Scottish Parliament Region: Glasgow

Case 200601357: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mr C) raised a number of concerns about the treatment his late mother, (Mrs A) received at the Victoria Infirmary, Glasgow in February 2006. These included communication failures between staff and the relatives; inadequate care and treatment; and difficulties in reporting lost property.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) staff failed to ensure that Mrs A's nutritional intake was monitored and did not obtain a complete medical history *(not upheld)*;

(b) staff failed to communicate adequately with Mrs A's family *(upheld)*; and

(c) the procedure for reporting lost property was not adequately followed *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) ensure that this report is shared with the staff involved so that they are reminded of the importance of communication with relatives;

(ii) consider whether the procedure on change over of shifts for passing information to relatives about patients who have recently died is adequate; and

(iii) conducts a review of the availability of claim forms at ward level in the hospital and send Mr C a claim form and consider a request for reimbursement of Mrs A's glasses should he wish to pursue the matter.

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

Main Investigation Report

Introduction

1. On 9 August 2006 the Ombudsman received a complaint from Mr C about the treatment Mrs A received at the Victoria Infirmary, Glasgow (the Hospital) in February 2006. The issues included communication failures between staff and the relatives; inadequate care and treatment; and difficulties in reporting lost property. Mr C complained to Greater Glasgow and Clyde NHS Board (the Board) but remained dissatisfied with their response and subsequently complained to the Ombudsman.

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

(a) staff failed to ensure that Mrs A's nutritional intake was monitored and did not obtain a complete medical history;

(b) staff failed to communicate adequately with Mrs A's family; and

(c) the procedure for reporting lost property was not adequately followed.

Investigation

3. In writing this report I have had access to Mrs A's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional medical advisers (the Adviser) regarding the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) Staff failed to ensure that Mrs A's nutritional intake was monitored and did not obtain a complete medical history

5. Mr C said that Mrs A was initially admitted to a ward (the first ward) on 29 January 2006 where she was cared for appropriately until she was transferred to another ward (the second ward) where the level of care diminished until her discharge on 9 February 2006. Mrs A was readmitted to the Hospital on 10 February 2006 to another ward (the third ward) and was then transferred back to the second ward. Mr C complained that when Mrs A was admitted to the second ward for the second time the family made numerous enquiries to the staff about Mrs A's condition as it appeared she was not responding to treatment or eating. It was noticeable that Mrs A would not even

eat food which the family had brought in whereas she had previously been a good eater. Mr C was concerned that there appeared to be no means of flagging up that Mrs A was not eating and had lost weight. Mr C was also concerned that it was up to family members to tell staff that Mrs A had previously suffered from bowel disorders.

6. The Board's Acute Services Director (the Director) responded that the records indicated that Mrs A's fluid and food intake charts were completed and that the situation was closely monitored during her stay. It was accepted that staff did not record Mrs A's baseline weight and this important issue would be reinforced with the staff concerned. The Director also explained that initially Mrs A was thought to be constipated and was given an enema and laxatives. Mrs A continued to feel unwell and later developed diarrhoea which could have contributed to her loss of appetite. The Director also explained that staff endeavour to obtain as much medical history on admission from patients and relatives but there are times when they are unable to identify and treat problems and they cannot always be aware of the patient's entire medical history.

7. The Adviser told me that Mrs A's nursing and medical records (which I have seen) were satisfactory and it was possible to trace the journey of care and establish that she received an appropriate level of care. The presence of the fluid balance and food record charts demonstrated that staff considered this an important aspect of the care package.

(a) Conclusion

8. Mr C had concerns that staff failed to monitor Mrs A's nutritional status and that they had not obtained a full medical history. The advice, which I have received and accept, is that the level of documentation completed by staff in respect of Mrs A was of an acceptable standard and that they monitored her nutritional state adequately. I have seen that staff completed recording charts for fluid and food intake and I am satisfied that staff were monitoring this issue.

9. I have also seen that some information was recorded concerning Mrs A's past medical history. That indicated to me that staff had taken steps to ascertain Mrs A's relevant history. I am conscious that at times a patient's diagnosis can change or alter and that staff may have to approach the patient or relatives for further information. However, that does not necessarily mean that the initial request for information was inadequate. Accordingly, based on the evidence obtained, I have decided not to uphold this complaint.

(a) Recommendation

10. The Ombudsman has no recommendations to make.

(b) Staff failed to communicate adequately with Mrs A's family

11. Mr C said when the family asked to speak to a doctor they were told that it was early days yet and to give it time. Communication issues were not helped when staff changed over during evening visiting hours or were not available. Mr C also said that the family spent a considerable amount of time in the second ward on 1 March 2006 and were becoming more distraught at the lack of information. They were also concerned that they were not informed of how serious Mrs A's condition was. Mr C said he telephoned the second ward at 05.00 on 2 March 2006 to be told that there was no change in Mrs A's condition. Mr C's sister telephoned the second ward at 06.00 to be told that the hospital had contacted an elder brother to say that Mrs A's breathing was becoming shallow. The family had no knowledge of such a telephone call. Mr C then collected his brother and niece and went to the second ward at 07:30. They were met by a staff nurse who asked if they were there to see Mrs A and she guided them to her bed. When the screens were drawn back Mrs A was lying dead in the bed.

12. Mr C wanted to know at what time a doctor had seen Mrs A following his 05.00 telephone call on 2 March 2006 as it appeared the nurse did not check on Mrs A at that time. Mr C also wanted to know why the family were not contacted when it became clear that Mrs A's condition was terminal and why were they not taken to a side room to be told of her passing.

13. The Director said that the Acting Charge Nurse was concerned that the family felt staff were either unwilling or unavailable to answer questions at any time. It is emphasised to staff the importance of effective communication with relatives and this would be reinforced to all staff within the Medical Directorate in light of the concerns expressed. The Director continued that there was no record of any communication between senior medical staff and the family although Mrs A was constantly kept under review.

14. The Director explained that Mrs A was reviewed by a Senior House Officer (SHO) at 04.30 on 2 March 2006 as her condition had deteriorated overnight. The Director said it was the Nurse in Charge's intention to contact a member of the family following the medical review. However, this was pre-empted by a

telephone call from Mrs A's son at approximately 04:45. The son was told that Mrs A's breathing was shallow and that a doctor had reviewed her. The Director continued that it was noted at 06.00 that Mrs A's condition remained poor and this was explained to Mr C's sister when she telephoned the ward. It was also explained the Nurse in Charge on night duty recalled speaking to a member of Mrs A's family late on 1 March 2006 and discussed the medical review and that she could not provide a specific timetable with regard to potential deterioration.

15. The Director said the Deputy Lead Nurse had offered an unreserved apology for the distress caused to the family by not being informed on arrival at the second ward that Mrs A had died. It appeared there had been a serious breakdown in communication as staff thought the family were aware that Mrs A had died. The Director commented that the matter had been fully discussed and re-emphasised with medical and nursing staff.

16. The Adviser said that there was no recorded evidence of communication with the family until 1 March 2006. This would indicate that there was no attempt to interact with the family in a proactive way. The Adviser told me the records stated that following Mrs A being unwell and breathless at 11:00 on 1 March 2006, the family were spoken to by a SHO at 12:50. The SHO explained that Mrs A had been seen by the surgical team who had considered her unfit for surgery and the plan was to treat her symptoms and keep her comfortable. The family agreed that Mrs A should not be resuscitated should her condition deteriorate. This led the Adviser to believe that the family had been told the prognosis was poor but that they had not been informed as to what to expect within the next 24/48 hours. There was also an entry in the records timed at 16:00 which mentioned the family were in attendance and Mrs A remained poor. The Adviser noted there was no further mention of the family until Mrs A died the following morning.

17. The Adviser noted that the SHO was asked to review Mrs A at 03:50 on 2 March 2006 and she was seen by a JHO and SHO at 04:30. This meant that it was not Mr C's telephone call which prompted doctors to review Mrs A. The Adviser said that there was confusion about communication with the family following the review by the SHO but the calls were instigated by the family and not medical or nursing staff. In the Adviser's opinion the family should have been given the opportunity to remain with Mrs A overnight and certainly should have been contacted at 03.50 when the concerns were such that a doctor was

required.

18. The Adviser told me that it was unacceptable that the family had not been told of Mrs A's death. A member of staff should have had a conversation with the relatives to confirm that they did appreciate that Mrs A had died and should have discussed with them whether or not they wished to see her at that stage. Part of the Last Offices procedure[1] is to care for and support relatives at such a sensitive and difficult time. I have seen that the records show the night staff did not inform the family that Mrs A had died as the family were en route to the Hospital. The intention was to speak to them on arrival at the second ward but they had not arrived by the time the night staff had gone off duty. As a result a nurse from the day shift showed the family to Mrs A's bedside unaware that they did not know she had died.

(b) Conclusion

19. The evidence obtained during this investigation has revealed that medical staff did explain to Mrs A's relatives that the prognosis was poor and that they were made aware of her deteriorating condition (see paragraph 16). However, other than information about the prognosis I take the view that there were serious failings in communication. There was no indication that staff were proactive in contacting the relatives and that when the relatives requested to speak to staff their attempts were, for whatever reason, unsuccessful. Matters were compounded when the family were taken to Mrs A's bedside unaware that she had died. The Adviser has commented that part of the Last Offices protocol is to offer care and support for relatives at such a difficult time. I am aware that an unreserved apology has been given to Mrs A's relatives for the distress which was caused and the issue has been raised with staff. Nevertheless my investigation has identified serious communication failures, particularly during shift changeover which does not appear to have been addressed. Accordingly, I uphold this complaint.

(b) Recommendation

20. The Ombudsman recommends that the Board ensure that this report is shared with the staff involved so that they are reminded of the importance of communication with relatives and consider whether the procedure for passing

[1] Last Offices is the care given to a deceased patient which staff must adhere to following the death of a patient. It includes issues such as making arrangements for relatives to view the body.

information to relatives at shift change over times about patients who have recently died is adequate.

(c) The procedure for reporting lost property was not adequately followed

21. Mr C complained that Mrs A lost her glasses when she was transferred from the third ward to the second ward. Mrs A's main enjoyment was reading and this enjoyment was removed until the family obtained a spare pair of glasses. The family repeatedly asked for a claim form and were told the second ward were waiting for a form from Administration. When the family contacted the Administration Offices themselves they were told the second ward had not requested any forms.

22. The Director said that it was noted Mrs A wore glasses on admission to the third ward, which is a receiving ward, and as that ward deals with a high number of patients who are transferred to other wards it is not policy to document patient's belongings. Staff practice is that the area next to the patient's bed area is checked prior to the transfer and before the next patient arrives. Staff could not recall seeing Mrs A with her glasses. The Director added that loss/claim forms can be obtained from the Charge Nurse or Deputy and if the missing items cannot be located a form would be offered. Staff could not recall being asked for a form or a report that Mrs A's glasses were missing.

23. The Adviser said that the policy regarding documentation of belongings in what can be a busy receiving ward is acceptable. The Adviser noted the Board's response that claim forms are available at ward level to cover losses but there was nothing to indicate that the loss of the glasses was reported. The Adviser felt the family had reported the loss of the glasses and wondered whether the Board would consider a claim after such a length of time.

(c) Conclusion

24. I am satisfied that the Board have a policy for reporting lost items but it would appear that staff might not always be able to give appropriate advice. It was said forms are available from the nursing staff yet when Mrs A's relatives asked for a claim form none were available on the ward and it appears no offer was made to obtain one. On balance I am persuaded that the relatives did report the loss of Mrs A's glasses and that staff did not take action to follow up the reported loss. I uphold this complaint.

(c) Recommendation

25. The Ombudsman recommends that the Board conducts a review of the availability of claim forms at ward level in the hospital. The Ombudsman further recommends that the Board send Mr C a claim form and consider a request for reimbursement of Mrs A's glasses should he wish to pursue the matter.

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

23 May 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs A	Mr C's late mother
Board	Greater Glasgow and Clyde NHS Board
The Hospital	Victoria Infirmary, Glasgow
Adviser	The Ombudsman's professional adviser
First ward	Ward where Mrs A was admitted to on 29 January 2006
Second ward	Ward where Mrs A was transferred to twice and received most of her care and treatment
Third ward	Ward where Mrs A was admitted to on 10 February 2006
Director	The Board Acute Services Director
SHO	Senior House Officer
JHO	Junior House Officer