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 mother, 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 this 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 's 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 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 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. Code A Code A s, 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 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 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 s 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's 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