Briefing: Vale of Leven Hospital Inquiry

Summary of Report Findings

Background

In 2009, the then Scottish Cabinet Secretary of Health & Wellbeing Nicola Sturgeon MSP instructed that a public inquiry following 131 cases of Clostridium difficile infection (CDI), between 1 Jan 2007 and 1 June 2008 at the Vale of Leven Hospital (VOLH) in Alexandria, West Dunbartonshire and a number of associated deaths, 34 of which were directly associated with CDI.

VOLH is a smaller hospital, which had 234 beds in 2002 but this had reduced to 136 by 2008.

The Inquiry was initially chaired by Lord Coulsfield, but he fell ill after a short time and Rt Hon Lord MacLean was appointed in his place.

NHS Greater Glasgow & Clyde (NHSGCC) did on two occasions lodge an objection to the Inquiry taking evidence on some aspects of the quality of nursing care at VOLH, but on both occasions they were repelled.

After a number of further delays the Inquiry’s findings were published on 24 November 2014.

Serious failures

The report highlights a number of key areas which contributed to the CDI and associated deaths:

- Scottish Government (SG) failed to have in place an inspection regime to provide the necessary assurance that infection prevention and control was being properly managed.

- SG and NHSGCC gave inadequate attention to reports of other outbreaks of CDI reported in the UK. Many of the issues here were also prevalent at VOLH. This included repeated warnings about the importance of prudent antibiotic prescribing which at SG’s failure to monitor the implementation of this message.
Prolonged uncertainty of the future existence of VOLH had a damaging effect on recruitment and staff morale. This led to the physical environment of VOLH being compromised including a lack of wash hand basins and unsatisfactory repairs. This was partly the result of changes in the hospital's management after a restructuring the local NHS boards as subsequent reduction in services.

A lack of strong management and personal failings lead to a culture which meant VOLH lost sight of its purpose – “to be a caring and compassionate environment dedicated to the highest levels of care”.

The report also states: “It was surprising how managers at different levels within an organisation like NHSGGC failed in one of the most fundamental aspects of management, namely to ask questions.”

**Discovery of CDI at VOLH**

- The problem was not known until May 2008 when a local media enquiry requesting details about the number of CDI cases at the hospital.
- This revealed 131 patients had the *C. difficile* toxin. Under policies this should have been declared as an outbreak (i.e. two or more linked cases) but owing to dysfunctional nature of Infection Control Team at VOLH, this didn’t happen.
- The Report concluded that despite the failure to implement the policy it was “surprising” that the problem remained undiscovered for so long.

**Death Certification**

- The report highlights the importance of accurate death certification in order to understand the health needs of population and so that family members know. In the period 1 Dec 2007 to 1 June 2008, 7 out of 28 death certificates failed to mention CDI as a cause. This was attributed to the junior level of doctors certifying the deaths.
- Since the CDI problem emerged at VOLH, death certification guidance has been updated to ensure that where possible, consultants are involved in the certification of hospital based deaths. The report goes on to recommend that where CDI is the cause of death, then the families should be given a full explanation of the infection's role.

**Patient Records**

- The report highlights the failings of an initial internal investigation by NHSGCC and an independent review by Professor Cairns Smith to adequately examine patient medical records. The Inquiry took it upon itself to examine the records itself. It concluded both that the level of care provided was unacceptable as
was the failure of the internal investigation to uncover this through examination of the records.

- The actual quality of record keeping was also deemed “poor” and that nursing is “not a memory game”. The culture that had developed was one that record keeping was not seen as a priority but rather that nurses in a small ward were aware of patient needs without the need for detailed record keeping.

- Furthermore, there was no record auditing carried out between January 2007 and May 2008. No “peer audits” had been done since 2003. This contravenes NMC Guidance which emphases the importance of auditing.

Management Culture

- The report acknowledges that in addition to individuals failings, there existed a culture of management which relied on being told of failings, rather a more proactive one which sought assurances about what was in fact happening. It refers to a specific example of a manager who had the responsibility of ensuring a high quality of care, cannot fulfil their duty simply by relying on being told when a problem arises.

- Prolonged uncertainty following NHS board reconfiguration led to a reduction in services which meant that anesthetic services were not sustainable and thus the future of the hospital.

Patients and families

- This group was key to having the public inquiry as they had campaigned for it to happen.

- Other than providing details of their experiences, the other main area of concern was there was a lack of good communication and candour (the latter being an issue currently being consulted on by Scottish Government separately).

Nursing and Medical Care

- The report states that individual nurses may have been doing their best, but attributed a lack of training, work pressures, inadequate support and poor leadership to their failings. The report states the “message to be conveyed…is one of the absolute importance of good quality nursing care”.

- Singled out were not just the delays of up to 24 hours from a sample being taken to a lab analysis being available, but the further delay in providing treatments once the results were known.

- There was a lack of middle grade medical staff available with too much reliance on junior doctors, combined with consultants that were over stretched.
• Antibiotic prescribing, both failure to prescribe and prescribing unnecessarily, highlighted poor practice in this area.

Infection prevention and control

• This is a major part of the report which includes personal failings by the senior nurse at VOLH responsible for this area. It highlights that the nurse in question failed to consider that the cases of CDI over the period might be the result of cross-infection.

• The report also singles out the failing of the Infection Control Doctor for VOLH. Despite her being unhappy with the level of professional line management, the Inquiry her attitude to the role was “wholly inappropriate and professionally unacceptable”. Namely, the doctor’s failure to attend the hospital during the period (she was based at the Royal Alexandria Hospital for which she was also responsible).

• The report also criticizes systemic failure to address the Doctor’s behavior which was described by a witness as “accepted”. There should have been adequate reporting structures which might have addressed these.

• Most nurses at VOLH had no formal training in infection prevention and control prior to June 2008. The was a “mixed” knowledge of the seriousness of CDI amongst nurses.

• A lack of isolation rooms meant that the policy of dealing with patients who could contaminate a ward with faeces was not adhered to, meaning patients were only isolated post-diagnosis, rather than sooner.

Prudent prescribing

• As mentioned above, there were issues over prescribing antibiotics. As long ago as 1999, the then Department of Health at the then Scottish Office issued guidance on its importance. A number of subsequent action plans and guides were also published including one in 2005 which highlighted the requirement of adequate supervision of junior doctors. Even as late as 2008 another action plan was launched reiterating what had been said back in 1999 and subsequently repeated.

• However, these messages had no impact on antibiotic prescribing at VOLH and the report concludes there was a mismatch between what should or shouldn’t have been prescribed and what was actually happening.

Recommendations
• The report makes 75 recommendations in total. Recommendations 13 to 35 inclusive relate specifically to nursing care.

• In the main the recommendations require that procedures good practice that should have been followed are in fact adhered to, including the need for record keeping of various aspects. In addition, there should be suitable audit processes to ensure that this is happening.

• There is also the specific recommendation that a nurse appointed Tissue Viability Nurse is adequately trained and supervised, as well as broader findings about the lack of staff training. This issue will be picked up by Scottish Government and may have further implications for HEIs.

• All the recommendations will be of interest to members and can be viewed here.