Scottish Parliament Region: South of Scotland

Case 200503188: Dumfries and Galloway NHS Board

Summary of Investigation

Category

Health: Clinical treatment

Overview

The complainant (Mr C) raised a number of concerns about his mother (Mrs A)'s treatment in Dumfries and Galloway Royal Infirmary (the Hospital) prior to her death on 15 September 2005.

Specific complaints and conclusions

The complaints from Mr C which have been investigated are that:

(a) on 13 September 2005 his mother was inappropriately admitted to an assessment ward when her condition was already known (*upheld*);

(b) despite her agitated state and her family's request, she was not given any sedation or water (*upheld*); and

(c) there was delay in releasing his mother's body for cremation (*upheld*).

Redress and recommendation(s)

The Ombudsman recommends that the Board:

(i) confirms the palliative care nurse's recommendations to her with a view to their early introduction;

(ii) reinforce to nursing and medical staff the need for good assessment and evaluation for patients with pain and agitation and, to emphasise the importance of communicating to families;

(iii) formally apologise to Mr C for their failure to provide Mrs A with water and for the delay in re-evaluating her medication; and

(iv) confirm their improved procedures concerning cremation forms and the date when they are introduced.

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

Main Investigation Report

Introduction

1. On 20 February 2006, the Ombudsman received a complaint from Mr C concerning the treatment his mother (Mrs A) received in Dumfries and Galloway Royal Infirmary (the Hospital) prior to her death on 15 September 2005.

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

(a) on 13 September 2005 his mother was inappropriately admitted to an assessment ward when her condition was already known;

(b) despite her agitated state and her family's request, she was not given any sedation or water; and

(c) there was delay in releasing his mother's body for cremation.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Mr C and Dumfries and Galloway NHS Board (the Board). I have had sight of the Board's complaints file and Mrs A's medical records. A written enquiry was made to the Board on 31 July 2006 and their formal response was dated 25 August 2006. On receipt of this, I sought independent medical advice about the treatment given to Mrs A prior to her death.

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

(a) On 13 September 2005 his mother was inappropriately admitted to an assessment ward when her condition was already known

5. Mrs A, who was 77 years old, suffered from Alzheimer's dementia. In August 2005 she was diagnosed as having advanced lung cancer with symptomatic treatment only advised. She was discharged home to the care of her husband, Mr A, but her condition deteriorated and on 13 September 2005 she was admitted to the Hospital in what Mr C described as a 'highly agitated state'. He said there were no beds available so she was transferred to Accident and Emergency (A&E) where she spent about an hour on a trolley.

6. Mrs A was transferred to an assessment ward after about three and a half hours, which Mr C said was totally inappropriate as a diagnosis was already clear. He said that all the family wanted was for her to be comfortable. Mr C complained that it was not until 14 September 2005 that Mrs A was admitted to a ward appropriate for her condition. Mrs A died there on 15 September 2005.

7. In their response to me dated 25 August 2006 the Board confirmed that Mrs A had not been admitted to a palliative ward straight away. They said that the day of her admission had been a very busy one in A&E and there had been no beds in the assessment ward. But, because of Mrs A's poor condition, she was prioritised ahead of five other patients waiting and, after an hour and twenty minutes, put into a bed within the assessment ward. The next day, Mrs A was moved to a palliative ward. The Board agreed that Mrs A's admission to the assessment ward was inappropriate.

(a) Conclusion

8. The Board have said that the day of Mrs A's admission was a very busy one and that there were no immediately available beds in the assessment ward (paragraph 7) but that Mrs A received priority over other patients to be allocated a bed. However, Mr C complained that his mother's admission to this ward was totally inappropriate as she did not require assessment. He said she needed treatment for her anxiety. While the Board have confirmed that it was inappropriate to send Mrs A to an assessment ward, there is no evidence available from the medical notes to suggest to me that a doctor spoke with the family to explain the situation. I appreciate that there was a great deal going on at the time of Mrs A's admission but, I consider that someone should have taken a short time to explain. Furthermore, no explanation has been provided about the reasons why Mrs A could not have gone straight to a palliative ward. In all the circumstances I have to conclude that there was a service failure in the way in which Mrs A was admitted and I uphold this complaint.

(a) Recommendation

9. In advance of any recommendation by the Ombudsman, the Board have confirmed that admissions of patients like Mrs A to the assessment ward are currently under review by a palliative care nurse. The Board are to be commended

for taking prompt action in response to this aspect of the complaint and the Ombudsman recommends that the palliative care nurse's recommendations are confirmed to her with a view to their early introduction. As well as this, she recommends that the need for good assessment and evaluation of patients with pain and agitation be reinforced to nursing and medical staff. Furthermore she recommends that the Board emphasise to staff the importance of communicating to families, however briefly, what is going on.

(b) Despite her agitated state and her family's request, she was not given any sedation or water

10. Mr C said that on arrival the family asked that Mrs A be given some water but, that as none appeared after about 30 minutes, he bought some from the Hospital shop. Meanwhile he said that Mrs A continued to become more agitated and that, although assistance was asked for, none was offered. He said that he felt completely helpless even though later a drug was 'somewhat reluctantly administered but with no effect'. He said, a second drug was administered but, again, this had little effect. He alleged that staff didn't appear to know what they were doing.

11. No response or explanation has been given by the Board about the failure to give Mrs A any water. Although as part of the Board's reply to my enquiries the senior sister of the assessment ward offered a 'profuse' apology and said that staff may have been concentrating on 'sorting out (Mrs A's) symptoms'.

12. With regard to the family's request that Mrs A's agitation be dealt with; the medical records confirmed that on admission, she was agitated and nauseated but that a syringe driver was in place containing morphine, midazolam and haloperidol. Because of nausea Mrs A was given levomepromazine within 15 minutes of arriving on the assessment ward (although Mr C disputes this) but there was perhaps an hour's interval for evaluation and re-injection before a further dose of haloperidol was given in attempt to control her agitation. The Board's response stated that it was the professional opinion of the medical and nursing staff attending to Mrs A that she was distressed because of her nausea and she was, therefore, given something to deal with this. They deny completely that medication was offered reluctantly or that their treatment of Mrs A was anything other than sympathetic.

(b) Conclusion

13. I sought advice from an independent medical adviser (the Adviser) on the treatment given to Mrs A and he has taken the view that there can be no excuse for an at least 30 minute delay in offering Mrs A water and I have to agree. I uphold this aspect of the matter. Although Mrs A was given further medication within 15 minutes of arriving on the assessment ward, this was after an hour and a half of her arrival at the Hospital (see paragraphs 12 and 7). There was also delay in re-evaluating her medication. I consider that this was too slow, although I have seen no evidence to suggest that medication was given grudgingly or that staff were confused about what should be offered to Mrs A. The Adviser has confirmed that the appropriate medication was given. He made the point that it was important to realise that the nursing staff were aware that it was the nausea that was causing Mrs A's distress, and that the anxiety and confusion related to her dementia would have aggravated this. He said that Mrs A's dementia would have exaggerated her behaviour to a distressing degree but that a doctor should have taken the time to explain this to the family (see paragraph 8).

(b) Recommendation

14. The Ombudsman recommends that the Board formally apologise to Mr C for the failure to provide his mother with water and for their delay in giving her further medication. Her recommendations at paragraph 9 are also relevant here.

(c) There was delay in releasing his mother's body for cremation

15. Mr C said that his mother died on 15 September 2005, but by 19 September 2005 the appropriate release forms had still not be signed. He said that this caused his elderly father huge stress, at what was a difficult time, as the funeral had been arranged for 21 September 2005. Mr C said that it was not until after his personal intervention that his mother's body was released for cremation on 20 September 2005.

16. From the Board's response to me I understood that the doctor responsible said that she had been unaware that a cremation had been planned for Mrs A or that the appropriate form had not been signed. She said that she had never been approached to sign the form. However, on learning about the delay she completed the forms within a few hours and visited the mortuary, as she was required. She

said that she notified the relevant Hospital staff as soon as this was done but that she was unable to speak with the doctor who completed the second part of the form until the following day (20 September 2005).

17. The response, however, makes no reference to the period of time between Mrs A's death on 15 September and Mr C's contact with the Hospital about the delay on 19 September 2005. Nor is it clear how the Hospital was advised that Mrs A was to be cremated. I am, therefore, uncertain about what happened. Before the complaint was made to the Ombudsman, the Board apologised to Mr C for the delay and, as my investigation progressed, they suggested improved procedures to aid contact between the mortuary and the doctors concerned; also, that more comprehensive information be added to the notice which accompanied the patient to the mortuary.

(c) Conclusion

18. The Adviser explained that when a patient dies and is to be cremated, the normal procedure is for the ward doctor to be informed that the first part of the cremation form is ready for signing, sometimes together with, or shortly after, the death certificate. There is then a request for a senior doctor to sign the second part. He explained that there is often a 24 hour delay for both parts to be signed, but in this case there was a four day delay but that this could partially be explained by the intervening weekend. However, I take the view that there was delay in releasing Mrs A's body as there appeared to be no action until Mr C took matters in his own hands and rang the Hospital. I, therefore, uphold this aspect of the complaint.

(c) Recommendation

19. The Board's response reiterates an apology already made to Mr C for their delay in completing the necessary forms and I do not consider that there is anything else they can do to address the stress already suffered by Mr C's family other than to ensure that the circumstances are not repeated so as to avoid affecting someone else. It should be a priority that the appropriate certificates are signed by the doctors concerned. The Ombudsman is pleased to see that the Board are moving towards improved procedures (see paragraph 17) and she now recommends that they confirm their improved procedures to her and the date when they are introduced.

20. 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.

27 February 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs A	Mr C's mother
The Hospital	Dumfries and Galloway Royal Infirmary
A&E	Accident and Emergency
The Assessment Ward	The main admissions ward for the Hospital
The Board	Dumfries and Galloway NHS Board
The Adviser	An independent medical adviser