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: South of Scotland

Case ref: 201800015, Dumfries and Galloway NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / diagnosis

Summary
Mrs C complained about the care and treatment that her father (Mr A) received from Dumfries and Galloway NHS Board (the Board) in A&E and in the clinical assessment unit at Dumfries and Galloway Royal Infirmary. Mr A arrived at A&E late in the evening on 2 December 2017. Early in the morning on 3 December 2017, Mr A was admitted to the clinical assessment unit. While in the clinical assessment unit, Mr A had a cardiac arrest and he sadly passed away. The cause of Mr A's death was a ruptured abdominal aortic aneurysm (AAA).

Mrs C complained that Mr A's symptoms were not investigated appropriately in A&E. Mrs C also questioned whether the Board's record-keeping regarding Mr A's care and treatment was appropriate.

We took independent advice from a consultant in emergency medicine, a consultant in acute medicine and a nursing adviser.

We found that the history and initial examination carried out in A&E were reasonable. However, we also found that the Board failed to perform an ultrasound scan or a CT scan of Mr A's abdomen in A&E to confirm or exclude a diagnosis of an AAA. If a scan had been done in A&E this *may* have led to an earlier diagnosis of AAA, Mr A's transfer to a hospital with a vascular surgical capability (vascular specialists treat disorders of the circulatory system) and the chance of his survival may have been greater.

We found that Mr A was not reviewed promptly by medical staff on his transfer to the clinical assessment unit when he was suspected to have an infection and the nursing documentation and cardiac arrest documentation were not completed reasonably.

In view of these failings, we upheld Mrs C's complaint that the Board did not provide reasonable care and treatment to Mr A. We also found that the failings in care that our investigation identified could have and should have been established and acted upon during the Board's own complaints investigation.

Mrs C also complained that the Board did not communicate reasonably with Mr A's family. We found that Mr A's family were not kept updated about his deteriorating condition, they were informed in a corridor that he had passed away and clear information was not given about the time of Mr A's death.

In light of this, we upheld Mrs C's complaint that the Board did not communicate reasonably with Mrs C and her family regarding Mr A's care and treatment.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

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

Complaint number	What we found	What the organisation should do	What we need to see
(a) and (b)	• The Board failed to perform an ultrasound scan or a CT scan of Mr A's abdomen in A&E to confirm or exclude a diagnosis of an abdominal aortic aneurysm. • Mr A was not reviewed promptly by medical staff on his transfer to the clinical assessment unit when he was suspected to have an infection. • The nursing documentation and cardiac arrest documentation were not completed reasonably. • There were failures to communicate reasonably with Mr A's family	Apologise to Mrs C and Mrs C's family for the failure to perform a scan of Mr A's abdomen in A&E, that Mr A was not reviewed promptly on his transfer to the clinical assessment unit, that the nursing and cardiac arrest documentation were not completed reasonably and that there were failures to communicate reasonably with Mr A's family	A copy or record of the apology. The apology should meet the standards set out in the SPSO guidelines on apology available at: www.spso.org.uk/leaflets-and-guidance By: 19 December 2018

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

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board failed to perform an ultrasound scan or a CT scan of Mr A's abdomen in A&E to confirm or exclude a diagnosis of an abdominal aortic aneurysm	Medical staff in A&E should be aware of abdominal aortic aneurysm presentation and investigation	Evidence that the findings on this complaint have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that abdominal aortic aneurysm presentation and investigation has been included in A&E staff induction programme. Evidence that guidelines are in place for obtaining imaging when abdominal aortic aneurysm is suspected By: 13 February 2019
(a)	Mr A was not reviewed promptly by medical staff on his transfer to the clinical	Patients admitted to the clinical assessment unit who are suspected to have an infection	Evidence that the Board have reviewed the current system for the medical review of patients who are transferred from A&E

Complaint number	What we found	Outcome needed	What we need to see
	assessment unit when he was suspected to have an infection	should be reviewed promptly by medical staff	to the clinical assessment unit and identified areas where this system could be improved By: 13 February 2019
(a)	The level of nursing assessment and monitoring that Mr A needed was not recorded on his admission to the clinical assessment unit. Nursing staff in the clinical assessment unit failed to complete Mr A's vital signs chart	Patients admitted to the clinical assessment unit should have their required level of nursing assessment and monitoring recorded. Patients presenting with moderate pain and signs of shock should have their vital signs checked appropriately following admission to the clinical assessment unit	Documentary evidence that the findings on this complaint have been fed back to relevant nursing staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Board have reviewed the current system for nursing assessment and monitoring of patients admitted to the clinical assessment unit and identified any areas where this system could be improved By: 13 February 2019

Complaint number	What we found	Outcome needed	What we need to see
(a) and (b)	The documentation regarding Mr A's cardiac arrest was unreasonable and this may have led to Mr A's family being given unclear information about his time of death	Cardiac arrest documentation should detail: • the time a patient is found to be in cardiac arrest; • the time resuscitation started; • what events took place during resuscitation, such as the medication given; • a clear plan for who will speak to the family about the outcome; and • a readable signature, the printed name and job title of the person making the entry	Evidence that the findings on this complaint have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Board have reviewed the current system for documenting cardiac arrests in the clinical assessment unit and identified any areas where this system could be improved By: 13 February 2019
(b)	Mr A's family were informed in a corridor that he had passed away	Upsetting news should be communicated in a private and quiet area	Evidence that the Board have reviewed the current system for breaking upsetting news in the clinical assessment unit and identified any areas where this system could be improved By: 13 February 2019

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board's own investigation did not identify the serious failings in the care provided to Mr A	The Board's complaints handling system should ensure that failings (and good practice) are identified, and that it is using the learning from complaints to inform service development and improvement (where appropriate)	Evidence that the Board have reviewed why its own investigation into the complaint did not identify the failings highlighted in this report By: 16 January 2019

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	Outcome needed	What we need to see
(b)	There were failures to communicate reasonably with Mr A's family: • There was a lack of communication with Mr A's family regarding his deteriorating condition; • Mr A's family were informed in a corridor that he had passed away; and • Mr A's family were not given clear information about his time of death	The Board said that they had fed these failings back to the teams in A&E and the clinical assessment unit	Evidence that the findings on this complaint have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions) By: 16 January 2019

Feedback

Complaints handling:

Given that your complaint was received after 1 April 2017, the Board should have been adhering to the NHS Model Complaints Handling Procedure (CHP).

- on 4 January 2018, the Board said that Mrs C made contact with them by telephone to raise concerns about Mr A's care and treatment.
- on 23 February 2018, a meeting was held to discuss the concerns. The Board state the complaint was closed on 26 February 2018 following the meeting.

The meeting was held 36 working days after Mrs C contacted the Board to make the complaint. The CHP states that meetings should be held within 20 working days of receiving the complaint wherever possible. It is not clear from the records available to me why this meeting was not held within 20 working days of the complaint being received. I have drawn this to the Board's attention.

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 that her father (Mr A) received from Dumfries and Galloway NHS Board (the Board). Her concerns relate to the care and treatment Mr A received when he attended Dumfries and Galloway Royal Infirmary (the Hospital) in severe pain. Mr A arrived at A&E late in the evening on 2 December 2017. Early in the morning on 3 December 2017, Mr A was admitted to the clinical assessment unit. While in the clinical assessment unit, Mr A had a cardiac arrest and he sadly passed away. The cause of Mr A's death was a ruptured abdominal aortic aneurysm (AAA).

2. The complaints from Mrs C I have investigated are that:

(a) In December 2017, the Board failed to provide reasonable care and treatment to Mr A; (*upheld*); and

(b) In December 2017, the Board failed to communicate reasonably with Mrs C and her family regarding Mr A's care and treatment (*upheld*).

Investigation

3. I and my complaints reviewer considered the information provided by Mrs C and the Board. This included Mr A's relevant medical and nursing records and the Board's complaints file. We also obtained independent advice from a consultant in emergency medicine (Adviser 1), a consultant in acute medicine (Adviser 2) and a nursing adviser (Adviser 3) on the clinical aspects of the complaints.

4. I have decided to issue a public report on Mrs C's complaints because of my deep concerns about the significant failings identified; the significant personal injustice to Mr A and because I consider it is in the wider public interest.

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

(a) Complaint: In December 2017 the Board failed to provide reasonable care and treatment to Mr A

Concerns raised by Mrs C

6. Mrs C complained that Mr A's symptoms were not investigated appropriately. Mrs C said that Mr A had a blood count of 38 which was not followed up and that the Board did not take Mr A's history of heart attacks into consideration. Mrs C was concerned that Mr A was wrongly diagnosed with a

urine infection and that he did not receive an ultrasound scan in A&E. Mrs C considered that if Mr A had received an ultrasound scan then the aneurysm may have been identified and Mr A may have received appropriate treatment and a chance to survive. Mrs C was concerned about the amount of time Mr A spent in A&E before being moved to the clinical assessment unit. Mrs C also questioned whether the Board's record-keeping regarding Mr C's care and treatment was appropriate. When commenting on a draft of this report Mrs C said that the family did not know how unwell Mr A was. Mrs C explained that if the family had known how unwell Mr A was they would have stayed with him at the hospital.

The Board's response

7. In their response to Mrs C, the Board said that an immediate scan was not considered because Mr A's symptoms and blood test results indicated that he was suffering from kidney stones. The Board acknowledged that the symptoms of kidney stones and aneurysm are very similar and that, had Mr A been scanned immediately, his aneurysm probably would have been found. However, the Board said that the diagnosis, treatment and care provided was considered appropriate given Mr A's presentation and test results at the time.

8. The Board explained that Mr A presented to A&E during a particularly busy period and apologised that there was a delay in moving Mr A to a ward. The Board said that they had checked Mr A's records, which they said did not hold much information, but did show that Mr A's fluid balance chart was last checked at 10:05 hours on the morning of 3 December 2017 and the emergency cardiac arrest call was made at 11:03 hours.

Medical advice: A&E

9. First, given Mrs C's concerns about Mr A's diagnosis, I asked Adviser 1 whether the Board's assessment and examination of Mr A following his attendance at A&E was reasonable or unreasonable. In particular, whether Mr A had a history of heart attacks which was not taken into consideration by the Board.

10. Adviser 1 said that Mr A's past medical history had been documented in A&E records. Adviser 1 was of the view that there was no indication that Mr A's past history was not taken into account. Adviser 1 explained that as part of Mr A's history it had been recorded that Mr A previously had a myocardial infarction (a heart attack), and that he had high blood pressure and high

cholesterol. Adviser 1 also said that the medications Mr A was taking had also been recorded in detail.

11. From A&E records, Adviser 1 noted that:

- when Mr A was triaged (the process of determining the priority of patients' treatments based on the severity of their condition) he had severe onset of right groin pain radiating around to his back, that he was very grey in colour when the ambulance arrived, that he had good relief from intravenous morphine (pain killer) and that he had a history of chronic back pain due to arthritis;
- Mr A's vital signs were recorded;
- Mr A had experienced severe back pain and groin pain for the last two-three days, that Mr A had no urinary symptoms, no blood in his urine and that he had last passed urine the same evening;
- Mr A had been clammy and sweaty, had loin to groin pain, nausea and vomiting;
- Mr A's heart, chest sounds and capillary refill (the time taken for colour to return to the skin after pressure is applied) were recorded;
- Mr A had strong femoral pulses, his abdomen was soft with generalised tenderness, there was no peripheral oedema (accumulation of fluid under the skin causing swelling, usually in the lower limbs), no guarding (tensing of the abdominal wall muscles to guard inflamed organs) and no rebound tenderness (pain upon removal of pressure rather than application of pressure to the abdomen);
- the A&E letter on Mr A's transfer to the clinical assessment unit states that A&E diagnosis was sepsis and that Mr A had been managed with sepsis 6 (name given to a bundle of medical therapies designed to treat patients with sepsis);
- Mr A was prescribed morphine, ondansetron (medication used to prevent nausea and vomiting), amoxicillin (an antibiotic) and gentamicin (an antibiotic);
- a urine sample was analysed and this showed no evidence of blood, protein, nitrites (indicator of a bacterial infection) or leucocytes;
- an arterial blood gas sample was measured which showed a low bicarbonate and a low base excess. It was also recorded that Mr A had a raised lactate level; and
- blood tests were obtained and the results were for haemoglobin, the white cell count, neutrophilia and platelets.

12. In light of the above, Adviser 1 said that the history taken and the examination carried out in A&E were both of a good standard. Adviser 1 noted that the initial investigations requested were reasonable and the standard of record-keeping in A&E was also reasonable.

13. I also asked Adviser 1 about Mrs C's concern that Mr A did not receive an ultrasound.

14. Adviser 1 said that Mr A's diagnosis was not clear because he presented with a number of symptoms, clinical signs and abnormal results which did not fit with one particular diagnosis. Adviser 1 said three main possible diagnoses required consideration based on Mr A's clinical features. These were kidney stones, an infection and a ruptured AAA.

15. Adviser 1 said that an infection was suggested by Mr A's raised white cell count and raised C-reactive protein (CRP) measurement. Adviser 1 also explained that Mr A had a raised lactate level and low bicarbonate and base excess levels, which could be consistent with infection. It appeared that the doctor in A&E made a diagnosis of infection partly based on Mr A's CRP and white cell count.

16. Adviser 1 commented that the type of pain experienced by Mr A could have been due to kidney stones. However, Adviser 1 said that the absence of blood in Mr A's urine, his raised white cell count, CRP measurement and raised lactate level would make this diagnosis unlikely. Adviser 1 also explained that Mr A's low bicarbonate and base excess levels would also not be in keeping with a diagnosis of kidney stones.

17. Adviser 1 said that the severity, location and nature of Mr A's pain (loin to groin pain radiating to his back) would be consistent with an AAA. Adviser 1 explained that the description of Mr A being grey, clammy and sweaty, along with his raised lactate and low bicarbonate and base excess levels could also be in keeping with a diagnosis of an AAA.

18. Adviser 1 noted that the pain had been there for a few weeks which would be less suggestive of a diagnosis of AAA. However, Adviser 1 also noted that the pain had suddenly increased. Adviser 1 said that Mr A's raised white cell count and CRP measurement would not be in keeping with an AAA. Adviser 1

explained that patients with a leaking AAA typically present with low blood pressure and Mr A's blood pressure was within the normal range.

19. Adviser 1 said that the conflicting information facing the doctor in A&E was not conclusively in support of one particular diagnosis. The fact that the doctor in A&E documented an examination of Mr A's femoral pulses demonstrates that they were considering the possibility of an AAA. Adviser 1 explained that given Mr A's history and his presentation, the doctor in A&E should have requested investigations to confirm or exclude the presence of a leaking AAA. In particular, Adviser 1 was of the view that the doctor should have requested an ultrasound or CT scan of Mr A's abdomen to confirm or exclude this diagnosis. They advised that the failure to do so was unreasonable.

20. Adviser 1 said that carrying out an abdominal ultrasound or CT scan while Mr A was in A&E may have led to an earlier diagnosis of AAA. Adviser 1 explained that this may have resulted in Mr A being transferred to a hospital with a vascular surgical capability in order to have this repaired (vascular specialists treat disorders of the circulatory system). They referred me to the Best Practice Guidelines for the Management and Transfer of Patients with a diagnosis of Ruptured Abdominal Aortic Aneurysm to a Specialist Vascular Centre which states where an alternative diagnosis is considered more likely on clinical grounds, an AAA must still be excluded. Adviser 1 said that Mr A's chance of survival may have been greater if he had been scanned during his time in A&E.

21. I asked Adviser 1 whether the amount of time Mr A spent in A&E before being moved to a ward was reasonable or unreasonable.

22. Adviser 1 said that it was not ideal but it appeared that the receiving ward was full, with no available beds. Adviser 1 said it is not uncommon for patients to spend prolonged periods of time in A&E waiting for beds to become available and that this was not unreasonable in the circumstances.

Medical advice: clinical assessment unit

23. Adviser 2 was asked if the Board's assessment and examination of Mr A following his admission to the clinical assessment unit was reasonable or unreasonable. Adviser 2 noted that Mr A was transferred to the clinical assessment unit at 05:25 hours on 3 December 2017, having been seen by an emergency medicine doctor between midnight and 02:00 hours. Adviser 2 said

that there are no medical notes from the time of Mr A's admission to the clinical assessment unit until his cardiac arrest.

24. Adviser 2 said there is no evidence that Mr A was seen, examined or assessed by another clinical decision maker until his cardiac arrest at approximately 11:00 hours. They considered it was unreasonable that Mr A was not seen more quickly by another clinician given that he had a high white blood cell count and pain which required intravenous fluids to be administered quickly.

25. Adviser 2 said they could not say for certain if an earlier review in the clinical assessment unit would have identified the AAA or hastened an ultrasound scan. Adviser 2 noted that appropriate treatment for a suspected infection (fluids and antibiotics) had already been started in A&E. However, Adviser 2 said that patients who are considered to be septic (have an infection) and are therefore at risk of further deterioration, should be seen more promptly than Mr A was. Adviser 2 said that the acute medicine quality standards recommend a review by a competent clinical decision maker within four hours of admission to an acute medical unit. Adviser 2 explained that the acute medicine quality standards are currently being introduced to improve the quality of care provided in acute medical units but that they are not obligatory.

26. Next, I referred Adviser 2 to Mrs C's concern regarding the Board's record-keeping following Mr A's admission to the clinical assessment unit. Adviser 2 said that the entry in the notes about Mr A's cardiac arrest was documented at 11:38 hours. Adviser 2 explained that this entry does not state when Mr A was found to be in cardiac arrest, what time resuscitation started or what medication was given to Mr A during his cardiac arrest, such as adrenaline. Adviser 2 said that from looking at the hospital records of cardiac arrest calls (a call to key people in the hospital to get them to come to the scene of the cardiac arrest) during that period, a cardiac arrest call was put out at 11:03 hours. Adviser 2 thought that this would have been within a few minutes of when Mr A was found to be in cardiac arrest.

27. Adviser 2 referred to the Intensive Care National Audit and Research Centre (ICNARC) National Cardiac Arrest Audit which recommends the key information to be recorded during or immediately after a cardiac arrest such as the timing of key events, medication given and the outcome. Adviser 2 said that cardiac arrest situations are rushed and it can be difficult to record events in real time, however, efforts should be made in retrospect to document key events such as when the

patient was discovered to be in cardiac arrest, any medication given and discussions with key people, such as relatives.

28. Next, Adviser 2 referred to the Royal College of Physicians generic medical record-keeping standards which state that every entry in the medical record should be dated, timed, legible and signed by the person making the entry. It also states that the name and designation of the person making the entry should be legibly printed against their signature. Adviser 2 also referred to the General Medical Council guidance on good medical practice which states that medical records must be clear, accurate and legible. It states that records should be made at the same time as the events being recorded or as soon as possible afterwards. Adviser 2 explained that the medical notes regarding Mr A's cardiac arrest are not clear and that the signature of the person who made the entry was not readable. Adviser 2 also said that the staff member had not printed their name clearly or their job title. Adviser 2 stated that the note ended with "family to be informed" but it does not establish who would take on that important task. Adviser 2 said that the standard of documentation regarding Mr A's cardiac arrest was unreasonable.

29. Adviser 2 noted that the nursing notes and vital signs chart were filled in up until 07:15 hours. Adviser 2 said that there were no nursing notes after 07:15 hours. Adviser 2 also noted that Mr A had his intravenous fluids increased at approximately 10:00 hours. Given the rate fluids were being given to Mr A, Adviser 2 considered Mr A was not thought to be very unwell or unstable at that time. Adviser 2 said that it is very difficult to establish a timeline of events due to the lack of nursing documentation between around 07:15 hours and the cardiac arrest documentation at 11:38 hours.

Nursing advice: clinical assessment unit

30. Adviser 3 was asked for their views on the nursing documentation in the clinical assessment unit. Adviser 3 said that the first nursing assessment in the clinical assessment unit was at 05:25 hours. Adviser 3 noted that Mr A's vital signs were recorded, including blood sugar and temperature. Adviser 3 stated that Mr A was noted to have a pain score of 6 out of 10 (moderate pain), he was given pain medicine and that Mr A had a urinary catheter on hourly volumes to identify kidney function and the level of hydration or dehydration.

31. Adviser 3 explained that Mr A's fluid balance chart was started at 05:40 hours and that intravenous fluids and Mr A's hourly urine volumes were recorded

at 06:45 hours, 07:55 hours, 09:00 hours and 10:00 hours. Adviser 3 stated that Mr A would have been seen at those times to empty the urinary catheter bag and record the urine volumes.

32. Adviser 3 noted that a venous cannula (tube inserted into the vein) was inserted at 10:30 hours. Adviser 3 also said that a waterlow pressure ulcer assessment, falls assessment, infection control assessment, mobility assessment and nutritional care assessment were completed at 07:00 hours.

33. Adviser 3 said the vital signs chart was completed at 07:15 hours and there are no further entries after this. Adviser 3 stated that this was unreasonable, particularly as Mr A was presenting with moderate pain and showing signs of shock (skin grey and cold and clammy). Adviser 3 explained that the nurses should have been carrying out more frequent observations so that they were alert to any deterioration in Mr A's condition.

34. They also advised that nursing staff should have been carrying out at least hourly checks on Mr A's vital signs, asking how Mr A was feeling and checking if he was still in pain. Adviser 3 also stated that they would expect the level of nursing assessment and monitoring that Mr A needed to be recorded in the nursing notes on his admission to the clinical assessment unit. Adviser 3 concluded that the nursing care in the clinical assessment unit was unreasonable.

(a) Decision

35. 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 a complaint.

A&E

36. The advice I have received and accept is that the history and initial examination carried out by the doctor in A&E were reasonable. In particular:

- Mr A's history of heart attacks was taken into consideration;
- the record-keeping in A&E was of a good standard; and
- the length of time Mr A had to wait in A&E before being moved to a ward was not unreasonable in the circumstances.

37. I note that Mrs C was concerned that Mr A had a blood count of 38 which was not followed up. While blood tests were taken, there is nothing in the medical records to evidence that Mr A had a blood count of 38.

38. However, the advice I have received and accept is that Mr A had a number of symptoms, clinical signs and abnormal results which did not fit conclusively with one particular diagnosis. Based on the Board's history and examination, they appear to have been considering kidney stones, an infection and an AAA as possible diagnoses. Given Mr A's history and presentation, the doctor in A&E should have requested an ultrasound scan or a CT scan of Mr A's abdomen to confirm or exclude a diagnosis of AAA and that the failure to do this was unreasonable.

39. I also note that the relevant best practice guidelines refer to the need to exclude an AAA in these circumstances. I accept the advice that if a scan had been done in A&E this *may* have led to an earlier diagnosis of AAA, Mr A's transfer to a hospital with a vascular surgical capability and the chance of his survival may have been greater.

Clinical assessment unit

40. The Board have acknowledged that Mr A's medical records do not hold much information. My investigation has established that there are no medical records from the time of Mr A's admission to the clinical assessment unit at approximately 05:45 hours until his cardiac arrest at approximately 11:00 hours. There is no evidence that Mr A was seen, examined or assessed by a clinician during this timeframe and I accept the advice that this was unreasonable.

41. At the time of Mr A's admission to the clinical assessment unit he was suspected to have an infection. I accept Adviser 2's comments that patients who are suspected to have an infection are at risk of deterioration and should be seen by a clinician more promptly than Mr A was. I also accept Adviser 2's comments that it is not possible to establish if an earlier review by a clinician in the clinical assessment unit would have identified the possibility of an AAA.

42. I am critical that the documentation regarding Mr A's cardiac arrest does not state the time that Mr A was found to be in cardiac arrest, what time resuscitation started or what medication he received. I also note that the signature of the person who made the entry about Mr A's cardiac arrest is not readable and they did not print their name or record their job title. This is contrary to national

guidance on the standard of record-keeping. The record of Mr A's cardiac arrest also does not state who would be informing his family about the outcome. I accept the advice that the standard of documentation regarding Mr A's cardiac arrest was unreasonable.

43. I also accept Adviser 3's comments that most of the nursing documentation was completed. However, Mr A's vital signs chart was not completed after 07:15 hours and that this was unreasonable given Mr A was recorded as having moderate pain and was showing signs of shock. I also accept the advice that on Mr A's admission to the clinical assessment unit, the nursing notes should have indicated the level of nursing assessment and monitoring that he needed.

44. In concluding that the care and treatment Mr A received was unreasonable I am also of the view that the failings in care my investigation has identified could have and should have been established and acted upon during the Board's own complaints investigation. Not to do so was a further failing that had the consequence of prolonging the family's worry and pain in losing a loved one.

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

(b) Complaint: In December 2017 the Board failed to communicate reasonably with Mrs C and her family regarding Mr A's care and treatment

Concerns raised by Mrs C

46. Mrs C complained that the Board did not keep her and her family updated regarding Mr A's condition. Mrs C said that the Board informed her and her family in a corridor that Mr A had passed away. Mrs C also said that a nurse indicated that Mr A had passed away at an earlier time, which was different to the time stated on Mr A's death certificate.

The Board's response

47. In response to Mrs C's complaint, the Board said that they would expect patients and their families to be kept updated and for their questions to be answered appropriately. The Board apologised to Mrs C for the lack of communication regarding Mr A's deteriorating condition. The Board said this has been fed back to the teams so that they can reflect on how the experience of Mrs C and her family could have been better with effective communication.

48. The Board accepted it was not appropriate that Mrs C and her family were informed in a corridor about Mr A's death. They apologised that this happened and said it had been discussed with the team. The Board also apologised for the miscommunication about the time of Mr A's death and for the distress this caused. They said that the importance of clear communication had been discussed with the nursing team.

Medical advice

49. I asked Adviser 2 if the steps already taken by the Board were sufficient to address the failings they identified.

50. Adviser 2 noted that the Board said they had discussed with the team the concern about the way Mrs C and her family were informed of Mr A's death. Adviser 2 explained that the Board's response did not set out a robust plan for how to ensure that improvements are made and how the actions of the Board had been taken forward. Adviser 2 said it is important to ensure that there is a quiet area to break bad news and where relatives can have privacy. Adviser 2 was of the view that the Board should set out what further steps have been taken to try to ensure that the breaking of bad news is handled more sensitively in the future.

51. Adviser 2 also said that improving the documentation and time-keeping in cardiac arrest or peri-arrest (the period before and after a cardiac arrest where the patient is unstable) situations may prevent similar confusion regarding the time of death. As established in Complaint (a), Adviser 2 said that the records regarding Mr A's cardiac arrest were poor and would be improved by more detail around timing of events.

(b) Decision

52. The Board have acknowledged failures in their communication with Mrs C and her family and said these had been fed back to the teams involved. While this is to be welcomed, the advice I have received, and accept, is that this only partly addresses the failings identified and the Board should set out what further steps have been taken to try to ensure that the breaking of bad news is handled more sensitively in the future. I also accept the advice that improving the documentation in cardiac arrest or peri-arrest situations may prevent confusion regarding time of death occurring in the future.

53. In light of the failings identified, I uphold this complaint. I will be recommending that the Board provide the SPSO with additional evidence of the action that they have taken to address the failings that they identified.

54. 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.

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 and her family:

Complaint number	What we found	What the organisation should do	What we need to see
(a) and (b)	• The Board failed to perform an ultrasound scan or a CT scan of Mr A's abdomen in A&E to confirm or exclude a diagnosis of an abdominal aortic aneurysm. • Mr A was not reviewed promptly by medical staff on his transfer to the clinical	Apologise to Mrs C and Mrs C's family for the failure to perform a scan of Mr A's abdomen in A&E, that Mr A was not reviewed promptly on his transfer to the clinical assessment unit, that the nursing and cardiac arrest documentation were not completed reasonably and that there were failures to	A copy or record of the apology. The apology should meet the standards set out in the SPSO guidelines on apology available at: www.spso.org.uk/leaflets-and-guidance By: 19 December 2018

Complaint number	What we found	What the organisation should do	What we need to see
	assessment unit when he was suspected to have an infection. • The nursing documentation and cardiac arrest documentation were not completed reasonably. • There were failures to communicate reasonably with Mr A's family	communicate reasonably with Mr A's family	

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

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board failed to perform an ultrasound scan or a CT scan of Mr A's abdomen in A&E to confirm or exclude a diagnosis of an abdominal aortic aneurysm	Medical staff in A&E should be aware of abdominal aortic aneurysm presentation and investigation	Evidence that the findings on this complaint have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions) Evidence that abdominal aortic aneurysm presentation and investigation has been included in A&E staff induction programme. Evidence that guidelines are in place for obtaining imaging when abdominal aortic aneurysm is suspected By: 13 February 2019
(a)	Mr A was not reviewed promptly by medical staff on his transfer to the clinical	Patients admitted to the clinical assessment unit who are suspected	Evidence that the Board have reviewed the current system for the medical review of patients who are

Complaint number	What we found	Outcome needed	What we need to see
	assessment unit when he was suspected to have an infection	to have an infection should be reviewed promptly by medical staff	transferred from A&E to the clinical assessment unit and identified areas where this system could be improved By: 13 February 2019
(a)	The level of nursing assessment and monitoring that Mr A needed was not recorded on his admission to the clinical assessment unit. Nursing staff in the clinical assessment unit failed to complete Mr A's vital signs chart	Patients admitted to the clinical assessment unit should have their required level of nursing assessment and monitoring recorded. Patients presenting with moderate pain and signs of shock should have their vital signs checked appropriately following admission to the clinical assessment unit	Documentary evidence that the findings on this complaint have been fed back to relevant nursing staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Board have reviewed the current system for nursing assessment and monitoring of patients admitted to the clinical assessment unit and identified any areas where this system could be improved By: 13 February 2019

Complaint number	What we found	Outcome needed	What we need to see
(a) and (b)	The documentation regarding Mr A's cardiac arrest was unreasonable and this may have led to Mr A's family being given unclear information about his time of death	Cardiac arrest documentation should detail: • the time a patient is found to be in cardiac arrest; • the time resuscitation started; • what events took place during in resuscitation, such as the medication given; • a clear plan for who will speak to the family about the outcome; and • a readable signature, the printed name and job title of the person making the entry	Evidence that the findings on this complaint have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions). Evidence that the Board have reviewed the current system for documenting cardiac arrests in the clinical assessment unit and identified any areas where this system could be improved By: 13 February 2019
(b)	Mr A's family were informed in a corridor that he had passed away	Upsetting news should be communicated in a private and quiet area	Evidence that the Board have reviewed the current system for breaking upsetting news in the clinical assessment unit and identified any areas where this system could be improved By: 13 February 2019

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board's own investigation did not identify the serious failings in the care provided to Mr A	The Board's complaints handling system should ensure that failings (and good practice) are identified, and that it is using the learning from complaints to inform service development and improvement (where appropriate)	Evidence that the Board have reviewed why its own investigation into the complaint did not identify the failings highlighted in this report By: 16 January 2019

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	Outcome needed	What we need to see
(b)	There were failures to communicate reasonably with Mr A's family: • There was a lack of communication with Mr A's family regarding his deteriorating condition; • Mr A's family were informed in a corridor that he had passed away; and • Mr A's family were not given clear information about his time of death	The Board said that they had fed these failings back to the teams in A&E and the clinical assessment unit	Evidence that the findings on this complaint have been fed back to relevant staff in a supportive way (e.g. a record of a meeting with staff; or feedback given at one-to-one sessions) By: 16 January 2019

Feedback

Complaints handling:

Given that your complaint was received after 1 April 2017, the Board should have been adhering to the NHS Model Complaints Handling Procedure (CHP).

- on 4 January 2018, the Board said that Mrs C made contact with them by telephone to raise concerns about Mr A's care and treatment.
- on 23 February 2018, a meeting was held to discuss the concerns. The Board state the complaint was closed on 26 February 2018 following the meeting.

The meeting was held 36 working days after Mrs C contacted the Board to make the complaint. The CHP states that meetings should be held within 20 working days of receiving the complaint wherever possible. It is not clear from the records available to me why this meeting was not held within 20 working days of the complaint being received. I have drawn this to the Board's attention.

Terms used in the report **Annex 1**

abdominal aortic aneurysm (AAA)	a weak point in the large artery that carries blood from the heart, causing it to balloon out
Adviser 1	a Consultant in Emergency Medicine
Adviser 2	a Consultant in Acute Medicine
Adviser 3	a Nursing Adviser
base excess	in simple terms this is a measure of acidity in the blood
bicarbonate	a chemical which prevents the pH levels of the blood from turning too acidic
cardiac arrest	a condition in which the heart suddenly and unexpectedly stops beating
c-reactive protein (CRP)	a protein found in blood plasma (pale yellow liquid component of blood), whose levels rise in response to inflammation
CT scan	(computerised tomography) scan uses x-rays and a computer to create detailed images of the inside of the body
femoral pulses	a large artery in the thigh and the main arterial supply to the leg
haemoglobin	a protein found in the red blood cells that carries oxygen around your body and gives blood its red colour
intravenous	into a vein

kidney stones	small hard mineral deposits that form inside the kidneys
lactate level	the amount of lactic acid in the blood
leucocytes	presence of white blood cells, typically related to an infection
Mr A	the aggrieved
Mrs C	the complainant
neutrophilia	the primary white blood cells that respond to a bacterial infection
platelets	react to bleeding by forming a blood clot
resuscitation	where the heart and/or breathing is re-started if it stops
sepsis	a potentially life-threatening complication of an infection
the Board	Dumfries and Galloway NHS Board
the Hospital	Dumfries and Galloway Royal Infirmary
ultrasound scan	a scan that uses sound waves to create images of organs and structures inside the body
urinary catheter	a thin tube used to drain and collect urine from the bladder
vital signs	signs of life including the heartbeat, breathing rate, temperature, and blood pressure

white cell count	also called leukocytes or leucocytes. Help to fight infections

List of legislation and policies considered — Annex 2

Best Practice Guidelines for the Management and Transfer of Patients with a diagnosis of Ruptured Abdominal Aortic Aneurysm to a Specialist Vascular Centre.

General Medical Council (GMC), Good Medical Practice Guidance (April 2013).

Intensive Care National Audit and Research Centre (ICNARC), National Cardiac Arrest Audit.

Society of Acute Medicine, Clinical Quality Indicators for Acute Medical Units (AMUs).

The Royal College of Physicians, Generic Medical record-keeping standards (June 2015).