Scottish Parliament Region: North East Scotland

Case 201300003: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; Accident and Emergency, clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns about her husband (Mr C)'s care and treatment when he was admitted to the Emergency Department of Aberdeen Royal Infirmary on 19 November 2012. She said that despite being assessed at 09:20 for transfer to the Acute Medical Assessment Unit he was not transferred there until 20:18. In the meantime, he had been lying on a trolley. Once transferred, Mrs C said that there was a delay in him seeing a doctor and that his condition continued to decline. Regrettably, Mr C died at noon the next day and Mrs C further complained about Mr C's appearance when she arrived in hospital after his death.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the care and treatment given to Mr C on his admission to hospital in November 2012 were unreasonable (*upheld*);

(b) Grampian NHS Board (the Board) unreasonably asked Mrs C to sign Mr C's death certificate before she had been given a chance to see him (*upheld*); and

(c) the Board unreasonably failed to properly lay out Mr C before Mrs C saw him (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Mrs C for the fact that Mr C was not examined further by the medical team whilst he was still in the Emergency Department;	26 March 2014
(ii) provide a plan detailing the changes they have made to prevent such a recurrence (that is, missing target times and a failure to assess and treat in a	26 March 2014

	timely manner);	
(iii)	confirm the learning gained as a consequence of this complaint and provide details of how this has been passed to and considered by relevant staff;	26 March 2014
(iv)	emphasise to all staff in the Emergency Department the importance of keeping accurate and timely clinical records;	26 March 2014
(v)	advise me of the steps they have taken to ensure that staff are aware of their responsibilities in similar circumstances and to be alert to the sensitivities of family members;	26 March 2014
(vi)	take steps to ensure that this does not happen again and emphasise to all appropriate staff the necessity of preserving a patient's dignity in death; and	26 March 2014
(vii)	be sensitive to the needs of close family members in such matters and advise appropriate staff accordingly.	26 March 2014

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

Main Investigation Report

Introduction

1. On 31 October 2012, Mr C had heart surgery. He was discharged from hospital on 7 November 2012, however, he was readmitted as an emergency on 19 November 2012 suffering stomach pains. Mr C arrived at the Emergency Department at 09:20 and was assessed at 09:38. Arrangements were made to admit him to the Acute Medical Assessment Unit (AMAU) at 10:30 but Grampian NHS Board (the Board) said this proved not to be possible due to the large number of other patients who also required to be transferred there.

2. Mr C remained in the Emergency Department until 20:18, when he was transferred to AMAU. (Meanwhile, the Board said, at 15:00, the trolley on which he was lying was exchanged for a bed.) Mr C was subsequently seen by a doctor at 21:50 and again at 23:10. After that, the Board said he had a settled night until he became unwell at about 06:00 on the morning of 20 November 2012. Mr C was later transferred to the high dependency unit within AMAU but his condition continued to decline and he died at noon. His death certificate recorded that his cause of death was: '1) Ischaemic bowel, Atrial fibrillation, and 2) Severe left ventricular dysfunction. Aortic valve replacement.'

3. Mrs C complained about Mr C's care and treatment while he was in hospital: that he remained in the Emergency Department for 11 hours, spending much of that time on a trolley; there was a long delay before he was transferred to AMAU; and, once admitted there, it took about an hour and a half before he was seen by a doctor. Mrs C believed that these long waits prejudiced Mr C's treatment and his likelihood of survival. She further believed that his ischaemic bowel should have been considered and treated earlier. Mrs C was also most distressed about Mr C's appearance when she arrived to see him after his death.

4. The complaints from Mrs C which I have investigated are that:

(a) the care and treatment given to Mr C on his admission to hospital in November 2012 were unreasonable;

(b) the Board unreasonably asked Mrs C to sign Mr C's death certificate before she had been given a chance to see him; and

(c) the Board unreasonably failed to properly lay out Mr C before Mrs C saw him.

Investigation

5. The investigation of this complaint involved obtaining and reading all the relevant documentation, including all the complaints correspondence and Mr C's relevant clinical records. Independent advice was also obtained from a nursing adviser (Adviser 1) and from a consultant in emergency medicine (Adviser 2).

6. While this report does not include every detail investigated, I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) The care and treatment given to Mr C on his admission to hospital in November 2012 were unreasonable

The complaint

7. Mrs C said that after Mr C was taken into the Emergency Department on the morning of 19 November 2012, he was left on a trolley for 11 hours. She said that he was only transferred to a ward in the evening but that it was a while before he saw a doctor. She maintained that it was known he had recently had heart surgery, from which he was recovering well, but the delay in treating him contributed to his death on 20 November 2012.

The Board's response

8. As Mrs C was distressed about this, and other circumstances surrounding Mr C's death, she made a complaint to the Board on 18 January 2013. She received their reply dated 13 March 2013. The Board said that Mr C had arrived in the Emergency Department at about 09:20 and was assessed shortly afterwards (09:38). Then, after a period of assessment and treatment, Emergency Department doctors arranged (at 10:30) for him to be transferred to AMAU. Unfortunately, because of the large number of patients similarly requiring admission there, it became clear that there would be a period of delay. The Board said that Mr C was monitored and frequently assessed in a cubicle easily visible to staff in the Emergency Department. While Mr C had initially been lying on a trolley, the Board added that for his comfort, he was transferred to a bed in the cubicle at approximately 15:00. He was transferred to AMAU at 20:15 when he was noted not to be suffering pain but that his heart rate was fast and he was feeling breathless. He was seen again about an hour later. The Board advised Mrs C that Mr C had had a settled night but at about 06:00 the next day he became more unwell and showed signs of heart failure. This was confirmed by a heart scan and treatment began in an attempt to improve

the functioning of his heart. Mr C was moved to the high dependency area but, nevertheless, continued to decline and Mrs C was telephoned to advise her to attend the ward. The Board said that, unfortunately, Mr C's deterioration was too rapid and he died shortly before Mrs C arrived. The Board apologised that Mr C had had a prolonged wait in the Emergency Department and for the delay in him being seen by a doctor in AMAU. They further apologised for the added distress caused by Mrs C seeing Mr C shortly after he had died. A meeting was also arranged between Mrs C and staff.

9. Mrs C, accompanied by two friends, attended the meeting on 25 March 2013. The Board's Chief Executive, a consultant in emergency medicine (the Consultant) and the Board's Feedback Adviser were present. Mrs C detailed her concerns about Mr C's treatment and the Consultant explained that he had been asked to investigate her complaint on behalf of the Board. He admitted that there had been many things which could have been done better and accepted that changes required to be made. He gave Mrs C his assurances that things would change, however, he was of the view that even if Mr C had been on a ward, his outcome would not have changed. The meeting concluded with the Chief Executive saying that he was 'very, very sorry for what had happened to [Mr C]' but that if Mrs C wished to pursue her complaint further, it was open to her to complain to this office. This discussion was later confirmed by letter of 28 March 2013.

Advice received

10. Both Adviser 1 and Adviser 2 were asked to review Mr C's clinical notes. Adviser 1 said that the Scottish Government had national targets in place (Scottish Government – Accident and Emergency targets) to the effect that no patient should be in Accident and Emergency for more than four hours. Adviser 1 said that the target was in place to ensure that patients received optimal care in a ward situation where staff were best placed to provide this. She added that it was unacceptable for any patient to be on a trolley or in a cubicle for the length of time experienced by Mr C and that although the Board said that he had been moved to a bed at 15:00, there was no record of this having happened in the notes. Similarly, although the Board said that Mr C was seen by a doctor at 09:38, she said that she could find no record of any review by medical staff during Mr C's time in the Emergency Department until 10:30. However, she noted that nursing staff had taken a record of Mr C's vital signs (blood pressure, heart rate, oxygen saturation) and that these were outwith the normal range. Adviser 1 went on to say that the notes recorded that a box had

been ticked that 'a doctor/hospital at night team' was called but there was no record of a review until Mr C was admitted to AMAU at 20:15.

11. Adviser 2 confirmed Mr C's arrival time in the Emergency Department as 09:22 and that following clinical assessment, he said that Mr C was felt to have two problems; the first was that he was vomiting blood, which may have been due to the aspirin he was taking or damage to his gullet as a result of repeated vomiting; secondly, as Mr C was vomiting, he had not been able to take his medication, which resulted in a fast heart rate. Adviser 2 said that Mr C was given medication to control the vomiting and control his heart rate. He was then referred to the medical team for admission to a ward at 10:30.

12. Adviser 2 said that Mr C did not arrive in AMAU until 20:18. Thereafter, he was seen by a doctor at 21:51 and reviewed at 22:23. At approximately 06:00 on 20 November 2012, Mr C became unwell and was transferred to the high dependency unit. However, Adviser 2 said that he continued to decline and subsequently died. He added that it was felt that the cause of Mr C's death was ischaemic bowel (inadequate blood flow to small and large intestines) related to atrial fibrillation (a heart condition causing a fast and erratic heart beat) in a man with a very diseased heart with limited pumping capacity.

13. While Adviser 2 was of the opinion that Mr C's initial clinical assessment appeared to be of a reasonable standard, the fact that Mr C remained in the Emergency Department for eleven hours was not reasonable. In accordance with national targets (see paragraph 10), he should have been transferred much earlier. Additionally, Adviser 2 said that waiting in the Emergency Department for admission to a ward should not have been a barrier to Mr C being assessed further. He was of the opinion that Mr C should have been medically re-examined by the admitting medical team within four hours of his referral. However, Adviser 2 said that the assessments Mr C received in both the Emergency Department and later in the AMAU, appeared to him to be appropriate. He went on to say that the diagnosis of ischaemic bowel was notoriously difficult, so it was frequently missed in its early stages. Adviser 2 said that even if Mr C had been seen earlier by the medical team, it would not have necessarily meant that the true nature of his underlying illness would have been revealed.

(a) Conclusion

14. The advice received and accepted has outlined a number of problems subsequent to Mr C's admission to hospital. After an initial assessment in the Emergency Department (see paragraph 8), he remained on a trolley for an unacceptable period of time, whether or not he was transferred to a bed later. Then he failed to receive further treatment or to be re-examined. As Adviser 2 pointed out, the fact that there was a delay in transferring Mr C to AMAU should not have prevented him receiving further treatment. In the circumstances, I uphold the complaint and I note that the Board have already made a sincere apology to Mrs C for what happened to Mr C (see paragraph 9). However, I recommend that the Board should also apologise to her for the fact that he was not examined further by the medical team whilst he was still in the Emergency Department. As the Board have already assured Mrs C (at their meeting on 25 March 2013) that improvements would be made, they should provide a plan detailing the changes they have made or are making to prevent such a recurrence (that is, missing target times and a failure to assess and treat in a timely manner). Further, they should confirm the learning gained as a consequence of this complaint and provide details of how this has been passed to and considered by relevant staff. Finally, given Adviser 1's comments about Mr C's notes (see paragraph 10), the Board should emphasise to all staff in the Emergency Department the importance of keeping detailed and timely clinical records.

(a) Recommendations

15. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for the fact that Mr C was not examined further by the medical team whilst he was still in the Emergency Department;	26 March 2014
(ii) provide a plan detailing the changes they have made to prevent such a recurrence (that is, missing target times and a failure to assess and treat in a timely manner);	26 March 2014
(iii) confirm the learning gained as a consequence of this complaint and provide details of how this has been passed to and considered by relevant staff; and	26 March 2014
(iv) emphasise to all staff in the Emergency Department the importance of keeping accurate	26 March 2014

and timely clinical records.

(b) The Board unreasonably asked Mrs C to sign Mr C's death certificate before she had been given a chance to see him

The complaint

16. Mrs C, who herself has health problems, remained at home when Mr C was taken into hospital which was sixty miles away. She said that Mr C had had his mobile telephone with him and, initially, he called her every hour to tell her what was happening. She knew when he had been admitted to AMAU and said that from his voice she knew he had been given medication. She said on the morning of 20 November 2012 she received a call to tell her to be there 'now'. She said that, given the distance involved, this was impossible. However, when she eventually got to the hospital, she was told that Mr C had already died. Mrs C said that a doctor then thrust the death certificate in her face, saying that she had to sign it then.

The Board's response

17. When Mrs C met with representatives of the Board on 25 March 2013 (see paragraph 9), the Chief Executive acknowledged that things had gone badly wrong and that the incident with the death certificate was extremely insensitive and should not have happened. He apologised for this.

Advice received

18. Adviser 1 commented about the circumstances of Mrs C being called to hospital. By way of background, she said that nursing staff should assess critically ill patients and if there was a marked deterioration in a patient's condition, the importance of contacting relatives should be considered. She said that this would allow relatives to be fully informed and, in the situation where a patient was near the end of life, allow some quiet, private time. Adviser 1 commented that it could be very difficult to assess when to make contact, however, in Mr C's case, nursing staff were aware of how unwell he was from the early morning of 20 November 2012 and that he continued to deteriorate. She pointed out that there was evidence in the notes that Mr C's vital signs were well outwith the normal limits and that he needed regular review by medical staff. In the circumstances, Adviser 1 was critical of the fact that nursing staff did not make this clear to Mrs C when they called her at 10:30. She said that the appropriate note merely recorded that, 'wife informed that [Mr C] transferred to Medical HDU'. Adviser 1 added that the very fact that Mr C was transferred to the high dependency unit should have indicated to nursing

staff that the family should visit. Adviser 1 confirmed that the Nursing and Midwifery Council code made it very clear that registered nurses were 'personally accountable for actions and omissions in [their] practice and must always be able to justify [their] decisions'.

19. With regard to the matter of the death certificate, Adviser 2 confirmed that it would be normal practice for Mrs C to have been allowed to see Mr C to say goodbye and allow the start of the grieving process before having to sign the death certificate. In his view, it would have been inappropriate and distressing to ask Mrs C to sign the death certificate prior to seeing Mr C's body.

(b) Conclusion

20. It does not appear to have been disputed that Mrs C was not called to the ward as timeously as she could have been, nor that she was presented with a death certificate for signing in advance of her having the opportunity to see Mr C. Neither of these things should have happened and indicate a failure in service, in particular, a fundamental lack of sensitivity. I uphold the complaint. However, I have noted that the Board's Chief Executive has already acknowledged this and made a personal apology. Therefore, I do not consider that he should be required to do so again but the Board should advise me of the steps they have taken to ensure that staff are aware of their responsibilities in similar circumstances and to be alert to the sensitivities of family members.

(b) Recommendation

21. I recommend that the Board:	*Completion date*
(i) advise me of the steps they have taken to ensure that staff are aware of their responsibilities in similar circumstances and to be alert to the sensitivities of family members.	26 March 2014

(c) The Board unreasonably failed to properly lay out Mr C before Mrs C saw him

The complaint

22. Mrs C said that when she saw Mr C in hospital after his death, he looked as if he had died in extreme pain. She said that she has not been able to remove the image from her mind.

The Board's response

23. In both the letter to Mrs C of 13 March 2013 and at the subsequent meeting (see paragraph 9), the Board's Chief Executive apologised to Mrs C for the distress caused to her when she arrived and saw Mr C shortly after he died. He said that staff in AMAU very much regretted that they had not met her and explained what had happened to Mr C before she saw him.

Advice received

24. Adviser 1 said that if a patient died before a relative arrived at hospital, nursing staff should be prepared to meet them and take them to see their loved one. She made the point that it was considered to be a key role of the registered nurse to prepare relatives for this by ensuring that the patient was in a dignified position. She said she would have expected staff to have checked that Mr C was able to be seen on the ward following his death. However, she said that there was always the case that a relative could arrive without the knowledge of staff (although I noted that this was not the case, as Mrs C had already been presented with Mr C's death certificate).

(c) Conclusion

25. The circumstances of this complaint do not appear to have been in doubt and I uphold the complaint. The Board have already made a sincere apology to Mrs C for her undoubted distress and so I do not require them to do so again. Nevertheless, they must take steps to ensure that this does not happen again and emphasise to all appropriate staff the necessity of preserving a patient's dignity in death, and to be sensitive to the needs of close family members in such matters.

(c) Recommendations

26. I recommend that the Board:	*Completion date*
(i) take steps to ensure that this does not happen again and emphasise to all appropriate staff the necessity of preserving a patient's dignity in death; and	26 March 2014
(ii) be sensitive to the needs of close family members in such matters and advise appropriate staff accordingly.	26 March 2014

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

Annex 1

Explanation of abbreviations used

Mr C	the complainant's late husband
AMAU	the Acute Medical Assessment Unit
the Board	Grampian NHS Board
Mrs C	the complainant
Adviser 1	a nursing adviser
Adviser 2	a consultant in emergency medicine adviser
the Consultant	a hospital consultant in emergency medicine

Annex 2

Glossary of terms

Atrial fibrillation	a heart condition causing a fast and erratic heart beat
Ischaemic bowel	inadequate blood flow to small and large intestines