Scottish Parliament Region: Lothian

Case 200902581: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Accident and Emergency; clinical treatment; diagnosis

Overview

The complainant (Ms C)[1] was concerned about the care and treatment provided to her father (Mr A) when he had attended at St John's Hospital (Hospital 1) following a fall at home. Mr A had been taken to Hospital 1 by ambulance on 1 November 2008 but had been discharged a short time later. Mr A was found some distance from his home in the early hours of 2 November 2008. On that occasion he was taken by ambulance to a hospital in another board area (Hospital 2). Despite requests, Hospital 2 was not provided with Mr A's notes from Hospital 1. Mr A died in Hospital 2 on 5 November 2008.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the decision to discharge Mr A was inappropriate (*upheld*); and

(b) the complaints handling and information provided was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) undertake an audit of the action plan and provide him with details of the outcome;	25 August 2010
(ii) satisfy themselves that the transfer of records between hospitals and Board areas is being carried out quickly and efficiently;	25 August 2010
(iii) review their complaints procedure and related guidance to staff, in order to ensure that complainants are provided with a full response supported by staff statements and records;	25 August 2010

[1] The complaint was supported by Mr A's partner (Ms D).

(iv)	ensure, when investigating complaints, that documentation is kept of interviews and key actions; and	25 August 2010
(v)	apologise to Ms C and Ms D for the failings identified in this report.	21 July 2010

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

Main Investigation Report

Introduction

1. Mr A was taken to St John's Hospital (Hospital 1) Accident and Emergency Department (the Department) early on 1 November 2008. He had fallen at home and had injuries relating to this fall including dental injuries and bruising. After he was seen by a doctor (the Doctor) in the Department, Mr A was discharged. On 2 November 2008, Mr A was found outside some distance from his home and an ambulance called. Mr A was taken to a hospital in another Board area (Hospital 2). Mr A died in Hospital 2 on 5 November 2008.

2. Mr A's daughter (Ms C) and Mr A's partner (Ms D) complained to Lothian NHS Board (the Board) about the care and treatment provided by Hospital 1 to Mr A on 1 November 2008 and also said that Hospital 2 asked for but had not been given a copy of Mr A's clinical records. In a meeting on 21 April 2009 with Ms C and Ms D, Board staff acknowledged that there had been errors. It was accepted that Mr A should have been admitted and his discharge planned more carefully. However, it was also said that the doctor who had reviewed Mr A, (the Doctor) had 'not done anything medically wrong'. and had 'reasonably interpreted Mr A's comments and description of events'. The Board said there had been improvements which would prevent a recurrence of the events. The Board also said that an action plan, anonymised, would be put in place for this complaint to allow learning to be shared.

3. However, Ms C remained concerned given the Board had not accepted any medical problems and she remained unsure about what actions had been taken to prevent a recurrence. She also complained that no explanation had been given for the failure to provide the notes to Hospital 2.

4. The complaints from Ms C which I have investigated are that:

(a) the decision to discharge Mr A was inappropriate; and

(b) the complaints handling and information provided was inadequate.

Investigation

5. In investigating this complaint, my complaints reviewer has had access to Mr A's clinical records and the complaint file. She has taken advice from an independent professional adviser, a consultant in emergency medicine, (Adviser 1) and a dental adviser (Adviser 2).

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

(a) The decision to discharge Mr A was inappropriate; and (b) the complaints handling and information provided was inadequate

7. Mr A was 84 years old. He had been in Hospital 1 from 19 to 29 October 2008, following an emergency admission. Mr A was treated for gallstones during this admission. Mr A had also recently been diagnosed with lung cancer and was due to attend for a consultation on 5 November. In the early hours of 1 November 2008, Mr A suffered a fall at home. Ms D said this was very sudden and he had been unable to break the fall and had fallen badly. Mr A suffered damage to his teeth and was bleeding from his mouth. His hip was painful and bruised. An ambulance was called and Mr A taken to the Department at Hospital 1.

8. Ms D told my complaints reviewer she had taken details of Mr A's medication and had expected to be asked for information about Mr A's condition that day. This was based on her experience of previous admissions.

9. Ms D said she was surprised that not long after he was taken away to be examined, she was informed that Mr A would be discharged. She asked about dental care and was advised to contact Mr A's own dentist. This was the weekend and his dentist would not have been available until Monday. Ms D said she was given no assistance and had to ask a friend for help with supporting Mr A in and out of the car and up the stairs to their home.

10. Early in the morning of 2 November 2008, Ms D and then Ms C were both woken by the police and informed that Mr A had been found confused some distance from his home. Initially, because of his bruises, it had been feared he had been in a traffic accident. Mr A was taken to Hospital 2. Hospital 2 admitted Mr A and requested clinical records from Hospital 1. Mr A died in Hospital 2 on 5 November 2008. It was noted by Hospital 2 in their records that no notes had been sent by Hospital 1.

11. In response to the complaint, the Board wrote to Ms C on 9 January 2009 and a meeting was held.[2] The Board accepted that Mr A should have been admitted to Hospital 1 and his discharge planned more carefully. They said Ms D should have been involved in the assessment process and Mr A's medication and a full history recorded. The Board also said that the Doctor had been asked for comments and that 'he had not done anything medically wrong, however [Mr A] could have been dealt with in a more humane way'. The notes of the meeting additionally state that:

> '[The Doctor] had reasonably interpreted [Mr A]'s comments and description of events … [Mr A] had also been triaged by nursing staff and had observations taken. [Mr A] should have been looked after a little longer, particularly as he was being discharged at 06.00 on a winter's morning.'

12. The Board went on to say that the Doctor may have been tired and also that nursing staff should have pressed for an admission. It was also said that Mr A did not need x-rays or bloods taken.

13. The Board additionally provided information to Ms C and Ms D about changes in service provision and practice which had been made or which were to be implemented. These were: putting in place a 'safe home' facility; the completion of the roll out of the national SIGN guidance on falls; making permanent the provision of additional physiotherapy and occupational therapy resource.[3] They said that clinical records were now available electronically and that details of Mr A's previous admissions to Hospital 1 now would be accessible to staff when he was admitted as an emergency but would not have been on 1 November 2008. They were unable to respond fully to the question about the provision of notes to Hospital 2 as a key member of staff was on sick leave. The Board said an anonymised action plan for this complaint would be made available to different areas.

14. In concluding the meeting, it was noted that 'some things had been dealt with appropriately and some had not, however it was not good practice in most

[2] The meeting was held at the request of Ms C. It was accepted at that meeting that there had been errors in the letter of 9 January 2009 and that this had been defensive in tone. This section contains information from both the letter and the meeting notes. Where there is a conflict, the meeting notes, as the more recent, have been used.

[3] This had been trialled over the winter period.

circumstances to exclude relatives from conversations with patients and in this case might have helped provide a fuller assessment of Mr A's condition.'

15. My complaints reviewer asked the Board for initial comments before the full records and complaint correspondence were made available to Adviser 1. The Board provided details of the additional resources that were now in place (see paragraph 13). This made it clear that the 'safe home' facility was the additional occupational therapy resource[4]. They also provided information which showed this facility would be audited between November 2009 and February 2010. The Board further commented that:

> 'tiredness was not suggested as a factor in this case. What was stated was that it was possible that the doctor in question may have been tired, but that the decisions around further care and admission should have been made by the medical, nursing and multi-disciplinary team together.'

16. Adviser 1 reviewed the records and complaints correspondence, as well as the further comments from the Board and comments made by Ms C and Ms D in their complaint to this office.

17. Adviser 1 said that a referral from NHS 24 for Mr A had been faxed to Hospital 1 and referred to a head/facial injury. The fax was timed at 03.14. On arrival, the presenting condition was noted as a fall/facial injury. No initial triage assessment was documented other than a doctor was noted to be present. No observations or vital signs were noted. No conscious level or pain score or pain assessment was noted, despite the clinical notes documenting Mr A striking his face against the wall. No past medical history, drug history or social history was noted. A brief examination was recorded but there were no notes of any cardiovascular, respiratory, abdominal or neurological examinations. Adviser 1 explained these would have been undertaken to look for other injuries or to look for underlying causes of the fall. In the notes taken by the Doctor, Mr A was said to be weight bearing, have a tender thigh and damage to his teeth. The notes said that he was 'advised to attend dentist ASAP'.

18. On the evidence available, Adviser 1 concluded that Mr A was discharged without other obvious management or treatment. In particular, Adviser 1 noted: no written head injury guidance was provided; no blood test or investigations were undertaken; no social or multi-disciplinary assessment prior to discharge

[4] At Hospital 1 this is formally known as ROTA or Rapid Occupational Therapy Assessment.

was noted and there was no evidence of a discharge letter sent to Mr A's family doctor. All of these would have been regarded as normal practice or in line with national guidelines in force at the time. Adviser 1 said that given the inadequate documentation it was not possible to say that it was clinically safe to discharge Mr A or whether further blood tests or further investigations were or were not required. The only advice that, from the notes, had been given to Mr A was to seek dental care.

19. Adviser 1 sought comments on this point from a dental adviser (Adviser 2). Adviser 2 said it was difficult to confirm the injuries Mr A had from the documentation but that it would not be uncommon to refer a patient to an emergency dentist if the injury was isolated to the tooth. The availability of such services varied but in some cases this only required a call to the patient's own dentist, who should have information about the appropriate out-of-hours services. From the documentation, it was not possible to say whether such an approach was reasonable. Ms D has said she raised the question of access over a weekend but received no answer.

20. Adviser 1 considered the information given by the Board in response to the complaint and the comments on tiredness. He said that, as there was no note of any statement by the Doctor on the file, it was not possible to confirm if tiredness was or was not a contributing factor. It was also not clear what was meant by the reference to multi-disciplinary, as the decision to discharge Mr A was not obviously such a decision. However, he concluded that the inconsistency was likely to have been a matter of interpretation and context rather than substance.

21. Adviser 1 said that the improvements referred to by the Board were appropriate and referred to national guidance on care of the elderly and falls. He noted these should continue to be monitored. However, he also said that action should be taken around documentation and pain management and the Board should be asked for a more complete answer about why the records were not passed to Hospital 2.

22. As part of the investigation, my complaints reviewer sought further information from the Board about the concerns raised by Adviser 1 (see paragraphs 18 to 21). She also asked what information the Board would have expected Mr A to have been given about dental care and the action plan referred to in the notes. My complaints reviewer noted the complaints

documents referred to contact with staff and asked if any documentation had been kept.

23. In their response, the Board agreed that there had been inadequate care and treatment provided to Mr A. They agreed the documentation was poor and that the failure to provide head injury and pain advice was unacceptable. They also said that there was more detail in the assessment provided by the Doctor in discussions but this had not been noted.

24. On dental advice, the Board said that unless there was serious or complex problems, the standard advice given would be to see the patient's own dentist in the first instance. They accepted that the detail of the advice provided should have been more fully discussed with Mr A's family.

25. The Board confirmed that their health records department was manned 24 hours a day and any request should have been processed immediately. They said that in this case the correct procedures had not been followed. They had reminded health records staff of the importance of processing all such requests in line with the procedures and timeously.

26. The Board also provided a copy of an action plan for the complaint, which indicated that a number of actions had been undertaken in response to my complaints reviewer's enquiries. This included reminders to clinical staff about the importance of good documentation and pain management; and also stated that key documents and guidelines were available to staff. Most of the actions were noted as completed by June 2009. My complaints reviewer asked for clarification about the status of this document. The Board said that this had been created in response to the complaints reviewer's request for information and was not the action plan referred to in their response to Ms C and Ms D's complaint. In April 2009, a formal review of the complaints process had been held by General Medicine and, since that date, action plans had been completed for each complaint. Now, these plans were collated quarterly and discussed on a quarterly basis at a clinical governance steering group. Despite the statement to Ms C and Ms D, no action plan had been completed following the meeting with them because the complaint had been made prior to April 2009. The Board confirmed the actions had been undertaken but the discussions on the plan had not been formally minuted.

27. In their correspondence to this office, the Board repeated their unreserved apology to Ms C and Ms D for the inadequate treatment provided.

(a) Conclusion

28. In their response to Ms C and Ms D, the Board stated that 'nothing medically' had been done wrong but it was not possible to confirm this on the basis of the clinical information contained in the notes. I have received advice that Mr A was, in fact, discharged without obvious management or treatment other than basic dental advice. While the Board had accepted, in responding to Ms C and Ms D, that Mr A's discharge was inappropriate they based this in part on the fact that discharge had taken place at 06.00 on a cold winter's morning and that more support should have been given to Mr A and Ms D. I have, however, been advised that normal practice in line with the national guidelines was not followed. In particular, that no written head injury guidance was provided; no investigations undertaken; and no discharge letter sent to Mr A's GP. In the circumstances, I have decided to uphold this complaint.

29. In addition, I am also concerned that the Board only accepted that there had been inadequate medical care and treatment afforded to Mr A after Ms C and Ms D had complained to this office. This should have been recognised earlier.

30. My complaints reviewer asked Adviser 1 what outstanding actions should be undertaken. Adviser 1 was supportive of the action plan put in place (see below) but felt that this should have been more clearly shared and documented. My recommendations under heading (b) reflect this. In addition, I make the following recommendations.

(a) Recommendations

31. I recommend that the Board:	*Completion date*
(i) carry out an audit of the action plan and provide him with details of the outcome; and	25 August 2010
(ii) satisfy themselves that the transfer of records between hospitals and Board areas is being carried out quickly and efficiently.	25 August 2010

(b) Conclusion

32. The Board held a meeting with Ms C and Ms D to consider their complaint, this was good practice. However, it was accepted at this meeting that the initial

response letter had been disappointing. The notes of the meeting indicated apologies were made and significant errors again accepted. This was also good practice. This was though, again, undermined by the way that reassurances were given about the appropriateness of the clinical decisions which could not have been made on the basis of the information available (see paragraph 18). Ms C and Ms D were informed that appropriate actions had been taken and an action plan would be put in place. This does not match the information provided to this office. The action plan indicated that actions took place following the meeting but no written notes had been kept of these and the plan itself was not created until the Board were asked about this during my investigation. Notes of conversations with key staff were not kept. No further information was provided to Ms C and Ms D about the failure to provide notes to Hospital 2.

33. The inappropriateness of the discharge related to the documented lack of history, investigation and assessment. In addition, given Mr A had died following his admission in Hospital 2, I would have expected that a more formal clinical review of his treatment should have been undertaken. I note Board staff had discussed the matter with the Doctor but this was not documented. Actions were taken in response to the complaint (see paragraph 26) but these were not minuted or shared outside the immediate staff involved.

34. While noting the elements of good practice which occurred within this complaint, I feel these failings were significant and, therefore, I uphold this complaint. The process has now changed and, under the new system, complaints are now discussed quarterly at a clinical governance steering group. This is good practice and I would commend the Board for this development. The recommendations reflect this.

(b) Recommendations

35. I recommend that the Board:	*Completion date*
(i) review their complaints procedure and related guidance to staff, in order to ensure that complainants are provided with a full response supported by staff statements and records; and	25 August 2010
(ii) ensure, when investigating complaints, that documentation is kept of interviews and key actions.	25 August 2010

General recommendation

36. I further recommend that the Board:	*Completion date*
(i) apologise to Ms C and Ms D for the failings identified in this report.	21 July 2010

37. 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

Mr A	The aggrieved
Hospital 1	St John's Hospital
The Department	Accident and Emergency department
The Doctor	Doctor who saw Mr A on 1 November 2008
Hospital 2	Hospital in another Board area where Mr A was taken on 2 November 2008
Ms C	The complainant, Mr A's daughter
Ms D	Mr A's partner
The Board	Lothian NHS Board
Adviser 1	Independent adviser to the Ombudsman, a consultant in emergency medicine
Adviser 2	Independent dental adviser