**Parliament Region: Mid Scotland and Fife**

**Case 200904481: Fife NHS Board**

**Summary of Investigation**

***Category***

Health: Hospitals; care of the elderly; clinical treatment; diagnosis

***Overview***

The complainant (Mr C)'s father (Mr A) was admitted to Queen Margaret Hospital (the Hospital) after falling and breaking his left hip. Mr C raised a number of concerns relating to the care and treatment that Mr A received during his stay at the Hospital. He complained that Fife NHS Board (the Board) failed to maintain adequate standards of ward cleanliness, resulting in Mr A picking up two hospital-acquired infections. He also complained about the nursing care Mr A received, noting that his father had fallen four times whilst staying at the Hospital, on one occasion fracturing his right hip. Mr A died at the Hospital. Mr C raised further concerns regarding the Board's failure to contact his family in time for them to be with Mr A at the time of his death.

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) there was a lack of care and compassion by the nursing staff on Ward 14 when Mr A fell four times (*upheld*);
(b) there was a lack of cleanliness in Ward 14 (*not upheld*);
(c) there was a lack of concern from nursing staff in Ward 20 when Mr A's family highlighted that his blood pressure reading appeared high (*not upheld*);
(d) Mr A contracted MRSA twice (*not upheld*);
(e) the Board failed to inform Mr A's family of the rapid decline in his clinical condition or to contact them prior to his death (*upheld*); and
(f) the Board failed to remove a catheter tube from Mr A's body (*upheld*).

***Redress and recommendations***

| The Ombudsman recommends that the Board: | *Completion date* |
|---|---|
| (i) review the circumstances surrounding Mr A's falls with a view to identifying, and rectifying, underperformance in the practical implementation of their falls management and dementia care policies and procedures; and | 30 June 2011 |
| (ii) review the circumstances leading to Mr C's complaint and consider introducing measures to improve communication with patients' families. | 30 June 2011 |

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

## Main Investigation Report

### Introduction

1. The complainant (Mr C)'s father (Mr A) fractured his left neck of femur (left hip) and was admitted to Queen Margaret Hospital (the Hospital) on 31 July 2009. He underwent hip replacement surgery on 2 August 2009. Mr A was transferred to Ward 14 and was kept in hospital due to his complex medical history. During his stay, Mr A reportedly fell on a number of occasions and, after a fall on 24 August 2009, an x-ray found that he had fractured his right neck of femur (right hip). He underwent hip-replacement surgery on his right hip on 24 August 2009. Mr A picked up an MRSA infection whilst in the Hospital. He underwent further surgery to remove the new hip joint, which was considered to be the source of the infection. Mr A experienced complications during surgery and died in the Surgical High Dependency Unit (HDU) shortly after the procedure.

2. Mr C complained to Fife NHS Board (the Board) on 5 October 2010, raising concerns about the treatment that Mr A had received during his stay at the Hospital. He noted that the floor in Ward 14 had been unclean on a number of occasions when he and his family had visited Mr A, with food left on the floor. He also complained about the level of care provided by nursing staff in Ward 14. Generally, he felt that there was a lack of awareness of Mr A's needs.

3. Mr C further complained about the number of falls that Mr A had whilst in the Board's care and the fact that he had contracted MRSA on two occasions. He was also disappointed that Mr A's family were not contacted until some time after he had died and that surgical appliances were not removed from Mr A's body prior to release from the Hospital.

4. The Board responded to Mr C's complaint on 17 November 2009 and he was subsequently invited to a meeting to discuss his concerns with the Board's staff. Dissatisfied with the outcome of his complaint, Mr C raised his concerns with the Ombudsman in March 2010.

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

(a) there was a lack of care and compassion by the nursing staff on Ward 14 when Mr A fell four times;

(b) there was a lack of cleanliness in Ward 14;

(c) there was a lack of concern from nursing staff in Ward 20 when Mr A's family highlighted that his blood pressure reading appeared high;
(d) Mr A contracted MRSA twice;
(e) the Board failed to inform Mr A's family of the rapid decline in his clinical condition or to contact them prior to his death; and
(f) the Board failed to remove a catheter tube from Mr A's body.

**Investigation**

6. In order to investigate this complaint, my complaints reviewer reviewed all of the correspondence between Mr C and the Board, as well as documentation and statements relating to the Board's own investigation of Mr C's complaints. My complaints reviewer also reviewed Mr A's clinical records and sought advice from my professional medical advisers.

7. 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 a draft of this report.

**(a) There was a lack of care and compassion by the nursing staff on Ward 14 when Mr A fell four times**

8. Mr A, a 69-year-old-man, was admitted to Ward 13 at the Hospital on 31 July 2009, following a fall. The Consultant Orthopaedic Surgeon who examined him upon admission (Consultant 1) noted in Mr A's clinical records that he complained of pain in his left hip and reduced mobility. Consultant 1 also noted that Mr A was a 'poor historian' with a number of significant existing medical conditions, including the removal of one kidney, poor blood circulation to the heart, diabetes and dementia.

9. Consultant 1 arranged an x-ray of Mr A's hip and he was found to have a fractured left neck of femur (fractured left hip). Mr A underwent hip replacement surgery on 2 August 2009 and was subsequently transferred to Ward 14 for recovery. Mr A reportedly recovered well from his hip operation. In their response to Mr C's complaint, the Board commented that Mr A 'might well have gone home' following his recovery from the operation, however, he was considered to be at increased risk of post-operative complications due to his complex medical history. The Board were also mindful of the increased risk of infection for patients with diabetes.

10. In his complaint to the Board, Mr C noted that Mr A had fallen on four occasions during his stay in Ward 14. The Board, when responding to Mr C's complaints, also referred to four falls. Incident reports held in Mr A's clinical records recorded five falls between 9 August 2009 and 24 August 2009.

11. On 9 August 2009, Mr A was found on the floor of Ward 14, having slipped when sitting on the side of his bed. The corresponding Incident Report recorded no apparent injuries. The Hospital at Night team were informed of the incident.

12. Mr A was helped back into bed, moved closer to the nurses' station for observation and safety rails were fitted to the sides of his bed. The Board told Mr C, when responding to his complaint, that Mr A was also advised to use the call bell to attract a nurse's attention should he require assistance.

13. On 10 August 2009, Mr A was again found on the floor of Ward 14. He was noted as having cut his right elbow. A pressure bandage was applied to his injury. No subsequent action is recorded as having been taken.

14. Mr A fell for a third time on 13 August 2009. On this occasion, ward staff were alerted by another patient and found Mr A on the floor, at the foot of his bed. The bed rails were noted as being raised. Mr A was noted as being confused and unable to explain what had happened. He was found to be uninjured and the Hospital at Night team were made aware of the incident. The Board said that Mr A was placed on constant observation and the Clinical Co-ordinator was advised of the need for additional staff.

15. Constant observation was cancelled on 17 August 2009, as Mr A was considered to be more oriented and less confused than he had been previously.

16. On 21 August 2009, Mr A fell when attempting to move from his commode to a chair. Nursing staff helped him into bed and a full assessment was requested. No injuries were found. A wander guard was placed on his chair on 22 August 2009. This sets off an alarm when a patient moves from the chair, alerting nursing staff.

17. On 24 August 2009, Mr A fell again and ward staff found him on the floor with his back against one of the ward beds. Upon examination, he was found to have a minor cut above his eye. It was also noted that his right leg appeared

shortened and externally rotated. X-rays later showed that he had fractured his right hip.

18. Mr A underwent hip replacement surgery on his right hip on 24 August 2009.

19. In response to Mr C's complaint about the falls that his father had in Ward 14, the Board offered their sincere apologies, but assured him that measures were put in place to reduce the risk of Mr A falling.

20. In June 2010, the Scottish Government launched a National Dementia Strategy. The aim of this national strategy is to bring consistency to the way that dementia patients are cared for in Scotland and to ensure that a minimum standard is met by all NHS organisations. The National Dementia Strategy highlights five key challenges and two key service delivery areas to be addressed by health boards and includes eight specific actions that health boards must complete (these are detailed in Annex 4 of this report).

21. My complaints reviewer asked the Board to provide details of the action that they have taken to implement the National Dementia Strategy. The Board had developed their own dementia strategy prior to the launch of the National Dementia Strategy, therefore, they provided an internal report comparing their own strategy to the requirements set out by the Scottish Government. In the report, the Board set out the aims identified in their own dementia strategy and found that there were no obvious gaps between their strategy and the National Dementia Strategy. The report concluded that:

> 'the broad vision and intentions are the same, with the local strategy identifying specific measures necessary in Fife to achieve the aims. Services in Fife will be required to respond to and implement the relevant measures in both strategies, which should be considered as complimentary (sic) and should both be referred to when developing such action plans.'

22. The Board also provided my complaints reviewer with details of their staff dementia training schedule and a four-year plan for ongoing dementia training for their staff.

23. My complaints reviewer asked my nursing adviser (Adviser 1) to review Mr A's clinical records and the Board's response to Mr C's complaints. She

explained that there were significant challenges in caring for patients with dementia following surgery, as the anaesthesia and infection can increase their confusion. She noted that Mr A had a number of predisposing medical factors which, combined with his dementia, meant that staff would have had to use all resources available to them to manage Mr A's care and treatment.

24. Adviser 1 reviewed the High Risk Patient Care Management Plan (the Management Plan) completed by the Board upon Mr A's admission to the Hospital. This document lists the steps that should be taken to manage patients who are at high risk of falls, and includes a risk assessment for identifying the individual patient's needs. Annex 5 of this report lists the guidance set out in the Management Plan. Adviser 1 commented that the Management Plan's guidance represented good practice and noted that the majority of the measures listed in it were put into practice by nursing staff caring for Mr A. Generally, Adviser 1 was satisfied that the Board had adequate systems in place for assessing patients' likelihood of falls and preventing and recording incidents. The Board's staff completed Mr A's falls assessment chart daily and a falls diary was completed.

25. Overall, Adviser 1 was satisfied with the Board's processes and record-keeping regarding patient falls. That said, she noted that Mr A was identified as requiring constant observation, however, Mr A's clinical records stated on 14 August 2009 '... patient remains on constant observation policy, although no nurse allocated – nurse in attendance in the bay at all times'. Adviser 1 felt that this failure to provide the constant observation Mr A was assessed as requiring, without documented reasons as to why, defeated the purpose of this plan of care.

26. Adviser 1 also noted that, following his first fall, Mr A had been advised by nursing staff to use the call bell to attract staff members' attention should he require any assistance. Whilst this advice was in line with the Management Plan, Adviser 1 explained that it is well documented that patients with dementia do not understand this instruction. She felt that the Board's approach on this occasion showed a lack of awareness in the care of people with dementia.

*(a) Conclusion*

27. Mr C complained about a lack of care and compassion from nursing staff during his father's stay in Ward 14. It is extremely difficult for me to comment constructively on the issue of compassion, which is by its nature subjective. In

reviewing this complaint, I have considered the appropriateness and effectiveness of the Board's falls-prevention measures and whether they took adequate account of Mr A's dementia when caring for him.

28. I am satisfied that the Board have strong policies in place for minimising the risk of falls. The Management Plan and documentation associated with it demonstrate a clear understanding of the risk to elderly patients of falls and the Board have practical tools in place for assessing each patient's individual falls risk. I also found that the Board maintained clear and regular records in their falls assessment chart and falls diary throughout Mr A's stay. That said, as Adviser 1 highlighted, measures implemented in accordance with the Management Plan, namely Mr A's constant observation, were not carried out fully.

29. Similarly, whilst I am entirely satisfied that the Board's approach to caring for patients with dementia is in line with the National Dementia Strategy, and they have been able to demonstrate a thorough schedule of staff training in this regard, the Board's records show that Mr A was advised to use the call bell to attract nurses' attention should he require assistance. I accept Adviser 1's comment that dementia patients are known not to understand this instruction and found it significant that the record of this advice being given was enough for Adviser 1 to question the nursing staff's awareness of general dementia care.

30. Generally, I found the Board's policies and record-keeping with regard to falls management and dementia care to be of an acceptable standard, however, the two issues noted above demonstrate a failure on the part of the Board's staff to translate those policies into effective patient care on the ward. Therefore, I uphold this complaint.

*(a) Recommendation*

| 31. I recommend that the Board: | *Completion date* |
|---|---|
| (i) review the circumstances surrounding Mr A's falls with a view to identifying, and rectifying, underperformance in the practical implementation of their falls management and dementia care policies and procedures. | 30 June 2011 |

**(b) There was a lack of cleanliness in Ward 14**

32. In his complaint to the Board, and subsequent complaint to the Ombudsman, Mr C said that the level of cleanliness in Ward 14 was poor. Specifically, he said that he ran his hand over the floor and found it to be very dirty and on more than one occasion when visiting Mr A, he found food lying on the floor. Mr C explained during his meeting with the Board that he was concerned that Mr A could slip on the discarded food and fall.

33. When responding to Mr C's complaints, the Board expressed their disappointment at learning of Mr C's concerns and assured him that their staff take cleanliness seriously. They explained that Ward 14 had two domestic staff working between 07:30 and 13:30 and one domestic staff member working between 15:00 and 19:00. These shifts were timed to cover patient meal times. The Board told Mr C that the floors in Ward 14 were cleaned on a daily basis and more frequently if required.

34. Nursing staff reportedly advised Mr C during one of his visits that Mr A had spat his food out. Mr C disputed this, however, noting that Mr A had Parkinson's disease and was unable to spit in such a way.

35. The Board said that Mr C's comments had been shared with domestic staff and also with ward staff, as they shared a responsibility for ensuring that cleanliness and hygiene levels were high.

36. In 2004, the Scottish Government published the National Cleaning Specifications (the Specifications), which set out the expected standards for cleanliness in Scottish hospitals. The Specifications also provide templates for auditing tools which should be used to monitor cleanliness and ensure that specific, required, cleaning duties are carried out. My complaints reviewer asked the Board for copies of the cleaning schedule, staff rotas and cleaning audits for Ward 14 during the period of Mr A's stay. The Board's cleaning schedule, monitoring and auditing tools were in line with the guidance and templates in the Specifications.

37. The schedule of work for domestic staff in Ward 14 set out the individual cleaning tasks they were required to undertake. The list of tasks was extensive, however, with regard to floor cleaning, specifying that the floors in bed areas should be suction cleaned, damp mopped and burnished on a daily basis and should be scrubbed weekly. The records that my complaints reviewer received

showed that cleaning tasks were signed-off by domestic staff as being completed daily throughout Mr A's stay, however, they do not explicitly confirm that floors were cleaned. The monthly audit results for Ward 14 showed overall percentage cleanliness compliance scores as follows:

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|---|---|---|
| July 2009 | – | 98 percent |
| August 2009 | – | 98 percent |
| September 2009 | – | 96 percent |
| October 2009 | – | 97 percent |
| November 2009 | – | 98 percent |

38. A comment on the audit summary noted that the overall score dropped in September 2009, indicating that cleanliness in Ward 14 may have been at a lower standard in early September 2009.

39. Specific cleanliness problems were highlighted in cleanliness audits for Ward 14 dated 19 August 2009 and 24 September 2009. These included 'splash back' on the wash-hand basins and dusty window ledges but did not highlight dirty floors.

*(b) Conclusion*

40. Whilst I have been given no reason to dispute Mr C's observations, having not been present at the time of his visits to Ward 14 it is impossible for me to establish with any certainty the level of cleanliness on Ward 14 at those specific times. I have, however, considered the evidence made available to my complaints reviewer, the appropriateness of the Board's cleanliness monitoring procedures and the mechanisms that they have in place to identify and resolve any cleanliness issues.

41. As I commented in paragraph 28 of this report, I was satisfied that the Board's monitoring and auditing tools were appropriate and in line with the standards set by the Specifications. The documentation provided by the Board as evidence of cleanliness standards within Ward 14 during Mr A's stay demonstrated that cleaning was carried out daily and monthly audits were completed. Some cleanliness issues were identified, and whilst these did not correspond with the specific issues raised by Mr C, the Board accepted that the overall standard of cleanliness may have dropped in September 2009, based on the 96 percent audit score.

42. Cleanliness audits exist to identify problems and ensure that they are rectified by ward and domestic staff. A lower score of 96 percent is not necessarily indicative of a systemic cleanliness issue on Ward 14. The percentage scores obtained through cleanliness audits are a useful tool for management reporting, however, they do not detail the specific issues identified and their significance in terms of patient health. For example, marks may have been deducted for a number of minor problems, or for one or two major problems without being reflected in the overall score. With this in mind, it is essential that the problems identified in ward audits and other inspections are followed up and resolved promptly. The Board acknowledged Mr C's concerns regarding cleanliness on Ward 14 and advised that these points had been raised with the appropriate staff. I also note that Ward 14's percentage score increased after September 2009, indicating an overall improvement in standards. However, whilst the evidence submitted to my complaints reviewer showed thorough monitoring and recording of cleanliness levels, it did not demonstrate a routine process of following up on issues identified in ward audits. The Board should be able to show a clear audit trail from inspection through to identification of issues, action proposed and action completed.

43. Mr C raised specific complaints about the cleanliness in Ward 14 and whilst there is evidence to suggest a drop in cleanliness levels on Ward 14 at that time, I did not find this to be sufficient to conclude that those levels were below an acceptable standard. Therefore, I do not uphold this complaint and I have no recommendations to make.

**(c) There was a lack of concern from nursing staff in Ward 20 when Mr A's family highlighted that his blood pressure reading appeared high; and (d) Mr A contracted MRSA twice**

44. Following his hip operation on 2 August 2009, Mr A was kept in the Hospital for recovery. On 21 August 2009, he developed a sore on his right foot. This was examined and dressed by nursing staff. On 24 August 2009, the day of Mr A's second hip operation, a swab of the sore was taken and microbiological tests carried out. The microbiologist confirmed on 28 August 2009 that Mr A's swab was positive for meticillin resistant staphylococcus aureus (MRSA). Mr A was relocated to a side room in Ward 14 and put on a course of antibiotics.

45. Following his second hip operation, Mr A remained in the Hospital. His clinical records showed spells of confusion and other complaints such as loss of

voice and chest pains, however, he was generally considered to be recovering well from the operation. On 12 September 2009, Mr A was recorded as having complained of pain in his right hip. Blood samples were taken.

46. Mr A became unwell on 13 September 2009. He was reviewed by a Care of Elderly doctor (the Doctor), who believed he may have a urinary tract infection (UTI). The Doctor commenced Mr A on a course of antibiotics for this.

47. He was examined by Consultant 1 on 14 September 2009 and it was noted that he had had a high temperature over the weekend and that he remained pyrexial (feverish). Consultant 1 examined Mr A's operation wound on his right hip and noted that it was 'a bit red, otherwise ok'. A separate note of Consultant 1's examination states 'The wound has healed well. There is slight induration [hardening] below the wound but this certainly does not look infection (sic)'. This note also stated that Consultant 1 would arrange further x-rays to establish whether Mr A had a UTI or an underlying hip infection.

48. On the evening of 14 September 2009, Mr A's blood test results were received from the microbiologist and he was again found to be positive for MRSA. Appropriate antibiotics were prescribed to treat the MRSA infection, however, these were unsuccessful. On 15 September 2009, Mr A's renal function deteriorated and he was transferred to Ward 20, the Hospital's renal ward.

49. Upon examination in Ward 20 on 16 September 2009, the site of Mr A's second operation was found to be swollen and oozing pus. A note made by a Consultant examining Mr A in Ward 20 on 17 September 2009 (Consultant 2) stated 'His thigh is reddened and indurated [hardened] and I think his Furlong hemiarthroplasty [replacement hip joint] is infected. I think he needs to return to theatre for this to be explored and for a Girdlestone's procedure [surgery to remove the replacement hip joint. This procedure is used to fuse the thigh bone with the hip socket in cases where the replacement joint has caused infection]'. The Board considered Mr A's new hip joint to be a likely site of infection and it was decided that the joint should be removed, as the antibiotics that Mr A was taking were not improving his condition.

50. Mr C visited Mr A in Ward 20 on 16 September 2009. During his meeting with the Board he complained of a lack of care and compassion from nursing staff. He said that he had noticed on a monitor that Mr A's blood pressure was

high at 200. Upon arrival at Ward 20, he had been advised that Mr A's operation wound was swollen and oozing pus. He was assured that there was nothing to worry about, however, he was unconvinced, given the state of Mr A's wound and his high blood pressure reading. My complaints reviewer was unable to find any record of this discussion, however, the Board noted that Mr A was closely monitored and that his clinical records indicated that his systolic blood pressure reading was no higher than 150 on that day.

51. On 17 September 2009, Mr A was taken back into theatre, where his right hip joint was removed. Tests carried out on the hip joint later confirmed that it was positive for MRSA. During their meeting with Mr C, the Board suggested that Mr A's foot sore, which had been positive for MRSA, was the probable source of the infection in his hip.

52. My complaints reviewer asked my GP Adviser (Adviser 2) for some general information about MRSA. He explained that individuals often carry the MRSA bug on their bodies without realising it. Whilst the MRSA bug is easily transferred between individuals, infection typically occurs only where there is the opportunity for it to enter the body, via an operation site or open wound. Adviser 2 echoed the Board's comments in their response to Mr C's complaint, reiterating that Mr A would have been at a high risk of infection due to his complex medical history, the fact that he had diabetes, and the fact that he had undergone surgery.

53. The spread of MRSA is minimised and infection prevented by ensuring that wards are kept clean and good hand hygiene etiquette is maintained by staff, patients and visitors.

54. In an internal statement following Mr C's complaint, Consultant 1 commented that if Mr A had not suffered a second hip fracture whilst in the Hospital, he may have been able to return home. He added, however, that he did not consider there to have been any more that staff could have done from a medical point of view to prevent the MRSA infection that Mr A developed in his second hip replacement. He also felt that there was an extremely high chance of Mr A developing an infection even with one operation, due to the extent of his underlying medical conditions.

55. Adviser 1 reviewed the Board's internal investigation notes and responses to Mr C's complaints regarding Mr A's MRSA infection and found their comments to be reasonable.

*(c) Conclusion*

56. As I noted in paragraph 50 of this report, there is no written record of Mr C's conversation with staff in Ward 20. Furthermore, it is naturally very difficult for me to comment on the level of concern shown by staff during discussions about a patient's condition, in the absence of any independent, objective evidence.

57. As the Board highlighted, the clinical records record that Mr A's systolic blood pressure did not rise above 150 when observed by ward staff. Bearing this in mind, and the lack of available recorded evidence, I do not uphold this complaint and I have no recommendations to make.

*(d) Conclusion*

58. All parties commenting on this complaint agreed that Mr A was at an increased risk of infection due to his complex medical history and I accept that this was the case. As well as seeking to establish whether the Board could have done more to prevent Mr A's MRSA infection, I have considered the extent to which Mr A's falls and his subsequent need for a second operation could have directly contributed to his infection.

59. In complaint (b) of this report, I commented on the cleanliness levels in Ward 14 during Mr A's stay. As I was unable to confirm that cleanliness levels were of an unreasonable standard, and as hand hygiene and infection prevention is influenced by visitors to the Hospital as well as the Board's staff, I did not find any clear evidence of poor hygiene standards directly contributing to Mr A's infection.

60. Mr A first developed an MRSA infection via the sore found on his right foot on 21 August 2009. He was later found to have MRSA present on his right hip joint, which had been fitted during his second operation on 24 August 2009. No further MRSA tests appear to have been carried out between these dates and it may, therefore, be the case that the initial infection was not resolved (I note that antibiotic treatment of the second infection was noted to have been unsuccessful). I acknowledge the Board's comments suggesting that Mr A's hip infection may have spread from his foot sore.

61. I do not doubt that Mr A's chances of picking up an infection were increased by the fact that he required a second hip operation. And, as I commented earlier in this report, I found that the Board could have done more to prevent the falls that led to Mr A fracturing his right hip. I do not consider there to be conclusive evidence, however, of Mr A having two separate infections, or of the second hip operation directly causing an MRSA infection.

62. Mr A was clearly at a high risk of contracting an infection whilst in the Hospital and I found no evidence to suggest that the Board could have done anything more to prevent the initial infection of his foot sore. I also found the action taken by the Board following the discovery of MRSA on the site of Mr A's second operation to have been reasonable and in line with accepted practice.

63. There is no doubt that Mr A contracted MRSA at least once during his stay in the Hospital. The failings identified under conclusion (a) of this report would have increased his risk of infection and I consider that this increase in the level of risk was avoidable. However, with no clear evidence linking Mr A's MRSA to specific failures on the Board's part, or a direct link to Mr A's need for a second operation, I do not uphold this complaint and I have no recommendations to make.

**(e) The Board failed to inform Mr A's family of the rapid decline in his clinical condition or to contact them prior to his death**

64. Mr A underwent a third operation on 17 September 2009 to remove his new hip joint, which was suspected as being a site of his MRSA infection. During surgery, Mr A lost a lot of blood, due to his blood not clotting well, and Consultant 1 was contacted around 20:00 and asked to review Mr A's condition. The Board's records indicated that Consultant 1 provided advice over the telephone regarding packing Mr A's wound and providing blood clotting factors. Mr A was taken to the HDU at around 21:00, rather than returning to Ward 20.

65. Around 22:30, Mr A suffered a cardiac arrest and the Crash Team were called. Their attempts to resuscitate Mr A were unsuccessful and he died at 23:15.

66. Mr C complained that none of Mr A's family members were contacted by the Board prior to Mr A's death. He explained that the Board did not contact Mr A's family until 00:00, meaning that Mr A died without any of his family at his

bedside. During a conversation with my complaints reviewer, Mr C subsequently clarified that the Board had left a message on his answer machine at 23:15, explaining that Mr A had died, but he did not pick this message up until 02:00 the following morning. The Board telephoned Mr C's brother at 23:45 and informed him of Mr A's death. Mr C asked the Board why no contact had been made prior to Mr A's death, and why it had taken so long following his death for the family to be notified. At his meeting with the Board, Mr C explained that he had been at home all evening on 17 September 2009 but received no calls. He said that he telephoned the Hospital at around 21:00 and was told that Mr A was still in the recovery ward. Mr A was, in fact, in the HDU at that time.

67. The Board told Mr C that if he had called Ward 20 following Mr A's surgery, ward staff would not have been aware of the fact that Mr A had been taken to the HDU. The Board said that HDU staff had attempted to contact Mr A, but had been unable to do so until after Mr A had died.

68. In their response to Mr C's formal complaint, the Board noted that Mr A had been admitted to the HDU at around 21:00 on 17 September 2009. His condition was immediately considered to be of concern and the Orthopaedic Registrar attempted to contact Mr C on a number of occasions between 21:00 and 22:30 but there was no answer on the contact number that he had. It was not until 23:15, when Mr A had died, that nursing staff in the HDU had the opportunity to look through their documentation and find an alternative contact number. The Board apologised to Mr C for the delay in contacting his family.

69. Adviser 1 reviewed Mr A's records and commented that she would expect family members to be informed when a patient's condition deteriorates. She noted that Mr C was notified of Mr A's surgery at around 11:15, as he was required to provide consent on Mr A's behalf and attended the Hospital in person to do so. Adviser 1 was critical, however, of the lack of contact with Mr A's family between 20:00, when Mr A's condition deteriorated following surgery, and 23:15.

70. The documentation gathered by my complaints reviewer included a statement from nursing staff in response to Mr C's complaint, explaining that a number of calls were made between the HDU and the anaesthetic and orthopaedic teams between 21:00 and 22:30. Separate nursing notes recorded that the Orthopaedic Registrar attempted to contact Mr A's family on a number

of occasions during the same time period, but that there was no answer. A note made by staff on Ward 20 stated 'Went to theatre 15:40 awaiting return. Family phoned numerous times to enquire of his condition. Updated'. A further note from Ward 20 stated 'Awaiting return from theatre to ward. Phoned and he was in recovery room - awaiting consultant review'. The following page in the records contained clear contact information for Mr C and his brother.

71. The Board's records showed that an alternative contact number was found after 23:15 and that 'son' was notified of Mr A's death at 00:00. All of Mr A's children subsequently attended the Hospital.

*(e) Conclusion*

72. I consider there to have been a breakdown in communication between the staff of Ward 20 and the HDU. Had Ward 20 staff been aware of Mr A's transfer to the HDU following his surgery, Mr C and his family may have been better informed regarding Mr A's condition.

73. I acknowledge that attempts were made by the Orthopaedic Registrar to contact Mr C when Mr A's condition deteriorated and that a message was left for Mr C following Mr A's death at 23:15.

74. Whilst I am satisfied that the Board made attempts to contact Mr A's family, I am mindful of Mr C's comments regarding the fact that Mr A died alone and consider that more could have been done to prevent this. I share Adviser 1's view that contact should have been made around 20:00 when Mr A's condition first deteriorated. There may have been more time at this point to find and try each of the contact numbers held by the Board. Furthermore, the clinical records show that Ward 20 held contact information for Mr C and his brother on a single page and that family members had been in regular contact with Ward 20 seeking updates on Mr A's condition. Whilst Ward 20 staff evidently sought information from the surgical team, they were not updated when Mr A's condition deteriorated or when he was taken to the HDU. Had this information been fed back to Ward 20, the lack of contact with the family that followed could have been avoided. I also consider that messages could have been left on Mr C's answer machine during the Orthopaedic Registrar's earlier attempts at making contact and found the 30 to 45 minute delay between Mr A's death and contact being made with Mr C's brother to be excessive.

75. With all of the above in mind, I uphold this complaint.

*(e) Recommendation*

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| 76. | I recommend that the Board: | *Completion date* |
| (i) | review the circumstances leading to Mr C's complaint and consider introducing measures to improve communication with patients' families. | 30 June 2011 |

**(f) The Board failed to remove a catheter tube from Mr A's body**

77. Mr C complained that when Mr A died, a catheter tube was left in his body. He said that this meant that the family were unable to fulfil his father's wish of being buried in his suit.

78. The Board explained that, during last offices (the practice of preparing the body after death), which were carried out by nursing staff, there was a problem in trying to arrest the leakage of blood and a hip wound drain (rather than the catheter referred to by Mr C) was clamped and left in place in an attempt to stop the leaking blood. Nursing staff were aware that Mr A's case would be referred to the Procurator Fiscal, and for this reason, a number of other surgical devices were also left in place. The Board noted that, when this is the case, it is their normal practice to remove any devices during the post-mortem, or prior to the body being released to the Funeral Director. On this occasion, however, the Consultant Pathologist and Mortuary Technician decided not to remove the drain, as they felt that they would not be able to stop the ongoing leakage from Mr A's wound. It was assumed that the Funeral Director would remove the drain.

79. Mr C advised my complaints reviewer that the Funeral Director had refused to remove the drain, as he was concerned about contamination.

80. My complaints reviewer asked Adviser 1 whether she would expect hospital staff or the Funeral Director to remove such devices. Adviser 1 was unaware of any standard practice in this regard. She felt that it was reasonable to expect hospital staff to remove the drain but, noting the potential amount of fluid that could continue to drain from the body for several days, felt that it may be reasonable in certain circumstances to leave drains in place.

81. The Board accepted that they could have removed the device prior to releasing Mr A's body to the Funeral Director. As a result of Mr C's complaint,

they arranged for a review of their protocols within the Pathology Department to ensure that in future all devices are removed before transfer to funeral directors.

*(f) Conclusion*

82. I accept Adviser 1's comments regarding reasonable practice and acknowledge the Board's reasons for not removing the drain from Mr A's body. I also acknowledge that the Board have accepted that they could have removed the device and have taken proactive steps to change their protocols in this regard.

83. However, given the fact that the drain could have been removed by the Board, and in recognition of the impact that this had on Mr C's family, I uphold this complaint.

*(f) Recommendations*

84. In light of the action already taken by the Board, I have no further recommendations to make.

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

**Annex 1**

**Explanation of abbreviations used**

| | |
|---|---|
| Mr C | The complainant |
| Mr A | Mr C's father |
| The Hospital | Queen Margaret Hospital |
| HDU | The Surgical High Dependency Unit |
| The Board | Fife NHS Board |
| Consultant 1 | A consultant orthopaedic surgeon for the Board |
| Adviser 1 | The Ombudsman's nursing adviser |
| The Management Plan | The Board's High Risk Patient Care Management Plan |
| The Specifications | The Scottish Government's National Cleaning Specifications |
| MRSA | Meticillin-resistant staphylococcus aureus |
| The Doctor | Care of Elderly Doctor |
| UTI | Urinary tract infection |
| Consultant 2 | A consultant orthopaedic surgeon for the Board |
| Adviser 2 | The Ombudsman's GP adviser |

**Annex 2**

## Glossary of terms

| | |
|---|---|
| Furlong hemiarthroplasty | A replacement hip joint |
| Girdlestone's procedure | Surgery to remove a replacement hip joint. This procedure is used to fuse the thigh bone with the hip socket in cases where the replacement joint has caused infection |
| Induration | Hardening |
| Last offices | The practice of preparing a body after death |
| Left neck of femur | The left hip bone |
| Pyrexial | Feverish |
| Right neck of femur | The right hip bone |

**Annex 3**

## List of legislation and policies considered

The National Cleaning Specifications

Scotland's National Dementia Strategy

**Annex 4**

## Scotland's National Dementia Strategy – key points

### Key challenges

- Addressing the fear of dementia that means people delay coming forward for diagnosis
- Improving the information and support after diagnosis for those with dementia and their carers which is currently poor or non-existent
- Improving understanding in general healthcare services where the response to people with dementia and their carers can lead to poor outcomes
- Ensuring that people with dementia and their carers are always treated with dignity and respect
- Improving the help for family members who support and care for people with dementia in order to protect their own welfare and to enable them to continue caring both safely and effectively

### Key service delivery areas

- Improved post-diagnostic information and support
- Improved care in general hospital settings including alternatives to admission and better planning for discharge

### Specific actions

- To develop and implement common standards of care for people with dementia
- To improve staff skills and knowledge in both health and social care settings
- To provide support for local service change and pilot an integrated change programme in one area of Scotland
- To improve the information systems that are in place so that people managing, delivering and scrutinising services have better information about service delivery and outcomes
- To continue the work to increase the number of people with dementia who have a diagnosis as this improves access to services and support for them and their carers

- To ensure that people receiving care in all settings get access to treatment and support that is appropriate, with a particular focus on reducing the inappropriate use of psychoactive medication
- To improve the management of care for people with dementia through faster implementation of the dementia care pathway, with a particular focus on diagnosis and responding to behaviour that people find challenging
- To continue to support world class research into both medical treatments for dementia and the delivery of care for people with dementia

**Annex 5**

**Fife NHS Board Falls Risk Management: high risk patient care management plan**

1. If the patient has fallen prior to admission, document the circumstances surrounding the fall, if known.
2. If the patient has fallen or had a near miss whilst in hospital, document the circumstances surrounding the fall and action taken to prevent recurrence.
3. Document patient risk assessment score.
4. Document in falls diary.
5. Communicate risk assessment score to other members of the multidisciplinary team.
6. Keep bed on lowest height setting except when giving nursing care. Ensure brakes are on and locked.
7. Use a chair of appropriate design for the patient.
8. Ensure patient has all necessary items within reach, including nurse call bell. If the patient wears glasses or has a hearing aid ensure they are well fitting and are in working order and the patient is wearing them.
9. Check the patient's footwear, refer to Podiatrist/Chiropodist if required. Advise patient/carer on the appropriate footwear if necessary. Document any action.
10. Assess the patient's environment for safety hazards and remove clutter. Ensure spillages are wiped up immediately.
11. Assist with regular toileting, if required.
12. Refer to OT/Physiotherapist if assessment of function is required. Refer to Medical Team for review of medication.
13. Education of patient/carer in safe practices.
14. Frequently re-orientate confused patients to the location of facilities.
15. Assess patient regarding the use of bed rails. Complete risk assessment. Note in documentation if bed rails are used. NPSA Safer Practice Notice 17, February (2007) *Using Bedrails Safely and Effectively*.
16. Position patient in easily observable area if possible, ie, near to nurses' station.
17. Consider one to one nursing if possible. Review on a shift by shift basis.
18. Consider using Falls Prevention Monitoring Equipment. Note in documentation if used and advise next of kin/carers.
19. Consider the use of hip protectors following discussion with the Physiotherapist.