Scottish Parliament Region: Glasgow

Case 200402199: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; General Surgical; Admission, Discharge and Transfer Procedures

Overview

An Advocacy Worker (Ms C) complained on behalf of the family of an elderly woman (Mrs A) who had been a patient at Glasgow Royal Infirmary (the Hospital). She raised a number of concerns about the nursing care provided, communication with the family and procedures for discharge.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was a lack of communication with the family, in particular in relation to whether or not Mrs A had a stroke while in hospital (*partially upheld*);

(b) the standard of nursing care provided by some nursing staff was poor (*not upheld*);

(c) there was no effective planning of Mrs A's discharge from hospital *(upheld*); and

(d) pancreatitis was given as the secondary cause of death even though the family's understanding was that this condition had been successfully treated (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) highlight to staff the need to manage the expectations of the families of patients and to be aware of the need to communicate in non-technical language and provide clear explanations;

(ii) undertake an audit of the new care plan documentation and share the results of that audit with her;

(iii) apologise to Mrs A's family for their failure to carry out their own discharge policy effectively and the inconvenience, distress and concern that this caused; and

(iv) audit their discharge policy to ensure that it is now being fully

implemented.

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

Main Investigation Report

Introduction

1. The Ombudsman received a complaint from an advocacy worker (Ms C) made on behalf of the family of a woman referred to in this report as Mrs A. Mrs A, then aged 84, had been transferred on 31 May 2003 to Glasgow Royal Infirmary (the Hospital) following an initial admission to the Royal Alexandra Hospital in Paisley. Mrs A was discharged from the Hospital on 16 June 2003. Mrs A's family were concerned about the care provided to her while she was in the Hospital, a lack of communication about her condition, and that she was discharged without adequate support and no transport had been available. They said that when she was admitted to the Hospital she had been mobile and independent but that when she left she had declined considerably and required 24 hour nursing care. Mrs A died at home on 24 September 2003.

2. Ms C first raised her concerns with Greater Glasgow NHS Board (the Board) in October 2003 and, following their response requested an independent review in December 2003.[1] This request was passed to a Convener who felt that this matter should be referred back to the Board and, in February 2004, recommended a meeting with the family. Although a meeting was not held, the Board did respond further on 12 May 2004. Ms C again requested an independent review and this was refused on 7 October 2004. Ms C's complaint to the Ombudsman was received on 7 March 2005.

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

(a) there was a lack of communication with the family, in particular in relation to whether or not Mrs A had a stroke while in hospital;
(b) the standard of nursing care provided by some nursing staff was poor;
(c) there was no effective planning of Mrs A's discharge from hospital; and
(d) pancreatitis was given as the secondary cause of death even though the family's understanding was that this condition had been successfully treated.

[1] The NHS complaints procedure changed in April 2005. Prior to this, a complainant could ask for an Independent Review Panel to consider the complaint if they were not satisfied with the initial response from the Board. Such a request was considered by an independent convener. This step is no longer available and complainants can now come direct to the Ombudsman if they remain dissatisfied.

Investigation

4. The investigation of this complaint involved obtaining all the background documentation relating to the complaint and Mrs A's medical records. Advice was also obtained from clinical (Adviser 1) and nursing advisers (Adviser 2) to the Ombudsman. The abbreviations used in the report are explained in Annex 1 and the medical terms used in the report are explained in Annex 2.

5. 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) There was a lack of communication with the family, in particular in relation to whether or not Mrs A had a stroke while in hospital

6. Mrs A was initially admitted to the Royal Alexandra Hospital, Paisley on 19 May 2003 suffering from suspected gallstones. A CT scan and an ERCP (endoscopic retrograde cholangiopancreatography – endoscopic procedure used to identify stones, tumours or narrowing in the bile ducts) were carried out. During the tests, concerns were raised over the possibility of a tumour being present. It was noted the ERCP had not been very successful. Mrs A's consultant was going on holiday and suggested that a one-day transfer to the Hospital for a further ERCP would assist them to make a more accurate diagnosis.

7. On 31 May 2003, Mrs A was transferred to the Hospital. Ms C said that on arrival, she was informed that she was not expected until 1 June 2003 and subsequently had to wait three hours before being admitted and examined by a doctor. Mrs A underwent the ERCP on 2 June 2003. Prior to the procedure being carried out as planned, her family said that Mrs A was capable, mobile and able to shower without assistance. Following the procedure, they said she suffered considerable pain, appeared incoherent and never fully recovered. Mrs A's family have said that they were not informed of any possible adverse outcomes of this procedure.

8. One of Mrs A's daughters, Mrs B, and granddaughter, Ms D, met with the Consultant Surgeon (the Consultant) on 6 June 2003. They said that the Consultant produced a diagram to illustrate the pancreas (Mrs A had suffered from post-operative pancreatitis) and assured them that there was no cause for concern over Mrs A and everything would settle in a few days. However, Ms C said that was not the case and Mrs A's condition continued to deteriorate. On

15 June 2003 when Mrs B and her husband (Mr B) were visiting Mrs A they saw that her mouth was twisted and she was unable to communicate verbally. Mr B remained with her while Mrs B went to seek assistance from nursing staff. Two doctors, after examination, confirmed the possibility that she may have had a stroke. One doctor also pointed out that Mrs A was suffering from oral thrush, of which the family had no previous knowledge, and the condition had not received any form of treatment. Family members who examined her mouth, reported they were appalled at its condition.

9. In their response to the family's concern that Mrs A had suffered a stroke, the Board said that Mrs A was examined on several occasions with only some weakness detected. The doctor who examined Mrs A on 15 June 2003 considered that she may have had a transient ischaemic attack (TIA) (passing weakness) but this was not substantiated. The Consultant confirmed that she did not suffer a typical stroke.

10. In reviewing the complaint, Adviser 1 considered that the medical records were of good quality. The notes of 15 June 2003 record examinations by two doctors which detail Mrs A's symptoms. The first doctor was asked to see Mrs A by the nurses. Adviser 1 commented on the first doctor's notes that: 'The only objective sign of a stroke was her mild confusion and difficulty understanding questions and replying with mumbled speech. These features would correspond with a small dominant hemisphere stroke'. The second doctor noted the concerns of Mrs A's family about 'mouth drooping' but recorded that there was no droop and that Mrs A, though slow to answer and having difficulty responding to commands, was not slurring her speech. Adviser 1 said that the symptoms noted by both doctors were 'consistent with a TIA attack which might already be resolving'. A TIA is caused by a temporary reduction in blood and oxygen supply to part of the brain. This can then cause acute symptoms such as loss of vision, leg and arm weakness, slurring of speech and loss of consciousness. However, severe symptoms normally last up to 30 minutes and all symptoms disappear within 24 hours. Given Mrs A's symptoms continued Adviser 1 concluded it was likely she had suffered a stroke. Adviser 1 added that the second doctor had diagnosed oral thrush, prescribed appropriate antibiotic treatment and ordered neurological observations to be carried out. An entry in the records noted that this had been discussed with Mrs A's family and that they were 'happier [that the] patient [was] more 'herself' when they saw her when I examined her (?TIA, completely resolved)'.

11. Adviser 1 added that 'the evidence was in favour of his [the second doctor] having explained that the event was short lived and resolving and that they were happy with that expectation'. He also said that the thrush Mrs A experienced was not uncommon given her other conditions and was not evidence of poor care.

12. In correspondence with the Board, Ms C had said that Mrs A's family had been unaware of the nature of several aspects of Mrs A's condition during her stay. Amongst other points raised Ms C said they had not known there was a mortality rate related to the ERCP procedure, that pancreatitis was a possible side effect, or that the chest infection was pneumonia. In his conclusions Adviser 1 said:

> 'one of the areas of complaint which was never really adequately addressed was the fact that, in the family's perception, [Mrs A] had been an elderly lady living alone independently before her operation and was then discharged after 17 days in hospital in a clearly much frailer and dependent state, requiring 24-hour nursing care. Their expectations of rapid treatment and continuation of her independent living were drastically altered. Because of the poor communication with [Mrs A's] family on the ward, they underestimated, or were falsely reassured, about her really quite serious infections. [The Board] correspondence did not improve this miscommunication. Had the clinical advice been more forthcoming in terms of explanation (i.e less self-justifying and more explanatory in non-technical terms) the responses might have reflected the reasonableness of the treatment and care and the less than predictable nature of the complications.'

(a) Conclusion

13. On the basis of the advice from Adviser 1, I consider that Mrs A's family were probably informed that she had suffered a short lived TIA event and that this diagnosis was reasonable at the time this was communicated to them. However, it is clear from the advice given by Adviser 1 that Mrs A's family were never told the implications of her continuing symptoms and that there were failings in communication with Mrs A's family generally about her condition. This occurred both during her stay in Hospital and also in the Board's response to their complaints. It is also the case that there was a tendency to communicate in an 'overly-technical' way which only served to generate further confusion and concern. Therefore, although the initial communication was

correct, I partially uphold this complaint.

(a) Recommendation

14. The Ombudsman recommends that the Board highlight to staff the need to manage the expectations of the families of patients and to be aware of the need to communicate in non-technical language and provide clear explanations.

(b) The standard of nursing care provided by some nursing staff was poor

15. Ms C raised the family's concerns about nursing care in detail in her initial letter of complaint in October 2003. This said that staff had not cleaned Mrs A after she had been sick, pillows were not always provided, medication was left out of reach and the attitude displayed by staff was at times poor. They said Mrs A had limited assistance with eating and drinking and that, on discharge, Mrs A suffered from pressure sores.

16. In their letter to Ms C dated 17 November 2003 the Board said that:

> 'With regard to the nursing care provided to [Mrs A], I have been advised that the Ward Manager has discussed the concerns of the family with the ward staff and apologises unreservedly that the family were unhappy with the care their mother received. The Ward Manager has reviewed the notes and care plans which suggest that appropriate care was provided to [Mrs A]. Unfortunately, we are unable to establish when staff displayed the poor attitude in your letter. However, the Ward Manager apologises for any difficulties the family experienced with the ward staff.'

17. In the internal memo relating to this aspect of the complaint it is further stated that:

> 'the Ward Manager can find no written evidence to substantiate the claims that [Mrs A] was not given any assistance with activities of daily living'.

18. Adviser 1 has said that the notes show that the nursing staff were aware Mrs A had skin vulnerability and there were no pressure sores prior to her discharge. Adviser 2, who reviewed the nursing notes in detail, said that the initial nursing assessment of Mrs A identified few problems and that during her stay risk assessments were completed and progress notes kept. She said nursing progress records were of a 'reasonable standard' and recorded communication between clinical staff and the family. Adviser 2 was though concerned about the absence of 'adequate' Care Plans in the documentation

and that the actions of staff, therefore, appeared reactionary rather than anticipatory. She noted that, despite the obvious deterioration in Mrs A's condition, there was no review made of the initial assessment.

19. In response to further questions on this point, the Board said that in 2003 care plans were integrated within the nursing notes. They also said that they had been improving the care planning documentation for some time and that since 2003 had 'introduced a more individual patients' needs focus with a generic care plan based on an activities of daily living model of nursing'.

(b) Conclusion

20. There is evidence in the notes of the nursing care being adjusted in relation to Mrs A's changing needs and there is no evidence the care itself was inadequate or that nurses allowed pressure sores to develop. The family have expressed concerns about attitude, the provision of pillows and the storage of medication but, although notes were kept on communication, it has not been possible to clarify the other aspects of Mrs A's care.

21. Adviser 2 has criticised the failure to document and review Mrs A's initial assessment and said that the records showed reactive rather than anticipatory behaviour. Since this complaint, the Board has introduced new documentation and, while on the basis of the evidence, I do not uphold the complaint that nursing care was poor, a recommendation is being made to ensure this new documentation is being used effectively.

(b) Recommendation

22. The Ombudsman recommends that the Board undertake an audit of the new care plan documentation and share the results of that audit with her.

(c) There was no effective planning of Mrs A's discharge from hospital

23. Adviser 2 has said the notes do show that Mrs A had been scheduled for discharge three times and that this was cancelled for different reasons. At 08:15 on the day following the incident referred to in paragraph 8 (on 16 June 2003), Mrs B was told that she could take her mother home, however, no ambulance would be available because of a three day waiting list and private car provision also required a one day wait. The nursing notes indicate Mrs B volunteered to take her home in her own car and Mrs A was discharged on 16 June 2003.

24. Ms C has said that the information given to Mrs A's family and the district nurse about Mrs A's condition on discharge was inadequate and that, as a result, Mrs A's family had to cope for three days with no nursing support or equipment. The Board, in their letter of 17 November, said that Mrs B had signed the Home Plan and 'the Ward Manager apologises that a more thorough discussion of home requirements did not take place'.

25. Adviser 1 said in connection with this aspect of the complaint:

> 'The discharge care planning was not well managed, despite a care plan form being filled in. The Home Plan really only mentioned Mrs A's admission symptoms, not that she had suffered pancreatitis, chest infection and oral thrush and had had a TIA. Her discharge nutritional status and swallowing difficulties were not recorded. Her vulnerable pressure areas in the light of her poor mobility required pressure relieving equipment. The district nurse was not prepared for the real situation and so only visited on the third post-discharge day. No wonder the family felt they had been let down by the hospital.'

26. Adviser 1 concluded by saying that while it might have been a 'fine clinical judgement' as to whether or not Mrs A was fit for discharge, she should not have been discharged without provision having been made for the difficulties her family might encounter and the risks to Mrs A from inadequate or non-professional care at home.

27. Adviser 2 also said that this part of Mrs A's care fell below a reasonable standard and that the Home Care Plan was not a discharge plan but a record of medication and follow-up.

28. In response to further questions on this point the Board provided additional details of their discharge policy. They said that they have a discharge directory which covers every speciality and that this is used alongside a discharge checklist. They did not provide the full discharge directory because of its size. They also provided copies of the previous policy which was issued in 1997 and would have been in force during Mrs A's stay.

29. Adviser 2 reviewed the index to the discharge directory and said that it appeared to be 'comprehensive' although she had expected them to have a general policy as well as the speciality-specific procedures. She also considered the 1997 policy and confirmed that policy was not followed in

Mrs A's case.

(c) Conclusions

30. On Mrs A's admission it was anticipated she would only be in hospital for 24 hours and she was reviewed daily by medical staff. There is no evidence that the multiple decisions not to discharge were inappropriate given the way her condition changed during her stay. Indeed, on the basis of the advice given by both Advisers it now seems clear that Mrs A should not have been discharged on 16 June 2003. It is also clear that the planning surrounding the discharge was not in line with the Hospital's own procedure and neither the family nor the local district nursing service had adequate information about Mrs C's condition. On this basis I, therefore, uphold this complaint.

(c) Recommendation

31. The Ombudsman makes the following recommendations that the Board:

(i) apologise to Mrs A's family for their failure to carry out their own discharge policy effectively and the inconvenience, distress and concern that this caused; and

(ii) audit their discharge policy to ensure that it is now being fully implemented

(d) Pancreatitis was given as the secondary cause of death even though the family's understanding was that this condition had been successfully treated

32. Adviser 1 commented on this point:

> 'the secondary cause of death was erroneously stated as pancreatitis. There is evidence that Mrs A had been appropriately treated and had recovered from that infection and the daily nursing records for her care at home do not indicate a recurrence of any symptoms referable to that. In fact, Mrs A improved slightly at home for the first month and had a good appetite and was sitting out. It was on 20/09 that she had a right-sided stroke which was the primary cause of death.'

(d) Conclusion

33. Mrs A's family were understandably concerned that pancreatitis was listed as a secondary cause of death on her death certificate. However, it is clear that this was in error but it was not an error for which the Hospital was responsible given that it occurred after her discharge. I, therefore, do not uphold this aspect of the complaint.

34. 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.

23 May 2007

Annex 1

Explanation of abbreviations used

Mrs A	The patient
Ms C	The Advocacy Worker who complained on behalf of Mrs A's family
The Hospital	Glasgow Royal Infirmary
The Board	Greater Glasgow and Clyde NHS Board
ERCP	Endoscopic retrograde cholangiopancreatography
Adviser 1	The clinical adviser
Adviser 2	The nursing adviser
Mrs B	Mrs A's Daughter
Ms D	Mrs A's Granddaughter and Mrs B's Daughter
The Consultant	The Consultant Surgeon
Mr B	Mrs B's Husband
TIA	Transient ischaemic attack

Annex 2

Glossary of terms

Endoscopic retrograde cholangiopancreatography	Endoscopic procedure used to identify stones, tumours or narrowing in the bile ducts
Pancreatitis	Inflammation of the pancreas, which is an organ within the upper abdomen responsible for the production of insulin and glucagon (which are released into the blood stream) and for certain enzymes necessary for the digestion of food
Transient Ischaemic Attack	A condition caused by a temporary reduction in blood and oxygen supply to part of the brain. This can then cause acute symptoms such as loss of vision, leg and arm weakness, slurring of speech and loss of consciousness. However, severe symptoms normally last up to 30 minutes, and all symptoms disappear within 24 hours