Scottish Parliament Region: Mid Scotland and Fife

Case 201102756: Forth Valley NHS Board

Summary of Investigation

Category
Health: Hospital; care of the elderly; clinical treatment; diagnosis

Overview
The complainant, Mr C, raised a number of concerns about the care and treatment given to his father (Mr A) during the final days of his life.

Specific complaints and conclusions
The complaints which have been investigated are that:

(a) nursing staff at Bannockburn Hospital (Hospital 1) failed to recognise that Mr A's condition was such that he required appropriate medical assistance (*not upheld*);

(b) two out-of-hours doctors who separately attended Mr A assessed and treated him inappropriately. In particular, they failed to recognise his poor condition and arrange for a transfer to Stirling Royal Infirmary (*upheld*);

(c) the decision making, care and communication of nursing staff in relation to the provision of palliative care for Mr A was inappropriate (*upheld*);

(d) nursing staff inappropriately refused to provide even the most basic of medical records to a medically qualified relative, despite him having Mr C's consent as next of kin with welfare power of attorney (*not upheld*);

(e) a staff nurse refused to allow a medically qualified relative to speak to Mr A's on call consultant and the on call consultant failed to recognise the importance of having this conversation (*not upheld*);

(f) an inappropriate care and treatment plan was agreed between the staff nurse and the on call consultant pending the arrival of an out-of-hours doctor (*not upheld*);

(g) during his stay in Hospital 1, Mr A's consultant failed to make himself available to meet with Mr C, who was next of kin with welfare power of attorney. This was despite Mr C's best efforts (*not upheld*); and

(h) during Mr A's stay in Hospital 1 there was an unacceptable level of care with regard to his possessions, which resulted in the unacceptable loss of his spectacles for some weeks and his hearing aid which was never recovered (*not upheld*).

Redress and recommendations

The Ombudsman recommends that Forth Valley NHS Board:	*Completion date*
(i) complete a critical incident review regarding this situation, if they have not done so already;	19 December 2012
(ii) consider the practicality of having routine discussions regarding care escalation for patients admitted to Hospital 1 and other similar units;	19 December 2012
(iii) consider the means by which it can be ensured that severe illness is promptly recognised in such units, by use of a Scottish Early Warning Score or similar scoring system;	19 December 2012
(iv) consider a strategy for determining the appropriate limits of care as soon as a patient in Hospital 1 or similar unit becomes acutely unwell and where there has been no anticipatory care discussion;	19 December 2012
(v) emphasise to staff in Hospital 1 the importance of keeping full and proper records, including notes of conversations and telephone conversations; and	19 October 2012
(vi) remind Hospital 1 staff of the Do Not Attempt Cardiopulmonary Resuscitation Policy and provide evidence that they have done so.	19 December 2012

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

Main Investigation Report

Introduction

1. The complainant (Mr C) raised a number of concerns about the care and treatment given to his father (Mr A) during the final days of his life while he was a patient in Bannockburn Hospital (Hospital 1).

2. Mr A was an elderly gentleman who had been living in a residential home. After an admission to Stirling Royal Infirmary (Hospital 2) for, amongst other things, acute renal failure, he was transferred to Hospital 1 on 1 November 2010 for rehabilitation. His summary assessment was marked as being 'For CPR'. Mr A was also noted as having at the time Urinary Tract Infection (UTI), acute renal failure and a tracheostomy (he had laryngeal cancer). He also needed to wear glasses for reading and a hearing aid to follow ordinary conversation.

3. Mr C said that Mr A's condition declined, particularly over 26 and 27 December 2010 but that staff at Hospital 1 failed to take appropriate action or provide him with the appropriate treatment. He said that they did not recognise the seriousness of his condition nor arrange for his timely transfer to Hospital 2 for what he considered to be proper palliative care.

4. Mr A was transferred to Hospital 2, an acute unit, on 27 December 2010. Mr A died there on 28 December 2010.

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

(a) nursing staff at Hospital 1 failed to recognise that Mr A's condition was such that he required appropriate medical assistance;

(b) two out-of-hours doctors who separately attended Mr A assessed and treated him inappropriately. In particular, they failed to recognise his poor condition and arrange for a transfer to Hospital 2;

(c) the decision making, care and communication of nursing staff in relation to the provision of palliative care for Mr A was inappropriate;

(d) nursing staff inappropriately refused to provide even the most basic of medical records to a medically qualified relative despite him having Mr C's consent as next of kin with welfare power of attorney;

(e) a staff nurse refused to allow a medically qualified relative to speak to Mr A's on call consultant and the on call consultant failed to recognise the importance of having this conversation;

(f) an inappropriate care and treatment plan was agreed between the staff nurse and the on call consultant pending the arrival of an out-of-hours doctor;

(g) during his stay in Hospital 1, Mr A's consultant failed to make himself available to meet with Mr C, who was next of kin with welfare power of attorney. This was despite Mr C's best efforts; and

(h) during Mr A's stay in Hospital 1, there was an unacceptable level of care with regard to his possessions, which resulted in the unacceptable loss of his spectacles for some weeks and his hearing aid which was never recovered.

Investigation

6. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Mr C and the Forth Valley NHS Board (the Board). My complaints reviewer also had sight of the Board's complaints file and Mr A's appropriate clinical records. Independent nursing and clinical advice was also obtained and taken into account.

7. While this report does not include every detail investigated, 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) Nursing staff at Hospital 1 failed to recognise that Mr A's condition was such that he required appropriate medical assistance

The complaint

8. Mr C said that Mr A was seen by a number of visitors on Christmas Day, who found him to be well and in good spirits but, by 26 December 2010, when he visited, he said that Mr A looked generally unwell, was noticeably weaker and was breathing heavily and quickly. He had had a fall. Mr C believed that this change in circumstances should have prompted nursing staff to seek medical assistance. He said this only happened at his insistence and he maintained that nursing staff failed to recognise the fact that Mr A was seriously unwell.

The Board's response

9. Mr C considered that the Board had played a contributory role in Mr A's death, so he wrote to the Board complaining about this and other matters. His complaint letter was dated 27 March 2011 and on 14 July 2011 he received the Board's response. With regard to this aspect of the complaint, the Board

described Hospital 1. They said that it was a community hospital providing care for patients who required non-acute care, rehabilitation, palliative care and care for those awaiting care in another setting, such as a nursing home. They went on to explain that when Mr A was a patient in Hospital 1, GPs covered the wards from 09:00 until 17:00. Emergency medical cover out of hours and at weekends and public holidays was provided by the GP out-of-hours service (OOH). They pointed out that should patients become unwell while at Hospital 1, nursing staff were aware that they should contact OOH, who would assess the patient and decide the most appropriate management of care.

10. On 26 December 2010, the Board said that nursing staff telephoned Forth Valley OOH at 19:35. They said that Mr A had vomited during the afternoon and had a 'moist' chest. Blood pressure, pulse, temperature, respiratory rate and urine analysis results were provided. The call was registered as a routine visit which had a four hour priority. The first OOH doctor (Doctor 1) then visited Mr A at 21:30.(see below).

11. In the meantime, my complaints reviewer noted that on the morning of 26 December 2010, Mr A was found fallen at the side of his bed and he was 'checked over'. Observations were taken at 15:00 and it was noted that Mr C was present in the ward at 16:20. Mr C said that it was his concern expressed then that led nursing staff to contact OOH.

12. The following day, the Board said that nursing staff made further contact with OOH at 08:16 to say that Mr A was no longer passing urine and was more unwell. The visit was prioritised as 'soon', that is, within two hours. The second OOH doctor (Doctor 2) attended Mr A at 9:15, completing his visit at 10:05.

Advice received

13. My complaints reviewer asked the nursing adviser (Adviser 1) to consider the available nursing notes for this period of time. She said it was recorded that Mr A began to deteriorate at 19:30 on 26 December 2010 and from that point he was closely observed. She said records were completed at 22:10 when he was seen by Doctor 1. The next day (27 December 2010) at 02:30, 06:00 and 09:00, nursing staff continued to document Mr A's ongoing deterioration and OOH was contacted again as was the family, who were informed of his poor condition.

14. In the Adviser 1's view, she said there was evidence to suggest that staff recognised Mr A's deteriorating condition, recorded their findings, informed the family and took the appropriate action by calling OOH (Doctors 1 and 2).

(a) Conclusion

15. Mr C firmly believes that it was only after he expressed concern on the afternoon of 26 December 2010 that nursing staff contacted OOH. He did not consider that nurses recognised the severity of Mr A's condition on that day, or on the following day (27 December 2010).

16. The records show that Mr A was observed at 15:00 and 19:35 on 26 December 2010 and Doctor 1 was called because of a deterioration in his condition. Mr A continued to be observed (at 22:10 on 26 December and at 02:30, 06:00 and 09:00, after which OOH was contacted) and Doctor 2 visited. On the first occasion the OOH call was recorded as routine, whereas on 27 December 2010 the call had a two hour priority. Mr A's family were advised of his poor condition.

17. I have carefully considered what Mr C has said about this matter and I have also taken into account the independent nursing advice received. I am of the view that nursing staff were aware of the seriousness of Mr A's condition. They were monitoring it and, as staff were concerned, they called OOH to assess Mr A and determine the appropriate management of his case. This was in accordance with the Board's procedure (see paragraph 9). Taking into account all these circumstances, I do not uphold the complaint.

(b) Two out-of-hours doctors who separately attended Mr A assessed and treated him inappropriately. In particular, they failed to recognise his poor condition and arrange for a transfer to Hospital 2

The complaint

18. Mr C is of the opinion that Mr A was denied the level of care to which he was entitled and believed that the two OOH doctors who examined him on 26 and 27 December 2010 failed to do so properly or to appreciate the seriousness of his condition. He said that because they did not refer him to Hospital 2 earlier, he was denied standard palliative care.

19. At Doctor 1's visit, Mr C said Mr A was diagnosed as having a urinary tract infection and prescribed oral antibiotics but he said that this was inadequate and that steps should have been taken to change his catheter under

appropriate antibiotic cover. Thereafter he should have been monitored, particularly with regard to his fluid balance. He added that as Mr A was seriously unwell, he should have been admitted urgently to Hospital 2 for intravenous fluids, likely intravenous antibiotics and further investigations.

20. Mr C complained that he had even more serious concerns about Doctor 2's visit on 27 December 2010. By then, he said, it was apparent that Mr A's condition was seriously deteriorating. He said that Mr A was life-threateningly unwell but that Doctor 2 did little more than to change his catheter, draining two litres of urine. Mr C maintained that this alone should have prompted serious consideration of intravenous fluid therapy. Mr C maintained that at the time of Doctor 2's visit Mr A would have been in extreme pain and he should certainly have been transferred to Hospital 2.

The Board's response

21. Mr C raised his complaints about the OOH doctors in his letter to the Board of 27 March 2011. In their response of 14 July 2011, they said that Doctor 1 had taken a detailed history of Mr A from the staff nurse. At examination, the Board said, Doctor 1 said that Mr A was fully conscious, not distressed but clammy. His pulse was not raised although his respiratory rate was mildly raised. The Board said that Mr A was taking fluids orally and the vomiting had settled (see paragraph 10). A catheter was in place which was draining urine and his chest sounds were moist which, with a history of vomiting, raised the possibility of a chest infection. Ward testing of his urine and lower abdominal tenderness also suggested a urine infection. However, the Board said, Mr A's catheter was still draining and his bladder was not clearly palpable (capable of being touched or felt).

22. Doctor 1 concluded that Mr A was most likely to have a urinary tract infection, of which he had a previous history, and that there was also the possibility of a chest infection. Therefore, in order to cover both possibilities, the Board said Doctor 1 prescribed co-amoxiclav and requested that Mr A's intake of fluids be charted. The Board said that Doctor 1 considered changing Mr A's catheter but as it continued to drain, and because of the increased risk of septicaemia, he asked nursing staff to increase his fluids and report any further deterioration for medical review. In view of Mr A's previous history of renal dysfunction, Doctor 1 requested staff to check his FBC (full blood count) and U and Es (urea and electrolytes to determine kidney function) the following morning.

23. The Board said that in view of Mr A's previous history of significant illness, general frailty and renal dysfunction, Doctor 1 discussed with nursing staff the possibility that his current deterioration could develop into a more life threatening illness. However, Doctor 1 decided that Mr A's condition was not likely to be critical enough in the next few hours to telephone Mr C and that Mr A's condition should be reassessed the following morning when his blood tests were known (see paragraph 22).

24. The next morning (27 December 2010) nursing staff contacted OOH at 08:16 as Mr A was no longer passing urine and was more unwell (see paragraph 12). Doctor 2 arrived about an hour later. The Board said that, after examination, Doctor 2 summarised Mr A's most pressing condition as being the retention of urine because he had a distended bladder and no output from his catheter. The Board said that as nursing staff advised Doctor 2 that there was no nurse available to change Mr A's catheter, he made a decision to do it himself because of the delay and distress which would otherwise have been caused to Mr A. The Board said that Doctor 2 drained one litre of urine, with the aid of a senior nurse.

25. In reporting the circumstances of both OOH doctors' visits to Mr A, in their reply the Board said that they had asked the Clinical Lead of OOH to review what had happened. The Board said that the Clinical Lead was not of the view that there was any evidence that either Doctor 1 or Doctor 2 had shown a conscious intentional disregard to Mr A's care and that the treatment given to him had been in line with the symptoms he had shown at the time. The Clinical Lead said that it was not the case that Doctor 1 had failed to recognise how ill Mr A was but that in her assessment there was no indication that Mr A required an acute hospital admission (to Hospital 2). Doctor 1, in the Clinical Lead's assessment, had acted in accordance with appropriate guidance (SIGN Guideline 18). Similarly, the Board said that the Clinical Lead was of the opinion that the oral antibiotic prescribed to Mr A was in accordance with the guidelines (Scottish Intercollegiate Guidelines Network (SIGN) Guideline 18). The Board were of the view that there was no indication that Mr A should have been admitted to an acute hospital for intravenous antibiotics, as he was tolerating fluid and there was no clinical evidence of dehydration. As Mr C had maintained in his complaint letter that two litres of urine had been drained from Mr A's catheter by Doctor 2, the Board said that only 'one litre of urine was drained at the initial catheter insertion' and there was no evidence of

dehydration. They went on to say that had two litres been drained, Mr A would have required admission for renal function monitoring but that he would not have received intravenous fluids unless oral fluids were not tolerated.

Advice received

26. My complaints reviewer obtained independent medical advice (from Adviser 2) about the care and treatment given by Doctor 1 and Doctor 2. Adviser 2 was also requested to review Mr A's appropriate clinical records. Before providing his opinion on the care and treatment given to Mr A, Adviser 2 commented generally about the quality of the available medical records. He said that he was unable to locate any routine observations, Scottish Early Warning Score (SEWS, an assessment tool) or fluid balance charts. He went on to say that although the Board's response to Mr C suggested that discussions had taken place between nursing staff and OOH doctors (see paragraph 23), these were not all recorded in the clinical records, neither did there appear to be any assessment, by Doctor 2 in particular, of Mr A's overall condition other than 'observations as per nursing notes'.

27. In considering Mr A's clinical records, Adviser 2 said that it was his opinion that he was developing a shock syndrome on the evening of 26 December 2010. He said this was evidenced by his very low blood pressure, increased heart rate and the description of him being 'cold and clammy'. He said that it was likely that this clinical condition was caused by sepsis (infection in the bloodstream), hypovolaemia (low circulating blood volume) due to dehydration, or both. Adviser 2 added that low blood pressure of this degree in a hospitalised patient with two possible sources of infection constituted a medical emergency. He said that, given that Doctor 1 documented the blood pressure in her note and Doctor 2 referred to the nursing observations, both doctors must have been aware of the fact that Mr A's blood pressure was very low.

28. It was Adviser 2's view that it was not possible to determine whether or not OOH doctors had failed to appreciate the significance of the low blood pressure, but believed that the escalation of care to an acute hospital environment was futile (ie, not likely to make a difference to outcome); inappropriate in the context of Mr A's overall condition; or, not in accordance with Mr A's wishes or any existing power of attorney. He went on to say that in his professional opinion the appropriate management on the evening of 26 December 2010 would have been to treat Mr A aggressively with intravenous fluids and

intravenous broad spectrum antibiotics (including antibiotics to cover possible hospital acquired infections), change the catheter immediately, give supplemental oxygen and pain relief as necessary. He said that in Mr A's case this would have meant moving him to another hospital. Alternatively, to have immediately have discussed the appropriateness of such aggressive care with Mr A, if possible, or any other proxy decision maker if Mr A was unable to do so (Mr C had power of attorney), the nursing staff who knew Mr A well and the consultant on call for the unit. The medical adviser said that none of these courses of action occurred. Mr A was given inadequate antibiotic treatment for sepsis, no fluid replacement and did not have a catheter change.

29. Concerning Doctor 2's attendance with Mr A on the morning of 27 December 2010, Adviser 2 said that he could see no evidence that at that stage Doctor 2 considered Mr A's fluid balance status; the fact that he had significant hypotension which, sustained over this period of time, was a marker of serious illness; that diarrhoea would worsen fluid loss; or that Mr A had inadequate fluid intake despite nurses' prompting. He said there was no documentation of whether Mr A had or had not responded to the treatment started the previous evening or any documentation of any discussion or consideration of the need or appropriateness of escalating care in an acute setting. There was no documentation of the follow-up required over the day, when a doctor should review Mr A again, or what criteria nursing staff might use to request a further review. Adviser 2 said that, in the event, further review happened at Mr A's family's request.

30. Adviser 2 said the notes did not make it clear what discussions had taken place with the family about Mr A's condition because while the notes said that they had been 'updated', it was not clear what information had been provided. He said that, in particular, it was not clear whether there had been any discussion about transferring care to an acute hospital being appropriate, or an explicit explanation of 'the clearly life threatening nature of the patient's condition'. Adviser 2 said that later, during the evening of 27 December 2010, a nurse explained to the family that 'it would not be likely that a transfer would take place' as 'the patient was not for resus'.

31. Overall, Adviser 2 said that in his opinion, 'the medical management of this patient at the point of the first OOH assessment and subsequently until the decision to move the patient to Hospital 2 on the evening of 27th was clearly below a standard that can reasonably be expected in a unit of this sort'. He

further added that, although the Board maintained that action was taken in line with relevant guidance, he did not agree and said that the Board's response to Mr C's complaint contained a number of inaccuracies and omissions. For instance, he said that there was no mention of the fact that Mr A was significantly and suddenly hypotensive on the evening of 26 December 2010 and that he remained so while in Hospital 1; and they suggested that the appropriate guideline against which to judge treatment was SIGN Guideline 18 (in fact it was SIGN Guideline 88), which related to the management of urinary infection. At the point of presentation, the clinical situation did not indicate that a urinary tract infection was definitely the source of Mr A's infection. Doctor 1 considered that a chest infection was also present. He said the clinical situation was actually that of severe hypotension, probably secondary to sepsis, in a hospitalised older patient with an indwelling catheter. Treatment should have been based on this presentation; and the Board's reply also suggested that following catheterisation only one litre of urine was drained and suggested that if two litres had been drained Mr A would have been transferred to another hospital. Adviser 2 told me that Mr A was in fact drained of two litres of urine within the first hour of catheterisation, all of which was likely to have been in his bladder at the time of catheterisation.

(b) Conclusion

32. The circumstances surrounding Mr A's last few days in Hospital 1 have been given careful consideration and I have noted Adviser 2's opinion about the medical records, the care and treatment given to Mr A and the Board's response to Mr C's complaint. From this, I am satisfied that Mr A was not appropriately assessed or treated. While I recognise that Adviser 2 felt that it was not possible to determine whether or not the OOH doctors failed to appreciate the significance of Mr A's low blood pressure and thought that transferring him was futile or inappropriate (see paragraph 28), I am of the view that Mr A should have been transferred to Hospital 2. At the time of the initial deterioration, discussions should have taken place with either Mr A or Mr C about this. Therefore, I uphold the complaint.

33. Accordingly, I make the following recommendations; if the Board have not conducted a critical incident review regarding this situation, they should do so now. Further, that the Board consider the practicality of having routine discussions regarding care escalation for patients admitted to Hospital 1 and other similar units; the means by which it can be ensured that severe illness is promptly recognised in such units by use of a SEWS or similar scoring system;

and a strategy for determining as soon as a patient in Hospital 1 or similar unit becomes acutely unwell, and where there has been no anticipatory care discussion, the appropriate limits of care.

(b) Recommendations

34.	I recommend that the Board:	*Completion date*
(i)	complete a critical incident review regarding this situation, if they have not done so already;	19 December 2012
(ii)	consider the practicality of having routine discussions regarding care escalation for patients admitted to Hospital 1 and other similar units;	19 December 2012
(iii)	consider the means by which it can be ensured that severe illness is promptly recognised in such units, by use of a SEWS or similar scoring system; and,	19 December 2012
(iv)	consider a strategy for determining the appropriate limits of care as soon as a patient in Hospital 1 or similar unit becomes acutely unwell and where there has been no anticipatory care discussion.	19 December 2012

(c) The decision making, care and communication of nursing staff in relation to the provision of palliative care for Mr A was inappropriate

The complaint

35. Mr C said that on the morning of 27 December 2010, he received a call from Hospital 1 that the family were welcome to visit Mr A at any time, even outwith normal visiting hours. His view was that nursing staff were, therefore, aware of his father's life threatening condition but, despite that, did not summon medical assistance. He said that, furthermore, this implied that Mr A was for palliative care only. He was aggrieved because if this decision had been made it had been made by nursing staff without discussion with the family and, thereafter, such palliative care was not given. Mr C said that he arrived at Hospital 1 at lunch time but Mr A's care was still not discussed with him. By the evening, Mr A was in excruciating pain when further family members arrived (including Mr C's son, who was medically qualified). Mr C complained that staff did not summon an OOH doctor until his son became insistent that they did so.

36. Together with this, Mr C believed that nursing staff misunderstood the purpose of Mr A's 'Do not attempt CPR (Cardio Pulmonary Resuscitation) form'. He said he believed that this was interpreted not so much as not for CPR but

not for 'appropriate medical management' or transfer to a more appropriate hospital.

The Board's response

37. In response to this complaint, the Board said in their letter to Mr C (of 14 July 2011) that clinical records showed that Mr A continued to receive active treatment while he was in Hospital 1. That is, he received antibiotic therapy (but see advice at Complaint (b)); he was moved into a single room for privacy for him and his family; and total nursing care was administered. The Board said that a decision to place Mr A on the Liverpool Care Pathway (a care pathway for patients in the final days and hours of life, which becomes a structured record of the actions and outcomes that develop. It aims to help doctors and nurses to provide end of life care) was generally a multi-disciplinary decision which had not been taken at the time. The Board, however, maintained that nursing staff discussed Mr A's care with Mr C when he visited at lunch time on 27 December 2010 and that he raised no concerns. Similarly, they said the staff nurse on duty called Mr C, as it had been agreed she would, telling him of Mr A's deteriorating condition. She said that although Mr C's son called later (at about 20:00) asking for a detailed update, she was unable to give this over the telephone but the Board said she did give basic information. Mr C's son asked whether an OOH doctor had been called and the staff nurse agreed to call him if Mr C's son wanted this, which he did, and Doctor 2 was called and attended at 21:30.

38. The Board also said that as there appeared to be a misunderstanding about the purpose of Mr A's Do Not Attempt Resuscitation (DNAR) form, the staff nurse advised that she was fully aware what the definition meant and what it meant in so far as treatment was concerned. It was confirmed that in Mr A's case it did not mean that he should not receive active treatment.

Advice received

39. I asked both Adviser 1 and Adviser 2 to confirm from the notes what Mr A's status was in Hospital 1, in relation to CPR. Adviser 2 said that it was not clear. Mr A was transferred from Hospital 2 to Hospital 1 on 1 November 2010 for rehabilitation and while he was a patient in Hospital 2 his notes from his initial admission contain a (DNAR) form dated 21 October 2010. Adviser 2 said this seemed to him to be a 'local' form and not one of the nationally agreed forms. Notwithstanding, the justification for DNAR status was ticked as 'Successful CPR is likely to be followed by a length and quality of life

which has been assessed as not being in the best interests of the patient to sustain'. Adviser 2 said there was no evidence on file to confirm that a discussion about this took place with Mr A or his family, as he would have expected if the resuscitation decision was made on the grounds that the patient's possible quality and longevity of life following resuscitation would be unacceptable, as they appeared to be in Mr A's case. Nor was the DNAR form countersigned by a consultant, as he would have expected. He added that DNAR decisions related purely to cardiopulmonary resuscitation, that is, measures taken to restart the heart circulation and breathing should they cease. They did not apply to other decisions regarding patient care. Therefore, the patient's resuscitation status (which in his view was not adequately documented) had no direct bearing on the decision to initiate intravenous therapy or transfer Mr A to a setting where more intensive observation and treatment could be provided. In Mr A's case, Adviser 2 said, there was no evidence that any discussion took place with either Mr A or Mr C about the appropriate intensity of treatment in the event of a decline. This included any discussion about resuscitation.

40. In accordance with current practice, the DNAR form and accordingly Mr A's patient's resuscitation status, would follow him when he moved to Hospital 1. On the nursing admission document to Hospital 1, Mr A was clearly marked as 'For Resuscitation'. Adviser 2 said he could find no further documentation regarding Mr A's resuscitation status while he was in Hospital 1 until a nurse commented to a family member that he was not for resuscitation. He speculated that this decision was derived from the form in the notes from Hospital 2 (see paragraph 39) if those case notes were available to the nurse. Adviser 2 was of the opinion that, overall, the means by which resuscitation decisions were made, the documentation of resuscitation status and attention to the potential need to discuss or inform the patient and his family members of that status was below a standard which could reasonably be expected in a unit like Hospital 1.

41. Specifically, with regard to the nursing notes, Adviser 1 agreed and said she could find no record of a decision to implement a DNAR order.

(c) Conclusions

42. From the available medical notes I am satisfied that on 27 December 2010, nursing staff contacted an OOH doctor at 08:16 and he attended at 09:15 (see paragraph 24). About this time nursing staff also

telephoned Mr C. Thereafter, despite Mr A's condition which was deteriorating with a sudden decline at 19:20, no further call was made to an OOH doctor until 20:46, which was at the request of Mr A's family (see paragraphs 29 and 37).

43. The situation with regard to Mr A's resuscitation status was also confused and there was little documentary evidence concerning it or about any conversations which should have taken place between staff and Mr A and/or his family. I noted the staff nurse's comments above (see paragraph 28) but the advice I have received and accepted in complaint (b) above was that Mr A's treatment should have been better.

44. Both advisers have also told me there was little or no record of discussions with Mr A or his family about his resuscitation status or the severity of his condition. Taking all these factors into account, I uphold the complaint. In the circumstances, I recommend that the Board emphasise to staff in Hospital 1 the importance of keeping full and proper records, including notes of conversations and telephone calls. I also recommend that the Board remind Hospital staff of the Do Not Attempt Cardiopulmonary Resuscitation Policy and provide evidence that they have done so.

(c) Recommendations

45.	The Ombudsman recommends that the Board:	*Completion date*
(i)	emphasise to staff in Hospital 1 the importance of keeping full and proper records, including notes of conversations and telephone conversations; and	19 October 2012
(ii)	remind Hospital 1 staff of the Do Not Attempt Cardiopulmonary Resuscitation Policy and provide evidence that they have done so.	19 December 2012

(d) Nursing staff inappropriately refused to provide even the most basic of medical records to a medically qualified relative, despite him having Mr C's consent as next of kin with welfare power of attorney

The complaint

46. Mr C's son is a medical doctor. He went with Mr C to Hospital 1 on the evening of 27 December 2010. Mr C said his son was very concerned about Mr A's condition and he asked to look at his notes and observations. Mr C said that this was with his agreement as Mr A's Welfare Power of Attorney. Mr C said that despite this, the request was refused although the staff nurse present provided a stethoscope. Mr C's son later asked that Mr A be immediately

transferred to Hospital 2 and it was suggested that he speak to the on call consultant, which Mr C's son agreed he would do.

The Board's response

47. In responding to this complaint, the Board said that when Mr C's son asked for sight of the medical records, the staff nurse concerned explained to him that she was unable to allow him the access he wished. During the conversation, the staff nurse said that she questioned whether Mr C's son, as a relative, was allowed to examine Mr A.

Advice received

48. In considering this complaint, Adviser 2 commented that this was an extraordinary situation, which he recognised would be immensely stressful to both Mr A's family and to the nursing staff involved. Mr A's family were doing what they considered was best in his interests. However, Adviser 2 took the view that the staff nurse's understanding, that access to Mr A's medical records in the manner requested was not permitted, was correct and Adviser 1 agreed. He also agreed with the staff nurse's stated view that the examination of his relative was inappropriate. He said that the staff nurse's position was a reasonable position to take, even if the power of attorney gave permission for another to review the records or examine the patient. He said that the nurse in question twice telephoned the ward sister as the situation developed and she telephoned the on call consultant as the family requested.

49. Mr C questioned this advice when commenting on a draft of this report and Adviser 2 said that there was no doubt that a patient or proxy has the right to see case notes and that this has been so for some while. There is a process that an applicant must go through to see notes on an elective basis. However, if a patient or relative suddenly asks or demands to see case notes, he was aware of no advice that staff should accede to that request immediately. In his view, the response of most NHS staff would be what occurred in the situation described with regard to Mr A, which he said was a sensible and appropriate response.

(d) Conclusion

50. I accept that the circumstances described when Mr C and his family visited Mr A on the evening of 27 December 2010 would have been stressful for everyone involved. Mr C was trying to do the best for Mr A as he saw it. However, the advice I have received from both advisers is that the position the

staff nurse took by refusing access to the notes was a reasonable one. I do not uphold the complaint.

(e) A staff nurse refused to allow a medically qualified relative to speak to Mr A's on call consultant and the on call consultant failed to recognise the importance of having this conversation

The complaint

51. The staff nurse called the on call consultant (see paragraph 46) and Mr C said that his son waited at the nursing station. Some minutes later the nurse advised Mr C's son that the on call consultant had instructed her that they should wait for an OOH doctor to arrive and discuss ongoing management with him/her. Mr C said that his son was not given the opportunity to speak with the on call consultant. Mr C's son said given the fact that he had previously been informed that an OOH doctor could be two hours away, he was very concerned about this and said that he would wait only another ten minutes before he called 999. Fortunately, Mr C said, an OOH doctor arrived minutes later and confirmed that Mr A required immediate transfer.

52. The advice I received on this complaint was that the clinical notes confirmed that Mr C's son was not able to talk directly to the on call consultant, although Adviser 2 said that he did not feel that it could be said that Mr C's son was 'not allowed to speak' to the on call consultant. He said the nurse discussed the situation with the on call consultant and the on call consultant decided that it was the better course to wait until Mr C's son could speak with an OOH doctor attending to assess the patient.

(e) Conclusion

53. I am in no doubt about how fraught this situation was and how anxious Mr C and his family were over Mr A's condition. They wanted what they considered to be the best for him. As a consequence, the staff nurse telephoned the on call consultant and discussed the matter. It was the on call consultant's view that Mr C's son would be better speaking to an OOH doctor when they arrived. The advice I received does not criticise this approach and, accordingly, I do not uphold the complaint.

(f) An inappropriate care and treatment plan was agreed between the staff nurse and the on call consultant pending the arrival of the out-of-hours doctor

54. The circumstances concerned are discussed above (see paragraphs 51 and 52) and in corresponding with my office, the Board have said that no treatment plan was made between the staff nurse and the on call consultant. The on call consultant made a decision that it would be more appropriate to wait and for Mr C's son to speak with an OOH doctor.

55. Adviser 2 was not critical of this approach and taking into account what the Board have said, I do not uphold this complaint.

(f) Conclusion

56. For the reasons stated above (see paragraphs 54 and 55), I do not uphold this complaint.

(g) During his stay in Hospital 1, Mr A's consultant failed to make himself available to meet with Mr C, who was next of kin with welfare power of attorney. This was despite Mr C's best efforts

The complaint

57. Mr A was transferred to Hospital 1 on 1 November 2010 and stayed there until he was transferred to Hospital 2 on 27 December 2010. His son, Mr C, was next of kin, Power of Attorney (POA) and Welfare POA. He said that from the time of his admission he attempted to speak with Mr A's consultant to discuss his care but without success. Similarly, he said his telephone calls to the consultant's secretary were not returned. Mr C said that he eventually found the consultant's email address and sent him a message which resulted in a telephone call which he described as 'hurried' or 'quite brusque'.

The Board's response

58. In responding to this complaint the Board accepted that there had been an initial slight delay in speaking to Mr C and the consultant apologised. However, the consultant said that he only visited Hospital 1 on a weekly basis and preferred to have the patient's notes to hand when speaking to relatives.

59. The Board said that the consultant assessed Mr A's notes prior to speaking to Mr C on 15 November 2010. He recalled this as being a detailed conversation and not 'hurried'. The consultant maintained that he did not have a record of Mr C subsequently wishing to meet with him and that his email

contacting him (12 December 2010) did not request a meeting. He said that he considered that by telephoning Mr C on 13 December 2010 he was acting without delay. The consultant expressed surprise that Mr C referred to the telephone call as being brusque.

60. Meanwhile, from the information available during the investigation, it was noted that the consultant's secretary had noted that a message had been left by Mr C on the departmental answering machine and also that he had previously spoken to one of the departmental secretaries (on 5 November 2010). It was noted that Mr C was asking to speak with the consultant. The consultant, in providing his comments to the Board on Mr C's complaint, said that as he had not yet seen Mr A on 5 November he would not have been able to discuss his case with Mr C. Also, unfortunately, it was not highlighted to him by his secretary that Mr C wished to speak with him. The consultant apologised for the slight delay in contacting Mr C (two weeks after Mr A's admission and after he had seen Mr A).

(g) Conclusion

61. Mr C wanted to speak with Mr A's consultant on his admission to Hospital 1 but it was not until the consultant had seen Mr A that he spoke to him. Mr C left messages to speak with the consultant but it seemed that these were not brought to his attention. The consultant reviewed Mr A on 8 November 2010 and then spoke to Mr C on 15 November 2010, on receiving Mr C's email. He spoke to him again on 13 December, after receiving his email of 12 December 2010.

62. I have carefully considered what Mr C said in relation to this but I accept that the consultant was unaware of his attempts to contact him by telephone. After receiving messages from Mr C, the consultant called. I do not uphold the complaint, however, I suggest that the Board remind secretarial staff of the importance of passing on messages.

(h) During Mr A's stay in Hospital 1, there was an unacceptable level of care with regard to his possessions, which resulted in the unacceptable loss of his spectacles for some weeks and his hearing aid which was never recovered

The complaint

63. Mr C said that some of Mr A's possessions were lost or mislaid while he was in Hospital 1, for instance his spectacles and hearing aid disappeared for

weeks. In fact, his hearing aid was never found. Mr C said that as Mr A was a great reader, this led to a distinct fall in his quality of life and he became quieter and more withdrawn. He said that there was no sense of urgency to try to find these lost articles and, indeed, Mr C said on at least one occasion he was made to feel he was being awkward for mentioning their loss.

The Board's response

64. The Board apologised to Mr C about the loss of Mr A's property in their letter of 14 July 2011. They said they were sorry for the concern and frustration this caused Mr A. They mentioned that Mr A's spectacles had once been found in the laundry room and once in his toilet bag. They were later labelled and a case for them was obtained. No mention was made of his hearing aid.

Advice received

65. I asked Adviser 1 about this type of situation and she said that in community hospitals in particular, like Hospital 1, where there is often a more homely environment small articles are often misplaced. She said the Board had appeared to have investigated when items went missing and they had found Mr A's spectacles on two occasions. They also took action to try to prevent the situation recurring.

(h) Conclusion

66. I have no doubt that the loss of Mr A's spectacles and hearing aid affected his quality of life. However, I am satisfied that on being notified of their loss, on occasion, the Board were able to find them. While there is no mention of his hearing aid, I have not seen any evidence to suggest that these losses were necessarily as a consequence of the Board's action or inaction. Such items are easily misplaced. So while I regret the loss these articles had on Mr A and appreciate Mr C's upset about the matter, I do not uphold the complaint.

67. The Board have accepted the recommendations made in this complaint and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mr A	The complainant's late father
Hospital 1	Bannockburn Hospital
Hospital 2	Stirling Royal Infirmary
The Board	Forth Valley NHS Board
OOH	The out-of-hours service
Doctor 1	The first out-of-hours doctor
Doctor 2	The second out-of-hours doctor
Adviser 1	A nursing adviser
FBC	Full Blood Count
U and Es	Urea and Electrolytes
SIGN	Scottish Intercollegiate Guidelines Network
Adviser 2	A medical adviser
SEWS	Scottish Early Warning Score
CPR	Cardio Pulmonary Resuscitation
DNAR	Do Not Attempt Resuscitation
POA	Power of Attorney

Annex 2

Glossary of terms

Hypotension	low blood pressure
Hypovolaemia	low circulating blood volume
The Liverpool Care Pathway	a care pathway for patients in the final days and hours of life, which becomes a structured record of the actions and outcomes that develop. It aims to help doctors and nurses to provide end of life care
Palpable	capable of being touched or felt
Sepsis	infection in the bloodstream
Tracheostomy	a surgical procedure to assist breathing