SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Highlands and Islands

Case ref: 201508324, Highland NHS Board
Sector: Health
Subject: Hospital / Clinical Treatment / Diagnosis

Summary
Mrs C complained about the care and treatment her late husband (Mr C) received at Raigmore Hospital after he attended the Emergency Department (ED) by ambulance. Despite Mr C being initially diagnosed with a chest infection, his condition deteriorated suddenly and he died the following day. Mrs C questioned whether her husband was given appropriate treatment and complained that staff did not properly communicate with her.

When the board investigated Mrs C's complaint, they did not identify any failings in relation to the treatment provided to Mr C, although they acknowledged that staff could have communicated better with Mrs C.

We took independent advice from a consultant in emergency medicine and a consultant cardiothoracic anaesthetist. We were concerned about significant failings the emergency medicine consultant adviser identified in relation to the treatment Mr C received whilst in the ED, including the fact that the board's local investigation of the complaint did not pick these up. We accept that the treatment in the ED led to Mr C's abrupt and unexpected deterioration.

Whilst we found that the care provided in the Intensive Treatment Unit (ITU) was of a reasonable standard, we were critical of the communication with Mrs C about her husband's continuing deterioration. We found that Mrs C had been waiting for a significant period of time in a side room in the ED when ITU staff were trying to contact her and that this was likely the result of poor documentation and communication by ED staff.

Redress and Recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) conduct a Significant Event Analysis (SEA) into the care Mr C received in the ED in order to identify appropriate improvements in clinical practice and share these findings with the family and my office;	22 June 2017

(ii)	ensure that the findings of this investigation and the outcome of the SEA are shared with the doctors involved in Mr C's care in the ED and discussed at their next appraisal for shared learning and improvement in clinical practice;	22 June 2017
(iii)	conduct a review of the complaint in order to explore how the complaints handling failed to identify these issues;	22 June 2017
(iv)	provide documentary evidence showing the steps that have been taken to improve triage record-keeping;	25 May 2017
(v)	apologise to Mrs C and the family for the failings this investigation has identified; and	25 May 2017
(vi)	share these findings with relevant staff who had been involved in Mr C's care to highlight the importance of documenting conversations with relatives to ensure effective communication between hospital wards.	25 May 2017

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained to my office about the care and treatment her late husband (Mr C) received from Raigmore Hospital (the Hospital) after he attended the Emergency Department (ED) on 17 September 2015. The complaints from Mrs C I have investigated are that:

(a) the treatment provided to Mr C was unreasonable (*upheld*);
(b) the treatment provided to Mr C was unreasonably influenced by inaccurate records (*not upheld*);
(c) the Hospital staff unreasonably failed to consider Mrs C's wishes regarding resuscitating Mr C (*not upheld*); and
(d) the communication with Mrs C was inappropriate (*upheld*).

Investigation

2. In order to investigate Mrs C's complaint, my complaints reviewer obtained and reviewed copies of the complaint correspondence and medical records; made further enquiries with Highland NHS Board (the Board); and sought independent advice from two clinical specialists. Specifically, a consultant in emergency medicine (Adviser 1) and a consultant cardiothoracic anaesthetist (Adviser 2) who have respectively reviewed Mr C's care and treatment in the ED and the Intensive Treatment Unit (ITU). In this case, we have decided to issue a public report on Mrs C complaint due to concerns about the treatment given in the ED and the significant personal injustice to Mrs C regarding the death of Mr C.

3. In bringing her complaint to my office, Mrs C is seeking acknowledgement that Mr C's treatment was not satisfactory; for recognition of the impact the circumstances can have on relatives; and for a review of procedures to ensure that patients and families are recognised as being important in the provision of care and treatment.

4. 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.

Background

5. Mrs C complained about the care and treatment Mr C received from the Hospital after he attended the ED on 17 September 2015 until his death the following evening. Mrs C said she was led to believe that Mr C had a chest infection and would only be in the Hospital for a short stay. She returned home

and shortly thereafter received a telephone call from the Hospital advising her that Mr C's condition had deteriorated. When Mrs C returned to the Hospital late evening, she was left alone in a room for 30 to 40 minutes during the early hours of the morning before a doctor spoke with her and said that Mr C had had a heart attack, needed to be resuscitated, and was receiving treatment. Some time later, Mrs C recalled a doctor updating her that Mr C was being transferred to the ITU but she was not allowed to see him yet. At 03:15, an ITU Consultant (the ITU Consultant) updated her that Mr C had experienced a further heart attack and had been resuscitated again. Mrs C said that after seeing how unwell Mr C looked on a life support machine, she had asked the ITU Consultant that no further resuscitation attempts be made. However, she said that the ITU Consultant advised her that it would be for them to make a clinical decision as to whether or not resuscitation would be attempted. Mrs C was also dissatisfied that, despite there being no chance of survival, Mr C was kept on a life support machine for a number of hours on 18 September 2015 until her sons travelled to the Hospital from some distance. Mrs C also felt that the Hospital staff failed to communicate the severity of Mr C's condition at the time of his admission and that their communication with her was inappropriate throughout.

6. In responding to Mrs C's complaint, the Board acknowledged Mrs C's extremely distressing experiences but did not identify any issues with Mr C's care and treatment. However, they apologised that more time was not spent by an on-call medical consultant (the on-call Medical Consultant) discussing Mr C's condition with her. Mrs C was dissatisfied with the Board's responses and complained to my office.

(a) The treatment provided to Mr C was unreasonable; and (b) The treatment provided to Mr C was unreasonably influenced by inaccurate records

Concerns raised by Mrs C

7. Mrs C complained that Mr C's condition was not appropriately monitored and treated at the time of his admission to the Hospital during the evening of 17 September 2015. Mrs C was concerned that when Mr C was given morphine (strong pain relief medication) around 00:00, he deteriorated suddenly and she felt this may have been avoidable.

8. Mrs C felt that Mr C's treatment should have been discontinued the following morning on 18 September 2015 after it was clear that survival was not

possible. She said that the Hospital staff took it upon themselves to prolong Mr C's life until her sons arrived at the Hospital, despite it being clear there was no positive outcome to be obtained in doing so.

9. Mrs C's also complained that Mr C's medical records inaccurately stated that he had a history of chest infections which may have affected his treatment.

The Board's response

10. In responding to the complaint, the Board set out that the diagnosis of sepsis was made in the ED but then Mr C suddenly deteriorated around 23:55. It was explained that the resuscitation team were called where the on-call Medical Consultant responded and judged that this was a new event in addition to Mr C's original presentation of severe sepsis secondary to a respiratory infection and the likely cause of a heart attack. The Board commented that Mr C's condition was very unstable at this time and efforts were focused on preventing further deterioration. Despite the attempts of the medical team to stabilise Mr C's condition, he went into cardiac arrest (his heart and breathing stopped) and a complex resuscitation period followed. The Board further commented that the decision about further treatment was made with the ITU Consultant and Mr C was subsequently transferred there.

11. The Board explained that the progress after cardiac arrest in situations similar to Mr C's is highly variable and that a full recovery remained possible at that stage. They said that the presumption must always be in favour of giving resuscitation unless it is clearly futile, or there is a clear directive available that this is not the wish of the patient. The Board further advised that when the ITU Consultant met around 03:00 with Mrs C in the ITU to update her about what had happened, staff informed the ITU Consultant that his condition had deteriorated further and cardiopulmonary resuscitation (CPR) was in progress. After further discussion with Mrs C, she indicated that Mr C would not want further CPR. A management plan was then put in place, including a form stating Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and that the present level of care was to continue but would not be escalated. The ITU Consultant also informed Mrs C at 03:45 that they were struggling with Mr C's oxygen therapy and if this continued, consideration might have to be given to withdrawing it.

12. The Board further commented that, as long as the patient is not suffering, it is standard practice in intensive care for the process of withdrawal of

therapies to take place at a time to try and minimise distress and allow family members to be there together in the final moments if that is their wish. The Board said that despite therapy, Mr C's condition continued to deteriorate and when a different ITU doctor came on duty, it was documented that they could wait for Mrs C's two sons to arrive and then withdraw therapy at that time. It was also noted that they would make Mr C comfortable but would not escalate therapy and that there was a possibility he may die before all the family arrived. A discussion then took place with the family present at 17:30 that unfortunately Mr C would not survive and how withdrawal of therapy would be done. The Board apologised to Mrs C for any confusion in the way this was communicated.

Medical advice (treatment in ED)

13. My complaints reviewer obtained independent advice from a consultant in emergency medicine (Adviser 1) on the care and treatment Mr C received in the ED after his arrival around 22:30 on 17 September 2015. Adviser 1 was critical of there being no recorded evidence showing the triage category that had been assigned to Mr C. The Board informed my complaints reviewer that Mr C had not been triaged when he arrived at the Hospital because of the pressures within the ED at the time but since 2015, the ED have improved their recording status of triage information. It was explained that Mr C would have been triaged verbally between the ambulance team during the handover to the ED team and that the nursing team would have been in attendance. Adviser 1 raised concerned with the Board's reasoning about it being due to the pressures the ED was under at this time. Adviser 1 said that triage becomes more important at times when the ED is busy in order that the most urgent cases are identified early and are seen by a doctor at the earliest opportunity.

14. Adviser 1 advised my complaints reviewer that Mr C was fully conscious at the time of his arrival to the ED. Observation checks showed that his breathing rate, blood pressure, temperature, and heart rate were all high. His blood oxygen level was also low. Adviser 1 noted that a blood gas sample was analysed in the ED's blood gas analyser at 22:47 which showed no evidence of severe sepsis or severe pulmonary oedema (a build-up of fluid in the lungs) at this time.

15. By 23:00, Mr C's blood oxygen level had improved with treatment and he was seen by a general practitioner qualified to work in the ED (Emergency Practitioner 1). A past medical history of atrial fibrillation (irregular heart beat)

was documented but no description of Mr C's normal function had been recorded which Adviser 1 would have expected to see. In terms of Mrs C's concerns about there being an inaccurate history of chest infections being documented in Mr C's records, Adviser 1 said that there was nothing recorded in the ED records about previous episodes of chest infections. It was documented that Mr C had not been on his feet that day, that he was confused and had a cough and yellow sputum. Given Mr C's symptoms of high temperature and crackles on the left side of his chest, Adviser 1 said that it was reasonable to make a diagnosis of sepsis (symptoms and signs of a chest infection) and commence antibiotics in the initial stages of the consultation.

16. However, Adviser 1 highlighted significant concerns regarding two litres of intravenous saline stat (fluid to be given as fast as they could be administered) which was started at 23:00. Adviser 1 considered that this treatment was not appropriate because it was consistent with a diagnosis of severe sepsis or septic shock. Adviser 1 explained that there was no indication to administer such a large volume of fluid so quickly given there was no evidence of blood acidosis (where pH of the blood is abnormally low) or severe sepsis from the blood gas results available at 22:47. Mr C's blood pressure was also not low. Adviser 1 explained that as Mr C had a history of atrial fibrillation, the ability of his heart to tolerate this volume of fluid in such a short space of time was doubtful. Adviser 1 said it was not reasonable to prescribe this volume of fluid at such a fast rate to Mr C as it likely caused him to develop heart failure (a condition where the heart is unable to pump blood around the body properly) and caused pulmonary oedema. Adviser 1 explained that, instead, it would have been reasonable to administer a smaller volume of fluid (250 to 500 millilitres) at a slower rate and to re-assess Mr C after that fluid had been administered.

17. Adviser 1 said that when the second litre of fluid was started at 23:45, this was after Mr C had shown signs of deterioration which was most likely as a result of the first litre of fluid. Adviser 1 further noted that by this time Mr C's chest x-ray would have been available to Emergency Practitioner 1 which clearly showed evidence of significant pulmonary oedema. Also, Mr C's blood test results would have been available for the ED medical staff to review which were not consistent with severe sepsis and showed evidence of mild renal (kidney) impairment. Adviser 1 said that renal impairment would have made Mr C even less able to respond to the intravenous fluids which had been administered.

18. Adviser 1 said that, when Mr C deteriorated at 23:55 another general practitioner qualified to work in the ED (Emergency Practitioner 2) correctly diagnosed pulmonary oedema and appropriately started him on a special type of ventilation to help keep his breathing airways open. However, Mr C was then given 200 milligrams of intravenous frusemide in a single dose which Adviser 1 considered to be an excessive amount to administer and likely to cause Mr C's high blood pressure to fall significantly. Adviser 1 said that 50 milligrams would have been a reasonable initial dose to administer in these circumstances. Adviser 1 further commented that modern emergency medicine practice is to administer nitrates (medication to increase blood flow to the heart) to patients in pulmonary oedema, especially those with high blood pressure which applied to Mr C. Emergency Practitioner 2 also documented at this time that the on-call Medical Consultant was in attendance.

19. Adviser 1 was further critical that it was not reasonable to administer 10 milligrams of intravenous morphine at this time to Mr C who was described as being peri-arrest (the recognised period just before full cardiac arrest where the heart stops working properly) because this treatment would have further decreased Mr C's conscious level and respiratory function. A peri-arrest emergency call was made at 00:08 and by 01:00, Mr C was almost in cardiac arrest where his blood pressure was critically low and he was unresponsive. Adviser 1 said that it was appropriate that Mr C was anaesthetised at this point to maintain his airway and support his ventilation. However, Adviser 1 considered that the 300 milligrams of thiopentone for anaesthesia purposes was not an appropriate dose to administer because it was highly likely to worsen Mr C's low blood pressure and to cause a significant risk of cardiac arrest.

Medical advice received (treatment in ITU)

20. My complaints reviewer also obtained independent advice from a consultant anaesthetist (Adviser 2) on the treatment Mr C received after he was transferred to the ITU.

21. In terms of the decision to perform CPR, Adviser 2 said that the General Medical Council's Good Practice Guide (2013) and End of Life Decision making (2010) is summarised as follows:

> 'That after assessing a patient lacks capacity to make a decision, the doctor must be clear what decisions about treatment and care have to be made.

This must include a check of the patient's medical record for any information suggesting that they have made a potentially legally binding advance decision or directive refusing treatment and make enquiries as to whether someone else holds legal authority to decide.

The doctor takes responsibility for deciding which treatment will provide overall benefit to the patient when no legal proxy exists, and they are the doctor with responsibility for the patient's care. However, they must consult those close to the patient and members of the healthcare team to help make those decisions.

As with other treatments, decisions about whether CPR should be attempted must be based on the circumstances and wishes of the individual patient. This may involve discussions with those close to the patient, as well as members of the healthcare team. The doctor must approach discussions sensitively and bear in mind that some patients, or those close to them, may have concerns that decisions not to attempt CPR might be influenced by poorly informed or unfounded assumptions about the impact of disability or advanced age on the patient's quality of life.'

22. Adviser 2 explained that the first cardiac arrest requiring full resuscitation occurred whilst Mr C was still in the ED when he was intubated and required moving to ITU. Adviser 2 considered that this was a reasonable and correct approach as the doctors were working on the basis of a cardiac arrest, having effectively dismissed early suspicion of sepsis. There was a plan documented at 02:00 on 18 September 2015 for active treatment and family discussion. A further entry in the medical records at 03:15 documented that Mr C suffered a second arrest requiring resuscitation when the ITU Consultant had been speaking with Mrs C. A decision was taken by the ITU Consultant to continue treatment but not to escalate care if Mr C deteriorated further. It was also recorded that it may be necessary to completely withdraw treatment if the ventilator was unable to deliver enough oxygen. A DNACPR order was then put in place. Adviser 2 considered, therefore, that the two significant resuscitation episodes were at times when the working diagnoses appeared to suggest survivable illness. Furthermore, the DNACPR was placed as soon as it became apparent that resuscitation attempts would be futile.

23. My complaints reviewer asked Adviser 2 whether the decision to continue active treatment was reasonable until Mr and Mrs C's sons arrived at the Hospital. Adviser 2 noted there was a continued decline in Mr C's condition and it was clear that this was not survivable. In effect, he was being treated to keep him in a comfortable and as stable condition as possible in the knowledge that the outcome was inevitably fatal. Adviser 2 said that, rather than actively withdraw treatment at that point (such as switching off adrenaline and reducing ventilation support), the staff delayed this until the full family had a chance to be there which Adviser 2 did not consider to be an unreasonable approach. A discussion with the sons present centred on how this withdrawal of treatment would be managed. It appears to have been described in detail and involved removing the breathing tube and stopping medication. An 'end of life' plan was prescribed which made provision for adequate analgesia and sedation. Treatment remained as a means of stabilising Mr C and then a planned withdrawal took place.

(a) Decision

24. I acknowledge the distress and anxiety caused to the family at the sudden and unexpected loss of Mr C. In reaching a decision on the care and treatment Mr C received both in the ED and ITU, I have taken into consideration Mrs C's concerns; the Board's comments; and the independent advice my complaints reviewer obtained from the two clinical specialists.

25. I have not identified failings in the treatment Mr C received after he was transferred to ITU, however, I acknowledge the distressing experiences described by Mrs C under complaints (c) and (d). Whilst I note that the initial diagnosis of sepsis/chest infection was reasonable and in keeping with Mr C's symptoms, it is clear from Adviser 1's advice that there were a number of failings by the ED medical staff when treating Mr C within the initial few hours of his arrival at the Hospital which in turn appear likely to have led to his abrupt and unexpected deterioration. I accept the advice I have received that, in light of the blood and x-ray results available at the time, there was no indication of severe sepsis to warrant the volume and speed of intravenous fluids which were administered. I note that this treatment was likely to have led to cardiac failure and pulmonary oedema. Furthermore, I accept that the amounts of frusemide and morphine were also inappropriate to administer as initial treatment for pulmonary oedema. This is because they were also likely to have caused Mr C's condition to worsen.

26. I am particularly critical that the Board's local investigation of the complaint does not appear to have scrutinised effectively the care and treatment Mr C received in the ED or at the time my complaints reviewer offered the Board a further opportunity to comment on the complaint. There was no mention in the Board's response to the complaint about the treatment provided by the emergency practitioners who initially treated Mr C or any reasoning given for the diagnosis and treatment of sepsis.

27. I conclude that the care provided in the ED fell below a reasonable standard. I uphold the complaint and make the following recommendations to ensure these failings do not recur.

(a) Recommendations

28. I recommend that the Board:	*Completion date*
(i) conduct a Significant Event Analysis (SEA) into the care Mr C received in the ED in order to identify appropriate improvements in clinical practice and share these findings with the family and my office;	22 June 2017
(ii) ensure that the findings of this investigation and the outcome of the SEA are shared with the doctors involved in Mr C's care in the ED and discussed at their next appraisal for shared learning and improvement in clinical practice;	22 June 2017
(iii) conduct a review of the complaint in order to explore how the complaints handling failed to identify these issues;	22 June 2017
(iv) provide documentary evidence showing the steps that have been taken to improve triage record-keeping; and	25 May 2017
(v) apologise to Mrs C and the family for the failings this investigation has identified.	25 May 2017

(b) Decision

29. I have taken into account Mrs C's concerns about the possibility that Mr C's treatment had been influenced by information documented in his medical records about a history of chest infections. Whilst, I have upheld complaint (a), I do not consider there is evidence to show that the treatment provided was influenced by any records referring to a history of chest infection. In view of this, I do not uphold the complaint. I have no recommendations to make.

(c) The Hospital staff unreasonably failed to consider Mrs C's wishes regarding resuscitating Mr C

30. Mrs C complained that after the first resuscitation hospital staff did not seek to engage with her in their considerations of further resuscitations of Mr C and dismissed her expression of Mr C's wishes when voicing concerns over this with the ITU Consultant. At this time, Mrs C said she was advised by the ITU Consultant that Mr C had gone into cardiac arrest again and she asked the ITU Consultant that no further resuscitation attempts be made given her awareness of Mr C's wishes in this respect. She said the ITU Consultant informed her that it would be for him to make a clinical decision as to whether or not resuscitation would be attempted.

The Board's response

31. The Board advised Mrs C that the presumption in relation to resuscitation must always be in favour of giving it, unless it is clearly futile or a clear directive available that it is not the wish of the patient. The Board said that the first resuscitation was correctly commenced and successful. With regards to the second resuscitation, they said that it is common good practice to try to ensure the family are made to understand that the healthcare team will try to make a decision in the best interests of the patient and that, in doing this, they take full account of the family's perception of the patient's wishes but that the responsibility for the decision to resuscitate should be with the healthcare team.

32. The Board apologised on behalf of the ITU Consultant if Mrs C felt that they were being dismissive of her views as his intention was to be supportive and do what was best for Mr C. After further discussion with Mrs C, the Board said that a management plan was put in place not to resuscitate Mr C and that the ITU Consultant would continue with the present level of care which would not be escalated if he were to deteriorate further.

33. Mrs C told my complaints reviewer that she had obtained a copy of Mr C's medical records and said that no discussion took place about DNACPR. Mrs C said that it was her who had asked for no further CPR.

Medical advice received

34. Adviser 2 said that Mr C clearly lacked capacity to be involved in decisions about resuscitation, therefore, the doctors involved are obliged to take that responsibility. Whilst Adviser 2 considered that the ultimate responsibility for

resuscitation and associated treatments lies with the doctor, a failure to make reasonable attempts to include and consult with those closest to the patient would fall short of good practice.

35. Both advisers noted that that there was no record in the medical records clearly showing the conversation that took place with Mrs C when a member of staff called her at home to say that Mr C's condition had deteriorated. According to Mrs C, she was contacted around 00:00 about Mr C's condition and asked to return to the Hospital. Mrs C commented in her complaints correspondence that medical staff had spoken to her prior to the ITU Consultant's conversation at 03:15, however, there was no record of these conversations noted in the medical records either. After some delay in the waiting room Mrs C was advised about Mr C's very unstable condition. Adviser 2 explained that around the time of the first resuscitation, there would have been no opportunity or legal obligation to have discussed this with Mrs C without compromising care at that point. Adviser 2 highlighted that there are fewer staff on during night shift but acknowledged the understandable distress caused to Mrs C being kept waiting for information. Adviser 2 considered that it would have been good practice in line with the General Medical Council's Good Practice Guide to involve Mrs C when it was clear that Mr C's condition was still very unstable and would likely require further resuscitation. This would be at the time he was transferred to ITU at 02:00. The ITU consultant had documented at 02:00 that they tried to contact Mrs C but was unable to do so (I comment on this matter further under complaint (d)).

36. Adviser 2 noted that from the record made of the discussion the ITU Consultant had with Mrs C at 03:15, they made it clear how unstable Mr C's condition remained. During this conversation Mr C had a further cardiac arrest and it was recorded that Mrs C clearly expressed concerns based on her belief as to Mr C's wishes. Taking this view into account it was documented that the ITU Consultant planned to continue treatment but not to escalate care if Mr C deteriorated further. Mrs C was advised that the limited treatment plan might include withdrawal of all therapy.

37. As set out under complaint (a), Adviser 2 considered that a DNACPR plan was appropriately in place as soon as it became apparent that resuscitation attempts would be futile. Adviser 2 said that at no time was Mrs C placed in a position where she was made to feel she had to make decisions about resuscitation on behalf of Mr C. Adviser 2 concluded that Mrs C views were

taken into account and she was made aware of the plans although her distress would have been amplified by the long periods of waiting that she described.

(c) Decision

38. This was clearly a distressing time for Mrs C to be informed that Mr C had suffered a cardiac arrest on more than one occasion. As commented upon under complaint (a), I am satisfied that the resuscitation episodes were performed appropriately when it was considered that Mr C's condition was reversible.

39. Based on the advice my complaints reviewer has received, the first opportunity to involve Mrs C in line with the General Medical Council's Good Practice Guide was after Mr C was transferred to ITU around 02:00. It was clearly documented that the ITU consultant had attempted to contact Mrs C around 02:00 but did not manage to until 03:15. When the ITU Consultant then spoke with Mrs C following further resuscitation, they did take into account her views and that a mandate not to perform CPR was subsequently put in place which was at an appropriate point in time when it was clear Mr C would not survive. In view of the foregoing, I do not consider that the Board failed to consider Mrs C's wishes regarding Mr C's resuscitation. Therefore, I do not uphold the complaint. I have no recommendations to make.

(d) The communication with Mrs C was inappropriate

40. Mrs C complained about the information she was given in respect of Mr C's condition when she made the decision to return home to rest; and the delays in providing information on her return to the Hospital (including the inability to contact her when she was on site in the hospital). Mrs C said she was left alone in a side room for long periods of time and that when she did see Mr C in the ITU, staff had not prepared her for seeing him on a life support machine. Mrs C said that the Hospital missed opportunities to support and involve her which resulted in her feeling isolated, disregarded and uncared about.

The Board's response

41. The Board informed Mrs C that communication can always be improved and that the on-call Medical Consultant was sorry for not spending more time discussing matters with her after Mr C's condition had deteriorated.

Advice received

42. As set out under complaint (c), there were no entries in the medical records documenting the telephone call that was made to Mrs C around 00:00 asking her to return to the Hospital nor any record of the updates that she was given prior to his transfer to ITU. According to Mrs C, she was asked to return to the Hospital as Mr C's condition had worsened. At the time of Mr C's admission to ITU around 02:00, there was a record made by the ITU Consultant that initial attempts to contact Mrs C were unsuccessful. After some delay in the waiting room, it appears that a conversation took place with Mrs C at 03:15 that Mr C had needed to be resuscitated and was in ITU. Adviser 2 highlighted that it was unfortunate Mrs C was kept waiting for information but acknowledged that the doctors were dealing with Mr C who required care at that time.

(d) Decision

43. I acknowledge the Board's apology and their comments that communication can always be improved. As set out under complaint (a), Adviser 1 had considered that the initial diagnosis of sepsis/chest infection was reasonable. Therefore, as Mr C was not critically unwell when he presented to the ED, I have no concerns in terms of the advice Mrs C was given by the ED when she decided to return home on the evening of 17 September 2015. In addition, prompt action was taken by the ED staff to notify Mrs C when Mr C's condition deteriorated (around 00:00).

44. However, I am critical that this discussion and the updates that were given to Mrs C after she returned to the Hospital were not recorded in the medical records. Had these discussions been recorded, I consider it likely that the ITU Consultant, when attempting to contact Mrs C at 02:00, would have known that she had returned to the Hospital and was waiting in a side room. This miscommunication appears to have resulted in Mrs C waiting for a protracted period of time whilst on the Hospital's premises for information about Mr C's condition which I am critical of. While I appreciate that there are less staff on duty during night shift hours and that some staff would have been attending to Mr C, I consider that better communication should have taken place between ED and ITU staff regarding Mrs C's whereabouts. On balance, I uphold the complaint and make the following recommendation.

(d) Recommendation

45. I recommend that the Board: *Completion date*

(i)	share these findings with relevant staff who had been involved in Mr C's care to highlight the importance of documenting conversations with relatives to ensure effective communication between hospital wards.	25 May 2017

46. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mr C	the complainant's husband
the Hospital	Raigmore Hospital
ED	Emergency Department
The Board	Highland NHS Board
Adviser 1	consultant in emergency medicine
Adviser 2	consultant Cardiothoracic anaesthetist
ITU	Intensive Treatment Unit
ITU Consultant	consultant anaesthetist
on-call Medical Consultant	the Medical Consultant in charge
CPR	Cardiopulmonary Resuscitation
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
Emergency Practitioner 1	a general practitioner qualified to work in the ED
Emergency Practitioner 2	a general practitioner qualified to work in the ED
SEA	Significant Event Analysis

Annex 2

Glossary of terms

atrial fibrillation	irregular heart beat
blood acidosis	where pH (acidity) of the blood is abnormally low
cardiac arrest	where the heart and breathing stop
Cardiopulmonary Resuscitation	lifesaving procedure that is done when someone's breathing or heartbeat has stopped
frusemide	diuretic drug which promotes the kidney's generation of urine
morphine	strong pain relief medication
pulmonary oedema	a build-up of fluid on the lungs
sepsis	a complication of infection that can arise as a result of infections in, for example, the lungs. There are difference severities including – sepsis (mild), severe sepsis, and septic shock
triage	the process of determining the priority of patients' treatments based on the severity of their condition

Annex 3

List of legislation and policies considered

The General Medical Council's Good Practice Guide (2013)

The General Medical Council's Treatment and care towards the end of life: good practice in decision making (2010)