April 2008 in the medical notes. [The Specialist Registrar] had seen her earlier that morning independent of me had made a note stating home later in the day. However the nursing notes do allude to my ward round at 09:00. It is my practice to see all my postoperative patients and to ascertain all is well before they are discharged home. As I had a busy cancer clinic that morning it was my intention to return as soon as the clinic was over to see [Miss C].'

The Consultant Anaesthetist

44. The Consultant Anaesthetist said that 'issues for postoperative care include monitoring and provision of analgesia, which are always important and in particular with [Miss C]'s combined conditions of myotonia and special needs/learning difficulties'. He said that he considered both of these issues as follows:

> 'special 1:1 nurse monitoring had been arranged and I assumed that this would entail the necessary postoperative monitoring. This special monitoring was arranged for [Miss C's] special needs issues rather than specifically for her medical issues and this lack of clarity I will return to. I

calculated that the quality of [Miss C's] initial recovery and indeed subsequent few hours of good recovery, with overnight “special” monitoring would be adequate.'

45. In relation to the use of opioids he went on to explain that he felt that Miss C's anxiety would benefit from such treatment. He took account of Miss C's history of difficulty with tablet swallowing and prescribed Co-codamol for ease of administration. He also prescribed oral morphine for breakthrough pain because of ease of administration and as additional analgesia, if required, expecting the need for this to be limited, if at all, but available as a back-up. He said that the last recorded analgesia for Miss C was at 22:00, with Miss C subsequently being awake for a further three hours, with no demonstration of any respiratory depression. He said 'we were attempting to manage [Miss C]'s postoperative care in a sympathetic fashion for monitoring and analgesia, acknowledging her anxieties'.

46. The Consultant Anaesthetist also noted that Miss C was:

'intolerant of postoperative oxygen, and some of the monitors and so it was felt by the nursing staff that blood pressure readings and saturation and ECG monitors should be left … There was I believe an attempt to minimise distress and upset for [Miss C] and to reduce the presence of physical monitoring. In particular the 02:00 and 06:00 recordings were omitted for this reason, although I cannot speak for the nursing staff. Clinical observation of being settled and sleeping and breathing comfortably were made.'

47. In relation to Miss C being placed in a side room, he explained that the side room was allocated for Miss C's comfort and avoidance of placement on a busy ward area, for Miss C's and other patients' benefit.

48. Regarding the question of a heart monitor, he said 'while it is true that patients would not routinely be monitored with heart monitors, someone with potential heart and respiratory problems would be monitored either in a 'specialising' ward environment or in a high dependency environment'.

The Clinical Team Manager

49. The Clinical Team Manager provided comments on behalf of the nursing staff. Referring to the 'Scottish Early Warning Score' chart (SEWS) (the SEWS

chart is a patient management tool used to record vital signs) she said that the nursing notes confirmed that Miss C was to have routine post-operative care.

50. She said that Miss C's vital signs were recorded at 17:00 (on her return to the ward), 17:30, 18:10, 19:00, 20:00 and 21:15. The recording at 20:00 indicated a SEWS score of 2, meaning the nurse in charge should be notified and hourly observations should follow. The following recording at 21:15 indicated a SEWS score of 0, which requires routine four hourly observations.

51. The Clinical Team Manager said that, following the change of staff at 21:30, Miss C was described as being alert and was eating and drinking. An additional member of untrained staff had been rostered onto the night shift to sit with Miss C to ensure that she did not become upset and that support was immediately available if she became anxious. She said that this member of staff was known to Miss C and her family and was comfortable that she could cope with any potential behavioural needs.

52. She went on to explain that the arrangements for this additional staffing had been put in place following a request from the Consultant Surgeon:

> 'the level of nursing staff required had been clarified and it was confirmed that this was not a clinical requirement and was purely to manage any potential behavioural issues. The side room (which was adjacent to the Nurses Station) was also requested at this point for reasons of patient comfort. Again this was clarified as it is not normal practice for a patient with learning difficulties to be placed in a side room unless family members/carers are present throughout the duration of their stay.'

53. She also acknowledged that the vital signs were not taken at 02:00 or 06:00 as Miss C was sleeping. 'The nursing staff had chosen to leave [Miss C] to sleep as they were aware that she had not settled until the early hours of the morning and that she would benefit from this rather than be woken abruptly, which may have caused unnecessary upset'. She said that this was a clinical judgement and there were no other contra indications to suggest that this was not appropriate.

54. In referring to a heart monitor, the Clinical Team Manager explained that Miss C did not return from recovery with a heart monitor in situ and this was not a concern to nursing staff as it was not normal practice for patients to be

returned to the ward with continual heart monitoring and in Miss C's case a heart monitor had not been requested by medical staff.

The Board's response to the complaint

55. In their response to the complaint, the Board explained that there was a misunderstanding in relation to the level of nursing support Miss C was to receive. The Consultant Anaesthetist had indicated that he was aware that special arrangements had been put in place to ensure one-to-one nursing care was provided to Miss C post-operatively and he assumed that this support would have included appropriate post-operative recordings as well as care of emotional needs.

56. The Board went on to explain that the nursing team was clear that the additional member of staff was obtained to provide emotional support, therefore a health care assistant (the HCA) had been requested to stay with Miss C throughout the night, with the clinical post-operative care to be undertaken by the ward staff on duty. They explained that the HCA was supported by a registered nurse, with this arrangement being put in place following discussions with the Consultant Surgeon, to ensure that Miss C was provided with emotional support.

57. In response to Mr C's concerns about Miss C being placed in a side room, the Board explained that the Consultant Surgeon had also requested the side room to allow family members to be with Miss C outwith normal visiting hours and for her comfort. They said that Miss C was placed in a side room beside the nursing station to allow a degree of flexibility in observation.

58. The Board said that, over the course of the evening following her surgery, Miss C's blood pressure was monitored until 21:15. Her blood pressure had been noted to be low and the medical team were made aware of this, however, at 21:15 Miss C's blood pressure was found to have returned to a level which would be considered usual for her. The Board also acknowledged that nursing staff did not waken Miss C to further record her blood pressure throughout the night and this was a judgement made by nursing staff, as Miss C had settled very late and the last recorded blood pressure was noted to be within normal limits. Miss C had been upset following surgery and it was considered that she would benefit from the rest.

59. The Board went on to say that if the staff had tried to take blood pressure, Miss C would most likely have woken up as the cuff tightened on her arm and this may have caused her alarm.

60. In relation to the provision of a heart monitor for Miss C, the Board said she did not return to the ward with a heart monitor in place and this was not specifically requested. The medical staff, surgeon or anaesthetist would normally make this request, where considered appropriate.

61. The Board advised Mr C that on the morning of 1 April 2008 the Consultant Surgeon visited the ward to see all of his post-operative patients. He was informed that Miss C's blood pressure had been low but that the last recording had been normal. He was also aware that Miss C had been very late to settle (the HCA had reported that Miss C went to sleep at 01:30) but appeared to be well throughout this time. When the Consultant Surgeon saw Miss C at 09:00, he did not consider her to be any more pale than usual. In addition, both the nursing and medical teams had noted that her complexion was usually pale. They said that Miss C was asleep but obviously breathing and her wound site was satisfactory, and the Consultant Surgeon felt she would benefit from further rest and so did not waken her.

62. The Specialist Registrar who had assisted during Miss C's surgery had also seen Miss C in the morning and had indicated she would be able to go home later that day. The Consultant Surgeon's usual practice was to ensure that all patients are seen, to ensure that all is well prior to them going home. Following the morning round, the Consultant Surgeon left the ward to conduct his clinic, however it was his intention to return to the ward to speak with Miss C before she went home.

63. In correspondence, the Board told me that 'since the tragic death of Miss C, an ENT Perioperative Group has been established. This group comprises of ENT surgeons, anaesthetists involved in ENT surgery and senior nursing staff as well as management staff. This group has developed an ENT anaesthetic assessment referral form, which is designed to alert anaesthetic staff to patients undergoing ENT procedures who may require additional anaesthetic assessment'.

64. The Board also told me that, in an effort to ensure that post-operative failings in relation to recording vital signs and observations do not reoccur, they

have developed 'Standardised Post Operative Observations' for the ward, which are intended as mandatory observations for nursing staff and detail the minimum requirements to be adhered to. Any deviation from the guidance must be recorded in the nursing notes.

Adviser 1

65. I asked Adviser 1 to comment on the care and treatment Miss C received post-operatively. He said that in his opinion, given Miss C's history of myotonia and the fact that her blood pressure had been significantly below normal for most of the evening, it was unreasonable to have failed to record her blood pressure at regular intervals throughout the night.

66. He acknowledged that it was possible that taking Miss C's blood pressure would have wakened her, however, he said that in this case, the degree of the post-operative hypotension combined with Miss C's medical history should have mandated frequent recordings, even if she was disturbed and distressed by doing so. He said that he considered the failure to record blood pressure and/or to react to the hypotension by getting senior assistance was a serious failing.

67. Adviser 1 also said that in his opinion Miss C should have been attached to a continuous ECG recording and pulse oximetry monitor overnight. He said that providing that monitor was being observed (either by telemetry at a central station or by a nurse at the bedside) the issue of a side room was not relevant.

68. He went on to say 'As nobody had undertaken any observations at all since 21:15 the previous day and she was described as “very pale” (in the nursing observations at 07:00), I cannot conceive of a circumstance where a consultant surgeon would not conduct a rudimentary clinical assessment of the patient laying in front of him on a ward round before deciding on discharge'. Adviser 1 said he was 'extremely critical of this shortfall in care'.

69. In response to Adviser 1's comments, the Board said 'it is fully acknowledged that post operative recordings of blood pressure over the night following [Miss C]'s surgery should have been undertaken. This should have been done irrespective of whether this would disturb her'.

Adviser 2

70. I asked Adviser 2 to comment on the post-operative nursing care provided to Miss C.

71. She explained that SEWS is a track and trigger system used throughout Scotland, to assess a patient's condition and to recognise when a patient's condition begins to deteriorate. The SEWS methodology is intended to alert staff to patients at risk of deteriorating health and instructions are provided about when to escalate the actions taken.

72. She said that observations such as blood pressure and heart rate must be taken by staff with the appropriate competence and understanding and pointed out that the normal ranges (within the SEWS approach) are not specific to individual patients, therefore each individual patient's condition must be taken into account to ensure subtle changes and trends are not overlooked.

73. She noted that Miss C's observations were carried out routinely until 20.00, when her blood pressure was low. This contributed to a SEWS score of 2, indicating that hourly observations were required. At 21:15 the recording was repeated and the blood pressure was found to be within the normal range. This contributed to a SEWS score of 0, meaning that four hourly observations were appropriate.

74. Adviser 2 noted that because Miss C took some time to settle, the nursing staff decided to allow her to sleep rather than disturb her. She said that when patients are asleep, the nursing staff should use their judgement to decide whether to disturb a patient overnight. In this case, however, the scheduled observations due at 02.00 and 06.00 were not done and Miss C was left undisturbed. Adviser 2 said that she agreed with Adviser 1, in that Miss C should have had observations carried out overnight and at the very least the 06.00 observations should have been done, prior to the morning ward round.

75. She said that the presence of the HCA was good practice; however, it was the responsibility of the nurse in charge to provide supervision during the post-operative period. She acknowledged that the registered nurse with responsibility for Miss C may have been well intentioned in allowing her to sleep; however, she said that this resulted in a failure to monitor and record Miss C's vital signs during the post-operative period and, therefore, to recognise and manage any deterioration in her condition.

76. Adviser 2 found the nursing notes and the care plan to be sparse. She said that they contained very little detailed information relating to the individual

care required for Miss C. She noted that Miss C's records did not include a learning disability assessment plan, admission to hospital plan or treatment plan.

77. She said that, while the Consultant Surgeon had requested 'Special' nursing for Miss C to provide additional support on a one-to-one basis, the rationale for this was not documented and, therefore, there was miscommunication between the medical and nursing staff. As reported in paragraph 40, the Consultant Surgeon did not include the post-operative observation instructions in his operative note.

78. I asked Adviser 2 to comment on whether Miss C's nursing care was compromised because of her learning disability. She said that there was some evidence that, in taking account of Miss C's needs, the clinical team made efforts to provide specific care for Miss C, such as booking a single room to allow the family open access; admitting Miss C on the day of surgery; her brother accompanying her to theatre; and having a HCA on a one-to-one basis overnight. She also noted, however, that in looking holistically at the care and treatment provided to Miss C, this meant she did not have the same level of pre-assessment care that might have been expected had she been admitted the day prior to surgery. In addition, the miscommunication about the reason for the one-to-one nursing meant that priority was given to the management of the behavioural and emotional care of Miss C, to the detriment of her post-operative care.

79. She said that, on balance, the decision taken not to disturb Miss C was probably taken to allow her as much rest as possible. She considered if the same course of action would have been taken in a person without a learning disability and concluded that, yes, the same course of action may have been taken at 02.00, but that it was unacceptable to leave any patient (regardless of having a learning disability or not) undisturbed until after 09.00.

(b) Conclusion

Recording of blood pressure and other vital signs

80. I have noted that, other than arranging for one-to-one nursing of Miss C’s emotional needs, the Consultant Surgeon failed to document and communicate her post-operative care requirements. This failing was compounded by the Consultant Anaesthetist, who by his own admission ‘assumed that the

postoperative one-to-one nursing would entail the necessary postoperative monitoring'. It did not.

81. I considered the Board's failure to record Miss C's blood pressure and other vital signs after 21:15 on 31 March 2008. The Board stated that this was a judgement made by nursing staff, as Miss C had settled very late and the last recorded blood pressure was noted to be within normal limits. The Board subsequently confirmed, however, that post-operative recordings of blood pressure over the night following Miss C's surgery should have been undertaken, irrespective of whether this would disturb her.

82. Nurses play a key role in ensuring an appropriate level of post-operative care and treatment is provided. Patient observations, which form part of a nurse's core skill set provide the best early information on a patient at risk of deterioration. The taking and recording of observations is, therefore, vital to illustrate how the patient is progressing, or to identify areas of potential concern.

83. In paragraph 49 I report that the Clinical Team Manager said that the nursing notes confirmed that Miss C was to have routine post-operative care; however, from 21:15 on 31 March 2008, until Miss C was discovered unresponsive the next morning, I found that she had not received this routine post-operative care.

84. I acknowledge the role of the HCA in providing emotional support to Miss C should she have required it, however, this one-to-one nursing was over and above what Miss C required in terms of clinical nursing; not an alternative.

85. Not only was Miss C's blood pressure not observed after 21:15, neither were any of the other vital signs used to calculate the SEWS score (respiratory rate, pulse oximeter oxygen saturation, temperature, heart rate, neuro response and pain). Adviser 2 told me that respiratory rate, pulse oximeter and heart rate could all have been observed without disturbing Miss C as she slept. I do not, therefore, accept as reasonable the Board's decision to attempt to minimise distress and upset for Miss C by reducing the presence of physical monitoring.

86. Given that the last SEWS chart entry was at 21:15 on 31 March 2008, I cannot understand the basis upon which nursing staff would make an informed decision not to record blood pressure and other vital signs throughout the night and into the next morning, even at the risk of awakening Miss C.

87. Both Adviser 1 and Adviser 2 considered that, given Miss C's blood pressure had been significantly below normal for most of the evening, it was unreasonable to have failed to record her blood pressure at regular intervals throughout the night. I accept this advice and consider that the nursing decision not to record Miss C's blood pressure (and other vital signs) throughout the night and into the following morning, together with the absence of a detailed explanation for this decision in the nursing record, was a serious failing on the part of the registered nurse with responsibility for Miss C.

Heart monitor

88. In considering whether Miss C should have had a heart monitor during her post-operative care period, I have noted that she did not return to the ward with a heart monitor in place and the Consultant Surgeon did not specify the required post-operative observation instructions, or the need for a heart monitor. It is understandable, therefore, in the absence of a specific request from either the Consultant Anaesthetist or the Consultant Surgeon, that the nursing staff did not consider a heart monitor to be appropriate.

89. Adviser 1 considered that Miss C should have been attached to a continuous ECG recording and pulse oximetry monitor overnight. Adviser 2, however, told me that this is not standard procedure for minor surgery and would be requested by the surgeon or anaesthetist where considered appropriate.

90. The Consultant Anaesthetist had acknowledged that patients with myotonia may have cardiac and respiratory problems. He also said that:

> 'while it is true that patients would not routinely be monitored with heart monitors, someone with potential heart and respiratory problems would be monitored either in a 'specialising' ward environment or in a high dependency environment.'

91. The Report also noted that surgical intervention and the post-surgical period place physical and psychological stress upon the heart muscle, which in Miss C’s case may have been more vulnerable.

92. In the circumstances, and taking account of Adviser 1's comments, I conclude that Miss C should have had a heart monitor during her post-operative care. This requirement should have been identified by both the Consultant

Anaesthetist who was aware that patients with myotonia may have cardiac problems, and the Consultant Surgeon, who failed to make clear the post-operative observation requirements.

93. Certainly, ECG recordings would have alerted staff of the deterioration in Miss C's condition; however, it was the absence of any observations or monitoring on the part of the nursing staff, of Miss C's vital signs after 21:15 (on 31 March 2008) that gives particular cause for concern.

94. Again, I have found failings on the part of the Consultant Surgeon, the Consultant Anaesthetist and the nursing staff.

Use of the side room

95. Mr C raised an issue about Miss C being in a side room. It is accepted that patients with learning disabilities should not be nursed in a side room; indeed the nursing staff sought clarification regarding this matter as they were aware that it was not normal practice for a patient with learning difficulties to be placed in a side room unless family members/carers are present throughout the duration of their stay.

96. I recognise that the decision to nurse Miss C in a side room on a one-to-one support basis was made with the best of intentions, taking account of her needs, and I am inclined to agree with Adviser 1 when he said that the issue of a side room was not relevant, providing that a monitor was in place and being observed. I consider that the side room would not have been an issue if nursing staff had checked Miss C's vital signs as they should have.

Lack of post-operative examination and specialised nursing

97. The Consultant Surgeon saw Miss C at 09:00 (on 1 April 2008), however he did not examine her as she was asleep. Adviser 1 was 'extremely critical of this shortfall in care'; this is understandable.

98. Given that Miss C's vital signs had not been observed since 21:15 the previous day, it is difficult to understand why the Consultant Surgeon did not examine Miss C, or at the very least direct the nursing staff to monitor her vital signs. In his complaint, Mr C said 'he obviously never checked her observation sheet or notes and questioned why her blood pressure had not been taken, or that she was pale. A worse scenario is if he did check the chart and notes and failed to act'. I agree.

99. I also consider that the breakdown in communication between the Consultant Surgeon and the nursing team, in terms of what he required in relation to specialised nursing, contributed to the care and treatment provided to Miss C being inadequate.

100. The Consultant Surgeon's failure to communicate properly the post-operative nursing requirement was compounded by the nursing staff's failure to complete any form of monitoring or recording of Miss C's condition after 21:15 on 31 March 2008.

101. I note Mr C's concerns that the Consultant Surgeon had sanctioned Miss C's discharge without actually speaking with her first; however, I also note the Consultant Surgeon's comments that it was his intention to return to see Miss C as soon as his morning clinic was over.

102. A further cause for concern relates to the role of the Specialist Registrar referred to in paragraph 43. The clinical records indicate his (un-timed) written entry on 1 April 2008 as 'nil significant in drain, home later today'. In the absence of any post-operative examination of Miss C, it is difficult to understand the basis for this entry.

103. Given the comments received from both Adviser 1 and Adviser 2, I consider there to have been a lack of post-operative examination on the part of the Consultant Surgeon, and a lack of any form of specialised clinical nursing. These are indicative of further serious failing failings in Miss C's post-operative care.

104. I have found systemic failings in the post-operative care of Miss C, specifically in relation to the lack of recording of blood pressure and other vital signs, communications, record-keeping and decision making. I conclude that failings on the part of the Consultant Anaesthetist, the Consultant Surgeon and the nursing staff all contributed to this.

Miss C's learning difficulties

105. In concluding my consideration of the post-operative care provided to Miss C, the question I have asked myself is whether the failings in the care provided were due to the fact that she had learning difficulties.

106. Adviser 2 noted that there was some evidence that in taking account of Miss C's needs, the clinical team made efforts to provide specific care for Miss C. This confirmed that they were aware of Miss C's special needs and attempted to achieve equality in the care provided to her. Adviser 2 also said, however, that miscommunication about the reason for one-to-one nursing meant that priority was given to the management of the behavioural and emotional care of Miss C, to the detriment of her post-operative care.

107. In their report 'Six lives: the provision of public services to people with learning difficulties', the LGO/PHSO found that on many occasions basic policy, standards and guidance were not observed, adjustments were not made and services were not co-ordinated. They found failings in communication, partnership working and co-ordination, following routine procedures and the quality of management. I have, therefore, considered whether any of these failings were identified in the care and treatment of Miss C.

108. I found that communication, partnership working and co-ordination between the Consultant Surgeon and the nursing team was poor. The Consultant Surgeon failed to include the required post-operative observation instructions for Miss C to the nursing team, thus requiring the nursing staff to confirm the level of nursing staff required was 'not a clinical requirement but was purely to manage any potential behavioural issues'. The Consultant Anaesthetist, however, referred to a lack of clarity in relation to 'special 1:1 nurse monitoring', stating that he assumed this would entail the necessary post-operative monitoring, and I have noted Adviser 2's comments that this miscommunication led to priority being given to the management of behavioural and emotional care to the detriment of post-operative care.

109. The LGO/PHSO's report found that 'standards and guidance were not followed, significantly increasing the risk to vulnerable individuals'. In the case of Miss C, it is clear that there was a failure in the nursing care to follow the routine procedure of post-operative observations. There is no doubt that this failing in post-operative care significantly increased the risk to Miss C, whose nursing care had been prioritised to manage any behavioural issues.

110. Miss C's behaviour, which was linked to her learning disability, meant that she could become distressed in a hospital setting and nursing staff made the decision to allow her to sleep rather than disturb her by completing the required routine post-operative assessments. Had these routine observations (as

required by SEWS) been completed, an early indication of her deterioration may have been identified. I, therefore, conclude that failures in the Board's post-operative care and treatment of Miss C were, in part, for reasons related to her learning disabilities.

111. In taking account of the evidence considered by me, together with the comments from Adviser 1 and Adviser 2, I consider there to have been serious systemic and individual failings in the standard of post-operative care provided to Miss C. I, therefore, uphold this complaint.

(b) Recommendations

112. I have noted the specific actions taken by the Board as a result of this case, as reported in paragraphs 63 and 64, and I recognise that this goes some way towards addressing the failings identified in this report. I have also noted the NHS QIS report 'Tackling Indifference' (Healthcare Services for People with Learning Disabilities. National Overview Report December 2009). This report reflected that, in general, people with learning disabilities who have planned admissions to hospital experience good liaison arrangements but unplanned admissions were less so. It also reflected that in 2008 boards were required to prepare action plans which largely focus on improving primary and secondary care responses to people with learning difficulties.

113. The Ombudsman, therefore, recommends that the Board:

(i) provide a copy of the appropriate action plans which specifically contain details of how the Board will implement and meet the relevant policies, including:
   - NHS QIS quality indicators for people with learning difficulties (NHS QIS report 'Learning Disabilities' Quality Indicators February 2004);
   - NHS QIS report 'Tackling Indifference', (Healthcare Services for People with Learning Disabilities. National Overview Report. December 2009);

(ii) provide a copy of their education and training strategy, including the specific requirement relating to patients with learning disabilities;

(iii) review and evaluate the current arrangements for pre-operative admission for people with learning disabilities and provide him with a report of the findings; and

(iv) confirm the specific action taken to clarify the terms 'special nursing' and 'routine monitoring' to avoid ambiguity over what level of nursing support is required when caring for people with learning difficulties.

(c) Communications with Miss C's family were not appropriate

114. Mr C said that both he and Miss C's mother (Mrs B) phoned the Hospital on the morning of 1 April 2008. Mr C called twice, at 09:00 and at 09:30, with Mrs B calling just after 09:30. They were both told that Miss C had an unsettled night and was still sleeping. He said that Mrs B was told that they had kept breakfast back for Miss C and were going to wake her.

115. Mr C said that the ward notes indicated that Miss C had a settled night and questioned why they had been advised that she had an unsettled night. He also asked why his wife was told by telephone that Miss C had died, considering this to be insensitive.

116. In responding to Mr C's complaint regarding communication, the Board acknowledged speaking to Mr C and Mrs B on the morning of 1 April 2008. They said that reference to an 'unsettled night' related to the time until 01:30, however, the term 'settled night' referred to Miss C's overall recovery and behaviour.

117. The Board also explained that the Consultant Surgeon felt that it was his duty to make contact with Mrs B to inform her of events. He called her home and spoke with her husband (Mr B). He decided to explain the events to Mr B as he felt that this was appropriate, given Mr B's previous involvement. The Board also said that he wished to extend his unreserved apologies if this caused additional upset or distress, as it was never his intention to do so.

118. Adviser 1 said that, in light of the failure to record observations beyond 21:15 on 31 March 2008, the Board's communication of Miss C's condition overnight did not make any sense: 'As nobody had assessed her, it was not possible to describe her condition.'

(c) Conclusion

119. I believe that the Consultant Surgeon acted in good faith in attempting to notify Mrs B of Miss C's death. He subsequently apologised for any additional distress caused by the manner of notification and I consider this to be reasonable in the circumstances.

120. In reaching my conclusion, however, I have taken account of the Board's response to Mr C and Mrs B's telephone calls on the morning of 1 April 2008,

and I have taken note of Adviser 1's comments that 'in light of the failure to record observations beyond 21:15 on 31 March 2008, the Board's response to the communication of Miss C's condition overnight does not make any sense. As nobody had assessed her, it was not possible to describe her condition.' I therefore uphold this complaint.

(c) Recommendations

121. The Ombudsman recommends that the Board

(i) provide assurance that policies and procedures are in place to ensure that the *Nursing and Midwifery Council* Code of Conduct and in particular the 'Guidance for record keeping' (2009) is implemented so that communication with patients' families is clear and unambiguous; and

(i) provide an explicit, unambiguous and meaningful apology to Miss C's family for all the failings identified in this report, detailing the steps they have put into place to ensure that a similar occurrence is not repeated.

Annex 1

Explanation of abbreviations used

Miss C	The complainant's daughter
The Hospital	Ninewells Hospital, Dundee
The Report	The Post Mortem Examination Report
Mr C	The complainant
The Board	Tayside NHS Board
Adviser 1	The Ombudsman's independent medical adviser
Adviser 2	The Ombudsman's independent nursing adviser
LGO	Local Government Ombudsman
PHSO	Parliamentary and Health Service Ombudsman
NHS QIS	NHS Quality Improvement Scotland
ENT	Ear, nose and throat
The Consultant Surgeon	The ENT surgeon who operated on Miss C
Mr B	Miss C's stepfather
Mrs B	Miss C's mother
The Consultant Anaesthetist	The anaesthetist with responsibility for Miss C

The Specialist Registrar	The registrar who made an entry in Miss C's medical records on 1 April 2008
ECG	Electrocardiogram
SEWS	Scottish Early Warning Score
The HCA	The Health Care Assistant

Annex 2

Glossary of medical terms

Anaesthetic	A substance that makes you unable to feel pain
Analgesia	An insensibility to pain without loss of consciousness
Cardiac arrest	A condition in which the heart stops beating
Cardiac problems	Problems relating to the heart
Cardiovascular depression	Related to heart failure
Co-codamol	A painkiller (a combination of Paracetamol and Codeine)
Electrocardiogram	A drawing or electronic image made by an electrocardiograph
Guided needle aspiration	A diagnostic procedure sometimes used to investigate superficial (just under the skin) lumps
Hypotension	Low blood pressure
Learning disability	A significant, life-long condition which reduces the ability to understand new or complex information or to learn new skills, reduces the ability to cope independently and begins before adulthood (before the age of 18) and has a lasting effect on the individual's development

Morphine	A painkiller used in the management of severe pain
Myotonia	Increased muscular irritability and contractility with decreased power of relaxation; toxic spasm of muscle
Myotonic dystrophy	An inherited disorder of the muscles and other body systems
Neuro response	Response pertaining to a nerve or the nervous system
Opioids	Powerful painkillers
Parotid gland	The saliva producing gland
Perioperative	The period extending from the time of hospitalisation for surgery to the time of discharge
Post mortem	An examination in order to determine cause of death
Pre-operative anaesthetic assessment	Consultation by an anaesthesiologist for the medical assessment of a patient prior to anaesthesia for surgery
Pulse oximeter oxygen saturation	Method of monitoring the percentage of haemoglobin which is saturated with oxygen
Respiratory depression	Decrease in the rate or depth of breathing
Respiratory problems	Problems affecting the breathing system

Ultrasound	Images of the internal organs created from sound waves
Vital signs	Indicators of body function, usually meaning heartbeats per minute, breaths per minute, blood pressure, body temperature and weight

Annex 3

List of legislation, policies and reports considered

'Six lives: the provision of public services to people with learning difficulties' produced jointly by the Local Government Ombudsman and the Parliamentary and Health Service Ombudsman 2009

'Death by Indifference' MENCAP 2007

NHS QIS report 'Learning Disabilities' Quality Indicators February 2004

NHS QIS report 'Tackling Indifference', Healthcare Services for People with Learning Disabilities. National Overview Report. December 2009

The Nursing and Midwifery Council Code of Conduct and in particular the 'Guidance for record keeping' (2009)