SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Tel **0800 377 7330**
SPSO Information **www.spso.org.uk**
SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: Glasgow

Case ref: 201701226, Greater Glasgow and Clyde NHS Board - Acute Services Division
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mrs C complained about the care and treatment that staff at Queen Elizabeth University Hospital (the Hospital) provided to her late husband, Mr A.

Mr A previously received hip replacement surgery at the Hospital and was discharged. He was given clexane on the ward and aspirin on discharge as prophylaxis (preventative medication) to reduce the risk of venous thromboembolism (VTE - blood clots that start in the vein), including pulmonary embolism (a sudden blockage in a major artery).

Approximately three weeks later, Mr A suffered a sudden bleeding from his bowels. He was re-admitted to the Hospital with a suspected upper-gastrointestinal bleed. Staff carried out an endoscopy (a procedure to look inside the oesophagus, stomach and first part of the small intestine) and took blood tests. A sigmoidoscopy (a procedure that involves looking inside the large intestine) could not be carried out. The next evening, Mr A suffered a sudden collapse and died as a result of a cardiac arrest caused by a pulmonary embolism.

Mrs C raised concerns about the medical and nursing care provided to Mr A, including the investigations carried out, a decision not to give a blood transfusion, monitoring, and the events surrounding his death.

We took independent advice from three clinical specialists: an orthopaedic surgeon, a consultant in acute medicine and a nurse.

As the cause of death was pulmonary embolism, we investigated the VTE prophylaxis given to Mr A during his first admission to the Hospital. We found VTE prophylaxis in the Hospital was appropriate, but discharge on aspirin was not supported by national guidance and the Board's own guidelines were not followed. We noted that there is no completely effective way of preventing

pulmonary embolism; however, providing appropriate medication could have reduced the risk to Mr A. We were unable to rule out the possibility that this failing may have contributed to Mr A's death. We also found there was an apparent lack of consultant involvement in Mr A's pre-operative management.

Our investigation found medical care during the second admission was reasonable. We noted this was a complex admission, but the correct investigations were carried out and it was appropriate not to give a blood transfusion. We found medical staff did not miss any warning signs of the pulmonary embolism, noting that pulmonary embolism can occur suddenly, without warning, and with no obvious signs.

We found that nursing care during the second admission was unreasonable. In particular, there was a failure to record repeat observations for the evening Mr A died. We also noted, as the Board acknowledged, the difficult circumstances surrounding Mr A's death could have been handled more sensitively by some staff.

We upheld Mrs C's complaints and made a number of recommendations to address the issues identified.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

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

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a) & (b)	There was a failure to provide appropriate medication to reduce the risk of blood clots following Mr A's discharge from the Hospital. Mr A's National Early Warning Score observations were not adequately recorded on 13 June 2016 and there was a failure to re-check his capillary blood glucose levels	Apologise to Mrs C for failing to provide Mr A with appropriate medication and to carry out appropriate nursing observations and blood glucose checks. 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: 24 September 2018

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

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	Aspirin alone was prescribed to prevent blood clots on discharge, contrary to the Board's guidance and national guidance	Patients should be prescribed prophylactic blood clot prevention medication following hip fracture surgery, in line with the Board's guidelines and national guidance	(1) Documentary evidence that the orthopaedic team have been made aware of the case and considered it for relevant learning at an appropriate meeting (such as a minute from an orthopaedic morbidity and mortality meeting). (2) Documentary evidence that the Board has taken steps to ensure that relevant staff are aware of and take into account the guidance on venous thromboprophylaxis in their clinical practice. By: 22 October 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
	Theatre notes and the prescription form were not completed appropriately.	Theatre notes and prescription forms should be adequately completed.	(3) Documentary evidence that this has been fed back to relevant staff in a supportive manner that encourages learning. By: 22 October 2018
	There is no record of pre-operative consultant involvement in Mr A's medical management during his admission in May 2016, prior to his surgery.	Patients admitted for hip fracture surgery should receive an appropriate level of consultant involvement in their pre-operative care. This should be properly recorded in the medical records.	(4) Documentary evidence that this has been fed back to relevant staff in a supportive way that promotes learning. By: 22 October 2018
	The Board did not provide all of the relevant records until after the circulation of the draft of this report	The Board should ensure that clinical evidence demonstrating the treatment and care provided is provided at the appropriate point in an SPSO investigation	(5) Documentary evidence of the steps the Board will take to ensure *all relevant clinical evidence is provided at the appropriate point of an SPSO investigation* By: 22 October 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	There was a failure to carry out repeat National Early Warning Score (NEWS) observations. Observations following the endoscopy were not charted on NEWS. Capillary blood glucose levels were not re-checked	Patient observations should be appropriately taken and charted	(1) The Board should demonstrate that they have reviewed their policy for recording observations after a procedure and on return to the ward area. (2) The Board should demonstrate that the monitoring issues have been discussed with relevant nursing staff in a supportive way that promotes learning (such as a minute from a relevant ward/unit meeting) By: 22 November 2018

Evidence of action already taken

The Board told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	What the organisation say they have done	Evidence SPSO needs to check that this has happened and deadline
(b)	The Board accepted that nursing staff did not deal sensitively with providing Mr A's death certificate	The Board said that staff would reflect on this	Evidence that this has happened By: 22 October 2018

Feedback

Communication

I urge the Board to reflect on how they communicate with families, particularly in sensitive and difficult situations such as the death of loved ones. In doing so, it would be appropriate to consider what use is made of resources such as death and dying teaching and written resources such as the Scottish Government's publication 'What to do after a death', to support the families of patients at such difficult times.

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 me about the care and treatment provided to her late husband (Mr A), by Greater Glasgow and Clyde NHS Board – Acute Services Division (the Board) following his admission to the Queen Elizabeth University Hospital (the Hospital) in June 2016. The complaints from Mrs C I have investigated are that the Board:

(a) failed to provide the late Mr A with appropriate medical care and treatment (*upheld*); and
(b) failed to provide the late Mr A with appropriate nursing care and treatment (*upheld*).

2. Mrs C's concerns stem from the events surrounding Mr A's unexpected death in June 2016. Mr A had previously attended the Hospital for surgery to address a hip fracture and was discharged on 23 May 2016. He was re-admitted to the Hospital on 12 June 2016 after suffering bleeding from his bowels. Mr A died suddenly on the evening of 13 June 2016 from a pulmonary embolism (a blood clot in the pulmonary artery, the blood vessel that carries blood from the heart to the lungs).

Investigation

3. I and my complaints reviewer considered all the information provided by Mrs C and the Board. This included Mr A's medical and nursing records and the Board's complaint file. We also obtained independent advice from three advisers: a consultant in acute medicine (Adviser 1), a consultant orthopaedic surgeon (Adviser 2) and a nursing adviser (Adviser 3).

4. I have decided to issue a public report on Mrs C's complaint because of the significant and serious failings identified; the personal injustice to Mrs C; and because I consider there may be wider learning for other NHS Boards. I should stress that the failings I identified were in relation to specific areas of care, and not to the entirety of the care the Board provided which in other respects was of a reasonable and appropriate standard.

5. I note that this is not the first time the Ombudsman has made similar findings to those set out in this report: my predecessor made similar findings in respect of a different Board in 2016 (ref: 201507970). As I consider there to be potential learning for all Boards, I will bring this report also to the attention of the Chief Medical Officer.

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 I can confirm that all of the information provided during the course of the investigation was reviewed. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Background

7. At the time in question, Mr A had a medical history of type 2 diabetes, chronic kidney disease stage 3, hypertension (high blood pressure) and right foot drop.

8. Mr A attended the Hospital on 16 May 2016 and underwent surgery to address his hip fracture. Due to the risk of venous thromboembolism (VTE – blood clots that start in the vein) following the surgery, Mr A was given medication during the in-patient period (Low Molecular Weight Heparin (LMWH)). He was then discharged from the Hospital on 23 May 2016 with a prescription of aspirin, again to reduce the risk of blood clots.

9. On 12 June 2016, Mr A moved his bowels and suffered bleeding. His family called NHS 24, who arranged for an ambulance. Mr A was taken to A&E at the Hospital in the afternoon of 12 June 2016. He was admitted with peri-rectal bleeding and malaena (black stool). At the time, staff diagnosed Mr A with a probable upper gastrointestinal bleed (bleeding from the oesophagus, stomach or upper small bowel).

10. Mrs C visited Mr A on the morning of 13 June 2016, and understood from staff that Mr A was fasting before having investigations done. Blood tests were taken that morning. Mr A underwent an upper gastrointestinal endoscopy (a procedure where a thin, flexible tube called an endoscope is used to look inside the oesophagus, stomach and first part of the small intestine) that afternoon. This revealed gastritis (inflammation of the lining of the stomach). A sigmoidoscopy (a procedure that involves looking inside the large intestine) could not be carried out due to the presence of solid stool.

11. Mrs C subsequently spoke with Mr A on the telephone. Later that day, she received a call from the Hospital about obtaining Mr A's insulin pen, as staff did not have a supply of this.

12. Mr A was seen by a nurse at about 19:00 on 13 June 2016, and the nurse documented that Mr A was settled and chatting to staff at that time.

13. At 20:36, a cardiac arrest call was placed as Mr A had been found lying on the floor by nursing staff. Staff attempted to resuscitate Mr A over the following 15 minutes; however, this was unsuccessful.

14. The subsequent post-mortem indicated that the cause of Mr A's death was a bilateral pulmonary embolism.

Complaint (a): The Board failed to provide the late Mr A with appropriate medical care and treatment

Concerns raised by Mrs C

15. Mrs C raised a number of concerns about the care and treatment provided to Mr A following his admission to the Hospital in June 2016. In particular, she was surprised that Mr A was not given a blood transfusion when he attended the Hospital, as he had lost a large amount of blood. She had a number of concerns about the actions of staff in investigating the bowel problems that Mr A was experiencing, including that the Hospital did not have a supply of his insulin. Mrs C was also concerned about the circumstances of Mr A's death; how he was found unconscious; and about the way the Board's staff communicated with the family after Mr A's death.

The Board's response

16. When responding to Mrs C's complaint, the Board told her that they considered the medical care and treatment provided to Mr A was appropriate.

17. Regarding the blood transfusion, the Board stated the standard guidance is that people should not have a blood transfusion unless the haemoglobin level (a protein in red blood cells that carries oxygen from the lungs) is less than about 80, or the patient's pulse and blood pressure are affected. No transfusion was given to avoid the complications associated with the procedure, which the Board advised was in line with their clinical guidelines.

18. The Board explained they planned to carry out an endoscopy and a sigmoidoscopy, but that the sigmoidoscopy could not be carried out due to the presence of black solid stools. They considered the most important test to look for bleeding was an endoscopy and that test was performed promptly. The Board

advised investigation of the lower gastrointestinal tract was more complicated, requiring proper preparation, and this could not be achieved in a short timescale. They explained that the subsequent post-mortem did not find any bleeding that had been missed, but instead identified that a pulmonary embolism had occurred.

19. The Board advised they were sorry staff did not ask Mrs C about the insulin before she returned home after visiting Mr A. They explained that the type of insulin required was not stocked in the ward in question, or in the diabetic wards or pharmacy, and that was why staff contacted her.

20. They provided details of what appeared to have occurred on the evening of Mr A's death. Mr A was reviewed at 19:00 and was due to be checked at 21:00. They explained that his fall was not witnessed. The Board greatly regretted that they could not ascertain how long Mr A had been on the floor and why his buzzer had not been used. They explained staff attempted to resuscitate Mr A but this was unsuccessful.

21. As the cause of Mr A's death was pulmonary embolism, comments were sought from the Board on the VTE prophylaxis that was given to Mr A following his previous surgery to reduce the risk of blood clots.

22. The Board responded that consideration was given to the risk of VTE to Mr A as, at the time of the surgery, staff recorded this as 'high' in the operation note. The Board said in-patient VTE prophylaxis was prescribed and given appropriately (in particular, LMWH). They also said that aspirin post-discharge was prescribed and given.

23. The Board commented that aspirin has a protective effect in patients with hip fracture, as per Scottish Intercollegiate Guidelines Network (SIGN) guidance on 'Management of hip fracture in older people' (SIGN 111). They accepted that aspirin should not be given as monotherapy (taken alone); however, the Board's view was that this was not given as monotherapy in this case because LMWH had been given during the in-patient period.

24. The Board added that, unfortunately, Mr A may still have developed a fatal pulmonary embolism even if LMWH had also been given on discharge, as there is no certain means to prevent this. For these reasons, the Board considered that the medication provided was appropriate in the circumstances.

Medical advice

25. My complaints reviewer sought the advice of Adviser 1 (a consultant in acute medicine) on Mrs C's complaints.

26. As a preliminary point, Adviser 1 noted this was a complex case involving a number of different aspects of care. The relevant guidelines in relation to the management of each individual aspect of care were:

- SIGN 'Management of acute upper and lower gastrointestinal bleeding' (September 2008) (SIGN 105);
- National Institute for Health and Care Excellence (NICE) 'Venous thromboembolism: reducing the risk for patients in hospital' (January 2010) (CG 92);
- NICE 'Blood Transfusion' (November 2015) (NG 24); and
- NICE 'Diabetes in adults' (March 2011) (QS 6).

27. Mrs C had questioned why Mr A was not given a blood transfusion when he was taken to Hospital on 12 June 2016 with bleeding. Adviser 1 considered that this decision was appropriate. They confirmed Mr A's haemoglobin level was 90g/l, which was above the levels which NICE guidelines would recommend for a transfusion, even given Mr A's other health problems. Adviser 1 noted that the plan was to monitor his haemoglobin levels with consideration of blood transfusion if there was evidence of major bleeding or his haemoglobin dropped.

28. Adviser 1 also considered that the Board carried out appropriate investigations in order to assess the problems Mr A was experiencing. They said the presence of malaena was suggestive of upper gastrointestinal bleeding (bleeding from the oesophagus, stomach or upper small bowel), as opposed to lower gastrointestinal bleeding (bleeding from the colon).

29. Initial clinical investigation in this case was an upper gastrointestinal endoscopy, which was consistent with the SIGN 105 guidelines. Adviser 1 said a sigmoidoscopy was also planned. This was due to the presence of fresh blood in the stool, which is less common with upper gastrointestinal bleeding and more suggestive of lower gastrointestinal bleeding.

30. Adviser 1 said it takes longer to prepare a patient for sigmoidoscopy as their bowel needs to be as empty as possible to allow good views, so patients require strong laxative treatment and often a special diet. As Mr A was constipated and

had iron tablets, Adviser 1 said it was correct to not attempt to perform the sigmoidoscopy immediately as it would have been futile.

31. Adviser 1 noted Mrs C's concern that the Board should have concentrated more on Mr A's bowels, whereas the Board's response was that they carried out the tests they could. Adviser 1 said the care was reasonable in this respect. They explained it is very difficult to see anything during a sigmoidoscopy or colonoscopy when there is stool present, as this coats the bowel lining and it is hard to visualise whether there are any parts of the bowel that are bleeding. They explained that the details of the case made it more likely to be an upper gastrointestinal bleed and that it is a quicker process to perform an upper gastrointestinal endoscopy.

32. In that context, Adviser 1 agreed with the Board's actions to investigate an upper gastrointestinal source of bleeding initially and plan to investigate the colon after sufficient bowel preparation. Adviser 1 also noted evidence in the file suggested a rectal examination was performed.

33. Adviser 1 considered that the key investigations indicated were identified by the Board. A CT scan (a specialised type of x-ray) could be carried out, but it was relevant that Mr A had existing kidney disease. The dye used for a CT scan can cause problems in patients with kidney disease. They considered that additional investigations of Mr A's bowels would have been unlikely to change the course of events.

34. Mrs C was concerned by the Hospital contacting her about Mr A's insulin as they had no supply. Adviser 1 explained that there are many different types of insulin and insulin delivery systems, and hospitals will not stock all of these. In these circumstances, they advised it is reasonable to ask patients or their relatives to bring in the type and device they normally use, as this also encourages self-management in hospital. Adviser 1 considered the evidence suggested that staff made reasonable attempts to obtain the correct insulin, then enquired about getting Mr A's own insulin in when possible and sought a suitable alternative. As he was fasting and his blood glucose was not significantly high, Adviser 1 noted staff felt he did not require insulin that evening, just monitoring of his capillary blood glucose levels. Adviser 1 considered this was reasonable in a person with type 2 diabetes.

35. Adviser 1 considered whether, from a clinical perspective, there was an appropriate degree of monitoring of Mr A's condition on the ward during this admission (June 2016). Adviser 1 said they had one concern in this respect, in relation to the monitoring and charting of Mr A's observations on his NEWS chart. As this relates primarily to nursing care, I have covered this in detail under complaint (b).

36. In relation to the circumstances of Mr A's death, Adviser 1 explained that major pulmonary embolism is a common cause of sudden death in hospital. The records suggested that Mr A had been well after his endoscopy and into the early evening, before he was found to be in cardiac arrest. Adviser 1 said that major pulmonary embolism can occur suddenly, without warning or obvious signs, and cause the heart to stop. A patient may well then collapse in cardiac arrest.

37. Adviser 1 noted that staff started cardiopulmonary resuscitation (CPR) immediately and followed the recommendations by the UK Resuscitation Council 'Advanced Life Support'. Adviser 1 said that, unfortunately, resuscitating a patient from the type of cardiac arrest Mr A suffered (asytole) is virtually unheard of. Adviser 1 raised no concerns about the treatment provided in this respect.

38. The Board considered that the pulmonary embolism likely developed after the surgery for a fractured femur but Mr A's presentation was not consistent with this, so it was not detected. Adviser 1's view was that staff did not unreasonably fail to identify signs of Mr A's condition during his admission in June 2016.

39. Adviser 1 explained that Mr A's history, examination and investigations were not suggestive of pulmonary embolism. In particular, his oxygen levels were good; he was not in respiratory distress; his heart rate was not high; and his electrocardiogram (ECG) had no features to suggest pulmonary embolism. Adviser 1 added that Mr A's presentation at the Hospital was of gastrointestinal bleeding, so he was not investigated with an aim of excluding pulmonary embolism. If pulmonary embolism had been suspected based on his history, routine tests or clinical examination, then Adviser 1 would have expected different tests. As his presentation was that of gastrointestinal bleeding, his tests were targeted to looking for and treating a source of bleeding. In this context, Adviser 1's view was that the Board did not fail to identify the signs of a pulmonary embolism.

40. Adviser 1 noted that Mr A's VTE prophylaxis medication (aspirin) was withheld after he was re-admitted because of concerns about gastrointestinal bleeding. They considered that this was appropriate in the circumstances. They advised that even a reassuring upper gastrointestinal endoscopy and sigmoidoscopy may not have prompted the aspirin to be restarted, given the history of bleeding. Adviser 1 considered, in all likelihood, this would not have been responsible for the large pulmonary embolism which caused Mr A's death, as aspirin continues to work for about 72 hours after the last dose.

41. Adviser 1 noted that Mr A's family sought an assurance that his death was fully investigated. Adviser 1 considered the Board's actions were of a reasonable standard. They noted the case was discussed with the procurator fiscal, who was satisfied that they did not need to investigate further. The Board pursued a hospital post-mortem, which Adviser 1 said was reasonable in the circumstances.

42. In relation to the concerns raised about how staff communicated with Mr A's family after his death and having reviewed the records, Adviser 1 considered the communication by medical staff was of a reasonable standard.

43. Adviser 1 noted the doctor who had documented the discussion with family members after the cardiac arrest provided a best estimation as to why Mr A had collapsed in cardiac arrest, but said that a post-mortem was required to be certain. The doctor thought that Mr A might have died from a major haemorrhage based on an arterial blood gas test.

44. Adviser 1 said this was not unreasonable and that it was not uncommon for medical staff to base the death certificate on their 'best estimation' – looking at the events leading up to the cardiac arrest and the type of cardiac arrest (both major haemorrhage and pulmonary emboli can cause asystolic cardiac arrests) with the knowledge that death certification information is then updated after a post-mortem has been performed. In this way, they said registering a death and proceeding to funeral arrangements is not held up.

Surgical advice

45. My complaints reviewer sought the advice of Adviser 2 (an orthopaedic surgeon) as to whether Mr A received appropriate prophylaxis during his earlier admission to the Hospital, and following discharge.

46. Adviser 2 noted the relevant guidance for VTE prophylaxis following hip replacement surgery (extracts from the guidance are at Annex 3):

- SIGN (111), 'Management of hip fracture in older people', which states that aspirin monotherapy is not recommended as appropriate pharmacological prophylaxis for patients after hip fracture surgery;
- NICE, 'Venous thromboembolism: reducing the risk for patients in hospital'; and
- the Board's guidance on 'Risk Assessment for Venous Thromboembolism (VTE) Trauma and Orthopaedic Surgery' (15 April 2014), which indicates that for patients with 'increased' risk, then enoxaparin (a type of LMWH) should be continued for an overall treatment course of five weeks.

47. Adviser 2 reviewed the records. Adviser 2 observed that the operation note stated for Mr A: 'VTE risk High. Clexane [a type of LMWH] 40mg S/C [through a subcutaneous injection] then aspirin for 35/7'. Adviser 2 also noted the drug cardex recorded 'enoxaparin [the active ingredient of Clexane] 20mg (renal dose)'. This was continued for five days. Adviser 2 observed that the British National Formulary (BNF) states a daily dose of 40mg for high risk patients, but goes on to comment to reduce the dose if Estimated Glomerular Filtration Rate (eGFR – a blood test result) is less than 30. Adviser 2 noted the discharge documentation referred to a prescription of 'aspirin 150mg OD [oral dose] for five weeks, then reduce to 75mg', which was Mr A's usual dose.

48. Having reviewed the medical notes, and considering SIGN and NICE guidance, Adviser 2 considered that Mr A's VTE prophylaxis while he was in the Hospital in May 2016 was appropriate, but discharge on aspirin alone was not supported by SIGN or by NICE. Adviser 2 also noted that the Board's guidelines were not followed.

49. Adviser 2 commented that theatre notes regarding VTE prophylaxis and the prescription form recording the assessment of VTE prophylaxis appeared to be blank: they considered these should have been completed. They reiterated that intra-operative prophylaxis is recommended by SIGN and NICE and commented that this should have been considered, used and recorded.

50. Adviser 2 noted SIGN 111 concludes that aspirin can cause increased risk of haemorrhage. This *may* have therefore contributed to Mr A's readmission with rectal bleeding. Adviser 2 noted that the post-mortem identified the cause of death as bilateral pulmonary embolism and considered that appropriate VTE

prophylaxis might have reduced this risk. They also noted that no source for bleeding was found at post mortem.

51. In addition, Adviser 2 commented on the level of consultant involvement during Mr A's admission in May 2016.

52. First, regarding pre-operative care, it did not appear from the medical records that a consultant surgeon saw Mr A prior to his surgery on 17 May 2016. Adviser 2's view was that the responsible consultant should see the patient (awake) within 24 hours of admission, and certainly pre-operatively. In commenting on a draft of this report the Board stated that Mr A would have been discussed at a trauma meeting attended by trauma consultants held on 17 May 2016 and a plan put in place. The Board confirmed these meetings are not documented and there is no list of attending doctors. Adviser 2 said discussion as part of the trauma meeting should have been documented. We pressed the Board for supportive evidence that Mr A was seen by a consultant surgeon pre- operatively. In response the Board advised that, although there was no ward round note from 17 May 2016, it is routine for the operating consultant surgeon to review patients on the ward on the morning prior to surgery.

53. Second, regarding post-operative care, Adviser 2 was of the view that the records provided by the Board indicated an appropriate level of care. They noted that a number of electronic records representing dictated consultant ward rounds were only provided at a late stage in the investigation, after the circulation of the draft of this report. Adviser 2 commented that these documents should have been filed within Mr A's medical records at the earliest possible opportunity. Moreover, it would have been preferable if the Board had provided these records at the relevant time.

(a) Decision

54. The basis on which I reach decisions is reasonableness. My 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. I do not apply hindsight when determining the outcome of a complaint.

55. Mrs C complained that the Board failed to provide Mr A with appropriate medical care and treatment. She raised a number of concerns in relation to his second admission to the Hospital in June 2016. Given the cause of Mr A's death,

I have also investigated whether the Board took appropriate steps to reduce the risk of pulmonary embolism following his surgery in May 2016.

56. The Board considered that the medical care was reasonable in both admissions. My investigation findings support this position with regard to Mr A's admission in June 2016. In particular:

- it was reasonable not to provide Mr A with a blood transfusion, given the results of Mr A's blood tests and the applicable guidance;
- investigations that were carried out to ascertain the problems Mr A was suffering were appropriate, as staff had a reasonable basis for thinking Mr A was suffering from an upper gastrointestinal bleed, and the investigations were appropriate to check this. It was also reasonable not to perform a sigmoidoscopy at the time;
- it was reasonable to withhold Mr A's VTE prophylaxis medication when he was readmitted; it was unlikely that this would have been responsible for the large pulmonary embolism which caused Mr A's death and there is no evidence that the Board missed signs of a pulmonary embolism during Mr A's second admission;
- it was reasonable that the Hospital had no supply of Mr A's insulin, as there are different kinds of this medication and it was appropriate for staff in the circumstances to contact Mrs C about this;
- the Board's actions when they found Mr A collapsed and their attempts to resuscitate him were reasonable; and
- the Board's actions following Mr A's death were appropriate in relation to contact with the procurator fiscal and post mortem, as was their communication with Mr A's family

57. Clearly, the situation during this admission was a complex one for the medical staff involved to manage. Equally, given Mr A's collapse and unexpected death, it is understandable that Mrs C has concerns and questions about the medical care he received.

58. As regards the care provided, I have established that the medical care during this admission and in the period immediately before Mr A's death was appropriate and reasonable. I hope this gives some sense of comfort to Mrs C and her family.

59. However, the advice I have received is that there was a significant failing in relation Mr A's VTE prophylaxis medication in May 2016. Staff provided appropriate medication to prevent pulmonary embolism during this admission, but Mr A was discharged on aspirin as a single agent to prevent pulmonary embolism, contrary to national guidance and the Board's own guidance. In particular, SIGN 111 recommends against prescribing aspirin to be taken alone as an appropriate VTE prophylaxis for patients after hip fracture surgery and concludes that aspirin can cause increased risk of haemorrhage. Additionally, the theatre notes and prescription form regarding VTE prophylaxis were not completed as they should have been.

60. While there is no completely effective way of preventing pulmonary embolism, Adviser 2 considered that providing appropriate medication in line with SIGN 111 and the Board's guidance could have reduced the risk to Mr A.

61. I accept this advice and consider that there was a significant failure in this aspect of treatment. In light of the advice I received, while I cannot reach a definitive view, I am unable to rule out the possibility that this failing may have contributed to Mr A's death.

62. I am also concerned at the apparent lack of consultant involvement in Mr A's pre-operative management while he was an in-patient in May 2016. Mr A was admitted on 16 May 2016 and received surgery on 17 May 2016. The advice I have received and accept is that there was no record of Mr A being seen by the consultant surgeon prior to his surgery, and I am critical of this. I note the Board's comments that the matter was discussed at a trauma meeting and that it would be normal practice for the operating consultant surgeon to review patients on the ward on the morning prior to surgery, but in the absence of clinical records to support this, this cannot be verified. The level of post-operative consultant input was appropriate. However, I am critical that this only became clear at a late stage in my investigation when the Board provided additional notes. The Board should ensure complete clinical records are provided in response to my office's enquiries, and I am critical that this did not happen in this case.

63. Based on the information that the Board and Mrs C have provided, and the advice I have received and accept, I uphold this complaint. I have made recommendations to address the failings identified at the end of this report.

Complaint (b): The Board failed to provide the late Mr A with appropriate nursing care and treatment

Concerns raised by Mrs C

64. Mrs C's concerns about the Board's actions also extended to nursing staff. In particular, she questioned the monitoring of Mr A during his June 2016 admission, and raised concerns about the way nursing staff communicated with his family following his death.

65. In Mrs C's complaint correspondence with the Board, she also raised concerns about nursing care during his admission in May 2016. These related to problems with the bed Mr A was nursed on; problems with the blinds and heating; and that the food Mr A was given did not take into account that he was a diabetic.

The Board's response

66. The Board apologised to Mrs C that there were elements of nursing care which could have been better, in relation to Mr A's admission in May 2016. Their response in relation to Mr A's June admission concentrated on the medical care he received. However, they apologised for communication failures in relation to the death certificate.

Advice received

(1) Monitoring

67. As explained under complaint (a), Adviser 1 highlighted concerns about NEWS charting during Mr A's June admission. NEWS observations are recorded by nursing staff and are used by both nursing and medical staff to monitor patients.

68. Adviser 1 noted that Mr A's blood pressure, pulse and oxygen saturations were last performed at around 14:00 on the day he died, when he was in recovery after his endoscopy. The last capillary blood glucose they could see recorded was from 11:10 on the same day. His observations taken in recovery were not charted on his NEWS chart. Adviser 1 said if they had been recorded, his NEWS would have been 3. Adviser 1 explained that national recommendations state that if a patient's NEWS is 3 (which is classified as 'low risk') they should have repeat observations within four hours. However, Mr A did not have his observations repeated.

69. Adviser 1 considered it was unreasonable that Mr A did not have repeat NEWS calculated/observations taken during the late afternoon/early evening on 13 June 2016.

70. Adviser 1 also noted that there was no documentation of Mr A's blood glucose being checked after the endoscopy and noted his pre-endoscopy blood glucose level measured at 13.8mmol/l. Given the concerns about obtaining Mr A's insulin during the evening, Adviser 1 said it was surprising that his blood glucose was not re-checked at this time. However, Adviser 1 said it was difficult to state with confidence that these deficiencies contributed to Mr A's death.

71. My complaints reviewer sought the advice of Adviser 3 (a nurse). Adviser 3 noted the comments Adviser 1 made about monitoring generally (as set out above) and their concerns about the NEWS observations.

72. Adviser 3 reviewed the nursing notes from 12 and 13 June 2016. They noted that the key documents they would expect in such a case were the NEWS charts and the active care checklist (record of care focusing on pain assessment, skin care and mobility, elimination, eating and drinking, environment, information and escalation).

73. Adviser 3 commented that the active care was carried out two hourly and was complete, and the last entry was at 19:00 on 13 June 2016 prior to the cardiac arrest at 20:36, which was recorded on the resuscitation record. Adviser 3 considered this was reasonable.

74. Adviser 3 noted that NEWS was completed:

- on admission on 12 June 2016 at 16:05 as blood pressure low and NEWS 4;
- at 16:35 NEWS was recorded as score 2, which meant that four hourly recording was indicated;
- again at 17:40, 18:30 and 19:50;
- on 13 June 2016, at 01:50, 05:50 and 08:40, which was the final recording

75. As previously noted by Adviser 1, the endoscopy was carried out around 14:00 on 13 June 2016. Adviser 3 indicated that they would have expected vital signs to be carried out after the endoscopy. While vital signs were taken after the endoscopy, these were not recorded on the NEWS chart.

76. Adviser 3 commented that they would have expected, at the very least, four hourly monitoring, which would mean observations performed again at around 18:00. Adviser 3 shared the concerns of Adviser 1 that the NEWS charts did not show that this was performed on 13 June 2016.

77. Having reviewed the records available, Adviser 3 considered that nursing staff acted appropriately when Mr A was discovered on the evening of 13 June 2016. They noted that Mr A was found at around 20:30 and was last seen on the ward by nursing staff at 19:00. Immediately, a cardiac arrest was called and resuscitation commenced, which was appropriate.

(2) Communication

78. Mrs C had raised concerns about how nursing staff communicated with Mr A's family following his death. Adviser 3 said that it was very difficult to substantiate concerns about what happened. Clearly, Mr A's family were very upset at the sudden death and emotions would have been understandably very high. Adviser 3 considered that, from the records available, the communication was within a reasonable standard at that time. They noted that Mrs C also described a situation where nursing staff did not deal sensitively with providing Mr A's death certificate. They considered that the Board's apology and assurance that staff would reflect on this was appropriate.

79. Adviser 3 observed this was a very challenging issue to address, as there were many factors involved. They added that the Board might consider how best they communicate with families, making use of resources such as death and dying teaching, and using written resources such as the Scottish Government's publication 'What to do after a death' to support the families of patients at difficult times.

80. Overall, while Adviser 3 considered that the nursing care provided to Mr A in June 2016 was in many respects reasonable, there was a gap in the vital signs recording which they considered was a failing.

81. With regard to the concerns raised by Mrs C in her initial complaint to the Board, Adviser 3 considered that the Board had apologised appropriately and taken reasonable action to address Mrs C's concerns.

(b) Decision

82. Mrs C's complaint was that the Board failed to provide the late Mr A with appropriate nursing care and treatment.

83. In correspondence with the Board, she raised a number of concerns in relation to nursing care during Mr A's first admission in May 2016. The advice I have received and accept is that, in general, the Board took reasonable action to address the issues Mrs C raised and offered an appropriate apology for the failures in care.

84. In relation to Mr A's admission in June 2016, I accept the advice received from both Advisers 1 and 3 that there was a gap in NEWS recording during the late afternoon and early evening of 13 June 2016 (indeed, this is apparent from the records). While observations were taken and recorded when Mr A was recovering from his endoscopy at around 14:00, these were not entered onto his NEWS chart, meaning that the final NEWS recorded was much earlier, at 08:40 on that day. Mr A should have had four hourly NEWS observations and further NEWS observations ought to have been carried out at 18:00.

85. I am concerned that, firstly, the observations taken following the endoscopy were not recorded on the NEWS chart and that further observations were then not taken four hours later. In addition, Mr A's capillary blood glucose levels should have been re-checked after the endoscopy.

86. I am mindful of the advice I have received and accept, that pulmonary embolism can occur suddenly and without warning, and that these failings are unlikely to have had an impact on the final outcome. Nevertheless, I consider the failure to take and record NEWS observations and capillary blood glucose level monitoring were concerning omissions in care.

87. I have also noted Adviser 3's comments regarding the communication with Mr A's family following his death. The Board have acknowledged that elements of communication could have been more sensitive and supportive at this difficult time. They should now take steps to consider how they can improve this very important element of care for patients and their families.

88. For the reasons outlined above, I consider that there were failings in the nursing care provided to Mr A. I uphold Mrs C's complaint and I have made recommendations to address the failings identified at the end of this report.

89. I am pleased to note that the Board have accepted the recommendations and will act on them accordingly. The Board are asked to inform my office of the steps that have been taken to implement the recommendations by the dates specified. I would expect evidence (including supporting documentation) that appropriate action has been taken before I can confirm that the recommendations have been implemented to my satisfaction.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

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

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a) & (b)	There was a failure to provide appropriate medication to reduce the risk of blood clots following Mr A's discharge from the Hospital. Mr A's National Early Warning Score observations were not adequately recorded on 13 June 2016 and there was a failure to re-check his capillary blood glucose levels	Apologise to Mrs C for failing to provide Mr A with appropriate medication and to carry out appropriate nursing observations and blood glucose checks. 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: 24 September 2018

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

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	Aspirin alone was prescribed to prevent blood clots on discharge, contrary to the Board's guidance and national guidance	Patients should be prescribed prophylactic blood clot prevention medication following hip fracture surgery, in line with the Board's guidelines and national guidance	(1) Documentary evidence that the orthopaedic team have been made aware of the case and considered it for relevant learning at an appropriate meeting (such as a minute from an orthopaedic morbidity and mortality meeting). (2) Documentary evidence that the Board has taken steps to ensure that relevant staff are aware of and take into account the guidance on venous thromboprophylaxis in their clinical practice. By: 22 October 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
	Theatre notes and the prescription form were not completed appropriately.	Theatre notes and prescription forms should be adequately completed.	(3) Documentary evidence that this has been fed back to relevant staff in a supportive manner that encourages learning. By: 22 October 2018
	There is no record of pre-operative consultant involvement in Mr A's medical management during his admission in May 2016, prior to his surgery.	Patients admitted for hip fracture surgery should receive an appropriate level of consultant involvement in their pre-operative care. This should be properly recorded in the medical records.	(4) Documentary evidence that this has been fed back to relevant staff in a supportive way that promotes learning. By: 22 October 2018
	The Board did not provide all of the relevant records until after the circulation of the draft of this report	The Board should ensure that clinical evidence demonstrating the treatment and care provided is provided at the appropriate point in an SPSO investigation	(5) Documentary evidence of the steps the Board will take to ensure *all relevant clinical evidence is provided at the appropriate point of an SPSO investigation* By: 22 October 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	There was a failure to carry out repeat National Early Warning Score (NEWS) observations. Observations following the endoscopy were not charted on NEWS. Capillary blood glucose levels were not re-checked	Patient observations should be appropriately taken and charted	(1) The Board should demonstrate that they have reviewed their policy for recording observations after a procedure and on return to the ward area. (2) The Board should demonstrate that the monitoring issues have been discussed with relevant nursing staff in a supportive way that promotes learning (such as a minute from a relevant ward/unit meeting) By: 22 November 2018

Evidence of action already taken

The Board told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	What the organisation say they have done	Evidence SPSO needs to check that this has happened and deadline
(b)	The Board accepted that nursing staff did not deal sensitively with providing Mr A's death certificate	The Board said that staff would reflect on this	Evidence that this has happened By: 22 October 2018

Feedback

Communication

I urge the Board to reflect on how they communicate with families, particularly in sensitive and difficult situations such as the death of loved ones. In doing so, it would be appropriate to consider what use is made of resources such as death and dying teaching and written resources such as the Scottish Government's publication 'What to do after a death', to support the families of patients at such difficult times.

Terms used in the report **Annex 1**

Adviser 1	a consultant in acute medicine
Adviser 2	a consultant orthopaedic surgeon
Adviser 3	a nurse
Clexane	is one among the group of medications called low molecular weight heparins (LMWH)
Enoxaparin	the active ingredient in Clexane
Gastritis	inflammation of the lining of the stomach
LMWH	low molecular weight heparin, a class of anticoagulant medications, which are used in the prevention of blood clots (venous thromboembolism)
Malaena	black stool
NEWS	National Early Warning Score chart: this is an aggregate of the patient's observations such as temperature, respiratory rate, oxygen saturations, blood pressure and pulse.
NICE	National Institute for Health and Care Excellence
Prophylaxis	a measure taken to prevent the occurrence of a disease or condition
Pulmonary embolism	a blood clot in the pulmonary artery, the blood vessel which carries blood from the heart to the lungs

Venous thromboembolism (VTE)	a blood clot which forms within a vein
Sigmoidoscopy	a procedure which involves looking inside the large intestine
SIGN	Scottish Intercollegiate Guidelines Network
The Board	Greater Glasgow and Clyde NHS Board
Upper intestinal endoscopy	a procedure where a thin, flexible tube called an endoscope is used to look inside the oesophagus, stomach and first part of the small intestine

List of legislation and policies considered **Annex 2**

Greater Glasgow and Clyde NHS Board ‘Risk Assessment for Venous Thromboembolism (VTE) Trauma and Orthopaedic Surgery’ (April 2014)

National Institute for Health and Care Excellence ‘Venous thromboembolism: reducing the risk for patients in hospital’ (January 2010) (CG 92)

National Institute for Health and Care Excellence ‘Blood Transfusion’ (November 2015) (NG 24)

National Institute for Health and Care Excellence ‘Diabetes in adults’ (March 2011) (QS 6)

Scottish Intercollegiate Guidelines Network ‘Management of acute upper and lower gastrointestinal bleeding’ (September 2008) (SIGN 105)

Scottish Intercollegiate Guidelines Network guidance on ‘Management of hip fracture in older people’ (June 2009) (SIGN 111)

Relevant guidance **Annex 3**

Scottish Intercollegiate Guidelines Network guidance on 'Management of hip fracture in older people' (June 2009) (SIGN 111)

'Heparin (UFH or LMWH) or fondaparinux may be used for pharmacological thromboprophylaxis in hip fracture surgery.

Patients without a contraindication should receive thromboprophylaxis using fondaparinux for 28 days starting six hours after surgery.

- Fondaparinux should not be used before surgery because of the increased potential for spinal haematoma after spinal or epidural anaesthesia.
- If surgery is delayed patients should receive thromboprophylaxis with heparin (UFH or LMWH).
- Fondaparinux should be considered for all patients after surgery, unless contraindicated.

Aspirin monotherapy is not recommended as appropriate pharmacological prophylaxis for patients after hip fracture surgery.'

National Institute for Health and Care Excellence 'Venous thromboembolism: reducing the risk for patients in hospital' (January 2010) (CG 92)

- Start mechanical VTE prophylaxis at admission. Choose any one of the following, based on individual patient factors:
  - anti-embolism stockings (thigh or knee length), used with caution (see recommendations 1.3.2–1.3.11)
  - foot impulse devices
  - intermittent pneumatic compression devices (thigh or knee length).

Continue mechanical VTE prophylaxis until the patient no longer has significantly reduced mobility.

- Provided there are no contraindications, add pharmacological VTE prophylaxis. Choose any one of:
  - Dabigatran etexilate, starting 1-4 hours after surgery
  - fondaparinux sodium, starting 6 hours after surgical closure, provided haemostasis has been established and there is no risk of bleeding (see box 2)
  - LMWH, starting at admission, stopping 12 hours before surgery and restarting 6–12 hours after surgery
  - UFH (for patients with severe renal impairment or established renal failure), starting at admission, stopping 12 hours before surgery and restarting 6–12 hours after surgery.

Continue pharmacological VTE prophylaxis for 28–35 days, according to the summary of product characteristics for the individual agent being used.

Greater Glasgow and Clyde NHS Board 'Risk Assessment for Venous Thromboembolism (VTE) Trauma and Orthopaedic Surgery' (April 2014)

Procedure	**On discharge**	
Hip fracture	Standard VTE risk	Continue enoxaparin SC for an overall treatment course of 2 weeks or until discharge (whichever is sooner)
	Increased VTE risk	Continue enoxaparin SC for an overall treatment course of 5 weeks.