Portsmouth Hospitals NHS
NHS Trust

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Chief Executive

Complaints Dept
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Code A

PRIVATE AND CONFIDENTIAL

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Code A

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(Please quote Our Ref: on all correspondence)

Dear **Code A**

I am pleased to say that the investigation into your concern about your **Code A** care while a patient and Portsmouth Hospitals NHS trust is now complete. To enable me to address your concerns I have taken evidence from **Code A**, Consultant Vascular Surgeon, **Code A**, Consultant Physician, **Code A** Ward Sister, **Code A**, Consultant Nephrologist and **Code A** Ward Sister.

I am sorry it has taken so long to respond to you but it was important to address all the issues you have raised. To aid clarity, I have addressed the issues in date order, commencing with **Code A** transfer from Blendworth 2 to Blendworth 4 on 1st October 1999.

Medical Report - Dr Stevens, Consultant Nephrologist

Code A was admitted to hospital under the care of **Code A**. It was noted at the time that Code A was suffering from high blood pressure, with Pulmonary Oedema (fluid on the lungs). An ultrasound investigation suggested that the renal artery was not functioning properly. To confirm this diagnosis, **Code A** underwent an angiogram (x-ray examination) on the 18th October. Unfortunately, this investigation was not successful so a second was performed on the 25th October 1999. This confirmed that Code A did have a problem with the artery leading to Code A kidney and, as a consequence, Code A was referred to the vascular surgeons. Code A was initially seen on the 1st November 1999 by Mr Payne.

Code A general condition remained poor and, therefore, could not immediately be considered for the surgery necessary to address the renal blockage.

Angiogram.

Dr Stevens has made the point that the second angiogram was successful and it gave her all the information required to confirm the diagnosis which in turn led to the request for a surgical opinion.

It was initially hoped that if your Code A blood pressure could be brought under control, Code A would be better prepared for a surgical operation. However, as Code A continued to have episodes of fluid on the lungs it became imperative that Code A undergo surgery sooner, rather than allowing Code A to go home and have elective surgery at a later date.

Rash.

The rash you mention in your letter was first noted by the nursing staff on the 14th October 1999. The rash was thought to be caused by the drug, Methyl Dopa, one of the blood pressure tablets your Code A was taking. This drug was stopped immediately, and the rash improved.

I would like to reassure you that the rash was not due to an infection caused by the intravenous line. Code A has said that it in no way contributed to any of Code A Code A health problems.

You also ask the question of when Venflons are re-sited, do the doctors record this in the notes? Code A says that, ideally, this should be done, however, it is not always recorded.

Treatment of Chest Infection.

I would like to reassure you that your Code A chest infection was taken very seriously and dealt with appropriately. A nebulizer and inhalers were given in response to Code A wheezing and breathlessness. Code A wheezing was suggestive of asthma, although it is equally a common sign with fluid on the lungs. It is often very difficult to differentiate between the two problems. It is therefore not unusual to initially give a treatment that covers all options.

Seizures.

The seizures Code A suffered were a cause for concern to you. I understand that they are symptomatic of a patient suffering from very high blood pressure. The treatment for this was to gradually bring the blood pressure under control. This, according to the notes was successful and the seizures ceased.

Flexible Sigmoidoscopy Investigation.

Given all the clinical findings, the need for a flexible sigmodoscopy was not indicated during Code A admission to St Mary's Hospital and Code A has assumed that your reference to it may relate to Code A care and treatment later.

Delay in being seen by a Doctor.

I am sorry for the distress caused by the delay in getting a doctor to see your Code A on Sunday. There were three doctors on duty that weekend coping with a large number of acute medical admissions. Unfortunately, they have to deal with calls in order of clinical priority. This inevitably means a delay for some patients before they can be seen.

Code A did experienced delays in getting investigations done during Code A admission to St Mary's Hospital. This again is a matter of managing demand according to clinical priority.

The diagnosis of a renal artery stenosis was made at the time of the initial admission and only confirmed by an angiogram at a later date. Your Code A had such a good quality of life prior to admission, Code A was put forward for surgery almost immediately. However, subsequent symptoms did cause a delay.

Code A care was transferred to Code A at Queen Alexandra Hospital on the 15th November and an operation to un-block the renal artery took place on the 17th November.

Code A team kept in contact with the surgical Senior House Officers for a few days after surgery so as to determine that Code A renal function remained stable and Code A blood pressure settled.

Nursing care on Blendworth 4, St Mary's Hospital

Sister Code A Ward Manager for Blendworth 4, has addressed issues you raise in your letter. I believe these to be:

a) that an intravenous needle (Venflon) was left in your Code A hand for approximately six weeks without being checked or changed, and
b) your Code A rash was not treated until three days after it appeared.

It was normal practice for the nursing staff to inspect the venflon at regular intervals during your Code A admission. Code A was given intravenous antibiotics for one week and then intravenous Fruzemide. Lastly, Code A was transfused with two units of blood on the 23rd of October 1999. If the Venflon was blocked or the site became inflamed, antibiotics or transfusion would not have been successful and this would have brought any problem to the attention of the nursing staff.

The nurse who was responsible for the removal of the Venflon had documented her action in Code A medical notes. She does not recall the site being inflamed or sore and believes she would have written a note to this effect had there been a problem.

On the Sunday, your Code A started to deteriorate and required medical assessment. Sister Jackson recalls that the ward was extremely busy, a situation made worse by staffing difficulties. Although your Code A condition was brought to the attention of the on-call doctor, due to the heavy workload, he was unable to come to Blendworth 4 until the evening. Following examination, Code A he was sent for a chest X-ray and then immediately prescribed intravenous antibiotics for a chest infection.

Medical Report – Code A Consultant

Code A was transferred to the care of Mr S Payne, on the 15th November 1999. I have received a report from Code A addressing the issues you raised. He informs me that he has spoken to you on several occasions, before and after your Code A operation, and also since Code A He very much regrets that there may have been issues not dealt with to your satisfaction. Code A came to surgery extremely unwell suffering from heart failure, deteriorating renal function and poor circulation in Code A legs.

Code A underwent a major surgical operation carrying a substantial risk. Unfortunately, after a good initial recovery, the graft to Code A right renal artery developed an infection. Code A believes that Code A was very aware of the serious risks involved.

Infection level in the Blood.

Mr Payne's concern about the infection led him to discuss Code A case with other vascular surgical colleagues. He felt Code A would not survive a second operation and it was decided that the best course to take, in the circumstances, was to allow your Code A to go home. Subjecting Code A to further tests would have been unkind and not in Code A best interests.

Mr Payne has asked me to convey his apologies if he failed to keep you fully informed. He believes, however, that there was nothing which might have substantially altered the inevitable outcome.

Nursing, E3 Ward, Queen Alexandra Hospital

Sister Code A Ward Manager for E3, has said that the nursing notes record that your Code A developed faecal incontinence, which was first recorded on the 23rd November 1999. The records also show that the nurses frequently and regularly attended to Code A hygiene needs. However, it has been acknowledged that because of Code A MRSA status, Code A was not in the best possible place to be easily observed.

This led to some distress for both your Code A and the family and I would like to add my apologies to those of Sister Code A for this.

The nursing notes record that on the 2nd December 1999 your Code A was found sitting on the floor. He told the nurses Code A had felt giddy. Code A was known to have these spells and the medical staff had been made aware. Sister Code A discovered that an Incident Form was not completed relating to the fall. As a consequence, she spoke to the staff who were on duty that day and stressed that even if there are no witnesses to an event such as this, or the facts are unclear, the incident should still be treated as a fall and the appropriate observations and documentation completed as per hospital protocol.

Sister Code A also raised this incident at the following ward meeting to ensure all the staff were reminded of procedures.

Sister Bownass recalls that both you and your Code A were frequent visitors to the ward and on each occasion sought out both nursing and medical staff to discuss your Code A condition. It is also recorded that you telephoned the ward at regular intervals. I believe the nursing staff spent some considerable time with your family and endeavoured to keep you involved and informed, especially with regard to discharge planning. She feels that such close contact gave them an awareness of your anxieties and expectations. There are several references detailing your concern about Code A emotional state. These indicate that his moods varied.

During the time of Code A admission, E3 ward was extremely busy. There were several incident reports during this time indicating the excessive workload. Regrettably, at such times, the standards of care are compromised. Sister Code A would like to apologise for any shortcomings in the care received by Code A I am assured that these matters have been discussed at ward meetings to ensure that lessons are learned and, more importantly, acted upon.

Your Code A was discharged home on the 15th December 1999 and Code A was re-admitted on Christmas Day. During this admission over the Christmas period and during late January he came under the care of Dr Code A Consultant Physician.

Medical Report - Code A Consultant Physician

On examination following Code A second admission, it was found that your Code A had electrolyte (blood chemistry) imbalance, still suffered giddy spells, was dehydrated and had pneumonia in Code A left lung. It was decided to re-hydrate Code A and treat Code A with antibiotics.

Dr Clark was aware that your Code A was very keen to go home again and so Code A was discharged on the 2nd January. The plan was for Code A to be followed up by the Renal Physicians but, in the meantime, request that Code A General Practitioner keep a close eye on Code A progress and do follow up blood tests.

Code A was readmitted on the 18th January with further episodes of dizziness, vomiting, electrolyte disturbance and a raised white blood cell count. Although Code A temperature was slightly raised, it was not markedly so. The clinical indications suggested that Code A may have been suffering from an infection.

Ultrasound Investigation

Dr Clark has said that on the 20th January, your Code A did not have a temperature but did have a raised white cell count. Code A felt the priority at this time was to perform an ultrasound of the abdomen in order to determine if an infection was present.

The ultrasound test on the 24th January showed there was no fluid collection or evidence of infection. At the same time, Dr Code A continued to investigate the blood electrolyte disturbances. A test was also performed to exclude adrenal failure as the possible cause of his giddy spells.

Code A condition was also discussed with the Renal Physician. Dr Code A remained concerned, despite the negative ultrasound, that your Code A had a graft infection and, once again, referred Code A on the 22nd January to the Vascular surgeons.

Following consultation with Mr Code A who agreed that a graft infection was possible, it was decided that Code A should undergo a CT scan. In the meantime, repeated sets of blood cultures and a culture of Code A diarrhoea failed to shed light on the cause of the infection. There was concern also that the diarrhoea could be antibiotic related, therefore it was deemed best not to prescribe any, even though there was continued evidence of infection.

At this time, I understand there was an enormous demand for the CT scanner and Dr Clark's request for a scan had to take its turn. Dr Clark was unhappy with this situation, although not in a position to do anything about it.

Dr Code A saw your Code A again on the morning of Monday 31st January and reassessed Code A It was agreed that Code A was far less well. Dr Code A again requested an abdominal CT scan or, if this was not immediately available, to have an abdominal X-ray performed. Code A to review Code A again. At this time, the possibility was considered that your Code A raised white cell count was due, not to infection but to a blood disorder and this was also investigated.

Sadly, Code A died the following morning.

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I understand that Dr Code A had spoken with you and your family before Code A death about your concern for Code A general state of health and the delay in reaching a confident diagnosis.

Dr Code A saw you again on the evening of the 3rd February, during which time he agreed that it was unsatisfactory that a firm diagnosis could not be made. Although I believe he pointed out that had all the investigations been done in a more timely manner this still would not have altered the outcome.

Nursing Care on F4, Queen Alexandra Hospital

I have received a report from Sister Code A Ward Manager for F4, Queen Alexandra Hospital and it is my understanding that the concerns you have about your Code A care on F4 are predominantly to do with Code A not being seen at regular intervals by medical staff.

As explained when your Code A was a patient on Blendworth 4, there are always fewer doctors on duty over a weekend period and it is their remit to clinically prioritise their workload. This means that the patients who are most ill must be seen first and, therefore, the order in which patients are seen is constantly changing. Sister Jackson has studied your Code A notes and explains that your Code A was seen at least twice a week by the Consultant and by another doctor, regularly. She also confirms that when Code A condition changed, the doctors where informed immediately and Code A was seen as soon as possible.

I am very sorry to read about the deep distress you felt, not being informed of your Code A death until fifteen minutes after Code A had died. Telephoning relatives to inform them of the death of a loved one is the most difficult thing a nurse has to do. Sometimes a nurse will avoid giving the information on the telephone, preferring to break the news in person. In this case, Sister Code A has asked me to apologise unreservedly to you for causing you additional distress. She has spoken with the nurse who telephoned you.

As is standard practice with all complaints that involve nursing care, Sister Jackson has spent time discussing your concerns with her staff so they too can identify any shortcomings in care and endeavour to improve practice.

In summary, Code A had a very complex medical condition and in order to treat Code A many doctors from different specialties had to be involved in Code A care. The notes detailing examination, investigation and treatment, along with discussions between the doctors, lead me to believe that all appropriate and essential action was taken to help Code A

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I am aware that when a number of different medical specialties are involved in a patient's care, the information given to the relatives can be complex and confusing. As a consequence, relatives often feel poorly informed. If this was the case, I apologise to you for the distress this will have caused.

I must also acknowledge that the heavy workload experienced by both doctors and nurses during your Code A admissions, will have resulted in delays in treatment and, sometimes, less than optimum care. I very much regret this situation and hope you will accept my sincere regrets. Thank you for taking so much trouble to bring these matters to me. I do appreciate it has been most distressing for you.

Yours sincerely

Mr M Smith
Chief Executive

s.c. Code A, Consultant General Surgeon, Queen Alexandra Hospital
Code A, Consultant Physician, Respiratory Centre, St Mary's Hospital
Code A, Consultant Nephrologist, St Mary's Hospital
Code A, Ward Sister, E3, Queen Alexandra Hospital
Ward Sister, B4, St Mary's Hospital
Code A, Administration Manager, Medical Services, Queen Alexandra Hospital
Code A, Directorate Senior Nurse, Medical Services, Queen Alexandra Hospital