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: North East Scotland

Case ref: 201603186, Grampian NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Ms C complained about the treatment provided to her late mother (Mrs A). Mrs A was 53 years old when she attended at Aberdeen Royal Infirmary (the hospital) with lower abdominal pain and urinary frequency. She was discharged with plans for urgent follow-up. Before this took place, Mrs A was re-admitted via the emergency department. She was found to be suffering from cancer and procedures to insert plastic tubes into her kidneys to drain urine were necessary. The procedure, called nephrostomy, is carried out when the tube linking the kidney to the bladder has become blocked. After the nephrostomies were carried out, Mrs A later began to show signs of infection. Although antibiotic treatment was started, Mrs A developed sepsis (a severe complication of infection) and died.

Ms C complained that Mrs A had not been prescribed prophylactic antibiotics (antibiotics given as a precaution to prevent, rather than treat, an infection) prior to the nephrostomies. The board initially responded that there was no requirement to prescribed these and Ms C brought her concerns to this office for investigation. A short time later, the board advised us that a hospital policy recommending the use of prophylactic antibiotics had been identified. We suspended our investigation to allow the board to address this matter and a number of further issues Ms C raised. After the board issued their final response, Ms C brought the complaint back to this office and we restarted our investigation.

We took advice from a consultant urologist. We found that there had been a failure to follow the hospital policy on prescription of prophylactic antibiotics for Mrs A. We established that Mrs A had a poor prognosis due to the extent of her cancer. While prescribing prophylactic antibiotics may have prevented her from developing sepsis, it was impossible to definitively determine the effect they would have had.

Although the board latterly acknowledged its policy had not been followed, no apology was offered to Ms C for either the failing itself or for the fact its initial

complaint response was inaccurate. We upheld Ms C's complaint and made a number of recommendations to address the issues identified.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Ms C:

What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
The Board acknowledged that the local recommendation to prescribe prophylactic antibiotic was not followed but has not apologised	Apologise to Ms C for the failure to follow local guidance. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology By: 20 October 2017
The initial complaint response gave inaccurate information on the prescription of prophylactic antibiotics for nephrostomies	Apologise to Ms C for not giving a full and accurate response. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology By: 20 October 2017

We are asking the Board to improve the way they do things:

What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
The Board has advised its intent to review the local policy on prescribing prophylactic antibiotics for nephrostomies	The local policy should provide clear guidance to clinicians on when prophylactic antibiotics are to be prescribed and by whom	Evidence that the policy has been reviewed including the choice of antibiotic, length of prescription and clear definition of the clinician responsible for prescribing By: 20 November 2017
At the time of Mrs A's admission and the initial complaint response, staff were not following local policy	All relevant clinicians should be aware of the guidance	Evidence, such as memos, emails, training resources, to confirm that awareness of the policy has been raised with relevant staff By: 20 December 2017

Feedback

Complaints handling

Due to new issues being raised by Ms C, this investigation was suspended to allow the Board to respond. By this time, the Board had recognised that there was, in fact, a local recommendation to prescribe prophylactic antibiotics for patients like Mrs A. This represented an opportunity for the Board to acknowledge that its original response was inaccurate and apologise. More effective handling of this complaint could have resolved the matter for Ms C at an earlier stage without the need for this further investigation. The Board should reflect on this.

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 Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to this office about care provided to her late mother (Mrs A) by Grampian NHS Board (the Board). Her concerns relate to Mrs A's treatment during an admission to Aberdeen Royal Infirmary (the Hospital) following symptoms of lower abdominal pain and urinary frequency.

2. The complaint I have investigated is that staff at the Hospital inappropriately failed to provide Mrs A with prophylactic antibiotics prior to undertaking two nephrostomy procedures (*upheld*).

3. A nephrostomy is a procedure to insert a small thin plastic tube called a catheter into the kidney to drain urine. This is done when the ureter (the tube linking the kidney to the bladder) has become blocked. Nephrostomies are routinely carried out by radiologists using medical imaging techniques like x-rays to guide them.

Investigation

4. In order to investigate Ms C's complaint, my complaints reviewer and I carefully considered all the information provided by Ms C and the Board. Independent medical advice was also obtained from a consultant urological surgeon (the Adviser).

5. In this case, I have decided to issue a public report on Ms C's complaint due to the significant personal injustice to Ms C, Mrs A and their family.

6. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered but can confirm that all of the information provided during the course of the investigation was reviewed. Ms C and the Board were given an opportunity to comment on a draft of this report.

Complaint: Staff at the Hospital inappropriately failed to provide Mrs A with prophylactic antibiotics prior to undertaking two nephrostomy procedures

Background

7. Mrs A, who was 53 years old, presented at the Hospital on 1 April 2016 with generalised lower abdominal pain and urinary frequency. An ultrasound scan (a scan that uses sound waves to create images of organs and structures inside the body) showed abnormalities in the left kidney and hydronephrosis in

the right kidney (a condition where the kidney becomes stretched and swollen due to a build-up of urine). The scan also showed that Mrs A had a bulky uterus and bladder. She was discharged the same day with plans for an urgent CT urogram (a computerised tomography scan to investigate conditions of the urinary tract and kidneys).

8. Before any planned follow up could take place, Mrs A re-attended at the Hospital's emergency department on 3 April 2016 due to her continuing symptoms. She was admitted and a CT urogram took place on 4 April 2016. This indicated that Mrs A was suffering from a disseminated malignancy of uncertain origin (cancer which has spread but where the primary source is unknown). A right sided nephrostomy was carried out on 6 April 2016. A left sided nephrostomy followed on 8 April 2016.

9. Mrs A showed signs of infection on 11 April 2016 and antibiotics were started. A blood culture confirmed staphylococcuss aureus (a group of bacteria). Mrs A developed sepsis (a severe complication of infection) and sadly, passed away on 18 April 2016.

10. The cause of death was reported clinically as sepsis and disseminated malignancy of unknown primary.

11. On 21 June 2016, Ms C complained to the Board about a number of issues, including that Mrs A had not been prescribed prophylactic antibiotics (antibiotics given as a precaution to prevent, rather than treat, an infection) prior to or immediately after the nephrostomy procedures.

12. The Board provided its response on 12 July 2016. This advised that there are no routine antibiotics given when nephrostomy tubes are inserted. Ms C remained dissatisfied and sought to access information about the Hospital's policy on prophylactic antibiotics herself. Ms C subsequently brought her complaint to this office for further investigation.

13. The Board were notified of the investigation and supplied the relevant paperwork to this office. Some days later, we received an email from the Board advising that on further investigation, its local policy stated that prophylactic antibiotics are recommended for nephrostomy procedures.

14. Also around this time, Ms C identified further concerns that she had not raised with the Board previously and the decision was taken to suspend the investigation until she received a response to all her complaints.

15. The Board issued its final response to Ms C's complaints on 17 November 2016. At Ms C's request, this included copies of comments from clinicians who reviewed the issue of prophylactic antibiotics. These were a urologist from another NHS board area and a radiologist.

16. The Board's covering letter for the clinicians' comments referred Ms C back to this office if she remained dissatisfied. It said that there was a commitment to prescribing prophylactic antibiotic for nephrostomy procedures. However, no apology was offered for the failure to follow the recommendation of the local policy or for the impact this may have had.

17. Following contact from Ms C on 19 January 2017, we reopened our investigation.

Key concerns

18. Ms C considers that Mrs A's death could have been avoided if staff caring for Mrs A had followed the local policy of prescribing prophylactic antibiotics for nephrostomy procedures. She complained that the failure to adhere to this policy resulted in Mrs A developing sepsis and caused her early death.

The Board's response

19. As noted above, the Board originally advised Ms C that routine antibiotics were not given for nephrostomy tube insertion.

20. During the initial stages of my investigation, the Board contacted this office to advise that it had continued to look into the situation surrounding the provision of prophylactic antibiotics. It advised that discussion with urology and radiology staff had originally indicated that antibiotics were not provided prior to the insertion of nephrostomy tubes.

21. The Board went on to say, however, that further searches of available documentation had discovered the local policy, which is based on the Scottish Intercollegiate Guidance Network (SIGN) Guideline 104 Antibiotic prophylaxis in surgery. The Board explained that provision of prophylactic antibiotics for nephrostomy procedures is recommended local practice. It advised that the

situation had been discussed with lead staff and that the matter would be on the agenda for next departmental consultants' meeting, with a plan to review the policy. A copy of the minutes from this meeting were obtained for this investigation.

Relevant policies and procedures

22. SIGN 104 does not specifically mention nephrostomy procedures within the prophylactic prescribing guidance it provides.

23. The local policy for urogenital surgery in adults provides the following:

Surgery	SIGN 104 Recommendation for Antiobiotic Prophylaxis	Antibiotic choice		Comments & Timing	
		1st Line	2nd Line		
Cystolitholapaxy, uretic stent insertion, uretic conduit stent and nephrostomy	Recommended (local practice)	*gentamicin 120mg IV (bolus over 3 mins)	*co-trimoxazole 960 mg IV (infuse over 60 min)	At induction, ≤ 60 mins before incision	Co-trimoxazole infusion must be started at least 20 minutes prior to incision

Medical advice

24. The Adviser was asked to comment on national guidance that is relevant to this case. The Adviser commented that SIGN 104 discusses the use of prophylactic antibiotics in surgery and noted that nephrostomies are not specifically mentioned within the guideline. They advised that the incidence of sepsis following the insertion of a nephrostomy is one to three percent. The Adviser explained that risk factors include the presence of infection in the kidney or urinary tract prior to the procedure, diabetes, low white blood cell count and co-morbidities such as poor nutritional status.

25. The Adviser went on to say that a review of clinical guidelines from urology departments in major UK hospitals revealed that the vast majority recommend the use of prophylactic antibiotics in nephrostomy, including the policy at the Hospital.

26. The Adviser was asked whether it was reasonable that Mrs A was not prescribed prophylactic antibiotics for the two nephrostomy procedures. The Adviser noted that on admission, Mrs A had an elevated white cell count which might have indicated an infection somewhere, a low serum albumin level (albumin is a protein found in blood and a low level can indicate a number of conditions including kidney disease), and evidence of disseminated malignancy. They considered that Mrs A was at a moderate risk of developing sepsis post procedure and that the majority of clinicians would have prescribed antibiotics.

27. The Adviser went on to say that the use of prophylactic antibiotics will reduce but not completely prevent instances of sepsis and it was not possible to say definitively what impact they would have had for Mrs A. They did, however, comment that prophylactic antibiotics may have prevented sepsis from occurring.

28. The Adviser reviewed the minute of the consultants' meeting that discussed prophylactic antibiotic prescription, including variations of clinical opinion in international guidelines. The Adviser agreed with the consultants' view that there is no clear indication for the use of prophylactic antibiotics in low risk patients but that they are of benefit in high risk patients. They noted that urology staff had accepted that the local policy favoured the use of prophylactic antibiotics and that the local radiologists confirmed they did not prescribe these prior to nephrostomies. The Adviser commented that there had been agreement at the meeting that prophylactic antibiotics would be prescribed in future for nephrostomy patients.

29. The Adviser considered that the Board had failed to follow its own policy on prophylactic antibiotic prescription in nephrostomy procedures in this case. They advised that the Board should further review its policy, including the choice of antibiotic and length of prescription. The Adviser commented that the policy must clearly define which clinician is responsible for the prescription ie the urologist/other specialist clinician looking after the patient or the radiologist undertaking the procedure.

30. The Adviser explained that Mrs A presented with an obstruction to both ureters by disseminated malignancy. They advised that taking the poor level of function in the left kidney into consideration, this had perhaps been present for several months. They noted Mrs A developed sepsis and a chest infection

following the insertion of nephrostomies. The Adviser concluded that the use of prophylactic antibiotics might have prevented sepsis and Mrs A's death in April 2016 although they were clear that her prognosis was poor due to the disseminated malignancy.

Decision

31. The basis we reach decisions on is reasonableness. Our investigations consider whether the actions taken, or not taken, were reasonable in view of the information available to those involved at the time in question. We do not apply hindsight when determining a complaint.

32. There has been an acknowledgement on the part of the Board that staff caring for Mrs A did not follow the local policy recommendation of prescribing prophylactic antibiotics for her nephrostomy procedures. I am deeply concerned that this was not identified during its original investigation of Ms C's complaint and only came to light once this office had become involved.

33. Whilst there may be some debate in clinical circles about the benefits of prophylactic antibiotics in nephrostomy, it is clear that there was a policy in place at the Hospital at the time of these events which staff were either unaware of, or not following for other reasons. In any case where a policy or procedure is not followed for clinical reasons, a clear rationale should be recorded in the medical notes. I found no evidence of this within Mrs A's medical notes.

34. I am also concerned that no apology was offered by the Board, despite the opportunity to revisit the matter when this investigation was suspended to allow Ms C to raise further concerns about Mrs A's care.

35. I note the Adviser's comments that while prescribing prophylactic antibiotics might have prevented Mrs A from developing sepsis, it is impossible to definitively determine what effect they would have had. The Adviser was also clear that Mrs A sadly had a poor prognosis due to the extent of her cancer. I accept this advice.

36. Nonetheless, the advice received is that Mrs A was at a moderate risk of developing sepsis following the nephrostomy procedures and prescription of prophylactic antibiotics, in line with the local policy, may have prevented it occurring. Although Mrs A's prognosis was poor, this could potentially have allowed her and her family more time together to come to terms with her

diagnosis and prepare. The best chance of this outcome would have been offered by following the local policy.

37. The Board have indicated that its policy will be reviewed and I will make a recommendation to ensure that the findings of this investigation are taken into account.

38. Taking all of the foregoing into consideration, I uphold this complaint. My recommendations for action by the Board are set out below.

39. 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 dates specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Recommendations

What we are asking the Board to do for Ms C:

What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
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Terms used in report **Annex 1**

CT	computerised tomography
CT urogram	a computerised tomography scan to investigate conditions of the urinary tract and kidneys
disseminated malignancy of uncertain origin	cancer which has spread but where the primary source is unknown
Mrs A	the aggrieved
Ms C	the complainant
nephrostomy	a procedure to insert a small thin plastic tube called a catheter into the kidney to drain urine
prophylactic antibiotics	antibiotics given as a precaution to prevent, rather than treat, an infection
sepsis	a severe complication of infection
SIGN	Scottish Intercollegiate Guidance Network
the Adviser	a consultant urological surgeon
the Board	Grampian NHS Board
the Hospital	Aberdeen Royal Infirmary