Scottish Parliament Region: Glasgow

Case 200502554: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Post-admission waiting times; medical care; record keeping; communication; complaints handling

Overview

The complainant (Ms C) raised a number of concerns about the care and treatment given to her late father (Mr A) at the Western Infirmary, Glasgow (the Hospital) from the day he was admitted on 10 August 2005, up to his death in the Hospital on 13 August 2005. Ms C also complained that the Hospital's communication with her during this period was poor and that her subsequent complaint to Greater Glasgow and Clyde NHS Board (the Board) was dealt with inadequately.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the late Mr A received inadequate care and poor treatment when he was a patient in the Hospital between 10 August 2005 and 13 August 2005 (*not upheld*);

(b) the Hospital's communication with Ms C was poor from 10 August 2005 to 13 August 2005 when Mr A was alive (*upheld*);

(c) no medical records were available for 12 August 2005 (*upheld*);

(d) the Board's reply to Ms C's complaint was unsatisfactory; she did not receive it in good time and they delayed in providing Ms C with a copy of Mr A's medical records or giving reasons why these were not sent (*upheld*); and

(e) nurses failed to attend a meeting between Ms C and Hospital staff on 27 March 2006 (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board

(i) advise her on the steps they have taken to avoid breakdowns in communication recurring;

(ii) advise her on the steps they have taken to avoid medical notes being

unavailable;

(iii) emphasise to staff the need to adhere to the terms of the NHS guidance for dealing with complaints and ensure that their records are updated when a patient dies; and

(iv) apologise to Ms C and explain the reason why the clinical nurse manager did not attend the meeting on 27 March 2006.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 6 June 2006 the Ombudsman received a complaint from Ms C concerning the care and treatment that her late father, Mr A, received during the time he was a patient at the Western Infirmary, Glasgow (the Hospital), from his admission on 10 August 2005 up to his death on 13 August 2005. Ms C complained that, during this period, the care and treatment which Mr A received was inadequate and fell short of an acceptable standard. Ms C, who lived a considerable distance from the Hospital, also complained that, despite her telephone contacts with the Hospital from 10 August 2005 to 13 August 2005 during the period Mr A was alive, she was not informed at any time of the seriousness of Mr A's condition. Sadly, Mr A died on 13 August 2005 and, thereafter, Ms C complained to the Hospital but she was dissatisfied with the way Greater Glasgow and Clyde NHS Board (the Board) dealt with her complaint.

2. The complaints from Ms C which I have investigated are that:

(a) the late Mr A received inadequate care and poor treatment when he was a patient in the Hospital between 10 August 2005 and 13 August 2005;

(b) the Hospital's communication with Ms C was poor from 10 August 2005 to 13 August 2005 when Mr A was alive;

(c) no medical records were available for 12 August 2005;

(d) the Board's reply to Ms C's complaint was unsatisfactory; she did not receive it in good time and they delayed in providing Ms C with a copy of Mr A's medical records or giving reasons why these were not sent;

(e) nurses failed to attend a meeting between Ms C and Hospital staff on 27 March 2006.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Ms C and the Board. I have had sight of the Board's complaint file and Mr A's medical records. Advice was also obtained from one of the Ombudsman's professional medical adviser (the Adviser) who reviewed all relevant documentation and medical records.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the

abbreviations used in this report is contained in Annex 1. A glossary of the medical terms used in the report can be found in Annex 2. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) The late Mr A received inadequate care and poor treatment when he was a patient in the Hospital between 10 August 2005 and 13 August 2005

5. According to Ms C, Mr A told her, during a telephone discussion on 10 August 2005, that he had waited six and a half hours to be admitted to a ward and during that period he had not been seen by a doctor. Ms C complained that Mr A had to wait an excessive time for admission to a bed and, thereafter, he was not seen by medical staff (doctors) for a period of 32 hours.

6. In their response letter to Ms C's complaint, dated 5 January 2006, the Board linked these issues together and stated that Mr A was admitted by the Medical Receiving Consultant (Consultant 1) to a Medical Receiving Unit (the Unit) on 10 August 2005 and diagnosed with a chest infection. The Board stated: '[Mr A] was commenced on oral antibiotics in addition to vitamins, because of his background of high alcohol intake'. According to Mr A's nursing documents, Mr A's stay in the Unit from admission until his transfer to a medical ward (the Ward) 'was largely uneventful'. Mr A 'was eating and drinking a small amount, had regular painkillers for rib pain and was alert and orientated. His temperature, blood pressure etc were all within normal limits and the score for assessing alcohol withdrawal was low, so he required only minimal sedation.'

7. Thereafter, at 18:30 on 11 August 2005, Mr A was transferred to the Ward under the care of a Medical Consultant (Consultant 2). Consultant 2 noted that 'at this point your father was stable but he had grossly abnormal liver function tests in keeping with his history of alcohol intake. At the time of admission to the Ward there were features suggestive of alcohol withdrawal'. Within a few minutes Mr A became 'cyanosed and sweaty'. A junior doctor attended Mr A and carried out an electro-cardiogram which was reported as normal. Thereafter, oxygen therapy commenced and Mr A was monitored. Nursing notes recorded that Mr A had an uneventful night. It is recorded that, the following morning, Mr A was well enough to have a bath and to be sitting out of bed for long periods and that '[Mr A] remained stable throughout the day and all of his observations were within normal limits'.

8. During that night (into the early hours of 13 August 2005), nursing staff noted that Mr A was agitated but that he settled and recordings by the night

staff at 07:00 were within normal limits. However, Mr A had a further deterioration around 09:00 on the morning of 13 August 2005. Consultant 2 saw Mr A at 09:30 when he was unwell and it was recorded that:

> '[Mr A] was cold, clammy and his oxygen saturation was low, which was in keeping with poor cardiac output. [Consultant 2] diagnosed septic shock and recommended that [Mr A] should be given intravenous antibiotics and fluids.'

9. According to the nursing records, it was clear at that time that Mr A's prognosis was very poor. Unfortunately, Mr A deteriorated further and died during the evening of 13 August 2005. Consultant 2 noted that Mr A 'suffered from severe alcohol related liver disease and developed septicaemia due to a chest infection. The outlook in such patients is very poor and, unfortunately, in [Mr A]'s case he did not survive'.

10. The Adviser considered the care and treatment Mr A received at the Hospital. He noted that Mr A, aged 59, had been under the care of the Board on several occasions prior to his hospital admission on 10 August 2005. Previous investigations had shown normal cardiac function but severe chronic obstructive airways disease with bullous emphysema.

11. The Adviser stated:

> 'Mr A was admitted to the Hospital on 10 August 2005 following a fall and complaining of pain in the region of the right ribs. He was diagnosed as having a chest infection, treated with antibiotics and admitted. He was found to be undernourished as a result of excessive alcohol use and transferred to [the Ward] at 18:30 on the evening of his admission. On 11 August 2005 at 16:30, Mr A had developed alcohol withdrawal symptoms, with agitation and hallucinations which were appropriately treated with diazepam. Shortly afterwards he became cyanosed, when his arterial oxygen saturation fell to 85% (normal is 98%). Mr A responded to treatment and remained stable until around 09:00 on 13 August 2005 when he became acutely unwell with severe shock (very low blood pressure) and oxygen saturation levels of 60%. He responded partially to standard intravenous volume expansion and antibiotics but sadly died at 17:10.'

12. The Adviser considered the waiting times Mr A encountered and noted that Mr A arrived at the Hospital's Accident and Emergency Department (A&E)

at 14:30 on 10 August 2005, he was triaged at 14:35 and seen by the A&E doctor at 15:15, 'a waiting time of only 45 minutes'. The Adviser noted that this did not correspond with Mr A's allegation to Ms C that he did not see a doctor for six and a half hours (see paragraph 5).

13. Thereafter, in accordance with normal clinical practice, Mr A was referred to the medical team on emergency intake. The Adviser noted that the medical team confirmed Mr A's diagnosis, started treatment and arranged his admission to the Unit at 20:30. During the intervening period, Mr A was taken to the x-ray department for a chest x-ray. According to the Adviser:

> 'Mr A appears to have arrived at the Unit at 00:19. If so, the waiting time for an available bed was in the region of four hours. Although treatment had commenced as indicated, a four hour delay in obtaining an available bed, while certainly undesirable, would be similar to that experienced at most inner-city NHS institutions that have to cater for highly variable demands within a fixed resource.'

14. The Adviser linked his considerations at paragraph 13 to Ms C's allegation that Mr A had not received medical care during a 32 hour period. The Adviser stated:

> 'There is an expectation that every in-patient in the NHS should normally be seen daily, although in some institutions staffing levels do not permit this frequency of routine visits during holiday periods and some weekends. However, more frequent medical assessment is always available in the event of clinical need, as assessed by medical or nursing staff. There are no medical notes during the 32 hour period. However, nursing observations indicate that Mr A's condition was stable during this period and there appears to have been no specific indication for urgent medical assessment.'

15. In the Adviser's opinion, Mr A suffered from chronic obstructive pulmonary disease (COPD). He added that this condition is well recognised as causing a very significantly increased risk of chest infection and pneumonia and he stated:

> 'The recorded clinical evidence is entirely compatible with a diagnosis of pulmonary infection. The diagnosis appears to have been supported by chest x-ray. The mode of death and the recurrent episodes of oxygen de-saturation are compatible with septic shock arising from pneumonic chest infection.'

16. The Adviser concluded 'in my opinion the diagnosis and management of Mr A's illness was appropriate and compatible with standard practice'.

17. Ms C alleged (see paragraph 5) that Mr A told her he had waited six and a half hours to be admitted to a ward and, during this time, had not been seen by a doctor. The Adviser stated:

> 'Confusion is frequently present at this stage of alcohol withdrawal. Hallucinations were also subsequently recorded. It is therefore quite likely that Mr A was confused about the time he was first seen by the medical staff.'

18. In the Adviser's view, 'the nursing record indicated that Mr A had been assessed by a doctor at 20:30 on the evening of 11 August 2005. He appears to have been seen by a junior house officer during the early hours (02:00) of 12 August 2005, who then discussed his management with a senior house officer. There is, therefore, evidence that Mr A was not reviewed by a doctor after 02:00 on 12 August 2005 for a period of 32 hours'. Thereafter, Mr A was next assessed by Consultant 2 at 09.30 on 13 August 2005 and subsequently received further treatment by the house officer at 17:10 on that day.

(a) Conclusion

19. In Ms C's view, Mr A had to wait an excessive time for admission to a bed and, furthermore, he was not seen by medical staff for a period of 32 hours. This led Ms C to believe that Mr A had not received adequate care or treatment at the Hospital.

20. I have considered carefully the Adviser's review of the timing of events from when Mr A was admitted to the Hospital, until he was moved into the Ward. Although the waiting time for an in-patient bed was undesirable, it was not unusual (see paragraph 13). I have also taken account of the Adviser's opinion that, due to Mr A's medical condition, he may have been confused about the time(s) he was seen by medical staff.

21. There is an expectation that every NHS in-patient should normally be seen daily to be medically assessed but, as explained (see paragraph 14), this does not always happen. I have considered very carefully the Adviser's comments in this regard and the recorded nursing observations, which indicated that Mr A's condition was stable during the 32 hour period (this included 12 August 2005). The fact that Mr A was not medically assessed during this period did not equate

as a failure by the Hospital to provide Mr A with reasonable treatment and care overall. Accordingly, having taken all these factors into account, I am not upholding this complaint.

(a) Recommendation

22. The Ombudsman has no recommendations to make.

(b) The Hospital's communication with Ms C was poor from 10 August 2005 to 13 August 2005 when Mr A was alive

23. During the period from 10 August to 13 August 2005, when Mr A was a patient at the Hospital, Ms C, who lived a considerable distance from the Hospital (see paragraph 1), also complained that despite her constant telephone contacts she felt it 'very strange' that the nurses she spoke to did not advise her about how ill Mr A was. Furthermore, Ms C told me that when she telephoned the Hospital on 13 August 2005, the day Mr A died, 'they said he wasn't very well but don't worry'. According to Ms C, had she been told how ill Mr A was, she would have travelled to the Hospital to see him and 'I could have been there with him at the end'.

24. Ms C (along with her sister and two family friends) attended a meeting at the Hospital on 27 March 2006 with Consultant 1 and Consultant 2 and the Patient Liaison Manager. Within the file note of this meeting, Consultant 2 accepted that communication with the family could have been better and 'apologised that staff had not conveyed to the family the seriousness of [Mr A]'s condition and that the family had been given the impression that [Mr A]'s illness was trivial, as this was not the case. [Consultant 2] advised that medical staff would assume that the family had been informed by nursing staff of [Mr A]'s condition and apologised that this breakdown in communication had such a serious impact on the family'.

25. In his review of the nursing records, the Adviser stated that there was a recorded discussion with Ms C at 22:00 on 11 August 2005. This recorded entry indicated that Ms C was made 'aware of patient's condition throughout the day, and at present'. In another telephone call with Ms C at 16:00 on 12 August 2005, it was recorded 'aware of father's poor condition'. A further telephone call from Ms C was recorded in the early hours (05:25) of 13 August 2005 by the night staff. In the Adviser's view, due to the timing of this telephone call, 'it seems reasonable to assume that her father's condition was discussed'. The recorded entry detailed that a request was made by Ms C to the nursing staff

that information on her father's condition should be passed to her in the first instance. Thereafter, there is no record of communication with the family by the medical staff until after Mr A's death.

26. In the Adviser's view, it was apparent from Ms C' correspondence that she and her family were unaware of the severity of Mr A's illness. The Adviser stated:

> 'There is no data in the record that would allow me to form an objective opinion on the quality of any information transmitted to the family, or for me to assess the degree of understanding of any information received. However, it seems clear from the notes of the [27 March 2006] meeting that either Ms C was given contradictory information ('Mr A did not have a medical problem'), or that an attempted explanation was not presented in a way that could be easily understood by a lay person. Moreover it would be reasonable to expect that the family should be informed of Mr A's sudden episode of de-saturation on 11 August 2005 (see paragraph 11). I note from the Board's record of the meeting on 27 March 2006 that the Board has accepted that communications were poor and has apologised to Ms C for this and discussed this failing with the staff concerned to prevent future recurrence.'

27. The Adviser concluded that it would appear from the nursing notes that discussion with the family of Mr A's condition did take place but, since the family apparently remained unaware of the severity of Mr A's condition, this may not have been in a manner which was easy to understand.

(b) Conclusion

28. Ms C felt that the Hospital's communication with her was poor during the period Mr A was alive. When the Board met with Ms C they accepted this and apologised to Ms C.

29. I share the Adviser's view that there was not enough recorded information to form an objective opinion on the quality of what was discussed between Ms C and the nursing staff. While the recorded telephone call from Ms C (in the early hours of 13 August 2005) shows she was concerned about Mr A, it is clear that Ms C was unaware of the severity of Mr A's condition, particularly following her telephone call in the early hours of 13 August 2005. Had she been aware of this, she has advised that she would have travelled to be with him at the end of life stage. It remains that Ms C was unaware of the severity of Mr A's medical

condition prior to his death. Accordingly, I uphold this complaint.

(b) Recommendation

30. I am pleased that the Board have acknowledged this, apologised to Ms C and taken steps to prevent future recurrence. The Ombudsman recommends that the Board advise her on the steps they have taken to avoid breakdowns in communication recurring.

(c) No medical records were available for 12 August 2005

31. On 15 February 2006 Ms C applied for a copy of Mr A's medical records. When these were received, no medical records were available for Friday 12 August 2005, the day prior to Mr A's death.

32. Within the Board's letter to Ms C dated 5 January 2006, Consultant 2 had reviewed Mr A's case notes and recalled that the case notes had not arrived at the Ward on 11 August 2005 and 'this led to some record-keeping difficulties' but that 'the evidence from the available records indicated that all that could be done was done for [Mr A] in a timely fashion and that the outcome was unavoidable'.

33. The Adviser considered that the standard of the contemporaneous medical notes was good on admission but generally poor thereafter. In particular, there is a complete absence of medical records from 12 August 2005 until 09:30 on 13 August 2005, just prior to Mr A's death. In the Adviser's view, this was not acceptable.

34. The Adviser stated 'The standard of nursing notes is of an acceptable quality and Mr A's clinical progress is recorded in the nursing record (see paragraph 18).

35. In the Adviser's view, the absence of medical records from 12 August 2005 is not acceptable (see paragraph 33). The Board indicated that the notes appear to have been mislaid in transit from the Unit to the Ward. However, the Adviser stated that normal standards of practice would be to record temporary notes contemporaneously for subsequent filing when the original folder becomes available. The Adviser noted that the Board recognised this failure and had apologised appropriately to Ms C.

36. The Adviser concluded that 'the quality of the medical record falls

significantly below a standard to be expected'.

(c) Conclusion

37. Within the review of Mr A's medical records it is clear that no medical records were available for 12 August 2005, the day before Mr A died. Furthermore, there were no medical notes for a 32 hour period which included 12 August 2005 (see paragraph 14). I share the Adviser's view that this is not acceptable. Accordingly, I uphold this complaint.

(c) Recommendation

38. I am pleased that the Board acknowledged this failure and apologised to Ms C, however, the Ombudsman requests the Board to advise her on the steps they have taken to avoid such events recurring in the future.

(d) The Board's reply to Ms C's complaint was unsatisfactory; she did not receive it in good time and they delayed in providing Ms C with a copy of Mr A's medical records or giving reasons why these were not sent

39. Ms C complained to the Board on 26 October 2005 about the circumstances of the death of Mr A. Within her letter, Ms C also requested a copy of Mr A's medical records. Ms C's complaint was acknowledged on 31 October 2005 and replied to on 5 January 2006. However, Mr A's medical records were not enclosed with this reply.

40. On 6 January 2006, the Board unreservedly apologised to Ms C for the delay in forwarding the application pack for her to complete in order to formally access Mr A's case notes/medical records. They explained that, in error, they had sent the application pack to the late Mr A's address and were sorry 'for any distress this caused you and your family'.

41. Thereafter, on 15 February 2006, Ms C made a successful formal request for a copy of Mr A's medical records, which were sent to her on 17 February 2006.

42. Ms C remained dissatisfied with the Board's response to her complaint (see paragraph 32) and a meeting was arranged and held at the Hospital on 27 March 2006 (see paragraph 24).

43. On 21 April 2006 the Board emailed Ms C and advised her that the draft of the filenote of the meeting was being sent for approval to Consultant 1 and

Consultant 2 who attended the meeting and would be sent to her as soon as it was approved. Thereafter, a copy of the meeting record was sent to Ms C on 16 May 2006. The Board apologised for the delay in sending the meeting file note and explained that the delay was due to a number of factors, including a period of leave and unexpected sick leave. Ms C was dissatisfied with the outcome of the meeting and the delay in receiving a copy of the meeting file note.

(d) Conclusion

44. I have read carefully the relevant paperwork and I have not seen any evidence to support Ms C's belief that the Board had not dealt with her complaint satisfactorily but I acknowledge that Ms C was dissatisfied with the substance of the replies she received. The reason given to Ms C by the Board for the delay in Ms C receiving a copy of the meeting file note is understandable. However, it was clearly unfortunate that the Board sent the application pack to the late Mr A's address, delaying the process for Ms C obtaining her late father's medical records. I have noted that the Board have explained the reason for this and apologised unreservedly, however, notwithstanding this, I can see no good reason why it took the Board from October 2005 to January 2006 to reply to Ms C's complaint. During this time, Ms C was not advised of the reasons for the delay or the fact that she could approach the Ombudsman's office under the NHS complaints procedure. Accordingly, in all the circumstances, I uphold the complaint.

(d) Recommendation

45. The Ombudsman recommends that the Board emphasise to staff the need to adhere to the terms of the NHS guidance for dealing with complaints and ensure that their records are updated when a patient dies.

(e) Nurses failed to attend a meeting between Ms C and Hospital staff on 27 March 2006

46. On 23 January 2006 Ms C made a telephone request to the Board for senior nursing staff to be present at the meeting on 27 March 2006. The Board confirmed that Ms C was advised that, although senior medical staff would usually be present, 'normally it is the clinical nurse manager, or occasionally a ward sister (who) would attend the meeting'.

47. In the event, the attendees were Consultant 1 and Consultant 2, who attended to Mr A, and the Patient Liaison Officer (see paragraph 43).

48. In my review of the relevant paperwork (see paragraph 3), I have not seen any reason given by the Board why the clinical nurse manager was not present.

(e) Conclusion

49. It is normal practice that general nursing staff do not attend meetings such as the meeting held on 27 March 2006. However, according to the Board on 23 January 2006, they advised Ms C that the attendance of a clinical nurse manager was a probability but the clinical nurse manager did not attend the meeting. It is reasonable to understand that in this regard Ms C's expectations were raised but not met. Accordingly, I uphold the complaint.

(e) Recommendation

50. The Ombudsman recommends that the Board apologise to Ms C for this failure and explain the reason why the clinical nurse manager did not attend the meeting held on 27 March 2006.

51. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board to notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mr A	The complainant's late father
The Hospital	The Western Infirmary, Glasgow
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	The Ombudsman's medical adviser
Consultant 1	The medical receiving consultant who assessed Mr A
The Unit	The medical receiving unit where Mr A was originally admitted
The Ward	The ward Mr A was transferred to from the Unit
Consultant 2	The consultant physician who cared for Mr A in the Ward he was transferred to
A&E	Accident and Emergency Department

Annex 2

Glossary of terms

Arterial oxygen saturation	Low levels of oxygen in the blood
Bullous emphysema	Chronic lung condition, associated with smoking, that predisposes to recurrent chest infections
Chronic obstructive pulmonary disease/ pulmonary infection	Lung disease
Cyanosed	Blue, due to a lack of oxygen in the tissues
Diazepam	A relaxant used for its sedative and anxiety relieving effects
Electro-cardiogram	A recording of the electrical activity of the heart
Hallucination	A false perception occurring in the absence of an appropriate sensory stimulus – for example hearing something that is not there
Intravenous volume expansion	Is the infusion of fluids into a vein in order to raise the blood pressure. Although it is used to combat renal failure, in this complaint it was appropriately used to combat the low blood pressure of septic shock
Oxygen de-saturation	An insufficient amount of oxygen in the bloodstream

Oxygen therapy	Benefits patients by increasing the supply of oxygen
Pneumonic chest infection	Pneumonia
Septic shock	A serious condition that occurs when an overwhelming infection leads to low blood pressure and low blood flow and many organs malfunction
Septicemia	A life-threatening infection that quickly worsens
Triaged	Medically assessed