Scottish Parliament Region: Glasgow

Case 200502666: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Care of the Elderly, Performing Last Offices and Complaint Handling

Overview

The complainant (Ms C) raised a number of concerns that her mother (Mrs A) had not been properly supervised by staff resulting in a number of falls which were not properly recorded or notified. Ms C also complained that she was not properly notified of her mother's death and that Greater Glasgow and Clyde NHS Board (the Board) failed to respond properly to her complaints.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board failed to properly supervise Mrs A and allowed her to fall on a number of occasions which were not properly reported *(not upheld)*;

(b) the Board failed to properly notify Ms C of her mother's death *(not upheld)*; and

(c) the Board failed to respond to her complaint accurately *(no finding)*.

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 23 December 2005 the Ombudsman received a complaint from the complainant (Ms C) about the care of her mother (Mrs A) at the Southern General Hospital, Glasgow (the Hospital).

2. The complaints which have been investigated are that:

(a) the Board failed to properly supervise Mrs A and allowed her to fall on a number of occasions which were not properly reported;

(b) the Board failed to properly notify Ms C of her mother's death; and

(c) the Board failed to respond to her complaint accurately.

Investigation

3. Investigation of this complaint involved obtaining and reviewing Mrs A's medical and nursing records from the Board. I have sought the views of a nursing adviser to the Ombudsman (the Adviser). I have made written enquires of the Board. I have reviewed the relevant policies and guidance issued by the Board.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to properly supervise Mrs A and allowed her to fall on a number of occasions which were not properly reported

5. Ms C complained that her mother was allowed to fall a number of times on 10 and 12 July 2005. Ms C was concerned that these falls were not properly recorded and notified to her. Ms C also complained that she was not informed of her mother's deteriorating condition the day before her death.

6. The Adviser reviewed Mrs A's clinical records and noted that the doctors spoke to Ms C about her mother's falls when the information from the x-rays taken subsequent to the falls was at hand and that this was an appropriate course of action. The Adviser also reviewed the Internal Accident Forms and found them to be completed appropriately. The Adviser told me that an appropriate risk assessment was made in respect of Mrs A's mobility status and falls history. The

Adviser noted that the only failsafe way to prevent falls is to have constant supervision of patients and this was simply not practical.

7. In response to my enquiries the Board provided me with copies of the Internal Accident Forms which were properly completed. The Board's response to Ms C indicated that these forms did not contain information about Mrs A's injuries as these would not have been known at the time the form was completed but that her nursing notes did have this information. This is correct and was not an indication that the forms were not correctly filled in.

(a) Conclusion

8. Ms C's concerns about the number of falls her mother experienced is entirely understandable but based on the advice I have received I am satisfied that the staff involved in Mrs A's care acted appropriately and in line with accepted practice in their day-to-day management of Mrs A and in reporting falls. Staff also tried to maintain a good level of communication with Ms C. I conclude that there was no failure in the duty of care by staff and do not uphold this aspect of the complaint.

(b) The Board failed to properly notify Ms C of her mother's death

9. Ms C complained that she was originally notified by staff that her mother had died at 05:25 but that she was then told her mother was found dead at 06:35 (as stated on the death certificate) but the Board now said the time of death was 07:00. Ms C also complained that staff had delayed notifying her of her mother's death and that the last offices had not been performed before she arrived at hospital.

10. In their response to Ms C's complaint the Board stated that nurses had noted Mrs A to have died at 06:35 but that the doctor had not been able to attend to confirm the death until 07:00. Despite investigation the Board could find no record of who had told Ms C that her mother had died at 05:25. The Board also advised that staff had tried to contact Ms C from 06:35 onwards but had been unsuccessful and apologised that they had not tried to contact her on her mobile telephone. The Board apologised that it had not been possible to prepare Mrs A's body before Ms C arrived at hospital and for the distress this had caused Ms C.

11. Ms C was unhappy with this response as the death certificate gave the time of death as 06:35 not 07:00. Ms C was also unconvinced that attempts had been made to telephone her at home as she had checked with the telephone provider and been told that there had been no attempt made to call her at that time. Ms C also considered that 1½ hours should have been sufficient time for the last offices to be performed.

12. In response to my enquiries the Board told me that they apologised again that the night nurse did not try to contact Ms C on her mobile telephone and confirmed that Mrs A's death was not certified until 07.00 when a doctor was present. The Board confirmed that they could not ascertain who might have told Ms C that her mother had died at 05.25. The Board provided me with a copy of their policies on 'Last Offices' and 'Informing Relatives of the Death of a Relative'. The Board told me that it is not the normal practice to perform the full last offices if a relative is coming into the ward to see the patient but to complete these after the relative has visited, but that, a patient's appearance would normally be attended to before a relative was admitted. In this case Mrs A's appearance had been attended to but it had not been possible to close her eyes although staff could not recall if there were other aspects of her appearance which might have caused Ms C distress. The Board stated that staff had been reminded of the importance of speaking to relatives of the deceased and explaining sympathetically any features which might cause distress.

13. The Adviser commented that the Board's policies were appropriate and that the actions taken by the ward staff were reasonable in the time frame as last offices would not have been commenced until after death had been confirmed and the nursing notes indicate Ms C arrived at 07:50.

14. The medical notes indicate that the doctor attended and certified the death at 07:00. The time the doctor confirms death is usually regarded as the official time of death, however, the nursing records also indicate that Mrs A was found to be cold to touch and not breathing by nursing staff at 06:35 and the doctor could, therefore, note that she was found to be dead at 06:35. I consider these different times to be a result of the difference between the time a death is noted and when death is legally confirmed.

(b) Conclusion

15. There are a number of events in this complaint where I am not able to obtain any further objective evidence to clarify matters. The purported telephone calls from the night nurse fall into this category as does the explanation of why or by whom Ms C was told her mother had died at 05:25. I am satisfied that the Board tried to address these points and have apologised for the failure to contact Ms C on her mobile telephone at the earliest opportunity. I am also satisfied that staff took appropriate steps to avoid the understandable distress experienced by Ms C when she arrived at the Hospital but that sadly this was by its very nature a distressful time. The Board can do nothing more to resolve matters now for Ms C. I, therefore, conclude that regrettably no further clarification can be achieved on a number of the issues raised by Ms C and that the Board have already made the necessary apologies to Ms C for the small but important failure to contact her earlier on her mobile telephone. I do not find any un-remedied failure and accordingly do not uphold this aspect of the complaint.

(c) The Board failed to properly address Ms C's complaint

16. Ms C complained that when she originally complained in person to Doctor 1 after her mother's death she was advised that the Senior Nurse Manager (SNM) would look into these issues and that she would receive a call but in fact she heard nothing from the SNM until ten days after she had submitted a formal complaint on 12 September 2005. Ms C also complained that the letter implied she met with Doctor 1 on 6 August 2005 to discuss the post-mortem when in fact this wasn't performed until 8 August 2005.

17. In their response to Ms C's complaint the Board stated that she had been offered a meeting with the SNM by Doctor 1 but had declined this and that the SNM had tried to call her prior to going on annual leave and left a message on her answering machine. The Board stated that the SNM had contacted Ms C on 22 September 2005 on her return from annual leave. Subsequent to this Ms C's formal complaint was received which was then dealt with by the formal complaints procedure and this ended the SNM's direct contact with Ms C.

18. Ms C disputed this account of events as she does not recall being offered the opportunity of a meeting, she does not have an answering machine and had in fact submitted her formal complaint on 12 September 2005.

19. My review of the Board's complaint file indicates that Ms C's formal complaint was received by the Board on 15 September 2005. Complaints staff wrote to relevant staff (including the SNM) on 21 September 2005 requesting their comments. It would seem very likely, therefore, that the SNM would not have received this letter until after her telephone call to Ms C. There is nothing in the medical records or the complaint file which would clarify whether or not the SNM left a message for Ms C or which telephone number she called. I would note that the contact telephone number on Mrs A's file is correct. There is nothing in the medical record to confirm whether or not Ms C was offered a meeting with the SNM by Doctor 1 but there is a statement to that effect from Doctor 1 in the Complaint File. The same statement also indicates that Doctor 1 met with Ms C on '06/08/05' to discuss the provisional post-mortem results – this is the date used in error by the Board and I consider it is most likely that this is a simple (but none the less unfortunate) typing error for '09/08/05'.

(c) Conclusion

20. Again there are a number of events in this complaint where I am not able to obtain any further objective evidence to clarify matters. The purported telephone call and answering machine message form the SNM is one such event. With respect to Ms C's other concerns I note that her recollection of the meeting does not correspond in every detail with Doctor 1's statement. Again there is no further objective evidence to be obtained in this regard. I would also note that while these differences are an understandable irritation to Ms C I do not consider them to be indicative of a more serious problem. A lack of evidence prevents me making any finding on this heading of the complaint but I am satisfied that the complaint was handled appropriately by the Board in all significant respects.

30 January 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mrs A	The aggrieved – Ms C's mother
The Hospital	The Southern General Hospital, Glasgow
The Board	NHS Greater Glasgow And Clyde Health Board
The Adviser	Nursing adviser to the Ombudsman
Doctor 1	The doctor Ms C first raised her concerns with
SNM	Senior Nursing Manager