Scottish Parliament Region: Mid Scotland and Fife

Case 200801921: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; Communication, DNR order, WanderGuard

Overview

The complainant (Mrs C) raised a number of concerns about the information provided to her about the extent of her late husband (Mr C)'s ill health and the operation of a Do Not Resuscitate (DNR) order. Mrs C was also concerned about the adequacy of steps taken to protect Mr C in hospital.

Specific complaints and conclusions

The complaints which have been investigated are that Fife NHS Board (the Board) failed to:

(a) communicate adequately with Mrs C and in particular failed to follow the procedure for instituting and implementing a DNR order (*upheld*); and

(b) keep Mr C safe using appropriate restraint (*partially upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) review the DNR policy, the use, and value added by the use of, the resuscitation box in the Unitary Patient Record; followed by an ongoing audit (or similar improvement methodology) to ensure that there is clarity about when the policy applies and whether it is sustained in practice. The audit should measure the completion of the DNR form and associated documentation in the patient record;

(ii) review how Cardio Pulmonary Resuscitation status is communicated at ward level, to ensure nursing staff are aware of the importance of robust communication at handover and transfer. The national 'Leading Better Care' policy may be helpful here;

(iii) consider including DNR orders in both induction and Basic Life Support staff training. This is already done in some parts of NHS Scotland and is endorsed by the Scottish Palliative Care Society;

(iv) review the mechanisms in place to ensure that communication between patients, their relatives and carers and staff is recognised as an important part of the patient experience; and

(v) develop a specific policy for the WanderGuard bracelet to ensure that its use complies with the Adults with Incapacity (Scotland) Act 2000 to ensure patients are treated with dignity and respect.

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

Main Investigation Report

Introduction

1. On 16 October 2008, the Ombudsman received a complaint from Mrs C expressing her concerns about the care her husband (Mr C) received from Queen Margaret Hospital, Dunfermline (the Hospital) between 7 December 2007 and his sudden death on 31 December 2007. Mrs C complained to Fife NHS Board (the Board) on 21 April 2008 and received a response on 26 May 2008. Following a meeting with the Directorate Nurse Manager on 8 September 2008, Mrs C received a further written response. Mrs C accepted a number of the explanations and apologies given by the Board but remained concerned about aspects of her husband's care and complained to the Ombudsman's office.

2. The complaints from Mrs C which I have investigated are that the Board failed to:

(a) communicate adequately with Mrs C and in particular failed to follow the procedure for instituting and implementing a Do Not Resuscitate (DNR) order; and

(b) keep Mr C safe using appropriate restraint.

Investigation

3. Investigation of this complaint required obtaining and reviewing Mr C's clinical records and the complaints correspondence. Ombudsman staff met with Mrs C. I have obtained advice from a medical adviser to the Ombudsman (Adviser 1) and a nursing adviser to the Ombudsman (Adviser 2). I have made written enquiries of the Board and reviewed relevant policies and procedures.

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

Medical background

5. Mr C was admitted to the Hospital on 7 December 2007. Following monitoring and tests in the Accident and Emergency Ward it was established that he had suffered a 'silent' heart attack. Mr C was transferred to the Acute Medical Assessment Ward where his medication and ongoing condition were assessed. Mr C was transferred to Ward 7 for rehabilitation and was found to be MRSA positive and transferred to a side ward to reduce the risk of infection

spread. On 31 December 2007 Mrs C arrived on Ward 7 for her evening visit (having already been in earlier that day) just as staff became aware that Mr C's condition had deteriorated very rapidly. Mrs C was asked to wait in the visitors' room while resuscitation equipment and medical assistance were obtained. Mrs C was asked by a member of staff if she had requested a 'Do Not Resuscitate' (she had not). Mr C died shortly afterwards of a second heart attack and Mrs C was advised by the doctor who broke the news of Mr C's death to her, that the decision had been taken not to carry on resuscitation as there were so many issues going on for Mr C.

(a) The Board failed to communicate adequately with Mrs C and in particular failed to follow the procedure for instituting and implementing a DNR order

6. Mrs C told me that she was naturally shocked by her husband's death but also stunned by the sudden and unexpected nature of his death. She had not been told his condition was so severe that he was at a 'major risk of sudden death' as the Board had stated in their complaints response, and could not understand why he had been transferred for rehabilitation if he was so seriously ill. Mrs C told me that she had not been advised of the existence of the DNR order until she received a response from the Board to her complaint. Mrs C also noted that she had not been advised of Mr C's transfer from one ward to another and had been distressed to arrive at the Hospital and find his bed occupied by another patient. Mrs C told me she felt she always had to proactively seek information from nurses and doctors.

The Board response

7. The Board made a number of apologies from nursing staff to Mrs C for the failures to inform her of her husband's transfer between wards. Medical staff advised that they were always happy to speak to relatives when asked but it appeared Mrs C had not requested a meeting. The Board also went on to explain that on 31 December 2007 after 18:30 the nursing auxiliary was delivering refreshments to patients and noticed Mr C was having breathing difficulties and alerted nursing staff immediately. The emergency on-call team were alerted and resuscitation was commenced. Shortly after a DNR was noted in Mr C's medical records and the resuscitation attempt was ceased. The Board advised Mrs C that while it was not a requirement that relatives are informed of a DNR it would clearly have been better if Mrs C had been made aware of the serious nature of Mr C's illness. The Board stated that the DNR order had been put in place by a registrar (the Registrar) on 18 December 2007

and that he had taken the decision based on the results of an echocardiogram noted that day which made it highly likely that Mr C was at major risk of sudden death.

The advisers' comments

8. Adviser 1 told me that the Unitary Patient Record (UPR) for Mr C had no entry in the resuscitation status box on the front of the record. The purpose of this box is to ensure that all staff are aware at a glance if a patient has a DNR in place. Adviser 1 noted that it is not clear from the Board's own DNR policy if this box should be completed for all patients irrespective of their resuscitation status or only those where a DNR decision had been reached. In any event the box was not completed for Mr C and this must be considered a breach of the Board's policy. Adviser 1 also noted that the incomplete documentation meant it was not possible to know if Mr C's resuscitation status had been considered by staff but not documented, or whether it had not been considered at all, before 18 December 2007 when the Registrar made and documented his decision. Adviser 1 did consider it was in line with usual practice for a registrar to reach a DNR decision but noted that the DNR form requires the decision to be 'fully discussed and agreed with the consultant/GP who must then counter sign the form at the earliest opportunity' (the Board's policy document suggests that this should be within 24 hours). There is no evidence of this happening either in the clinical records or on the form itself.

9. Adviser 1 told me that some DNR orders are made for patients with a relatively low risk of arrest but an anticipated poor outcome of any resuscitation attempt – that is, all patients for whom DNR orders are made are not in imminent danger of arresting. It is important to note therefore that a DNR order does not necessarily infer that the doctor concerned believes that there is an immediate or significant risk of arrest at that time. In Mr C's case there may have been no immediate concern that he would arrest again but it was recognised that if he did arrest then attempting resuscitation would be so unlikely to be effective as to make it unreasonable. Adviser 1 noted that in these circumstances it is not always appropriate or helpful to discuss DNR orders with the patients relatives as it can cause undue anxiety about a possibility that may never occur. Adviser 1 was however very critical though of the lack of communication with Mrs C by medical staff and noted there was no entry in the medical record throughout this entire admission of any discussion with Mr C's family regarding the severity of his illness.

10. Adviser 2 noted that there were a number of failures in communication between the healthcare team themselves and between the medical/nursing staff and Mrs C. The Board stated that staff are available to meet with relatives but Adviser 2 considered that talking with patients and relatives about care and treatment should be a key part of the individual plan of care. This is particularly valid here as Mr C was confused and disorientated. The lack of any ongoing dialogue with the staff meant Mrs C felt she was not being listened to and was unprepared for the death of her husband.

11. Adviser 1 was concerned that resuscitation was attempted despite the DNR order being in place as it suggests nursing staff were not made aware of the DNR status. This could relate to the fact that nurses referred to the UPR resuscitation box, rather than the separate filed DNR form, and that this box had not been completed. This highlights the need for review of the policy regarding completion of the UPR box as described above.

12. Adviser 2 noted that UK Guidance (Decisions relating to cardiopulmonary resuscitation (CPR). A joint statement from the British Medical Association, the Resuscitation Council, and the Royal College of Nursing. October 2007) states it is not necessary to initiate discussion with the patient (or the next of kin), but that 'Clinicians should document the reason why a patient has not been informed of a [DNR] Order if the decision is made not to inform the patient'. Adviser 2 also noted that once the decision was made to use a DNR order, there was a further failure in communication as the members of the nursing staff were unaware of this and went on to resuscitate Mr C. The UK Guidance goes onto state that:

> 'The person who makes the CPR decision is responsible for ensuring that the decision is communicated effectively to other relevant health professionals. This should be reflected in the local policy. The senior charge nurse is responsible for ensuring that every CPR decision is recorded in the nursing records and that all staff are aware of the decision.'

Adviser 2 told me that she considered this to be a failure in inter-disciplinary communication.

(a) Conclusion

13. Staff did not comply with the Board's policy on DNR or UK Guidance. Mrs C was not given sufficient information about Mr C's medical condition and

there was inadequate communication between staff which resulted in an aborted CPR attempt and caused additional distress for Mrs C at an already stressful time. I uphold this aspect of the complaint.

(a) Recommendations

14. The Ombudsman recommends that the Board:

(i) review the DNR policy, the use, and value added by the use of, the resuscitation box in the UPR; followed by an ongoing audit (or similar improvement methodology) to ensure that there is clarity about when the policy applies and whether it is sustained in practice. The audit should measure the completion of the DNR form and associated documentation in the patient record;

(ii) review how CPR status is communicated at ward level, to ensure nursing staff are aware of the importance of robust communication at handover and transfer. The national 'Leading Better Care' and 'Releasing Time to Care' policy may be helpful here;

(iii) consider including DNR orders in both induction and Basic Life Support staff training. This is already done in some parts of NHS Scotland and is endorsed by the Scottish Palliative Care Society; and

(iv) review the mechanisms in place to ensure that communication between patients, their relatives and carers and staff is recognised as an important part of the patient experience.

(b) The Board failed to keep Mr C safe using appropriate restraint

15. Mrs C was concerned that Mr C, who was known to be very confused and disorientated, had fallen on the ward and been found wandering in the car park on a December evening. She questioned why he was not being adequately supervised to prevent these occurrences.

16. In the Board response they noted that Mr C had been reminded of the importance of using a call bell to summon assistance from a nurse but that after the incident of his fall additional steps had been taken to use hip protectors to protect him from the consequences of any future fall. The Board also noted that the WanderGuard system had been utilised to alert staff if Mr C attempted to leave the ward as it was recognised he was confused and disorientated as to time and place. The WanderGuard system consists of a bracelet worn on the patient's wrist which activates an alarm at the ward exits. The Board apologised that Mrs C had not been advised of this safety measure.

17. In response to my enquires the Board advised me that there is no specific policy on the use of WanderGuard but its use is considered as a consequence of a 'falls assessment' where a patient is identified as a high risk. The decision to use it should be recorded in the nursing records and staff are expected to discuss the system with family members.

The advisers' comments

18. The advisers were of the view that staff reacted to Mr C's confusion in a practical and reasonable manner and that the escalation to hip protectors and use of WanderGuard were a recognition of his increased risk. However, both advisers expressed concern that the Board has no specific policy on the use of WanderGuard which they consider to be an indirect form of restraint apparently implemented without Mr C's consent. Adviser 1 noted there was evidence in the file that Mr C might lack capacity to make decisions for himself due to his confusion but there was no specific recording of incapacity and in the absence of such a record being made in terms of the Adults with Incapacity (Scotland) Act 2000, then patient consent should have been obtained. The advisers also noted that in the absence of a recording of incapacity it would also have been necessary to ask Mr C's permission before discussing treatment options with Mrs C and that any decision on Mr C's capacity would also have a direct bearing on any discussion of the DNR order with Mr or Mrs C (see complaint (a)).

(b) Conclusion

19. There was a failure to follow the Board's informal policy on the use of WanderGuard as it was not recorded and Mrs C was not advised of its use. I note that advising Mrs C would have allowed her to discuss her husband's condition and the limitations of fall protection measures and their purpose. The clinical advice I have is that the actions taken to reduce the risk of falls was reasonable but there is a concern that the use of WanderGuard was not appropriately recorded. Additionally the advisers are concerned that there is no specific policy on the use of WanderGuard for a patient who lacks capacity to consent to its use, or to routinely consider and document the capacity or incapacity of older patients suspected of being confused. Based on all these points I partially uphold this complaint.

(b) Recommendation

20. The Ombudsman recommends that the Board develop a specific policy for the WanderGuard bracelet to ensure that its use complies with the Adults with

Incapacity (Scotland) Act 2000 to ensure patients are treated with dignity and respect.

21. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	The aggrieved, Mrs C's late husband
The Hospital	Queen Margaret Hospital, Dunfermline
The Board	Fife NHS Board
DNR	Do Not Resuscitate
Adviser 1	Medical adviser to the Ombudsman
Adviser 2	Nursing adviser to the Ombudsman
MRSA	Methicillin resistant staphylococcus aureus
The Registrar	The medical registrar who took the DNR decision on 18 December 2007
UPR	Unitary Patient Record
CPR	Cardio Pulmonary Resuscitation

Annex 2

List of legislation and policies considered

Decisions relating to cardiopulmonary resuscitation (CPR). A joint statement from the British Medical Association, the Resuscitation Council, and the Royal College of Nursing. October 2007

Policy for the selection of patients for a 'Do Not Attempt Cardiopulmonary Resuscitation' order. NHS Fife policy C25 October 2002