Scottish Parliament Region: Lothian and Glasgow

Cases 200500505 & 200500510: Scottish Ambulance Service and Greater Glasgow and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Hospital and Ambulance

Overview

The complainant (Mrs C) had concerns about some aspects of communication at the Western Infirmary, Glasgow (the Hospital) and about their decision to transfer her 84-year-old husband (Mr C) to a hospital near his home in England. When Mr C was being transferred by ambulance from the Hospital to the English hospital, his condition worsened, and she complained that the ambulance crew continued the journey, instead of stopping at another hospital on the way. He died in the English hospital a few days later.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) communication with the family and care at the Hospital were inadequate (*not upheld*);

(b) the ambulance crew's decision to continue the journey was inappropriate (*not upheld*);

(c) the ambulance crew's record-keeping lacked detail (*upheld*);

(d) the Hospital should have operated (*not upheld*); and

(e) the Hospital should not have allowed the ambulance journey (*not upheld*).

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[1] On 1 April 2006 the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by Argyll and Clyde Health Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of Argyll and Clyde Health Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to Greater Glasgow and Clyde Health Board as its successor.

Redress and recommendations

The Ombudsman recommends that:

(i) the Board ensure that, where appropriate, 'Do Not Attempt Resuscitation' orders (DNARs) are communicated clearly, in writing, for ambulance crews and receiving hospitals;

(ii) the Scottish Ambulance Service ensure that, where appropriate, ambulance crews obtain formal written DNAR information from referring hospitals; and

(iii) the Scottish Ambulance Service ensure that record-keeping by ambulance crews during journeys is adequate.

The Board and the Scottish Ambulance Service have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. I shall refer to the complainant as Mrs C, her husband as Mr C, Greater Glasgow and Clyde NHS Board as the Board and the Scottish Ambulance Service as the Service. The Western Infirmary, Glasgow is referred to as the Hospital and the English hospital as the English Hospital. A reminder of all abbreviations is at Annex 1. On 18 May 2005 the Ombudsman received Mrs C's complaint about the death of her 84-year-old husband. Although the complaints are about the Board and the Service, the events are related and, therefore, have been investigated and reported as one complaint.

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

(a) communication with the family and care at the Hospital were inadequate; and

(b) the ambulance crew's decision to continue the journey was inappropriate.

As the investigation progressed, I identified some underlying issues concerning the Board and the Service. Therefore, the investigation additionally considered whether:

(c) the ambulance crew's record-keeping lacked detail;

(d) the Hospital should have operated; and

(e) the Hospital should not have allowed the ambulance journey.

Investigation

3. I was assisted in the investigation by three of the Ombudsman's advisers (the Advisers): a consultant neurosurgeon, an Accident and Emergency medicine consultant and a consultant orthopaedic surgeon. Their role was to explain to me, and comment on, the complaint's clinical aspects. We examined: the papers provided by Mrs C, the complaint files of the Board and the Service, clinical records (including Mr C's clinical records from the English Hospital), relevant policies and procedures, and replies to my enquiries. To identify any gaps and discrepancies in the evidence, the content of relevant documents was checked against information elsewhere on file and was compared with my own and the Advisers' knowledge of the issues concerned. I am, therefore, satisfied that the evidence has been tested robustly. That includes the Advisers' advice, which was checked to ensure that it was clear and (where relevant) logically based on the evidence. Therefore, I accept their advice. 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 the boundaries of what would be considered to be acceptable practice in terms of knowledge and practice at the time.

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

(a) Communication with the family and care at the Hospital were inadequate

5. Mr C, an 84-year-old, lived with his family in England but was visiting Glasgow when he fell on 1 November 2004, injuring his head. He was taken to the Hospital, one of the Board's hospitals in Glasgow.

6. Mrs C's complaints under complaint (a) were:

- the Hospital simply wanted Mr C transferred to a hospital near his home in England so that they did not have to deal with him themselves;
- the Hospital asked her for the name of her nearest orthopaedic hospital, rather than find out for themselves;
- Mr C was dealt with by too many doctors, rather than by one alone;
- the Hospital wrongly described her husband as an alcoholic; and
- the Hospital did not tell the family at the start everything that they should have done, and the doctor who took the family into a room to explain the situation was only a registrar, not a consultant.

7. The Board said that Mr C's family (particularly his son) and Mr C himself wanted him to be transferred, to be closer to home. The clinical records also indicate such a view. However, Mrs C told me that the family had definitely not requested a transfer (and would not necessarily have done so because Mr C was not alone in Glasgow, having connections with the city). Mrs C told me that, whenever the Hospital mentioned it to the family, the family tended to remain silent. This was because they were still so shocked about what had happened to Mr C and also because of the large number of doctors whom they were seeing. Mrs C agreed with me that it was possible that the reason the doctors continued to seek a transfer was that they interpreted this silence as agreement.

8. At paragraphs 8 to 10, I summarise the Advisers' comments about the other aspects of complaint (a). A doctor who is trying to identify a particular hospital near a patient's home a long way away may well start by asking the patient's family if they know the name of such a hospital. This can be a quick and effective method and is not evidence of any fault by the Hospital. It is true that many doctors were involved. However, it would not have been sensible, or, indeed, possible, to have limited that to one, mainly because of restrictions on the number of hours that doctors work and requirements for rest periods. It is common practice for patients and families to be seen by a number of doctors.

9. There is no evidence that the Hospital seriously labelled Mr C as an alcoholic. At one stage Mr C developed symptoms which were similar to those experienced when an alcoholic stops taking alcohol. The Hospital, therefore, reasonably treated these as though it was a case of alcohol withdrawal. For the record, Mrs C may be reassured to know that, as far as one can tell, Mr C could not have been an alcoholic. This is because a chemical that is found in the liver was measured repeatedly by the Hospital in Mr C's case and was well below even a normal level. This indicates that the liver was not being damaged by alcohol, which implies that he had a reasonable history of alcohol consumption.

10. The clinical records also show that the family were told at an early stage about the seriousness of Mr C's injury and the possibility that he might die. It is perfectly reasonable for a registrar to discuss such subjects with a family, although the seriousness of this case would have made it helpful for the consultant to have played some part in this. The Board told me that the consultant accepted this point, although he said that, at the time, he made frequent visits to the ward and was updated regularly by medical and nursing staff and was aware that doctors were keeping the family properly informed; therefore, he had not felt that he could have added anything by a greater involvement with the family.

(a) Conclusion

11. I have thought carefully about whether the family asked for Mr C's transfer. On the one hand, the Board state clearly that the family, and Mr C, wanted this. And there are indications of this from clinical records which were written at the time. On the other hand, Mrs C is clear that the family did not request it, and would not necessarily have wanted to do so. I can see the possibility that doctors made an obvious assumption and then simply took it as fact, and I can see that a family may, indeed, remain silent out of shock when repeatedly given

such information by a variety of staff. If the family did remain silent on a number of occasions, when spoken to about their wish for transfer, one cannot blame staff for taking that as agreement. Certainly, it is clear from the records that the Hospital were actively seeking the appropriate way to manage Mr C's condition, and I do not accept that they simply did not want to have to deal with him themselves. Based on a balance of probabilities, I have decided that the first aspect of complaint (a) should not be upheld. I have also thought carefully about the other four aspects of (a), and I recognise their importance for Mrs C. However, I accept the Advisers' views about those other four aspects. In other words, I do not uphold those aspects. This means that I do not uphold complaint (a).

(b) The ambulance crew's decision to continue the journey was inappropriate

12. Mr C's ambulance journey from the Hospital to the English Hospital was made on 17 November 2004. He had had breathing difficulties in the Hospital, and during the journey he experienced these again. The ambulance crew stopped the journey, giving him oxygen and making him as comfortable as possible, then continued the journey to the English Hospital. Mrs C felt that they should have taken him to one of a number of nearby hospitals for treatment.

13. The Service told me that the crew did not take Mr C to another hospital for treatment when his condition worsened because the Hospital had told the crew that a Do Not Attempt Resuscitation order (DNAR) was in place: the crew or their control centre would only have considered breaking the journey in this way if there was no DNAR. A DNAR meant that, if Mr C suffered a cardiac or respiratory arrest, he would simply be made as comfortable as possible and that symptoms only (such as pain) would be treated. In other words, there would be no attempt to resuscitate him. The Advisers have said that the crew's decision to continue the journey was, therefore, appropriate – provided that a DNAR was in place.

14. I turn, therefore, to that point. The Board's clinical records for the night of 13 to 14 November 2004 show that a DNAR was put in place at that time. In reply to my enquiries, the Service said that the Hospital told the crew orally of the DNAR and gave them the medical documents. The point about the documents is supported by the Board's nursing records, which say that, on 16 November 2004, Mr C's clinical records were photocopied in readiness to

accompany him on the ambulance journey the next day. Therefore, the Advisers accept that a DNAR was in place and that clinical records which included DNAR information were given to the ambulance crew. In the absence of firm evidence, the practice of the Ombudsman's office is to try to reach a decision which is based on a balance of probability; on that basis, the Advisers are satisfied that the crew were told orally of the DNAR.

15. The Advisers are not satisfied, however, with the communication aspects of the DNAR. As DNAR can mean the difference between life and death for patients, it is important that such decisions are properly documented and communicated.

16. In this respect, I turn firstly to the Service. Their own guidelines advise that crews should obtain a formal written DNAR from referring hospitals (except in certain circumstances, which did not apply here). Thus, the crew did not follow Service guidelines, and the Advisers criticise them for that.

17. I turn secondly to the Hospital. It follows from paragraph 16 that the Advisers criticise them for not handing over some form of formal written DNAR instructions to the crew. The Advisers have also referred to the clinical record for the night of 13 to 14 November (showing that a DNAR was put in place at that time), saying that this is 'buried' amongst the clinical documents. They have explained that no one could expect a receiving hospital (in this case, the English Hospital) to face a situation of having to respond quickly to a critically-ill patient but having to delay such response until they have read a file of manuscript records in case they contain important information, such as a DNAR note. The DNAR note should, therefore, have been placed prominently at the front of the transferring documentation. The Hospital have said that they gave the DNAR information by telephone to the English Hospital. Likewise, this is not enough when a patient is to be received by a team who could not necessarily be expected to have immediate knowledge of telephone conversations days earlier. Therefore, the Advisers criticise the Hospital's communication of the DNAR.

(b) Conclusion

18. I have accepted that a DNAR was in place and that the crew knew of it. Therefore, I conclude that the crew's decision not to seek treatment from another hospital during the journey was reasonable. However, there is no evidence that the DNAR was communicated formally and in writing, in line with

Service guidelines. Therefore, I conclude that the crew did not follow Service guidelines by not obtaining proper DNAR documentation from the Hospital. And I conclude that the Hospital's documentation and communication of the DNAR, both for the crew and for the receiving hospital, were not clear enough in the circumstances of this case. As the complaint was about the crew's decision to continue the journey, I do not uphold complaint (b). But the serious nature of DNARs makes the communication shortcomings important, prompting recommendations from the Ombudsman.

(b) Recommendation

19. The Ombudsman recommends that the Board ensure that, where appropriate, DNARs are communicated clearly, in writing, for ambulance crews and receiving hospitals. She recommends that the Service ensure that, where appropriate, ambulance crews obtain formal written DNAR information from referring hospitals.

(c) The ambulance crew's record-keeping lacked detail

20. The Advisers were concerned at the lack of information in the crew's records. The Service agreed that the patient report form, which is completed during an ambulance journey, could have been more detailed, possibly including four sets of basic observations to detail the supportive therapy which the crew gave during the journey. However, the Service explained to me that the crew would not have included handover information on the form because the form was not intended to include handover information for a receiving hospital: that would be given verbally, and ambulance staff were experienced at doing this. The Service said that the paramedic in question confirmed to them that he did give a full handover to the English Hospital. The Service would not expect a receiving hospital to accept a patient from a crew unless they had received detailed handover information; they saw this as evidence that the paramedic did provide this.

(c) Conclusion

21. I accept the Service's explanation about handover records. I am satisfied that the other lack of detail in the patient report form did not have adverse consequences in this particular case. However, because of the Adviser's more general concern, I uphold complaint (c).

(c) Recommendation

22. The Ombudsman recommends that the Service ensure that record-keeping by ambulance crews during journeys is adequate.

(d) The Hospital should have operated and (e) The Hospital should not have allowed the ambulance journey

23. As indicated at paragraph 2, complaints (d) and (e) were not raised by Mrs C. However, the Advisers and I considered that these were important areas to examine, and the Board co-operated fully in responding to my enquiries about them. I should explain that the question of an operation related to whether the Hospital should have operated to fix Mr C's neck in a more stable condition before transfer. I should also explain that complaint (e) is a separate issue to the issue discussed at paragraph 7 (that is, whether the family wanted Mr C's transfer to the English Hospital): it is about whether the Hospital's decision to allow such a transfer was clinically reasonable.

24. At Mr C's admission to the Hospital on 1 November 2004, he had a large haematoma (a solid swelling of clotted blood within the tissues) in his head, a tender neck and incomprehensible speech. There was no neurological (concerning the nerves) abnormality at that time and no evidence of body injury. A brain and neck scan showed a neck fracture and displacement (his neck was very loose). Evidence shows that orthopaedic doctors at the Hospital discussed the case on various dates with neurological doctors at the Institute of Neurological Sciences and the National Spinal Injuries Unit (a Scotland-wide resource at another hospital in Glasgow). The Hospital were advised that patients of Mr C's age, with his type of fracture, generally did not do well and that a particular type of collar was the best form of treatment. Such a collar was, therefore, fitted. Later advice was that Mr C was not suitable for stabilisation (fixing his neck in place by surgery). Evidence also shows that the National Spinal Injuries Unit advised the Hospital on two occasions that transfer to their own care would not be appropriate. As the Hospital considered they had done all they could for Mr C and believed the family wanted him to be nearer to home, they arranged for him to be transferred by ambulance to the English Hospital. He transferred on 17 November 2004 and, sadly, he died there on 22 November 2004.

(d) and (e) Conclusion

25. I summarise here the Advisers' comments about complaints (d) and (e):

'Mr C presented with an unstable fracture of the odontoid peg. Such fractures in patients of Mr C's age are notoriously difficult to treat. The death rate is high, regardless of the clinical approach that is adopted. It is recognised amongst spinal surgeons that, in elderly patients who have any signs of poor respiratory or cardiac function (such as Mr C), the chances of a successful outcome following surgery are low. For this reason, most spinal and neuro surgeons in the United Kingdom would have treated Mr C conservatively, in other words with a supporting collar and by the active medical management of any respiratory complications. This was, indeed, the thought process adopted by the Board, with direction from spinal experts. I cannot, therefore, criticise the Hospital's decision not to operate, and, indeed, I found the level of documentation and the number, and quality, of communications between relevant experts to be of a very high order.'

'Mr C's medical condition began to improve at the Hospital. However, rehabilitation following such a fracture in this age group is a long affair, requiring a long period of intense support on an appropriate ward. The decision to transfer a patient in this situation is never an easy one, and windows of opportunity can appear and disappear in a short space of time. In this case, the clinical notes indicate that the family wanted Mr C to be located closer to home. The nursing notes for 17 November 2004, when he was transferred to the English Hospital, paint quite a reasonable picture in terms of Mr C's stability. Bearing in mind that adequate support in the Hospital was possible with oxygen and general nursing care, the decision to transfer Mr C by ambulance to the English Hospital does not seem unreasonable. As such, I do not believe that the transfer arrangements were unreasonable, nor that the Hospital should have provided an escort for the journey.

'During the ambulance journey, Mr C showed some signs of deterioration, and he was given similar treatment (with oxygen) to the treatment he had had in the Hospital. There is no evidence whatsoever that this deterioration was caused by the fracture, in other words by fractured bone injuring the brain stem or spinal cord. In fact, the records clearly show Mr C as still being able to move his arms and legs on arrival at the English Hospital, which would almost certainly have been impossible if his brain stem had been compressed by fractured bone. The post mortem report confirms that there was no brain stem or cervical cord injury. It is my view

that the operation that the English Hospital conducted was possibly not required.

'In summary, any patient of Mr C's age who had this type of fracture and who deteriorates in a similar way to Mr C is almost certainly going to die, regardless of the level of expert care provided or any surgical manoeuvres administered.'

26. As indicated at paragraph 3, I accept the Advisers' advice. Therefore, I accept that the Hospital were not at fault in deciding not to operate on Mr C and in deciding on the ambulance journey. In all the circumstances, I do not uphold complaints (d) and (e).

27. The Board and the Service have accepted the recommendations and will act on them accordingly. The Ombudsman asks that they notify her when the recommendations have been implemented.

20 June 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	Mrs C's husband
The Board	Greater Glasgow and Clyde NHS Board
The Service	The Scottish Ambulance Service
The Hospital	The Western Infirmary, in Glasgow, to which Mr C was admitted after his fall
The English Hospital	The hospital in England to which Mr C was transferred
The Advisers	The Ombudsman's clinical advisers
DNAR	Do Not Attempt Resuscitation order