Scottish Parliament Region: Central Scotland

Case 200502688: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; Communication; Staff attitude; dignity/confidentiality

Overview

The complainant's father died in August 2004. She was concerned that his cancer had not been diagnosed during a hospital admission in April 2004. She also raised a number of concerns about the care provided during his stay in August 2004; that he had been left dirty, his fluid intake was not monitored and he was thirsty and his sanitary needs were not adequately dealt with. She was also aggrieved that he was told he had cancer in a public ward and without a member of his family present.

Specific complaints and conclusions

The complaints which have been investigated are:

(a) when Mr C was in hospital in April 2004 staff failed to diagnose his cancer *(not upheld)*;

(b) the nursing care provided to Mr C in August was inadequate *(not upheld)*;

(c) the doctor who informed Mr C and Ms C of his cancer did so in an inappropriate manner and in direct contravention of previously expressed wishes *(upheld)*.

Redress and recommendations

The Ombudsman recommends that:

(i) the Board apologise to Ms C and her family for the distress caused by the way in which the diagnosis was communicated to Mr C and subsequently to her. Given the training and support already provided to staff (see Annex 3), the Ombudsman is not recommending further action; and

(ii) the initial audits into the effectiveness of the new nursing documentation should be shared with this office.

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

Main Investigation Report

Introduction

1. On 4 January 2006 the Ombudsman received a complaint (dated 27 December 2005) from a woman referred to in this report as Ms C. Ms C's late father (Mr C) had been admitted to Monklands Hospital (the Hospital) on 12 April 2004 and was discharged on 14 April 2004. The clinical staff did not diagnose cancer. He was admitted again on 8 August 2004 and stayed there until his death on 25 August 2004. Ms C said that the nursing care received by her father was inadequate; that at various times her father was left dirty, his fluid intake was not monitored and he was often thirsty and that his sanitary needs were not adequately dealt with. On 16 August 2004 Mr C was informed by a doctor that he had bowel cancer with secondary cancer of the liver. No family member was present and he was in a public ward. She said staff had been asked not to give news to Mr C without a member of his family being present because he had hearing problems and was without a hearing aid. Ms C was told the news of her father's condition by telephone the same day.

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

(a) when Mr C was in Hospital in April 2004 clinical staff failed to diagnose his cancer;

(b) the nursing care provided to Mr C in August 2004 was inadequate; and

(c) the doctor who informed Mr C and Ms C of his cancer did so in an inappropriate manner and in direct contravention of previously expressed wishes.

Investigation

3. In investigating this complaint, I have reviewed the correspondence between Ms C and Lanarkshire NHS Board (the Board). I have seen all documents in the complaint file including notes and an action plan completed by ward staff. I have taken advice from a medical and a nursing adviser to the Ombudsman (Advisers 1 and 2). Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) When Mr C was in Hospital in April 2004 clinical staff failed to diagnose his cancer

4. Mr C, aged 82, was admitted to the Hospital on 12 April 2004. He was suffering from confusion, abnormal behaviour, was frequently passing urine and had pain on passing urine. Investigations revealed a high white blood cell count consistent with infection. Mr C was treated for a urinary tract infection (UTI) and discharged on 14 April 2004.

5. There were three main records of abdominal examination in the clinical notes. The referral letter from the general practitioner dated 12 April 2004 indicated significant liver enlargement on examination, the multidisciplinary emergency admission record showed minimal apparent enlargement and the consultant ward record showed none. Having reviewed the documentation, Adviser 1 has said that the 'balance of probability is that there was some degree of apparent liver enlargement but of a relatively minor degree'. Adviser 1 also observed that in his previous medical histories Mr C was consistently recorded as having chronic obstructive airways disease (COPD). Adviser 1 stated that:

> 'in this condition, the lungs are abnormally expanded which pushes the liver downwards. This will commonly result in the liver being palpable without the presence of liver enlargement'. Adviser 1 concluded that 'the presence of a palpable liver in COPD would have no ominous significance'.

6. Mr C did undergo liver function tests on 12 April 2004 and his alkaline phosphatase level was recorded at slightly over twice the normal level. Adviser 1 said that a bile duct obstruction could raise the level of this enzyme (and that such an obstruction could occur as a result of liver cancer), however, in the elderly a raised level was not uncommon and usually arose from an intestinal source. A much more sensitive indicator of liver bile duct obstruction was an enzyme known as GGT (gammaglutamyltranspeptidase). Adviser 1 said that Mr C's GGT level was 'unequivocally normal'.

7. Adviser 1 further stated:

> 'it seems clear from Mr C's symptoms, signs and rapid response to treatment that he did, indeed, have a urinary tract infection in April 04. There are no symptoms recorded to suggest the presence of liver problems at that time.'

(a) Conclusion

8. It is understandable that given Mr C's diagnosis of cancer in August 2004 and his rapid deterioration Ms C was concerned he could have been diagnosed earlier. Mr C's liver was of concern to the medical staff on admission and he did undergo tests. However, the results of these did not indicate anything which could not be attributed to either Mr C's COPD or to his UTI and, further, Adviser 1 has concluded that 'there was no definitive evidence of liver cancer in Mr C in April 04', I do not uphold this complaint. The Ombudsman has no recommendations to make on this aspect of the complaint.

(b) The nursing care provided to Mr C in August 2004 was inadequate

9. Mr C was in the Hospital from 8 August 2004 till his death on 25 August 2004. Ms C complained about the care he had received. She said this was inadequate and only improved after contact from the local hospice about this on 23 August 2004. The Hospital and the hospice had been discussing whether Mr C could be moved there.

10. At a meeting on 10 January 2005 the Board apologised and accepted that some aspects of Mr C's care were unacceptable. A ward meeting was held on 24 March 2005 which discussed the issues raised by this complaint and an action plan was put in place.

11. Nevertheless, Adviser 2 was concerned about the level of care and the lack of any meaningful documentation in this case. She was also concerned about the broad nature of some aspects of the action plan. In response to further questions, the Board provided details of improvements made since 2004 in their documentation and a copy of the updated action plan currently in force. This provided more detail on the ongoing nature of this process, including the improvements made to the nursing documentation. New procedures were implemented in December 2005. These were detailed in the Ombudsman's report following a separate complaint (200500399) laid before the Scottish Parliament on 30 May 2006.

(b) Conclusion

12. Mr C was not treated with the appropriate respect and care and his family were understandably extremely distressed by this. The Board does not dispute this and there has been no suggestion by them that the nursing care provided was anything other than inadequate. They have apologised to Ms C for this and have sought to improve the standards of care in the ward. An updated action plan provided more detail of the ongoing nature of this process. Additionally, since 2004, the Board have put substantial effort into improving and upgrading their nursing documentation and new procedures were implemented in December 2005 and the Ombudsman has commended them for these (see 200500399). As the Board had already accepted there were deficiencies in Mr C's care and had made efforts to prevent a recurrence before the investigation began, I do not uphold this complaint.

(b) Recommendations

13. The Ombudsman is pleased to see the positive response to this aspect of the complaint. However, as the documentation has now been some months in force, the Ombudsman is recommending that the initial audits into its implementation and effectiveness be shared with this office.

(c) The doctor who informed Mr C and Ms C of his cancer did so in an inappropriate manner and in direct contravention of previously expressed wishes

14. On 11 August 2004 Ms C was told that there were shadows on her father's liver and more tests would be needed. She asked if either she or her brother could be present whenever her father was told any news. She explained that her father was deaf and at times very confused and that they would need to explain to him what was being said. On 16 August 2004 she received a call from a doctor to say that she had had to give her father bad news. Ms C said she had asked to be there whenever he was given news and the doctor told her that her father had agreed to being given news without anyone present. The doctor then told her that her father had bowel cancer with secondary cancer of the liver. Ms C said that she was very shocked to hear this over the telephone. She was further shocked when she visited Mr C to discover his neighbour in the next bed appeared to have overheard Mr C's conversation with the doctor.

15. When responding to my enquiries, I was advised by the Board that the doctor

had been aware of the request that a family member be present but Mr C needed to be told he had cancer prior to his referral to an oncologist. As the oncologist only visited once a week, the doctor considered this to be a matter of some urgency. She had asked Mr C about his weekend to assess his ability to comprehend and then said she had bad news and that she should wait until his daughter was present. Mr C told her to go ahead and tell him. She was aware that his daughter was concerned and that he suffered confusion but this was intermittent, there was no confusion at the time and Mr C had been clear he wished to be told. The Board have advised that it was not the intention of the doctor to ignore the families' wishes, rather it was her intention to include the patient in decision-making. She now accepted that in this case this intention was inappropriate and she has advised the Board that she wished to apologise for the distress caused.

16. Adviser 1 said that at the time the doctor told Mr C he had cancer, curative treatment was not an option and Mr C was free from distressing symptoms. Both medical and nursing advisers have confirmed that normal good practice in breaking bad news would be to do this in private, with family and senior nursing support. Nursing support should also be available following this.

17. In response to questions from Adviser 2, the Hospital provided further information on the training and support given to staff in breaking bad news. The details of this are in Annex 3. Having reviewed this information, it was considered to be adequate by our internal clinical adviser.

(c) Conclusion

18. Adviser 1 is of the view that, given Mr C's condition, the visit of the oncologist did not confer any urgency on informing him of his illness. Although the doctor did ask Mr C whether he wished to be told and has indicated she considered he was not confused at the time, it should be noted that the way in which he was asked made it difficult for him to answer in any other way. Mr C's family had been regular visitors and it was unlikely to have been difficult to have arranged a meeting with them.

19. On the basis of the evidence, I uphold this aspect of the complaint.

(c) Recommendations

20. The Ombudsman recommends the Board apologise to Ms C and her family for the distress caused by the way in which the diagnosis was communicated to Mr C and subsequently to her. Given the training and support already provided to staff (see Annex 3), the Ombudsman is not recommending further action.

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

26 September 2006

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mr C	The complainant's father
Adviser 1	Medical adviser to the Ombdusman
Adviser 2	Nursing adviser to the Ombdusman
The Hospital	Monklands Hospital
The Board	Lanarkshire NHS Board
COPD	Chronic Obstructive Airways Disease
GGT	Gammaglutamyltranspeptidase
UTI	Urinary Tract Infection

Annex 2

Glossary of terms

Alkalinie Phosphotase	An enzyme.
Bile duct	Any of the ducts that convey bile from the liver. Bile is used by the body to aid digestion and is secreted from the liver and stored in the gall bladder.
Chronic Obstructive Airways Disease	A disease which leaves the patient with permanently damaged lungs, the patient will find it difficult to breathe most of the time.
Enzyme	An enzyme is a complex protein that causes a specific chemical change in other substances without being changed itself.
Gammaglutamyltranspeptidase	An enzyme.
Urinary Tract Infection	A bacterial infection of the kidneys, ureter, bladder and uretha.
White Blood Cell	Colourless or white cells in the blood which help protect the body from infection and disease.

Annex 3

List of legislation and policies considered

Extract from response from the Board – *information on support and guidance offered to staff on breaking bad news.*

> '…all NHS Lanarkshire trainees are offered, and virtually all receive, training in breaking bad news from the Professor of Palliative Care or the Consultant in Palliative Care at … Hospice … as a reinforcement of their previous training. Most Scottish trainees have also had at least three years of intensive training, several times a month, in this area as undergraduates. Specialist Registrars receive further training via the Deanery. Consultants are offered 'top-up' training which is not mandatory.
>
> The NHS Lanarkshire Practice Development Care purchases programmes for registered nursing staff on ' Breaking Bad News' and communications courses from … Hospice. The Hospice also facilitates a programme for Clinical Support Workers, funded by NHS Lanarkshire on 'Communication in Crisis'. The Practice Development Centre provides a session on breaking bad news for newly qualified staff nurses participating in the intern programme. In addition, through the Cancer Clinical Community, the Cancer/Palliative care nurses provide sessions for all staff on a regular basis. The principles of breaking bad news form part of the training of student nurses who are placed in our wards … the Cancer Nursing Education programme for nursing staff working within NHS Lanarkshire … is fully funded.'