Scottish Parliament Region: Glasgow

Case 200601122: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C) raised a number of concerns about the nursing care afforded to her late father (Mr A) during an admission at the Royal Alexandra Hospital, Paisley (the Hospital) from February 2004 to January 2005.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr A's fluid intake was inadequately monitored and there was a delay in commencing IV fluids *(upheld)*; and

(b) there was poor communication between nursing staff and relatives (*partially upheld*).

Redress and recommendation

The Ombudsman recommends that the Board apologise to Mrs C for the failure to chart fluid intake adequately and to consider commencing IV fluids earlier.

The Board have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. On 11 July 2006 the Ombudsman received a complaint from Mrs C about the nursing care afforded to her late father (Mr A) during an admission at the Royal Alexandra Hospital, Paisley (the Hospital). Mrs C had complained to Greater Glasgow and Clyde NHS Board (the Board) but remained dissatisfied with their responses and contacted the Ombudsman.

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

(a) Mr A's fluid intake was inadequately monitored and there was a delay in commencing IV fluids; and

(b) there was poor communication between nursing staff and relatives.

Investigation

3. In writing this report I have had access to Mr A's clinical records and the complaints correspondence. I made a written enquiry of the Board. I obtained advice from one of the Ombudsman's professional nursing advisers (the Adviser) on the clinical aspects of the complaint. An explanation of the abbreviations used in this report is contained in Annex 1.

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

(a) Mr A's fluid intake was inadequately monitored and there was a delay in commencing IV fluids

5. Mrs C and members of her family complained to the Board that Mr A had been a patient in the ward (the first ward) at the Hospital since February 2004 and that on 7 January 2005 he had to be transferred to another ward (the second ward) as his physical health had deteriorated and he was severely dehydrated. Mrs C said she had been told by staff in December 2004 that Mr A was refusing to eat or drink. She knew it was difficult to get Mr A to drink. She said it took two family members as one had to hold his head while the other gave him the drink. Mrs C also had concerns that staff continued to administer Furosemide (diuretic medication) to Mr A when it was known he had difficulty drinking.

6. Mrs C was aware that a doctor (Doctor 1) had prescribed IV fluids (fluids administered via a vein) for Mr C at 17:00 on 7 January 2005. The fluids were not started at that time as the nurses were waiting for an ambulance to transfer Mr A to the second ward whose staff would commence the fluids. (Note an ambulance was required because the wards were in different buildings). The family waited and became more concerned about the ambulance delay and asked for the duty doctor (Doctor 2) to see Mr A. Mrs C said Doctor 2 reviewed Mr A at 21:00 and immediately commenced the IV fluids and told the family that Mr A was seriously ill. Mrs C wondered if the delay in commencing the fluids could have had serious consequences for Mr A's health.

7. The Board's Director of Service Delivery (the Director) and the Board's Complaints Manager (the Manager) responded to Mrs C's complaints. It was acknowledged that a fluid balance chart should have been commenced to monitor Mr A's fluid intake and output. An apology was made for the shortfall and an assurance that lessons had been learnt from the complaint. The staff had confirmed that they had done their best to provide Mr A with fluids and nutrition. The staff recognised that Mr A took regular amounts of diet and fluid on a daily basis but was reluctant to do so particularly at the end of the day. Nursing staff saw no noticeable decrease in Mr A's intake so no report was made to the medical staff and the Furosemide continued.

8. The Director explained that on 7 January 2005 it was hoped Mr A could be managed by the first ward and a plan of care was developed which included IV fluids. However, a bed became available in the second ward and, therefore, staff there would decide on the plan of care. The second ward was situated in the main hospital building and facilities for monitoring and reviewing patients were available more easily as it was the weekend. The nurse did not commence the fluids at 17:00 as she did not expect the ambulance to be delayed. It was the Scottish Ambulance Service (SAS) who triaged the priority of calls dependent on the urgency of the individual cases. In addition the nurse thought that the IV line could have become dislodged during the ambulance transfer and this could have caused Mr A undue distress. Mr A was provided with oral fluids during the period he was waiting for the ambulance transfer to maintain his hydration. Doctor 2 reviewed Mr A at 21:00 and in view of the ambulance delay advised that the IV fluids be started.

9. In response to my enquiry the Board advised me that the SAS determined the urgency of cases which require an ambulance. Those which are classed as

urgent are dealt with first and other cases responded to within four hours. As Mr A was already a patient within a ward and being cared for by nursing staff and waiting to be transferred, it is likely that the SAS applied the second category and aimed to arrive within four hours.

10. The Adviser reviewed the records and told me that they were of a high standard and showed a picture of care delivered by both doctors and nurses. The Adviser explained that Mr A had dementia and his behaviour at times presented significant challenges for the nurses to manage. The Adviser considered that staff tried hard to cope with the challenges and there was no indication that Mr A had not been treated with dignity and respect. The Adviser said the family were also involved in Mr A's care as they wished. This included helping Mr A and providing meals.

11. The Adviser noticed that there was an entry prior to 14:00 on 7 January 2005 which read 'Fluid chart commenced' yet the first completed entry was at 21:30 when Mr A was admitted to the second ward. IV Fluids were prescribed at 17:00 and Doctor 1 entered 'Change of plans … Cancel/ignore all plans above and leave [the second ward] to decide plans to manage [Mr A]'. The Adviser said this was decided with the knowledge that the bed manager had ordered an emergency transfer ambulance. The Adviser was interested that the Board's response for the delay in starting the IV fluids was because the nurse felt it was for Mr A's comfort rather than on the instructions of Doctor 1. The Adviser believed that when the delay was obvious the nurse should have contacted the bed manager to check what information had been given to the SAS and to determine the likely delay time. She felt Mr A should have been reassessed if it was clear that the delay could be up to four and a half hours.

(a) Conclusion

12. It is clear that both Mrs C and the nursing staff were aware of Mr A's difficulties in taking fluids. The issues are whether Mr A's fluid intake should have been monitored and was there a delay in starting him on IV fluids. I am conscious that Doctor 1 prescribed IV fluids after examining Mr A as he was found to be dehydrated. In view of the advice which I have received and accept I find that Mr A's fluid intake should have been monitored by staff when concerns were noted about his ability to take fluids. As such any signs of dehydration could have been identified earlier and could have impacted on the need to continue the Furosemide. I also feel that nursing staff should have made earlier enquiries as to what status the SAS had afforded to the request for

an ambulance transfer, and had that identified a wait of over four hours was possible, then steps should have been taken to commence IV fluids at the first ward. Accordingly I uphold this complaint.

(a) Recommendation

13. The Ombudsman recommends that the Board apologise to Mrs C for the failure to chart fluid intake adequately and to consider commencing IV fluids earlier.

(b) There was poor communication between nursing staff and relatives

14. Mrs C complained that a nurse told the family at 19:00 on 7 January 2005 that as it was a Friday the SAS would be busy. At 20:00 the family asked a nurse to call the SAS back but she was reluctant to do so and said it would not be unusual for an ambulance to arrive at 02:00 as this had happened in the past.

15. The Manager responded that the Charge Nurse recalled that a full explanation regarding the ambulance situation was given to the family at 19:00. The Manager gave an apology if this had been inadequate and said staff had been informed of the importance of providing adequate and appropriate communication with relatives.

16. The Adviser said it was disappointing but factual that communications broke down around the transfer and the delay in the arrival of the ambulance in that the family were not made aware that a wait of over four hours was possible. However, there is evidence that Mr A's family were clearly involved in decisions relating to the package of care (including medication) for Mr A throughout the time he was in the Hospital.

(b) Conclusion

17. Mr A was a patient in the first ward for almost a year and there are indications from the records that there was regular communication between the nursing staff and Mr A's family. Communications during this period were of a reasonable standard with the exception of the incident concerning the wait for the ambulance transfer. I can fully understand Mrs C's concerns about the delayed starting of Mr A's IV fluids and that the family were forced to ask nursing staff to contact the SAS for an update and also that Mr A be reviewed by medical staff. In summary, there is evidence to suggest that staff were in regular communication with Mr A's family and the Board consider a full

explanation was given. However, I have found there was a failing in respect of communications about the ambulance delay and it is to this extent that I uphold this complaint.

(b) Recommendation

18. The Board has apologised for the breakdown in communications and the Ombudsman has no further recommendation to make.

20 June 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	Mrs C's father
The Hospital	Royal Alexandra Hospital, Paisley
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	The Ombudsman's professional nursing adviser
The first ward	The ward where Mr A was a patient up to 7 January 2005
The second ward	The ward where Mr A was transferred to on 7 January 2005
Doctor 1	The doctor who reviewed Mr A at 17.00 on 7 January 2005
Doctor 2	The doctor who reviewed Mr A at 21.00 on 7 January 2005
The Director	A Board Director of Service Delivery
The Manager	A Board Complaints Manager
SAS	Scottish Ambulance Service