Scottish Parliament Region: Mid Scotland and Fife

Case 200701701: Forth Valley NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mr C) raised a number of concerns about the care and treatment of his 86-year-old father (Mr A) at one of the hospitals of Forth Valley NHS Board (the Board), Stirling Royal Infirmary (the Hospital), between his admission, following a fall, and his death there, several months later.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) aspects of the care and treatment fell below a reasonable standard *(not upheld)*; and

(b) the Board's handling of the complaint fell below a reasonable standard (*upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. The complainant (Mr C) raised a number of concerns about the care and treatment of his 86-year-old father (Mr A) at one of the hospitals of Forth Valley NHS Board (the Board), Stirling Royal Infirmary (the Hospital), between his admission, following a fall, and his death there, several months later.

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

(a) aspects of the care and treatment fell below a reasonable standard; and

(b) the Board's handling of the complaint fell below a reasonable standard.

3. Mr C's complaint to the Board included 29 questions and a number of other points. In his later complaint to the Ombudsman, he explained that he had still not had full answers to these. I arranged for the Board to provide more detail, which I passed on to him. Part of my role is to identify what I consider to be the heart of the matter in a complaint, to try to establish the facts in respect of that, to consider whether there was unreasonable fault and, if so, to consider what action to take. Such action would take account of any fault acknowledged and actioned by the Board. It was clear to both the Adviser (see next paragraph) and me that the investigation should focus on the apparent delays before Mr A's hip operation and before his later operation on the swelling in his leg. As Mr C believed that inappropriate use of pain-relieving drugs had significantly contributed to his father's death, I also considered whether that was the case. As, sadly, Mr C's father had died, I considered whether that had been because of shortcomings in his care and treatment. I also included the Board's complaint handling in the investigation, and, as a main issue for Mr C concerned information given to him about infection, I will cover that in this report. Therefore, much of the information from the Board in answer to Mr C's questions was passed to him by me for information, rather than as part of the investigation.

Investigation

4. I was assisted in the investigation by a clinical adviser (the Adviser), a consultant hospital doctor, whose role was to explain to me, and provide an unbiased comment on, aspects of the complaint. We examined the papers provided by Mr C, which included his complaint correspondence with the Board and his own thoughts, and information provided by the Board, which included Mr A's clinical records. In line with the practice of the Ombudsman's office, the

standard by which the events were judged was whether they were reasonable. By that, I mean whether the decisions and actions taken were within a range of what would have been considered to be acceptable practice at the time in question. The purpose of the investigation was to use the information from Mr C and the Board to try to establish the relevant facts and then to consider whether the facts fell within this range of reasonable practice. I should also explain that we do not judge decisions and actions by using hindsight. In other words, our conclusions are not based on how things later turn out for a patient. Our approach is to consider what (for example) evidence and information were available to clinicians at the time in question and to consider whether their actions were reasonably based on that information. This is because that is the only information on which the clinicians could have based their decisions at the time.

5. This report omits much of the detail of Mr A's experiences and of information given by the Board to Mr C as this information is known to Mr C. (For example, he had seen his father's hospital clinical records.) However, I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) Aspects of the care and treatment fell below a reasonable standard

6. I turn now to the events in question. A reminder of the abbreviations and terms is at Annexes 1 and 2.

7. Mr A, an 86-year-old man, was admitted to the Hospital on 4 June 2006 after fracturing his hip through a fall. His existing conditions included the presence of an artificial heart valve, and because of this he was taking the drug warfarin. This is an anti-coagulant, ie it helps to prevent the blood from clotting. This is required when an artificial heart valve is in place because such a valve creates a greater tendency for the blood to clot. However, such a drug has to be stopped before a surgical operation to avoid excessive bleeding after the operation. Anti-coagulant control is maintained through regular checks but is easier for some patients and easier in some situations. Control may be being achieved but be adversely affected by a changed situation such as a hospital admission. The difficulties of anti-coagulant control in Mr A's case caused a delay in operating on his hip. The Adviser has advised that this delay was entirely appropriate.

8. The operation was, therefore, carried out on 9 June 2006 by putting in a metal device. Clinicians then faced the difficult balancing act of getting Mr A's anti-coagulation under control again. Some days after the operation, Mr A started to complain of severe pain in the leg, which was treated, with varying degrees of success, with pain-relieving drugs.

9. The same leg then became swollen. An x-ray did not identify a cause for the continuing pain or the swelling, and it was felt likely to be a haematoma. In essence, this is a pooling of the blood within the tissues, causing a swelling because of the volume collected. The Adviser has advised that this was an appropriate view and has emphasised that by far the most likely cause of such a haematoma, in Mr A's particular case, was an oozing of blood from the operation wound because of anti-coagulation problems and that such oozing would be expected to stop when the anti-coagulation was controlled. This was, in fact, the Hospital's thinking also and was the reason for the Hospital's not doing further investigations at that time. The Adviser is clear that this was an entirely reasonable and acceptable view. Mr C was particularly concerned by the apparent delay in the Hospital's operating, feeling that the Hospital were simply giving his father more and more pain relief without trying to identify, or deal with (through surgery), the cause. For example, he considered that they could have done a scan at an earlier date than they did, to identify the cause. However, the Adviser would not have expected such a scan to be done on a patient for whom surgery was not a realistic possibility at that time. In relation to such surgery, the Adviser is emphatic that it would have been highly dangerous to have operated earlier than was the case. This is because Mr A was seriously ill with other difficulties (such as severe, worsening, kidney deterioration and continuing anti-coagulation problems, all of which are clearly documented in the clinical records), which meant that it was essential to consider the haematoma as a low priority in comparison. Indeed, the Adviser would not have expected any surgical operation to be done at that time unless it was unavoidable. Although the Adviser remains of this view, he has noted the Board's own view that they could have managed Mr A's symptoms more aggressively and their description of various actions which they said they had put in place to help deal with such situations in the future. Mr C has a copy of the relevant action plan, detailing these, and I would say that this is a welcome example of the Board's wishing to learn from a complaint, despite the absence of clear fault.

10. On the subject of pain relief, the Adviser noted that the Hospital's concern about the difficulty in achieving adequate pain relief for Mr A, while avoiding

interactions with other drugs, was reflected in their early involvement of a pain management team and that this was good practice. I should also say that Mr A received pain relief of varying types at various times throughout the period between his first admission to the Hospital in June 2006 and his death there in September 2006. However, of particular concern to Mr C was the use of OxyContin and OxyNorm, two drugs for the relief of moderate to severe pain. He felt they were causing excessive confusion and a 'catastrophic' deterioration in his father and that they contributed significantly to his father's death. In their first response to Mr C's complaint, the Board discussed some of the difficulties of achieving adequate pain relief for Mr A but added that more effort could have been made to look into other methods of pain control. It is clear from the clinical records that there were great difficulties in achieving adequate pain relief. A note in the records said that patients can appear very sedated but be comfortable from a pain point of view - or they can appear less sedated, being more alert and able to talk with their relatives, but not have adequate relief for their pain. The Adviser agreed with this - ie sometimes, despite a family's distress at the apparent over-sedation, pain relief has to take priority over the patient's ability to be alert and to converse. The Adviser has considered the use of the OxyContin and OxyNorm (through examination of the clinical records and consideration of the known side-effects etc of these two drugs) and is satisfied that they did not cause, or contribute to, Mr A's death.

11. Returning to Mr A's swollen leg, I should say that, in fact, the swelling turned out to be a rare post-operation complication called a pseudo-aneurysm. This is a type of expansion and rupture of an artery wall. Mr A was known to have arterial wall abnormalities, which tend to distort and weaken artery walls. It is possible that manipulation of his hip area during his first operation may have weakened an artery wall further or caused the pseudo-aneurysm, although the Adviser has emphasised that it was not caused by poor surgery. Mr C said a doctor had told him that the artery wall had probably been damaged by a screw being inserted during the operation of 9 June 2006. That does not mean the surgery was poor: the Adviser has said that vascular and neurological damage are recognised complications of this type of surgery in even the most expert of hands, so their occurrence does not in itself imply that any error was made. He has also said that the complication would not necessarily have been noticeable during the operation itself. The Adviser is clear that this was a rare complication and that the Hospital could not have been expected to have predicted it or to have identified it earlier.

12. An operation was carried out on 2 July 2006. Over the next few months, both in the Hospital and in another hospital to which Mr A was transferred for a while for rehabilitation, Mr A's condition varied, with an overall trend of deterioration. Doctors at the Hospital started to question whether, in the event of a cardiac or respiratory arrest, resuscitation should be tried or whether Mr A should simply be made as comfortable as possible and have only his symptoms (such as pain) treated. Sadly, Mr A died on 28 September 2006, having suffered a stroke.

13. From his examination of the details of Mr A's hospital admissions from June 2006, the Adviser's overall conclusions are that: the fractured hip was a particularly serious event; Mr A had a number of serious conditions, including anti-coagulation and kidney problems; his infections (which I shall cover in the next paragraph) weakened him but were not the cause of his death; his particular deterioration from about 23 September 2006 was not predictable; and the course of events is most sad but is the reasonable, natural, history of an 86-year-old person with complex medical conditions. In summary, the Adviser has said that there is no evidence that Mr A's death was caused by any omission of care or treatment.

14. Finally, I said (see paragraph 3) that this report would cover the issue of information given to Mr C about infection as this was a particular concern for him. He said that the Hospital withheld the existence of Clostridium Difficile from the family, so that he only learnt of this infection when he read the clinical records after his father's death, and that he only learnt of the Methicillin Resistant Staphylococcus Aureus (MRSA) infection by a chance conversation with a nurse. Understandably, he was concerned that these were serious infections. In answer to one of his questions, the Board told Mr C that they had no particular protocol for telling families of such infections but considered that (with the patient's consent) it would be good practice to do so. They sent me details of action they had taken on this issue, which I have sent to Mr C and which the Adviser considers is appropriate. The Adviser has also commented that when, as with Mr A, there is a long and complex history, with many issues arising daily, it is simply not possible for clinicians to tell families everything. I acknowledge that, in commenting on a draft of this report, Mr C was very concerned about this view. The Adviser has, therefore, explained further that, in circumstances like Mr A's, information given to a family would depend on how important clinicians thought it was in relation to the patient's condition. In this case, Mr C said that he had been told his father had a bowel infection: this was,

in fact, the Clostridium Difficile. Clostridium Difficile is often in the media nowadays, so it and its abbreviation, C Diff, are names that many people are familiar with. But this was not so at the time in question, and a healthcare professional at that time could have been accused of inappropriate use of jargon by using the term Clostridium Difficile, rather than bowel infection. Additionally, because Clostridium Difficile is so often referred to in today's media, we would nowadays generally expect healthcare professionals to tell families (with the patient's consent) if it was present. But, again, this was not the case at the time in question. All of this applies also to MRSA infection. In Mr C's case, he said a doctor told him his father had a scapa infection. As there is no such infection, the Board speculated that Mr C might have misheard the doctor say 'Staph' – ie an abbreviation for a Staphylococcus infection, of which MRSA is an example. So it is possible that a doctor did tell Mr C about the MRSA, but it is not possible to be sure. However, it is important that the Board have taken action to give more information about infections, and I would regard this as an appropriate outcome. Although this part of Mr C's complaint was about information given to him, it may be helpful for him to know that the Adviser has examined the clinical records and is satisfied that the infections were treated appropriately and that, although they weakened Mr A, they did not contribute to his death: the particular MRSA infection which Mr A had was not life threatening, and, although Clostridium Difficile can be life threatening, it was appropriately treated in Mr A's case.

15. I now turn to the Board's reply to my enquiries. I shall not repeat much of this here as Mr C has had a copy of it, but it is important to say what action the Board have taken as this means that lessons have been learnt from this complaint. The Board said that they had always intended to follow up their reply to Mr C with a detailed action plan to him but acknowledged that they had not told him this. They accepted that their replies did not adequately address all the issues he raised or indicate what they had done about them. They also indicated how future complaints that involved (as did this one) more than one specialty and ward would be approached. They said they had initiated a review of how serious complaints were investigated and had formally linked this with a group that reviewed significant clinical incidents. (That group included the Board's head of clinical governance and the Board's medical and nurse directors.) And they enclosed a detailed action plan, showing what reviews had taken place to address, in particular, Mr C's various concerns about communication, for example: communication workshops for nursing and medical staff; record-keeping audits and reviews; pain team communication

protocol; and arrangements made for infection leaflets to be available for issue to patients and families. The Adviser is satisfied that these are adequate actions, demonstrating that the Board have taken the issues seriously.

(a) Conclusion

16. I accept the Adviser's advice, in particular, his conclusions at paragraph 13, and conclude, in respect of the issues investigated, that Mr A's care and treatment, overall, were within the boundaries of reasonableness explained at paragraph 4 above, that there is no evidence that the care and treatment caused or hastened Mr A's death, and that the Board have taken welcome and appropriate action to improve on the experiences of Mr A and his son for future patients and families. In all the circumstances, I do not uphold the complaint.

(b) The Board's handling of the complaint fell below a reasonable standard

17. Mr C's complaint to the Board included 29 questions and a number of other points. The Board's reply to him explained that they had collected the questions into themes and were responding accordingly. They said that, if Mr C was unhappy with this approach or wanted to discuss anything in more detail with a senior staff member, they would be happy to arrange a meeting. (At the time, Mr C gave an address which was within reasonable travelling distance of the Board's headquarters.) He replied from a new address (much further away), asking for specific answers and explaining 'Clearly it is important, for my understanding of my father's suffering and his eventual death, to have answers to … all of the questions included in my report'. The Board's second response to him was much fuller. However, where Mr C had asked for reasons, there was a tendency to give, instead, explanations. And other comments were unlikely to inspire Mr C's confidence. For example, the Board's second complaint reply gave an inaccurate date in respect of a Clostridium Difficile infection. Mr C had also asked some questions about his father's catheter, clearly relating these to a date in July 2006; however, the Board replied in respect of dates in September 2006.

18. The Board considered that there could have been improvements, for example, in the time taken to establish the cause of Mr A's leg pain after his first operation and in taking opportunities for alternative pain relief. However, the action which they said they would take to prevent a recurrence was either not mentioned in the two replies or was described in general terms or terms which

could not have been expected to be clear to a lay person – for example, 'More effort could have been made to investigate other methods of pain control and it is regrettable that this was not done' and, 'We deeply regret this and to ensure the learning from these events are shared within the organisation, the orthopaedic and geriatric teams this has been shared with the Clinical Governance lead for the unit who will have a role in monitoring the actions taken on an ongoing basis'.

19. The Board's reply to me is covered at paragraph 15 above.

(b) Conclusion

20. It was good practice for the Board to offer Mr C a meeting when they first replied to his complaint. Nevertheless, I consider that their first reply was rather too brief. Their second reply was much better. However, I share many of Mr C's concerns about it. Also, the replies used terms such as 'vascular injury', 'colonised with', 'organisation's strategic goals' and 'senior intensivist', which could not have been expected to mean much to Mr C. The lack of detail about action taken adds to my impression of a rather dismissive tone in places. Mr C wrote in his complaint to this office, 'I had hoped for [answers] and some reassurance that lessons had been learned'. Such reassurance is what many complainants tell us they want; they need to feel that their relative did not die for nothing - for example, that some good came out of the situation by lessons having been learnt that could prevent its recurrence for another patient or family. I agree with Mr C that such reassurance was not apparent enough in the Board's two complaint replies to him. In all the circumstances, I uphold the complaint.

21. The Ombudsman has decided to make no recommendations because of the welcome extent of the action taken by the Board (see paragraph 15) and the fact that they have clearly taken the issues seriously.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mr A	Mr C's father
The Board	Forth Valley NHS Board
The Hospital	Stirling Royal Infirmary
The Adviser	The clinical adviser to the Ombudsman
MRSA	Methicillin Resistant Staphylococcus Aureus infection

Annex 2

Glossary of terms

Haematoma	Collection/pooling of blood inside Mr A's leg
Pseudo-aneurysm	A type of expansion and rupture of an artery wall