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 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 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 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	"Dispute" 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 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 deterioration nor to her subsequent death. This view was upheld by Dr. Turner who gave a second opinion at Code A 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 Code A Code A 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.