THE HEALTH SERVICE
OMBUDSMAN

OFFICE OF THE HEALTH SERVICE COMMISSIONER FOR ENGLAND

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Your Ref: MM/BM/ncd
Our Ref: E2313/99-00

M Millett Esq
Chief Executive
Portsmouth Healthcare NHS Trust (Central Office)
St James' Hospital
Locksway Road
Portsmouth
Hampshire
PO4 8LD

22 March 2001

Thank you for your letter of 15 March about the draft report of the results of the investigation into the complaint to the Health Service Ombudsman by Code A against your Trust. I am grateful to you for replying so promptly.

In accordance with statute, I now enclose a copy of the final report which has been sent to Code A Code A A copy of the report has also been sent to the Secretary of State for Health. It is for your Trust to decide on, and arrange, any distribution of the report to staff directly concerned.

I am grateful to you for the additional information provided about the action your Trust has taken to prevent a recurrence of the error which led to some of Code A 's medical records being destroyed prematurely. Paragrah 29 of the report has been amended accordingly.

As Mr Jones said in the penultimate paragraph of his letter of 28 February, it is now open to you to write direct to Code A if you wish.

Code A

COLIN HOUGHTON
Investigations Manager
Enc: 1

E.2313/99-00

Health Service Commissioners Act 1993

Report by the Health Service Ombudsman
for England
of an investigation into a complaint made by

Code A

Complaint against: Portsmouth Healthcare NHS Trust

Complaint as put by Code A

1. The account of the complaint provided by Code A was that on 25 October 1998 his late Code A fell and broke her hip. Code A was admitted under the NHS to Royal Hospital, Haslar (the first hospital), which is administered by the Ministry of Defence. While in the first hospital Code A had an operation on her hip, after which she made a steady recovery. On 29 October Code A was able to sit out of bed and by 3 November she could be pushed in a wheelchair to the hospital shop and cafeteria. By 6 November she was no longer taking painkillers and on 11 November she was transferred to Dryad Ward at Gosport War Memorial Hospital (the second hospital). The second hospital is administered by Portsmouth Healthcare NHS Trust (the Trust).

2. When Code A visited Code A on 13 November he noticed that her condition had deteriorated. Code A believed that Code A had been sedated. On 14 November Code A complained about the level of sedation his mother was under and on 15 and 16 November he noticed an improvement in her condition. On 17 November Code A noticed that Code A was dehydrated and brought this to the attention of a nurse and asked that Code A be put on a drip. The nurse informed Code A that a drip was not available, a dispute ensued, and Code A was asked to leave the hospital. On the following day the Trust's medical director

was asked to review Code A treatment. As a result of thi Code A was given subcutaneous fluids. Code A condition continued to deteriorate and on 23 November instructions were given for diamorphine to be administered subcutaneously if required. Code A died of bronchopneumonia on 3 December 1998.

3. Code A had written to the medical director on 27 November 1998 complaining about the care Code A was receiving at the second hospital. The chief executive of the Trust replied in January 1999 and Code A met the medical director in February. In September the Trust arranged for an independent clinician to review Code A care. Code A remained dissatisfied and requested that an independent review panel be convened to consider his complaint. The Trust's convener refused that request.

4. The matters subject to investigation were that:

(a) Code A did not receive reasonable medical and nursing care after her transfer to the second hospital on 11 November 1998; and

(b) the doses of morphine administered to Code A after her transfer to the second hospital were excessive.

Investigation

5. The statement of complaint for the investigation was issued on 25 May 2000. The Trust's comments were obtained and relevant papers were examined. Those papers included records of Code A care and treatment in the first and second hospitals, correspondence concerning Code A complaint to the Trust, and the written observations of the consultant geriatrician (the consultant) responsible for Code A care while she was a patient in Dryad Ward. I obtained advice on the medical aspects of the complaint from one of the Ombudsman's professional advisers. Another of his professional advisers gave help with the nursing aspects. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked.

6. The investigation was somewhat hindered as a result of the Trust being unable to supply all of the records relating to Code A care and treatment in the second hospital. In April 1999 the original records were sent for microfilming and

destruction. The Trust's policy required some documents, such as temperature charts and daily fluid balance charts, to be destroyed without being microfilmed. As a result I had access to only those documents which had been microfilmed and I could not be certain what other documents existed before their destruction. The early destruction of the records was contrary to the Trust's own policy and went against official guidance. The Trust expressed their deep regret for what had happened and said that it was the only time such an error had been made. I return to this issue in my findings and conclusions.

Code A evidence

7. In letters to the Ombudsman's office Code A wrote that he could see no reason, in the light of Code A not needing morphine based drugs during the last week of her stay in the first hospital, why she was given such medication within 24 hours of being transferred to the second hospital. He did not accept the Trust's explanation that Code A needed the medication because she had developed extremely painful pressure sores and had pain in her neck and back. Notwithstanding those problems Code A considered that the choice of medication was inappropriate and that his mother was given excessive amounts of oramorph and diamorphine (both of which contain morphine). His other main concerns centred around what he saw as a failure to try and help Code A regain her mobility and a failure to ensure that she did not become dehydrated.

The Trust's formal response to the complaint

8. In their formal response to the complaint the Trust commented as follows:

> 'We do not consider that Code A complaint is justified and wholly reject his previously stated claim that Code A was "helped on her way". We do recognize, however, that we may have failed Code A by not helping him to a better understanding of his mother's prognosis. In the course of our investigation, a number of areas where practice could be improved were highlighted. We do not believe, however, that these areas contributed to Code A Code A deterioration nor to her subsequent death. This view was upheld by [the independent clinician who reviewed the complaint in September 1999].'

After commenting on individual aspects of the complaint the Trust gave details of the areas of practice which, following the meeting in February 1999 between Code A Code A and the medical director, they had undertaken to review. They were:

admission protocols, including support for relatives; pain control; fluid protocols; and medical cover during weekends and bank holidays.

Code A clinical and nursing records

9. Entries in the clinical and nursing records relating to the time Code A was a patient in the first hospital include a post-operative instruction indicating that she should be helped to regain mobility as soon as possible. Another entry, made on the day of Code A hip operation (26 October 1998), records that a doctor had spoken to Code A and told him she was unlikely to recover. Over the next few days Code A condition fluctuated a little. On 29 October it was recorded that she was chesty but felt better after sitting up in a chair. The next day there are entries in the nursing records indicating that Code A heels and sacrum were red. On 31 October a nurse recorded that she was much improved and had tried to walk but with little success. Her pressure areas continued to be a cause for concern and on 2 November, when a doctor recorded a 'dramatic improvement in her general state', there is a note that the area around her sacrum was deteriorating.

10. On 3 November the records show that a referral was made to the consultant for her advice on Code A future management. In a note to the consultant a doctor wrote that Code A was 'sitting out and beginning to mobilise', but the nursing records for that day included an entry stating that 'mobility remains poor'. After seeing Code A on 5 November the consultant wrote:

> '.. Code A son and daughter-in-law were present when I visited and I have pointed out to them that rehabilitation was going to be very difficult given her mental state and pressure sores. They have agreed to a month's gentle rehabilitation in a NHS continuing care bed for a month initially. Unless there is a dramatic improvement .... I feel she will need a nursing home'.

The nursing records for the remainder of Code A time in the first hospital show that, despite regular attention to her pressure areas and the use of a special mattress, by the time of her transfer to the second hospital the sores on her heels had blackened and she had a sore on her right elbow. Other entries indicate that during the latter part of her stay in the first hospital the staff there were experiencing difficulty maintaining a satisfactory fluid balance. She also had oedema (an accumulation of fluid) in both legs and her left arm.

11. The prescription and drug administration records in respect of Code A stay in the first hospital show that on 25 October she was prescribed morphine, 10 mg to be given as required. Only one dose was given, at 1.15am on 26 October. A prescription was also written that day for up to two tablets of co-codamol to be given as required. (Co-codamol is a proprietary non-opioid drug used for pain relief – it does not contain morphine.) Code A was given co-codamol 14 times between 25 October and 5 November, but none after that. Between 6 and 11 November she was given no pain relief medication other than aspirin.

12. The prescription and drug administration records in respect of Code A stay in the second hospital include a prescription dated 11 November authorising the administration of co-codamol, if required; Code A was given two tablets at 8.30am the next day. Later on 12 November a doctor wrote a prescription for 2.5 mls to 5 mls oramorph (a solution that would have contained 5 mgs to 10 mgs of morphine) to be given orally, as required, at intervals of four hours or longer. That afternoon, Code A was noted to be in a great deal of pain and was given 2.5 mls of oramorph at 2.05pm. She was given a further 2.5 mls at 6.30pm and 5 mls at 10.37pm. The two evening doses were given after nurses observed that Code A was still in pain.

13. Between 13 November and 24 November Code A was given a total of 15 further doses of oramorph. No dose exceeded 5 mls and she was never given more than two doses in one day. On 24 November, a doctor wrote a prescription for diamorphine to be given subcutaneously on a regular basis. Code A was given 20 mgs of diamorphine each day between 24 and 30 November. On 1, 2 and 3 December she was given 40 mgs each day. The nursing records indicate that Code A Code A was in pain on the day she was admitted to Dryad Ward and there are many subsequent references to her being in pain and needing pain relief to help her sleep at night.

14. On 14 November the ward manager recorded at 4.30pm that Code A had expressed concerns about the amount of sedation being given to his mother. On checking Code A she was described as 'rousable but not very communicative'. She had been given 2.5 mls of oramorph at approximately 10.35 am that day. The ward manager's note continued:

Code A is aware of Code A poor prognosis [and] .... that she may need opiates to control her pain [and] he agrees to this'.

15. An entry made by one of the doctors who attended Code A referred to a conversation which she had had with Code A during the evening of 17 November. She wrote:

'Code A seen. Very angry. Feels his mother is not being cared for adequately, is accusing nursing staff of murdering his mother by giving her oramorph .... She is clearly in distress when moved e.g. for washing/dressing and as such does require analgesia (Code A is not happy for her to have any analgesia). She is clearly also very poorly and I do not feel any active intervention is appropriate ....'

After discussion with the consultant the doctor concerned wrote a prescription for Code A to be given fluids, subcutaneously (under the skin).

16. A slightly later entry, in the nursing records for 17 November, referred to a conversation which one of the nurses had with Code A. She wrote:

Code A expressed his dissatisfaction with the treatment at [the second hospital]. He was concerned his mother was nursed in bed, did not have [intravenous fluids] in progress and had been given oramorph.

'Explained she was in bed because she had pressure sores on admission and was nursed on a pressure relief mattress.

'That I did not comment on the use of [intravenous] fluids as it was not my area of practice and that oramorph was used as Code A was in pain Code A Code A was verbally abusive to myself and the doctor ....'

In a further entry the nurse wrote that Code A had requested, and been given, a complaints form before leaving the ward and saying that he would not be coming back.

17. Another entry that evening, by the hospital's medical director, records that if Code A Purnell continued to be in pain or distress she should be given pain relief,

despite Code A wishes to the contrary. Because Code A was incapable of making decisions for herself the staff should act in what they believed to be her best interests. In order to increase Code A intake of fluids the medical director approved their administration, subcutaneously, for between five and seven days, to see if her condition improved. In doing so, he expressed concern that, in view of her general condition, giving fluids might not be appropriate. The medical director returned to the ward at 8.00am the next day in order to check on Code A.

18. The next day, 18 November, a nurse wrote that staff and the police had tried to contact Code A but that he was not at either of the addresses in the hospital's records and the telephone number in the records was unobtainable.

19. As at the first hospital, the staff at the second continued to nurse Code A on a special mattress designed for patients with pressure sores, or at risk of developing them. Her Waterlow score (giving an indication of the degree to which her pressure areas were at risk) was assessed on 11 and 23 November. Her scores on both those dates identified her pressure areas as being at very high risk. Staff also assessed her level of dependency on those days. She was incontinent of urine and faeces, and was totally dependent on staff for bathing, dressing and grooming. On 11 November she was described as needing help to feed herself but by 23 November she was unable to do so at all. With regard to her mobility she was assessed on both occasions as being completely dependent on others, unable to stand, and unable to transfer (e.g. from her bed to a chair) without a hoist.

20. On 11 November a care plan was produced with details of the action that was to be taken to address Code A s needs. Among other things she was to have regular mouth and pressure area care, be encouraged to take food and fluids, and receive adequate pain relief at night. Documents recording the care that was given indicate that her mouth care and personal hygiene were attended to daily. There are entries, on 14 November and 17 November (before Code A was given subcutaneous fluids) recording that her urine was either dark or concentrated, and that she was to be encouraged to drink more fluids. Corresponding entries elsewhere in the records indicate that on 13 and 14 November Code A could manage only small amounts of food and fluids and that staff continued to encourage them after 17 November, when fluids were being given subcutaneously. There are specific entries relating to pressure area care given on 13, 14, 20 and 22 November, and to Code A being turned and encouraged to lie on her side. On other dates

nurses recorded that care was given fully in accordance with the nursing care plan. The plan included instructions on how Code A was to be moved and on the care and treatment of her pressure areas.

Advice of the Ombudsman's Professional Advisers

21. The Ombudsman's medical adviser, Dr Ann Naylor, M.B., B.S., F.R.C.A., a consultant anaesthetist with wide experience in an acute pain team and in palliative medicine, commented as follows:

> *'Having reviewed the clinical and nursing records on the complaints file, I consider that the choice of pain relieving drugs for* Code A *was appropriate in terms of the type of drug, doses, methods of administration and frequency of administration. Staff were correct in their judgement that* Code A *required palliative care (active total care for a patient whose disease is not responsive to curative treatment). The drugs and doses used are within the ranges recommended in the BNF (British National Formulary) for palliative care. There is no evidence that* Code A *received excessive doses of morphine.*
>
> *'In my view, the same comments could be made about the management of* Code A *hydration. When* Code A *was admitted, she was able to take small amounts of fluid and food with assistance. There is no evidence that* Code A *was not sufficiently encouraged to drink during her first week on Dryad Ward. Over enthusiastic attempts to encourage a patient to drink can be very disturbing and not in their best interest. When her condition deteriorated, an appropriate regime of subcutaneous fluids was instituted. Earlier use of subcutaneous fluids would have made no significant difference to the outcome.*
>
> *'Following the fall when she broke her hip,* Code A *did not regain mobility. She was able to sit out of bed with assistance and at one time was fit to sit in a wheelchair. There is evidence of the staff having kept this aspect under regular review and I am convinced that all was done that could be done to increase* Code A *mobility. Given her age, her general physical and mental health, and her recent fracture, sadly it was impossible to improve her mobility and she developed pressure sores which made attempts at mobilisation considerably more difficult. Prior to her admission to*

hospital, Code A had been living in a nursing home and on admission to hospital she was noted to have senile dementia, oedema of the legs, pressure sores, urinary and faecal incontinence and to require full assistance with the activities of daily living. The plan had been for slow rehabilitation, although the likely limited effect of this was recognised and this proved to be the case.

'Conclusion

Code A made a steady recovery after breaking her hip in a fall. She was not mobile and her condition gave cause for concern that she might prove difficult to mobilise. After her transfer to the second hospital she developed pressure sores, mainly as a consequence of her immobility.

'She was treated with care and compassion and due to severe pain from her pressure sores required the use of morphine. At a later stage, when she became dehydrated, appropriate measures were used to treat this.

Code A received medical management entirely appropriate to her condition and prognosis and this was supported by the nursing care plan.'

22. The Ombudsman's nursing adviser reviewed the papers and concurred with the views of the medical adviser where they overlapped with issues concerning Code A Code A nursing care. She commented that Code A pressure sores would have been acutely painful, particularly during the early stages of their development. The records provided evidence of the nurses having formulated a timely nursing care plan following Code A 's arrival in Dryad Ward. In so far as it was possible to judge (owing to the lack of fluid balance charts and some of the other records), Code A s care appeared to have been delivered as required by the care plan. The drug administration records showed that at all times the nurses administered Code A medication in accordance with the doctors' prescriptions.

Action taken by the Trust

23. The Trust provided details of the areas where they had reviewed their written policies as a result of Code A concerns. Although they had not upheld Code A Code A complaint their investigation had highlighted issues that needed attention. Work had been done on an admissions policy for the ward. The policy defined more closely the categories of patients to be admitted to Dryad Ward and required a nominated member of the nursing staff to liaise with relatives before formulating

the nursing care plan. There was now an agreed policy for the prevention and management of malnutrition, under which every patient was assessed on admission to ascertain the degree to which s/he was at risk of malnutrition and to help identify the appropriate nursing interventions. A multi-professional policy was also being prepared for the assessment and management of pain, with patients' needs being reviewed on a regular basis. In addition to that the Trust had introduced new forms for the prescribing and administration of drugs using a syringe driver (an automated device for delivering a preset dose of medication). Since February 1999 consultant cover on the ward had been increased from one ward round every fortnight to one every week.

Findings

24. The Ombudsman's medical adviser has stated that in her opinion the medical management of Code A was appropriate, having regard to her condition and prognosis. I see no reason to believe otherwise. In caring for Code A the staff had to strike a balance between doing all they could to facilitate her rehabilitation (as long as that remained an option) and not doing anything that would cause her unnecessary suffering. I believe they approached Code A management in a considered and professional manner. Sadly, Code A prospects of recovery were very poor. That was explained to Code A while his mother was in the first hospital, and after she was transferred to the second.

25. Because some of the records were destroyed prematurely – an error for which I criticise the Trust – my findings in respect of the nursing care are based only on the documents which are still available. Although incomplete, the records provide evidence of the nurses having systematically assessed Code A needs, formulated a care plan, and delivered that care. Their approach was also influenced, to a large extent, by Code A poor condition and prognosis. I accept that, in view of her general condition and the pain she was in, it would not have been appropriate to have tried any harder to increase her mobility. I also accept that the staff did all they reasonably could to maintain Code A nutritional intake. The medical director was right in pointing out that the staff should act in what they considered to be Code A best interests, despite Code A objections.

26. Central to Code A concerns was his belief that the medication his mother was given was excessive. In his correspondence with the Trust he placed much emphasis on the fact that she had needed no pain relief during her last week in the

first hospital. I can see how it might have appeared to him that the second hospital were giving Code A more medication than she needed; however the records show clearly that she was in a great deal of pain and that pain relief was essential for her comfort. As for the choice of oramorph and diamorphine, the dosages prescribed, and the frequency of administration, the Ombudsman's medical adviser has commented that those were appropriate in the circumstances. I see no reason not to accept her view.

27. In their formal response to the complaint the Trust commented that they may have failed Code A by not helping him to a better understanding of his mother's poor prognosis. It appeared to Code A that his mother was improving up to the time she was transferred to the second hospital. His hopes may have been heightened by the consultant's plan 'for a month's gentle rehabilitation' and the prospect of her eventually going to a nursing home. It is entirely understandable, therefore, that he was greatly upset by the changes which followed so soon after Code A move to the second hospital. It seems, however, that when he raised his concerns on 14 November, the nurse to whom he spoke believed that she had reassured him. It was only later, on 17 November, that the full extent of his feelings became apparent, and for a time after that the staff were unable to contact him. In the circumstances I consider that the staff probably did all they could to try and help Code A understand matters.

28. To sum up, I have not found evidence of unsatisfactory medical or nursing care, and I am satisfied that Code A was not given excessive doses of morphine. I do not uphold the complaints.

Conclusions

My findings are given in paragraphs 24 to 28. I have not upheld the complaints. However, I hope that the Trust's actions following Code A complaint to them will reassure him that his concerns have resulted in improvements being made. I have been told by the Trust their procedures have also been improved to ensure that errors in the selection of records for microfilming are picked up before the records are destroyed. In addition to that the Trust have extended their microfilming

contract to include fluid charts and other items of clinical relevance which were not previously filmed. I regard that as a satisfactory outcome to my concerns about the premature destruction of some of the records in this case.

Code A

Colin Houghton
Investigations Manager
duly authorised in accordance with
paragraph 12 of Schedule 1 to the
Health Service Commissioners Act 1993

22 March 2001

Summary to Ombudsman.

Complaint Code A /Portsmouth HealthCare NHS Trust

(A) 1 Summary of Events

Following a fall at a nursing home on 3rd November, 1998 Mrs. Purnell was admitted to Haslar Hospital for operation on her broken hip. On 5th November, 1998 Dr. Althea Lord (Consultant Geriatrician) visited Code A at Haslar Hospital and on 11th November, 1998 she was transferred to Dryad Ward, Gosport War Memorial Hospital. In the transfer letter from Haslar Hospital (dated 10th November, 1998) it was noted that Code A next-of-kin were well aware of her poor condition and were realistic in their expectation (see (B) 1 for copy of this letter).

Whilst on Dryad Ward Code A was under the care of Dr. Lord who was in daily contact with the ward, and visiting fortnightly. The Clinical Assistant, Dr. Jane Barton, who usually visited the ward daily, was on annual leave during some of the time in question. Her absence was covered by colleagues from the practice (The Forton Road Surgery).

On admission assessment Code A was noted to have senile dementia, oedema of the legs, pressure sores, urinary and faecal incontinence (a catheter was insitu) and needed full assistance with the activities of daily living. Her Barthel ADL Index score was only 2 and a Waterlow Assessment showed she was at very high risk of pressure area damage. She had been experiencing swallowing difficulties and thus nutrition was variable in the post-operative period at Haslar Hospital. The plan was for slow rehabilitation, although the likely limited effect of this was recognised.

The nursing and medical records note that on 12th November, 1998, the day after admission, Code A began complaining of a great deal of pain despite having co-codamol, so a low dose of oramorphine was commenced. On the 13th there was not a great deal of change in her general condition, only small amounts of fluids and diet were taken. On 14th November, 1998 Code A voiced his concerns about the use of "sedation" and was seen by Sister Gill Hamblin and Staff Nurse Freda Shaw, who explained the use of oramorphine. They understood Code A to then be happy with its continuation and Sister Hamblin recorded that Mr. Wilson was aware of his mother's poor prognosis and that she might need opiates to control her pain.

On 15th November, 1998 the nursing record notes that Code A was more talkative; had a bath; it was noted that her neck was extending and that her back was rigid so diazepam was prescribed. She continued to complain of pain when being attended to but also slept for some of the morning.

On 17th November, 1998 Code A approached Staff Nurse Lynne Barrett, and she records that he was extremely angry and "accused us of trying to murder her (his mother) by keeping her sedated". A short while later he was also seen by Staff Nurse Shirley Hallman and Dr. Sarah Brook. Code A statement of complaint refers to a "dispute"; the nursing and medical records document aggressive and abusive behaviour by Code A to the extent that the general manager and the police were contacted for advice.

Code A clinical needs and current treatment were explained to Code A by Dr. Brook and nursing staff, including the fact that she was not being "sedated", that she was only being given analgesia when she was in pain. Dr. Brook discussed Code A condition with Dr. Lord, and Dr. Ian Reid (Medical Director) was asked to visit the ward to review her care. Code A left the ward stating that he was not coming back, that we could dispose of his mother's body and belongings as we wished, because as we did not have his address we could not contact him.

Dr. Reid visited the ward at 1930 on 17th November, 1998, that same day and also the next day as stated by Code A He noted that Code A was incapable of making her own decisions, that her son had left the ward and that "we" needed to act in what we believed was her best interest. If pain/distress was experienced she should have pain relief; choking on food and fluid was observed the previous day, therefore Code A was to be discouraged from pushing food and fluids into her mouth (swallowing difficulties were noted at Haslar Hospital); subcutaneous fluids to be tried for 5-7 days. The agreed medical conclusion was that Code A was very poorly and that active treatment such as intravenous or subcutaneous fluids was unlikely to be successful.

Code A condition declined and sadly she died on 3rd December, 1998. Repeated attempts were made between 17th November and 3rd December, 1998 to contact Code A in order to discuss his mother's care but to no avail. An appointment was made for Code A to meet with Dr. Lord on 23rd November, 1998 but he decided not to attend.

The Coroner's office confirmed a diagnosis of broncho-pneumonia and senile dementia, and a death certificate was issued accordingly.

On 27th November, 1998 Code A wrote a letter of complaint, which with a covering letter dated 1st December, 1998 was received by the Chief Executive on 4th December, 1998. This letter was duly acknowledged and a reply was sent on 8th January, 1999. A meeting was held on 3rd February, 1999, attended by Code A Community Health Council representatives and Trust staff. There then ensued much correspondence, including a clinical second opinion, until the Convenor refused Code A request for Independent Review on 19th December, 1999.

N.B. See (B) 1 for nursing/medical notes for a full record of the above events.

Relevant correspondence

This complaint has been so complex and protracted that it is difficult to isolate key documents. We have, therefore, provided a full copy of the complaints file papers - see (B) 5.

Key events

11th November, 1998 Code A admitted to Gosport War Memorial Hospital
17th November, 1998 Code A between Code A and staff
3rd December, 1998 Code A died

4th December, 1998	Code A complaint received
8th January, 1999	Response to complaint sent
3rd February, 1999	Meeting to discuss complaint - Code A, Dr. Reid (Medical Director), Mr. Bill Hooper (General Manager), Mrs. Barbara Robinson (Clinical Manager) and two representatives from the Community Health Council
26th February, 1999	Code A asks for more information on pain relief
17th March, 1999	Information on pain relief supplied and further meeting offered
12th June, 1999	Code A writes that he is still dissatisfied and further correspondence follows
28th September, 1999	Second opinion given by Dr. Gillian Turner and forwarded to Code A on 1st October, 1999.
12th November, 1999	Code A rejects second opinion and told Independent Review next step.
20th November, 1999	Request for Independent Review made
19th December, 1999	Requested rejected as Mr. Wilson indicated that he was taking the matter to the police

(A) 2 **Trust formal response to the complaint**

We are genuinely sorry that Code A believes his late mother was not given appropriate care and treatment on Dryad Ward, Gosport War Memorial hospital, and that despite our best efforts we have not been able to resolve his complaint. His strength of feeling and the nature of his relationship with the Trust is such that we doubt he will ever accept anything other than these beliefs.

The two main issues repeated throughout Code A's complaint are nutrition and dosage of morphine, and these have been extensively explored in the correspondence contained in (B) 5.

(a) That Code A did not receive reasonable medical and nursing care after her transfer on 11th November, 1998

We do not consider that Code A's complaint is justified and wholly reject his previously stated claim that Code A was "helped on her way". We do recognise, however, that we may have failed Code A by not helping him to a better understanding of his mother's prognosis. In the course of our investigation, a number of areas where practice could be improved were highlighted. We do not believe, however, that these areas contributed to Code A Code A deterioration nor to her subsequent death. This view was upheld by Dr. Turner who gave a second opinion at Code A's request.

Both the transfer letter from Haslar Hospital and Dr. Lord's pre-transfer assessment (see clinical notes) present a very different picture from the one described by Code A in the statement of complaint. Code A was 91 years old, had long standing poor health, and was recovering from major surgery. Her needs were assessed on admission and her care planned accordingly. Code A potential for recovery was recognised as being poor from the outset.

The nursing and medical records seem to demonstrate that Code A suffered a slow rather than sudden decline. They also suggest that efforts were made to help Code A recognise his mother's poor prognosis. With hindsight, however, one must wonder if more effort should have been made to this end.

The records made by Dr. Brook and Dr. Reid on the evening of 17th November, 1998 document the rationale behind the care provided Code A general condition was very poor and it was not felt that active treatment other than an analgesia was appropriate. Dr. Turner (second opinion) expressed the view that earlier rehydration would have been unlikely to have affected the outcome and that the fact that her condition did not subsequently improve with parenteral rehydration demonstrated that her poorly state was not due to fluid depletion (see report in (B) 5).

It is likely that the nature of the debate between Code A and various members of staff clouded rather than clarified the issues. The great irony is that both the medical and nursing staff were so intimidated by Code A aggressive style and approach that they were unable to achieve the type of relationship which might have resolved these issues at the time. It is regrettable that these disputes with the staff were not resolved and that the many subsequent efforts to contact him failed. This, and Code A distress and the potential for fundamental misunderstanding/ miscommunication were recognised from the outset of his complaint and apologies were duly offered.

The complaint file provided at (B) 5 provides specific detail of the complaint raised by Code A and the response from the Trust.

(b) That the doses of morphine administered by Code A after her discharge to Gosport War Memorial Hospital were excessive

This charge is completely refuted. The letter written to Dr. Turner (second opinion) to Mr. Max Millett, Chief Executive, on 16th September, 1999 explores the use of morphine in elderly people and its use for Code A Dr. Turner concludes that "the use of morphine was entirely appropriate and that the amounts administered could not be considered excessive" (see (B) 5, section M). Code A was sent a copy of this letter.

Actions taken to improve practice

Although Code A specific complaints were not upheld, a number of areas were identified where practice could be improved.

At the meeting on 3rd February, 1999, with the Community Health Council present, the following actions were agreed:

* Review admission protocols, to include support for relatives
* Review of pain control
* Review of fluid protocols
* Review of medical cover for weekends/bank holidays.

This action plan was taken forward by Mrs. Robinson, the then Service/Clinical Manager.

Dr. Turner wrote a second letter to Mr. Millett on 16th September, 1999. This letter makes some very helpful comments on issues which were outside the scope of Mr. Wilson's complaint; copy attached. Code A has not been given a copy of this letter.

Dr. Turner's private letter to Mr. Millett highlighted the following areas for action:

* Consultant visits to the ward have been raised to weekly
* The arrangement for microfilming notes are being reviewed within a major medical records project
* Guidelines for prescribing morphine for subcutaneous pumps have been reviewed.

Conclusion

From the outset we have wanted to help Code A and we greatly regret that this has not proved possible at Local Resolution. Although learning points have been identified from this complaint, we do not believe that the basic complaint is justified.

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We hope this information is helpful and we will willingly assist the Ombudsman in any further investigation he decides to take.

PORTSMOUTH HealthCare NHS TRUST

FAX

Please telephone Code A if any page is missing or indistinct

To Health Service Commissioner for England Date 19 June, 2000

For the Attention Of: Eric Drake
Investigations Manager Fax No: Code A

From Lesley Humphrey
Quality Manager Pages (include this sheet) 9

STRICTLY CONFIDENTIAL

Dear Mr Drake

Re: complaint made b Code A

Please find enclosed our summary of events and our formal response to the complaint made by Code A - items A 1&2 on the index sent to your office on Friday 16 June 2000.

A hard copy is also in the post today.

Code A

Lesley Humphrey
Quality Manager

Code A

PORTSMOUTH HEALTHCARE NHS TRUST CENTRAL OFFICE

St James Hospital
Locksway Road, Portsmouth, Hampshire, PO4 8LD
Telephone: Code A Facsimile: Code A

PORTSMOUTH HealthCare NHS TRUST

INDEX

(A) Information requested by Ombudsman's office

1. The Trust's summary of the actions complained about and list of relevant correspondence and key events.

2. The Trust's formal response on the statement of complaint.

(B) Schedule of documents requested

~~1. The photocopy of the enlarged microfilm record of Mrs. Purnell from Gosport War Memorial Hospital from 11th November, 1998 to 3rd December, 1998.~~

~~2. Copies of the only pages which refer to Mrs. Purnell from the relevant ward diaries.~~

~~3. A list of all nursing and medical staff who dealt with~~ Code A ~~with last known address or place of work for those no longer employed by the Trust and with GMC/UKCC registration numbers.~~

4. Organisation charts showing the responsibilities and lines of accountability of the staff listed at 3 above.

~~5. Copies of the internal and external correspondence and papers relevant to the complaint.~~

~~6. Copies of the statements already taken from staff - in bundle B5 (Enclosure C).~~

~~7. Copies of written policies relevant to the complaint:~~

Deleted above not included in this pack.

* Included.

Complaint: Code A Portsmouth HealthCare NHS Trust

(A) 1 **Summary of Events**

Following a fall at a nursing home on 3rd November, 1998 Code A was admitted to Haslar Hospital for operation on her broken hip. On 5th November, 1998 Dr. Althea Lord (Consultant Geriatrician) visited Code A at Haslar Hospital and on 11th November, 1998 she was transferred to Dryad Ward, Gosport War Memorial Hospital. In the transfer letter from Haslar Hospital (dated 10th November, 1998) it was noted that Code A 's next-of-kin were well aware of her poor condition and were realistic in their expectation (see (B) 1 for copy of this letter).

Whilst on Dryad Ward Code A was under the care of Dr. Lord who was in daily contact with the ward, and visiting fortnightly. The Clinical Assistant, Dr. Jane Barton, who usually visited the ward daily, was on annual leave during some of the time in question. Her absence was covered by colleagues from the practice (The Forton Road Surgery).

On admission assessmen Code A was noted to have senile dementia, oedema of the legs, pressure sores, urinary and faecal incontinence (a catheter was insitu) and needed full assistance with the activities of daily living. Her Barthel ADL Index score was only 2 and a Waterlow Assessment showed she was at very high risk of pressure area damage. She had been experiencing swallowing difficulties and thus nutrition was variable in the post-operative period at Haslar Hospital. The plan was for slow rehabilitation, although the likely limited effect of this was recognised.

The nursing and medical records note that on 12th November, 1998, the day after admission, Code A began complaining of a great deal of pain despite having co-codamol, so a low dose of oramorphine was commenced. On the 13th there was not a great deal of change in her general condition, only small amounts of fluids and diet were taken. On 14th November, 1998 Code A voiced his concerns about the use of "sedation" and was seen by Sister Gill Hamblin and Staff Nurse Freda Shaw, who explained the use of oramorphine. They understood Code A to then be happy with its continuation and Sister Hamblin recorded that Code A was aware of his mother's poor prognosis and that she might need opiates to control her pain.

On 15th November, 1998 the nursing record notes tha Code A was more talkative; had a bath; it was noted that her neck was extending and that her back was rigid so diazepam was prescribed. She continued to complain of pain when being attended to but also slept for some of the morning.

On 17th November, 1998 Code A approached Staff Nurse Lynne Barrett, and she records that he was extremely angry and "accused us of trying to murder her (his mother) by keeping her sedated". A short while later he was also seen by Staff Nurse Shirley Hallman and Dr. Sarah Brook. Code A statement of complaint refers to a "dispute"; the nursing and medical records document aggressive and abusive behaviour by Code A to the extent that the general manager and the police were contacted for advice.

Code A clinical needs and current treatment were explained to Code A by Dr. Brook and nursing staff, including the fact that she was not being "sedated", that she was only being given analgesia when she was in pain. Dr. Brook discussed Code A condition with Dr. Lord, and Dr. Ian Reid (Medical Director) was asked to visit the ward to review her care. Code A left the ward stating that he was not coming back, that we could dispose of his mother's body and belongings as we wished, because as we did not have his address we could not contact him.

Dr. Reid visited the ward at 1930 on 17th November, 1998, that same day and also the next day as stated by Code A He noted that Code A was incapable of making her own decisions, that her son had left the ward and that "we" needed to act in what we believed was her best interest. If pain/distress was experienced she should have pain relief; choking on food and fluid was observed the previous day, therefore Code A was to be discouraged from pushing food and fluids into her mouth (swallowing difficulties were noted at Haslar Hospital); subcutaneous fluids to be tried for 5-7 days. The agreed medical conclusion was that Code A was very poorly and that active treatment such as intravenous or subcutaneous fluids was unlikely to be successful.

Code A condition declined and sadly she died on Code A Repeated attempts were made between 17th November and 3rd December, 1998 to contact Code A in order to discuss his mother's care but to no avail. An appointment was made for Code A to meet with Dr. Lord on 23rd November, 1998 but he decided not to attend.

The Coroner's office confirmed a diagnosis of broncho-pneumonia and senile dementia, and a death certificate was issued accordingly.

On 27th November, 1998 Code A wrote a letter of complaint, which with a covering letter dated 1st December, 1998 was received by the Chief Executive on 4th December, 1998. This letter was duly acknowledged and a reply was sent on 8th January, 1999. A meeting was held on 3rd February, 1999, attended by Code A Community Health Council representatives and Trust staff. There then ensued much correspondence, including a clinical second opinion, until the Convenor refused Code A request for Independent Review on 19th December, 1999.

N.B. See (B) 1 for nursing/medical notes for a full record of the above events.

Relevant correspondence

This complaint has been so complex and protracted that it is difficult to isolate key documents. We have, therefore, provided a full copy of the complaints file papers - see (B) 5.

Key events

11th November, 1998	Code A admitted to Gosport War Memorial Hospital
17th November, 1998	Code A between Code A and staff
3rd December, 1998	Code A

4th December, 1998	Code A complaint received
8th January, 1999	Response to complaint sent
3rd February, 1999	Meeting to discuss complaint - Code A Dr. Reid (Medical Director), Mr. Bill Hooper (General Manager), Mrs. Barbara Robinson (Clinical Manager) and two representatives from the Community Health Council
26th February, 1999	Code A asks for more information on pain relief
17th March, 1999	Information on pain relief supplied and further meeting offered
12th June, 1999	Code A writes that he is still dissatisfied and further correspondence follows
28th September, 1999	Second opinion given by Dr. Gillian Turner and forwarded to Code A on 1st October, 1999.
12th November, 1999	Code A rejects second opinion and told Independent Review next step.
20th November, 1999	Request for Independent Review made
19th December, 1999	Requested rejected as Code A indicated that he was taking the matter to the police

(A) 2 Trust formal response to the complaint

We are genuinely sorry that Code A believes his late mother was not given appropriate care and treatment on Dryad Ward, Gosport War Memorial hospital, and that despite our best efforts we have not been able to resolve his complaint. His strength of feeling and the nature of his relationship with the Trust is such that we doubt he will ever accept anything other than these beliefs.

The two main issues repeated throughout Code A complaint are nutrition and dosage of morphine, and these have been extensively explored in the correspondence contained in (B) 5.

(a) That Code A did not receive reasonable medical and nursing care after her transfer on 11th November, 1998

We do not consider that Code A complaint is justified and wholly reject his previously stated claim that Code A was "helped on her way". We do recognise, however, that we may have failed Code A by not helping him to a better understanding of his mother's prognosis. In the course of our investigation, a number of areas where practice could be improved were highlighted. We do not believe, however, that these areas contributed to Code A Code A's deterioration nor to her subsequent death. This view was upheld by Dr. Turner who gave a second opinion at Code A's request.

Both the transfer letter from Haslar Hospital and Dr. Lord's pre-transfer assessment (see clinical notes) present a very different picture from the one described by Code A in the statement of complaint. Code A years old, had long standing poor health, and was recovering from major surgery. Her needs were assessed on admission and her care planned accordingly. Code A potential for recovery was recognised as being poor from the outset.

The nursing and medical records seem to demonstrate that Code A suffered a slow rather than sudden decline. They also suggest that efforts were made to help N Code A recognise his mother's poor prognosis. With hindsight, however, one must wonder if more effort should have been made to this end.

The records made by Dr. Brook and Dr. Reid on the evening of 17th November, 1998 document the rationale behind the care provided. Code A's general condition was very poor and it was not felt that active treatment other than an analgesia was appropriate. Dr. Turner (second opinion) expressed the view that earlier rehydration would have been unlikely to have affected the outcome and that the fact that her condition did not subsequently improve with parenteral rehydration demonstrated that her poorly state was not due to fluid depletion (see report in (B) 5).

It is likely that the nature of the debate between Code A and various members of staff clouded rather than clarified the issues. The great irony is that both the medical and nursing staff were so intimidated by Code A aggressive style and approach that they were unable to achieve the type of relationship which might have resolved these issues at the time. It is regrettable that these disputes with the staff were not resolved and that the many subsequent efforts to contact him failed. This, and Code A distress and the potential for fundamental misunderstanding/ miscommunication were recognised from the outset of his complaint and apologies were duly offered.

The complaint file provided at (B) 5 provides specific detail of the complaint raised by Code A and the response from the Trust.

(b) That the doses of morphine administered by Code A after her discharge to Gosport War Memorial Hospital were excessive

This charge is completely refuted. The letter written to Dr. Turner (second opinion) to Mr. Max Millett, Chief Executive, on 16th September, 1999 explores the use of morphine in elderly people and its use for Code A Dr. Turner concludes that "the use of morphine was entirely appropriate and that the amounts administered could not be considered excessive" (see (B) 5, section M). Code A was sent a copy of this letter.

Actions taken to improve practice

Although Code A specific complaints were not upheld, a number of areas were identified where practice could be improved.

At the meeting on 3rd February, 1999, with the Community Health Council present, the following actions were agreed:

* Review admission protocols, to include support for relatives
* Review of pain control
* Review of fluid protocols
* Review of medical cover for weekends/bank holidays.

This action plan was taken forward by Mrs. Robinson, the then Service/Clinical Manager.

Dr. Turner wrote a second letter to Mr. Millett on 16th September, 1999. This letter makes some very helpful comments on issues which were outside the scope of Mr. Wilson's complaint; copy attached. Code A has not been given a copy of this letter.

Dr. Turner's private letter to Mr. Millett highlighted the following areas for action:

* Consultant visits to the ward have been raised to weekly
* The arrangement for microfilming notes are being reviewed within a major medical records project
* Guidelines for prescribing morphine for subcutaneous pumps have been reviewed.

Conclusion

From the outset we have wanted to help Code A and we greatly regret that this has not proved possible at Local Resolution. Although learning points have been identified from this complaint, we do not believe that the basic complaint is justified.

On first examination, the processing of the complaint would appear to have been unduly protracted - this was primarily because Code A was unfortunately himself suffering health problems, which caused considerable delays in the correspondence.

From the beginning Code A has been threatening legal action and it is possible that he is using the complaints procedure to gather evidence to this end. In our desire to help him we chose to ignore these threats. The Convenor, however, felt he could not ignore Code A statement that he was going to the police.

We hope this information is helpful and we will willingly assist the Ombudsman in any further investigation he decides to take.

B4

Organisation Charts

1. The Nursing Staff

   (i) The Fareham and Gosport Community Hospitals management structure is attached.

   (ii) Within the hospital:

   The Ward Manager (Gill Hamblin, G Grade) has 24 hour responsibility for the nursing staff. Within the ward staff seniority is determined by grade from F Grade down to E then D Grade then Health Care Support Worker.

2. The Medical Staff

   (i) Medical accountability is to Dr. I. Reid, the Medical Director.

   (ii) The Consultant Geriatrician was Dr. A. Lord - with cover from the Elderly Services Consultant on call.

   (iii) The Clinical Assistant was Dr. J. Barton - whose duties were covered by colleagues from her practice as necessary.

   There is no specific organisation chart for medical staffing.

Fareh[illegible]n & Gosport Community Ho[illegible]pitals