Scottish Parliament Region: Mid Scotland and Fife

Case 201105263: Forth Valley NHS Board

Summary of Investigation

Category

Health: Hospital; Care of the Elderly; clinical treatment and diagnosis

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment provided to her late mother (Mrs A) in Stirling Royal Infirmary (the Hospital) between 21 and 23 February 2011. This included Mrs C's concerns: that hospital staff incorrectly diagnosed Mrs A with dementia rather than delirium, and failed to obtain proper consent for surgery; about how Mrs A's urinary tract infection was treated; and, about how Forth Valley NHS Board (the Board) responded to Mrs C's complaint.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board failed to explain how their diagnosis of dementia was reached (*upheld*);

(b) the diagnosis of dementia was inappropriately used to obtain consent for an operation (*upheld*);

(c) the approach to managing Mrs A's urinary tract infection was inappropriate (*upheld*); and

(d) there was a failure to accept clinical failings or offer an apology despite the findings of an external review (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Mrs C for incorrectly diagnosing Mrs A with dementia, and incorrectly completing a Certificate of Incapacity to obtain consent for Mrs A's operation;	14 May 2014
(ii) apologise to Mrs C for the poor standard of care provided to Mrs A;	14 May 2014
(iii) review their provision of specialist ortho-geriatric	31 July 2014

	care for patients like Mrs A, who commonly present with fractures but have other medical conditions that need to be managed in an orthopaedic ward;	
(iv)	apologise to Mrs C for their handling of her complaint, in particular their failure to accept the findings of the external review they commissioned; and	14 May 2014
(v)	carry out a Significant Event Analysis, with reflective commentary, of the care and treatment provided to Mrs A, the handling of Mrs C's complaint, and their response to the external review they commissioned.	31 July 2014

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

Main Investigation Report

Introduction

1. Mrs A was an 84-year-old woman who lived in a care home. She had a medical history that included recurrent urinary tract infections (UTIs).

2. On the morning of 21 February 2011, Mrs A fell at her care home and was taken to Stirling Royal Infirmary (the Hospital). Mrs A was assessed as needing surgery to repair a fractured wrist. After cancellation of her surgery on 22 February 2011 caused by concerns over her condition, Mrs A was taken back to theatre on 23 February 2011. Mrs A initially became very unwell during the anaesthetic, but was successfully resuscitated, and the fracture was manipulated into position. Mrs A then had a cardiac arrest and died in theatre.

3. This case came my office within time under Section 10(1) of the Scottish Public Services Ombudsman Act 2002. However, during investigation it became clear that the matter of Mrs A's death was being considered by the Procurator Fiscal (PF). The case was closed by us in October 2012 awaiting the outcome of the PF's involvement. Mrs C contacted the SPSO in May 2013 with a copy of the PF's letter of April 2013, which said that Crown Counsel had instructed that there was no basis for a Fatal Accident Inquiry. We received the necessary information from the PF in September 2013 which enabled us to recommence our investigation.

4. The complaints from Mrs A's daughter (Mrs C) which I have investigated are that:

(a) Forth Valley NHS Board (the Board) failed to explain how their diagnosis of dementia was reached;
(b) the diagnosis of dementia was inappropriately used to obtain consent for an operation;
(c) the approach to managing Mrs A's urinary tract infection was inappropriate; and
(d) there was a failure to accept clinical failings or offer an apology despite the findings of an external review.

Investigation

5. In order to investigate the complaint, my complaints reviewer considered copies of the complaint correspondence and Mrs A's clinical records, and

sought independent advice from one of my advisers, a consultant geriatrician (the Adviser).

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to explain how their diagnosis of dementia was reached

7. On 26 April 2011, Mrs C wrote to the Board to complain about the care and treatment Mrs A received at the Hospital. In her letter, Mrs C referred to an episode of confused speech and unusual behaviour by Mrs A at the Hospital on 22 February 2011. Mrs C said she informed a doctor that Mrs A did not normally behave in this way, as it was possible to hold a normal conversation with Mrs A, and that Mrs A did not have dementia. Mrs C said she got the impression that hospital staff thought Mrs A had dementia and disregarded any other cause of her state of mind. Mrs C said that if hospital staff had read Mrs A's notes they would have seen that Mrs A suffered from recurrent UTIs, and then acted appropriately to check whether this was a factor in her behaviour.

8. The Board responded to Mrs C's complaint in a letter of 15 July 2011. They said Mrs A was seen by an ortho-geriatric speciality doctor on 22 February 2011. The Board said that, at that time, Mrs A was not oriented to where she was, but she was oriented to the time and who she was, as she managed to answer questions regarding her date of birth, age, address and current year.

9. The Board commissioned an external review of Mrs A's medical care and treatment, and a meeting with Mrs C to discuss the review was suggested. In advance of a suggested meeting, on 13 December 2011 Mrs C emailed the Board a list of questions she wanted answered and points for discussion. In her document, Mrs C said she had never been informed that there had been an assessment or treatment for dementia, and she only became aware of it when she received a copy of Mrs A's medical records. Mrs C asked whether the Board could confirm which specialist clinician made this diagnosis, and if any treatment was provided. Due to the delay in arranging a meeting, Mrs C contacted the Board on 21 February 2012 and asked for a written response to her document, in advance of any meeting.

10. The Board sent their response to Mrs C's document on 21 March 2012. The Board said there were two written entries of dementia in Mrs A's notes, but they were not aware of a formal diagnosis of dementia being made at any time. The Board said it was unclear why dementia was first documented in Accident and Emergency when Mrs A was first admitted. The Board suggested that it was likely that delirium and confusion were misinterpreted as dementia, and they said that was regrettable. The Board said that all medical staff working with Mrs A were aware that she was suffering from delirium, rather than suffering from dementia.

11. The Adviser said the medical admission notes showed that an admitting doctor recorded Mrs A's past medical history as 'Depression, Dementia', and that a subsequent doctor also recorded: 'Depression, Dementia'. There was no other documentation of this aspect of Mrs A's health to support such a diagnosis, either in Mrs A's hospital notes or General Practitioner (GP) records. The Adviser noted that the information provided by the care home for Mrs A's admission to the Hospital was comprehensive, and described her relevant medical history as 'Hiatus Hernia, Prone to UTIs, Depression, Long standing personality problems'. The care home's information also noted Mrs A's recent problems were 'fell in her room, loss of balance, outstanding UTI results, confused, recent surgery R eye 3 weeks ago'. The Adviser said there was no documentation from the care home that supported a diagnosis of dementia.

12. The Adviser was of the view that it was an error for hospital staff to record Mrs A's past medical history as 'Depression, Dementia'. The Adviser was unable to comment on why this error occurred, as no statements were available from the medical staff who made these entries. The Adviser said the error was very important as it affected the judgement of clinicians both with regard to Mrs A's capacity for decision making, and also with regard the staff's view of Mrs A's confusion which was incorrectly interpreted as untreatable dementia, but was treatable delirium instead. The Adviser said that a formal diagnosis of dementia could not be made during an acute admission such as this without specialist help from psychiatrists or geriatricians. In the Adviser's view, the diagnosis of dementia was made inappropriately, and this process was not discussed with, or informed by, Mrs A's family. The Adviser said the medical notes did not show any evidence that staff were aware at any time that Mrs A was suffering from delirium, and there was no evidence that Mrs A received any specific assessment or treatment for delirium. The Adviser said that incorrectly

labelling Mrs A as having dementia was a level of care which fell that below that which she could have reasonably expected.

13. The Adviser noted that, in her complaint to the Board, Mrs C said 'I got the impression they thought she had dementia and disregarded any other cause of her state of mind'. Having read Mrs A's clinical notes, the Adviser found this to be an accurate summary of hospital staff's clinical thinking. The Adviser noted a comment from nursing staff that the 'family feel today that she is more confused than normal, telling them two men had been in and attacked her, family asking if it was a urine infection'. In the Adviser's view, this was a clear sign of a change in Mrs A's mental health which her family pointed out to staff. However, there was no evidence that action was taken on the basis of these concerns. The Adviser was critical of the superficial and incorrect assessment of Mrs A's mental and physical health on admission, and the continuation of this failure during the rest of Mrs A's admission. The Adviser said this continued despite evidence to staff of confusion, and the fact that Mrs A's family highlighted to staff that this was not her normal mental state. The Adviser concluded that the incorrect diagnosis of dementia and the failure to recognise or treat Mrs A's delirium were major failings in her care.

(a) Conclusion

14. In responding to Mrs C, the Board did not seem aware that a diagnosis of dementia had been made at any time, and they were unclear why it was recorded in Mrs A's notes. The Adviser's view, which I accept, is that hospital staff made an incorrect diagnosis of dementia and failed to recognise or treat Mrs A's delirium. It is clear that hospital staff were acting on the basis that Mrs A suffered from dementia (see also Complaint (b) below), and the Board have not been able to provide a satisfactory explanation for this. I conclude that the Board failed to explain how their diagnosis of dementia was reached and, therefore, I uphold this complaint.

(a) Recommendation

15. I have no recommendation to make under this specific complaint; however, I have made recommendations elsewhere in this report which are related to this matter.

(b) The diagnosis of dementia was inappropriately used to obtain consent for an operation

16. In order to obtain consent for an adult who is incapable of making a decision for themself, medical staff must complete a Certificate of Incapacity (the Certificate) under Section 47 of the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act). The 2000 Act set out five principles to be followed when this process is used, which are set out at Annex 4. An Orthopaedic Consultant (the Consultant) completed and signed the Certificate on 22 February 2011. The medical treatment that consent was obtained for was recorded as 'manipulation ± wiring right wrist fracture', and the nature of the incapacity was recorded as 'dementia'. Under the Consultant's signature, the Certificate stated 'In assessing the capacity of the patient, I have observed the principles set out in section 1 of the 2000 Act'.

17. In Mrs C's document emailed to the Board on 13 December 2011, she said she became aware in reading Mrs A's medical records that consent for the wrist operation was obtained by application under the 2000 Act. Mrs A questioned why it was necessary to obtain consent in this manner, and why Mrs A's family were effectively excluded from involvement in such an important decision. Mrs C said this was especially worrying given the heightened concerns raised by Mrs A's family when Mrs A's confusion appeared to be worsening. Mrs C believed that Mrs A, in her normal state, should have been able to give or withhold consent personally. Mrs C said the fact that consent was obtained due to dementia suggested that greater care should have been taken before pursuing surgical intervention with such eagerness, especially on a second occasion.

18. In their response to Mrs C, sent on 21 March 2012, the Board said the decision to perform surgery was based on Mrs A's clinical need. The Board said Mrs A was suffering from an acute confusional state and was unable to give consent. The Board said the decision ultimately lay with the consultant leading the medical team and, in this situation, a Certificate was used. The Board said it would have been more appropriate to document cognitive impairment as the reason, as confusional states in hospital were often due to multiple factors. The Board acknowledged and apologised that they did not inform and involve Mrs C in the discussion around the decision to take Mrs A to theatre, and they fully accepted that Mrs A's confusional state was not due to dementia.

19. The Adviser considered the degree to which Mrs A's capacity was assessed and the principles were observed:

- Principle 1 – the Adviser said it appeared to have been followed, but the case for surgery was not as clear and as inevitable as might be thought. The Adviser noted this issue was discussed in both the internal and external reviews of Mrs C's complaint;
- Principle 2 – the Adviser said that if not performing an operation was a realistic option for Mrs A, then this would have fulfilled the criteria of 'least restrictive option' and meant the choice of surgery was not inevitable for Mrs A;
- Principle 3 – the Adviser said there was no account of Mrs A's wishes. The Adviser said the Certificate presumed incapacity on the basis of dementia and appeared to have given medical staff the belief that they did not need to discuss treatment with Mrs A at all;
- Principle 4 – the Adviser said there was no evidence of consultation with relevant others at all; and
- Principle 5 – the Adviser said no effort was made to encourage Mrs A to exercise her capacity to make decisions.

20. The Adviser said the only assessment of Mrs A's cognitive function recorded in the notes was undertaken by an ortho-geriatrician who saw her at 10:15 on 22 February 2011. The Adviser said Mrs A answered four of the five questions correctly about her date of birth, her age, her address, and what year it was. Mrs A was unable to answer a question about where she was. In the Adviser's view, this level of cognitive function was relatively good, and should have made medical staff aware of the possibility that Mrs A could consent to the operation herself, and that her views were worth seeking. The Adviser said it was not apparent from Mrs A's clinical notes that there was any specific assessment of her capacity prior to the Certificate being completed and, as noted, the principles of the 2000 Act were not considered as part of its completion. The Adviser said these standards of care were described in the Board's consent policy, and recommended in guidance published by the British Orthopaedic Association, but were not followed in Mrs A's case. The Adviser concluded that Mrs A's care in this regard fell below a level she could have reasonably expected.

(b) Conclusion

21. As noted under Complaint (a), above, the Board were unable to provide a satisfactory explanation of why hospital staff were acting on the basis that Mrs A suffered from dementia. The Consultant signed a Certificate on the basis that Mrs A had dementia, and the Board said it was ultimately a decision for the Consultant. In signing the Certificate, the Consultant was stating that they had observed the principles set out in the 2000 Act. The Adviser has explained, based on the evidence, how the principles were not appropriately observed. The Adviser has also said that there was no specific assessment of Mrs A's capacity prior to the Certificate being completed. I accept the Adviser's view. I conclude that the diagnosis of dementia was inappropriately used to obtain consent for an operation and, therefore, I uphold this complaint.

(b) Recommendation

22. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for incorrectly diagnosing Mrs A with dementia, and incorrectly completing a Certificate of Incapacity to obtain consent for Mrs A's operation.	14 May 2014

(c) The approach to managing Mrs A's urinary tract infection was inappropriate

23. In her letter of 26 April 2011 to the Board, Mrs C said that after speaking to Mrs A on arrival at the Hospital on 21 February 2011, and becoming concerned about her confused speech, she went straight to the nurses' station and explained Mrs A's variation from her normal state. Mrs C asked staff to give Mrs A pain relief for her arm, and if they had checked her urine. Shortly after, Mrs C and her husband (Mr C) asked nurses for a jug of water for Mrs A as she needed to drink to swallow the pain relief tablets, and for her UTI. Mrs C said she reminded a nurse to make sure Mrs A's urine was investigated and to tell her doctor. Mrs C said that when she visited Mrs A on the evening of 22 February 2011, Mrs A was distressed and not behaving as she would normally. Mrs C said it was obvious to her that Mrs A's UTI had affected her mental state. Mrs C said she asked to see a doctor, and during their conversation she repeatedly told the doctor that Mrs A had a urine infection and that Mrs A's care home were waiting on a urine test result from Mrs A's GP. Mrs C said the doctor agreed with her that Mrs A could be suffering from a UTI.

24. In her letter, Mrs C said that on the morning of 23 February 2011 she went to see the manager of Mrs A's care home to see if they could get confirmation of the urine test result. Mrs C said the manager told her that if the Hospital had read Mrs A's notes that the care home sent in with Mrs A, they should have checked her urine straight away. Mrs C said care home staff contacted Mrs A's medical practice, who confirmed that Mrs A had a result from the laboratory taken a few days previously that confirmed she did have a UTI, and care home staff immediately telephoned the Hospital with this information. Hospital staff told the care home that Mrs A was on her way to theatre for her wrist operation, and Mrs C left Mrs A's care home to return to her home. Mrs C said that when she got home, Mr C told her the Hospital had telephoned to say that Mrs A had died. Mrs C said she believed a UTI had contributed to Mrs A's death and, by not doing tests and arranging treatment for a UTI, this put stress on Mrs A's heart, caused high blood pressure, and caused Mrs A to be anxious and mentally unstable.

25. In their letter of 15 July 2011, the Board said they found the clinical judgement and decision making of hospital staff, in particular the management of her UTI, to be appropriate. The Board said a staff nurse who Mrs C spoke to shortly after Mrs A's admission recollected that Mrs C had asked her about Mrs A having a severe UTI. The Board said the staff nurse told Mrs C that if Mrs A did have an infection, medical staff would prescribe antibiotics as per Hospital policy. The Board said it was reported that a urine specimen had been sent to the laboratory from the Accident and Emergency Department, that nursing staff were awaiting the results, and that this information was passed on to the night staff at handover. The Board said that Mrs A was seen by an ortho-geriatric speciality doctor on 22 February 2011, who reported that Mrs A was asymptomatic. They Board said the doctor requested blood tests to be carried out for serum calcium level, thyroid function and liver function.

26. The Board said that when Mrs A was taken to theatre for surgery to her wrist on 22 February 2011, staff found that she had a fast and irregular heartbeat. The Board said steps were taken to manage this, including a sepsis (infection) screen, as infection was one of the potential causes of both the fast and irregular heartbeat and Mrs A's confusion. The Board said that Mrs A returned to the ward and her surgery was postponed. The Board said Mrs C subsequently had a conversation with a doctor, but they regretted that no notes of the conversation were made by the doctor.

27. The Board said a staff nurse who cared for Mrs A overnight from 22 to 23 February 2011 arranged for blood cultures (samples of blood which are grown in a laboratory to see if they contain bacteria) to be taken, as Mrs A's temperature was elevated. The Board said the staff nurse was unable to obtain a further urine sample for testing. The Board said Mrs A seemed comfortable overnight, although she did not appear to sleep well because of her confusion. The Board said the staff nurse requested that a further blood test be done for Troponin, which the Board explained was a blood test undertaken to identify if someone had a heart attack.

28. The Board said the urine specimen taken on 15 February 2011, reported on 22 February 2011, indicated that bacteria very resistant to antibiotics were present. The Board said these bacteria would not have responded to normal antibiotics, and that bacteria that were highly resistant to many antibiotics were often due to previous antibiotic therapies. The Board said that general medical advice was not to treat urine infections of this type unless a patient was systemically unwell, as these bacteria were associated with the development of urine infections resistant to even more antibiotics, for which no antibiotic therapy may be available. The Board said medical staff did not consider that Mrs A was systemically unwell, as her temperature was elevated on only one occasion, the subsequent blood cultures taken at the time were negative, and her white cell count was normal. The Board said that while the decision not to treat was correct, there was no documented evidence that the medical team recognised the presence of an infection but made a conscious decision not to treat it. The Board acknowledged there was very limited documentation of discussions Mrs C had with hospital staff. The Board said their medical staff advised that many aspects of Mrs A's care were exemplary.

29. At a meeting between Board staff and Mr and Mrs C on 18 July 2011, an Associate Medical Director said that Mrs A's UTI was caused by very resistant bacteria known as extended-spectrum beta-lactamases (EBSL), and that treatment of this would subsequently result in bacteria they would have been unable to treat. The note of the meeting recorded that there was no documentary evidence of a decision being made not to treat the UTI. The note said that while not treating the UTI was appropriate, this should have been a conscious decision that was communicated to Mrs A's family.

30. The external review by a neighbouring health board of the medical care and treatment provided to Mrs A said that she did have clinical indicators of

severe sepsis, and treatment of sepsis should have been a clinical priority. In a document Mrs C emailed to the Board on 13 December 2011, she said it remained unclear to her why Mrs A was not treated for a UTI, and she asked why the clinical indicators highlighted by the external review were ignored. In their response to Mrs C, the Board reiterated their view from their 15 July 2011 letter.

31. The Adviser noted that based on the clinical records, staff were made aware of Mrs A's family's concerns about a possible UTI. The Adviser also noted the care home admission note clearly stated 'outstanding UTI results, confused', which communicated information to the Hospital that a urine sample had been taken before admission (requested on 15 February 2011 by Mrs A's GP), but that the result was not yet known to care home staff. In the Adviser's view, this should have prompted hospital staff to check the result of this sample on, and during, admission; however, there was little evidence of any subsequent action taken as a result of this information. The Adviser noted a request from medical staff in the admission note for a dipstick test of urine (this is where a sample is tested instantly to give an initial indication of if infection is present). The Adviser explained that this test would provide information on the chemical and cell count of a urine sample, and could sometimes indicate disease, including infection, which is presumably why it was requested in this case. The Adviser noted that the admission care plan stated that Mrs A did use a bed pan, so it was reasonable to assume that Mrs A passed some urine; however, there was no evidence in the records that any urine was collected or analysed in the Hospital.

32. The Adviser noted that the urine sample result, that was undertaken by Mrs A's GP and her care home before admission to the Hospital, included the information 'processed into store 21/02/2011 12:49:38'. In the Adviser's view, this would normally mean that the result was also available on the Hospital's electronic system from that time. The Adviser said this appeared to be confirmed by a note in Mrs A's GP records, which said the result was reported on 21 February 2011. The Adviser said Mrs A's admission was recorded as 11:51 on 21 February 2011. In the Adviser's view, the urine sample test result would have been available to medical staff during the day of Mrs A's admission and on subsequent days, if they had checked. Although some results such as Mrs A's blood test results were accessed from the Hospital's electronic results system into her paper record, the urine test taken by her GP and the care home was not. The Adviser noted that a nurse who saw Mrs A at 04:15 on

23 February 2011 wrote 'MSSU [mid-stream sample of urine] outstanding'; however, it was not clear whether the Hospital system was specifically checked at that time. The Adviser disagreed with the Board's assertion that the presence of a UTI was documented in the clinical notes, as the Adviser could not find a specific description of this. The Adviser said the clinical notes showed that medical staff were aware that Mrs A had a history of recurrent infections previously, but the Adviser could find no evidence that staff considered treating a UTI during this admission. The Adviser was critical that medical staff did not pursue the information provided on admission by the care home staff and highlighted to hospital staff by Mrs C.

33. In the Adviser's view, it was very poor care of Mrs A that meant Mrs C had to make such significant personal efforts to find the urine specimen test result that would have been immediately available to hospital staff via their own electronic results system. Hospital staff failed to check for the result, despite a potential infection and test result being highlighted to them by the nursing home staff on admission, and Mrs A's family during admission. The Adviser noted that the importance of good care of the patient as a whole, and not just their fracture, was noted in the British Orthopaedic Association guidance, which stated that 'The complexity of most fragility fracture patients is compounded by co-morbidities and polypharmacy. The priority is good initial medical assessment and review prior to surgery'.

34. The Adviser said the urine specimen test result showed that the bacteria growing in the laboratory from Mrs A's urine was resistant to several antibiotics. The Adviser's explanation about testing bacteria is attached at Annex 5. The Adviser said that hospital staff not only failed to diagnose Mrs A's urine infection, but also the specific nature of the bacteria that she had, and the treatment implications of this. The Adviser noted the Board's view that, although they later recognised Mrs A had an infection, she was not unwell during her admission. However, the Adviser said that by reading her notes it was easy to recognise there were several indications that Mrs A was unwell during her admission which included:

- an episode of low oxygen levels in her blood overnight;
- a fast irregular heart beat which postponed her surgery;
- a high C Reactive Protein (CRP) level on admission, which continued during admission, that was not specifically documented in the daily note of her care be medical staff, but was only documented on a summary sheet of all her blood results;

- Mrs A had low blood pressure overnight;
- Mrs A has an elevated troponin (marker of heart damage or systemic strain from illness such as infection) on the day of her operation; and
- Mrs A's family pointing out to hospital staff the variation from her normally good mental state.

The Adviser said that each of these abnormal indicators was noted separately by staff, but they were not considered collectively; in simple terms, the 'dots' of these clues were not joined to give a complete picture of Mrs A's poor state of health. The Adviser was critical that the ortho-geriatric specialist and the consultant surgeon who saw Mrs A after admission did not note her blood test results, or consider delirium. Additional blood tests were ordered, but medical staff failed to note or consider her raised CRP once these test results were available.

35. The Adviser noted the Board's assertion that although Mrs A had evidence of bacteria in her urine, this was not causing infection and making her unwell. The Adviser considered the clinical records, and was of the view that Mrs A's temperature and heart rate observations, and her altered mental state, would be sufficient findings for a reasonable clinician to consider infection. The Adviser noted that clinicians did start to suspect infection in the early evening of 22 February 2011, and performed a sepsis screen, including blood cultures to see if bacteria were present in Mrs A's blood. However, there was no specific consideration of treatment with antibiotics at that time. The Adviser noted that, specifically, there was no consideration of her raised CRP result, which was a significant failing in her care. The Adviser said that Mrs A had no inflammatory diseases, such as rheumatoid arthritis, which might cause her CRP to be raised for a reason other than infection. The Adviser said it was not clear why these blood test results were not noted more specifically or acted on.

36. The Adviser noted that, after Mrs A's operation was postponed because of a fast irregular heart rate, the anaesthetist who postponed the operation wrote 'Ward review. Exclude sepsis'. The Adviser was critical that after the postponement, the 'Ward review' of Mrs A by medical staff of her should have been done in person by a more senior doctor, and should not have been advice given over the telephone to an FY1 (first year of training) doctor. In the Adviser's view, the cancellation of an operation by a consultant anaesthetist because someone is unwell should have prompted more effort than this. In the Adviser's view, there should have been discussion with Mrs A and her family

about the plans for her operation and the type of anaesthetic. There should also have been consideration of delaying the operation until Mrs A's clinical condition had improved, or not performing an operation and managing her fracture without this.

37. The Adviser said that staff made the mistake of thinking Mrs A only had a fractured wrist. However, it was not just this, as Mrs A was unwell with a UTI and delirium. The Adviser said these conditions were life threatening, but Mrs A's fractured wrist was not. The Adviser was of the view that if the relatively simple steps the Adviser outlined had been taken, the chances of a better outcome for Mrs A would have been much higher. The Adviser concluded that, overall, the Hospital's care of Mrs A failed to adequately acknowledge or diagnose, and provide reasonable and effective treatment for her UTI; therefore, her care in this regard fell below a level she could have reasonably expected.

(c) Conclusion

38. The care home information provided to the Hospital stated that Mrs A had a history of frequent UTIs, and there was a test result due from a recent urine sample. Mrs C told hospital staff several times that Mrs A had a history of frequent UTIs, and her behaviour in the Hospital was not normal for her. Mrs C even went to the care home to chase information on the urine specimen test result, as hospital staff were not actively listening to her. The external review concluded that treatment of Mrs A's sepsis should have been a priority. In the Adviser's view, which I accept, hospital staff should have checked their system for the result of the test on the urine specimen that was taken before Mrs A's admission. I also accept the Adviser's view that staff failed to consider the obviously abnormal clinical indicators holistically, which meant that they did not see the complete picture of Mrs A's poor state of health. I conclude that the approach to managing Mrs A's UTI was inappropriate and, therefore, I uphold this complaint.

(c) Recommendations

39. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for the poor standard of care provided to Mrs A; and	14 May 2014
(ii) review their provision of specialist ortho-geriatric care for patients like Mrs A, who commonly present	31 July 2014

with fractures but have other medical conditions that need to be managed in an orthopaedic ward.

(d) There was a failure to accept clinical failings or offer an apology despite the findings of an external review

40. After an exchange of complaints correspondence, and the meeting of 18 July 2011, the Board wrote to Mrs C saying that, following discussion among senior staff, it was agreed that an external review of the medical aspects of Mrs A's care should be undertaken.

41. The external review was carried out by a neighbouring health board. The medical staff conducting the review read Mrs A's notes, and looked at reports and investigation results. The external review noted the:

> '… overall impression that this very frail, dependent, elderly lady with significant co-morbidities was admitted to hospital with a Colles fracture and undiagnosed sepsis, which may have been the reason she fell in the care home. She had clinical indicators of severe sepsis, including an elevated [modified early warning score (MEWS)] at 5, and delirium, which had a 20% 30-day mortality rate alone. She had been haemodynamically unstable prior to initial presentation to theatre, and whilst her arrest the following day may have been precipitated by local anaesthetic agent, she was very high risk due to the severity of her sepsis.'

The external review said that treatment of sepsis should have been a clinical priority given these findings.

42. The external review said that failure to recognise and treat Mrs A's urinary sepsis was a major factor in her subsequent arrest. The external review said that if Mrs A had been treated aggressively for this they could not be confident, given her frailty, dependency and medical risk that she would not have died. However, the reviewing staff believed Mrs A's UTI should have been treated. In terms of whether or not Mrs A should have had the wrist operation, or what kind of operation should have taken place, the external review said there was no evidence in the notes that there had been a weighing up of the risks and benefits of operative intervention versus conservative management.

43. In their response to Mrs C's further concerns, sent to Mrs C on 21 March 2012, the Board said that whilst the external review had concluded that the failure to recognise and treat Mrs A's urinary sepsis was a major factor

in her subsequent arrest, the reason for this conclusion by the review team was unclear. This Board said the external review's view was not held by the Board, and sepsis was not evident in the post mortem report. The Board said they did not agree with the external review that Mrs A had severe sepsis.

44. The Adviser was concerned by the lack of the Board's ability to accept the findings of an external review that they had commissioned specifically to provide independent advice. The Adviser noted that the Board described many aspects of care as exemplary; however, the Adviser could not find any examples of the care of Mrs A that would meet his criteria for this. In addition, the Adviser noted a comment in internal communication about hospital staff needing support during the complaint and review process, whilst the Board offered much less support to Mrs C, who had lost much more. The Adviser was of the view that the Board's response to Mrs C's complaint was unreasonable, as it attempted to minimise the effect of hospital staff's failings, when the evidence from the clinical records and external review was the opposite. In the Adviser's view, the overall tone of the Board's response fitted the description of 'delay, deny and defend', and that the Board's comments about the external review also highlighted that they were defensive about their care of Mrs A.

(d) Conclusion

45. The Board commissioned the external review but, in their response to it, they only accepted the positive comments and rejected the critical comments. Given the upheld conclusions reached in this report, it is clear that there were clinical failings in the Board's care and treatment of Mrs A. The Adviser's view, which I accept, was that contrary to the Board's analysis, there were no examples of exemplary care of Mrs A in the clinical records. I conclude there was a failure to accept clinical failings or offer an apology despite the findings of an external review and, therefore, I uphold this complaint.

(d) Recommendations

46. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for their handling of her complaint, in particular their failure to accept the findings of the external review they commissioned; and	14 May 2014
(ii) carry out a Significant Event Analysis, with reflective commentary, of the care and treatment	31 July 2014

provided to Mrs A, the handling of Mrs C's complaint, and their response to the external review they commissioned.

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

Annex 1

Explanation of abbreviations used

Mrs A	the complainant's late mother
UTI	urinary tract infection
the Hospital	Stirling Royal Infirmary
PF	Procurator Fiscal
Mrs C	the complainant
the Board	Forth Valley NHS Board
the Adviser	a consultant geriatrician
GP	General Practitioner
the Certificate	Certificate of Incapacity under the 2000 Act
the 2000 Act	Adults with Incapacity (Scotland) Act 2000
The Consultant	an orthopaedic consultant
Mr C	Mrs C's husband
EBSL	extended-spectrum beta-lactamases
MSSU	mid-stream sample of urine
CRP	C-reactive protein
FY1	a doctor in the first year of training

MEWS	modified early warning score

Annex 2

Glossary of terms

Asymptomatic	there are no symptoms, because a patient has recovered from an illness and no longer has symptoms, or they have an illness but do not show symptoms of it
Colles fracture	a type of wrist fracture, common in older people who fall onto an outstretched hand
Co-morbidities	one or more medical conditions in addition to the primary condition
Confusion	a term previously used to describe what is preferably called delirium
C-reactive protein	a protein found in the blood, the levels of which rise in response to inflammation or infection. It is measured as a simple blood test
Delirium	a state of mental disorientation or disordered thinking, or change in alertness that can happen when someone becomes unwell, traditionally known as an 'acute confusional state'
Dementia	a condition characterised by loss of memory, which can have many different causes and effects
Extended-spectrum beta-lactamases	enzymes that bacteria can carry which make them resistant to some antibiotic treatments
Haemodynamics	blood flow/circulation
Modified early warning score	a guide used to determine the degree of illness

	of a patient. It is a composite score of easily measured features such as blood pressure and heart rate
Polypharmacy	the prescription of multiple medications for a patient
Sepsis	a life-threatening illness caused by an infection, usually with bacteria growing in the bloodstream
Troponin	proteins in the blood, an increased level of which can indicate heart disorders, particularly a heart attack
Urinary tract infection	an infection which can affect all or some of the kidneys, ureters, bladder and urethra. It may cause symptoms of pain when passing urine, but it can occur without these symptoms and cause delirium
White cells	white cells in the blood are part of the body's immune system that help to fight infection

Annex 3

List of legislation and policies considered

Adults with Incapacity (Scotland) Act 2000

British Orthopaedic Association - The Care of Patients With Fragility Fracture (September 2007)

Annex 4

Five principles from the Adults with Incapacity (Scotland) Act 2000 (based on an extract from the Scottish Government's Adults with Incapacity (Scotland) Act 2000: A short guide to the Act)

Principles to be followed

The Act aims to protect people who lack capacity to make particular decisions, but also to support their involvement in making decisions about their own lives as far as they are able to do so. Anyone authorised to make decisions made on behalf of someone with impaired capacity must apply the following principles:

Principle 1 - benefit

Any action or decision taken must benefit the person and only be taken when that benefit cannot reasonably be achieved without it.

Principle 2 - least restrictive option

Any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option that restricts the person's freedom as little as possible.

Principle 3 - take account of the wishes of the person

In deciding if an action or decision is to be made, and what that should be, account must be taken of the present and past wishes and feelings of the person, as far as this may be ascertained. Some adults will be able to express their wishes and feelings clearly, even although they would not be capable of taking the action or decision which you are considering. For example, he/she may continue to have opinions about a particular item of household expenditure without being able to carry out the transaction personally.

The person must be offered help to communicate his or her views. This might mean using memory aids, pictures, non-verbal communication, advice from a speech and language therapist or support from an independent advocate. A Guide to Communication and Assessing Capacity is available at: http://www.scotland.gov.uk/Publications/2008/02/01151101/0

Principle 4 - consultation with relevant others

Take account of the views of others with an interest in the person's welfare. The Act lists those who should be consulted whenever practicable and

reasonable. It includes the person's primary carer, nearest relative, named person, attorney or guardian (if there is one).

Principle 5 - encourage the person to use existing skills and develop new skills

The person must be encouraged to exercise whatever skills he or she has concerning property, financial affairs or personal welfare, and to develop new such skills.

Annex 5

The Adviser's explanation about testing bacteria

Bacteria are grown in a laboratory in solutions containing antibiotics. If the bacteria grow in the solution without restriction, then they are considered to be resistant to that antibiotic, and the antibiotic is not chosen for treatment.

If the bacteria seems not to grow in the presence of an antibiotic, it is considered to be sensitive to that antibiotic and treatment with that antibiotic is chosen.

EBSL are factors that bacteria can carry which make them resistant to antibiotic treatment. As the bacteria are then resistant to antibiotics such as penicillin, they often require specific treatment with more powerful antibiotics, injected into a vein rather than taken by tablet. Decisions about treating these infections are more complex because of this resistance, but important because these bacteria can cause significant illness if they infect patients and are insufficiently treated. ESBL infection has a high mortality, particularly if antibiotics are chosen incorrectly.