Scottish Parliament Region: Glasgow

Case 200600459: Greater Glasgow and Clyde NHS Board [1]

Summary of Investigation

Category

Health: Hospital; Oncology; Clinical treatment/diagnosis

Overview

The complainant Mr C was concerned about the care and treatment provided to his late wife (Mrs C). He said that a delay in the initial diagnosis of her cancer meant she had to attend the hospital daily for injections for suspected deep vein thrombosis. He also said that he was unhappy about the care and treatment Mrs C had received following her admission to Inverclyde Royal Hospital (the Hospital) and felt that the communication both to Mrs C, her family and between the Hospital staff had been inadequate.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was a delay in the initial diagnosis of Mrs C's condition (*upheld*);

(b) the treatment given to Mrs C was inappropriate (*partially upheld*); and

(c) there were significant failures of communication, concerning her treatment and care, both to Mrs C and her family and between the Hospital staff (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mr C and his family for the delay in diagnosis and share this report with the clinical staff responsible for Mrs C's care;

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[1] Since the events in this report Inverclyde Hospital became part of Greater Glasgow and Clyde Health Board. Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to the former Board or Greater Glasgow and Clyde Health Board as its successor. However, the recommendations within this report are directed towards Greater Glasgow and Clyde Health Board.

(ii) review their pain assessment and management procedures and ensure that these include a full explanation of the role and involvement of specialist or palliative care teams in the care of patients with non-surgical pain;

(iii) apologise to Mr C and his family for not fully explaining Mrs C's pain management regime and for any unnecessary pain that Mrs C suffered as a result of this;

(iv) review their policies and procedures to ensure that there is suitable monitoring of nutritional care and management;

(v) provide evidence that standards of communication have improved and, in particular, that there are policies and procedures in place to ensure that patients who are terminally ill and their families are fully supported and treated with appropriate dignity;

(vi) emphasise to staff responsible for responding to complaints the importance of doing so in a non-defensive and open manner; and

(vii) apologise to Mr C and his family for all the failures identified in record keeping and communication; for failing to provide adequate support to them and Mrs C during her final illness; for the confusion about the circumstances surrounding Mrs C's death; and for failing to respond with appropriate care and sensitivity to the concerns raised by Miss C on their behalf.

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

Main Investigation Report

Introduction

1. Mrs C, aged 69, was admitted to Inverclyde Royal Hospital (the Hospital) on 21 October 2005 for assessment and treatment of suspected deep vein thrombosis (DVT). She was treated as an out-patient and had a Doppler/ ultrasound scan on 25 October 2005 and a CT scan on 2 November 2005. Following this she was diagnosed as suffering from cancer and admitted as an in-patient. She was treated at the Hospital from 4 to 11 November 2005 and from 14 November 2005 until her death on 22 November 2005.

2. Mrs C's daughter (Miss C) complained to Argyll and Clyde NHS Board (the Board) on behalf of the family on 19 December 2005.[2] She said she was concerned that because of a delay in the initial diagnosis Mrs C had had to attend the Hospital for daily injections. Once Mrs C had been admitted to the Hospital she said the family were often confused or concerned about Mrs C's care and treatment and unclear about the seriousness of her condition. The tests Mrs C underwent appeared to be arbitrary and Mrs C was given morphine inappropriately and against her and her family's wishes. Although special meals were ordered, Mrs C was often missed at meal times and they had been concerned about her nutrition.

3. The family were also unhappy about events surrounding Mrs C's discharge and return to hospital over the weekend of 11-14 November 2005. They said that the discharge had been substantially delayed while waiting for a prescription and that, on their initial attempt to return Mrs C to the Hospital on the evening of 13 November 2005, Mrs C had been put in a separate room but then moved to accommodate a disturbed patient. The family were told they could take Mrs C home and bring her back in the morning. They then had an extended wait on the morning of 14 November 2005 until a bed was found.

4. There had been further confusion about whether or not the family could have transported Mrs C to the Western Infirmary for a test on 21 November 2005. They had been told they could not do so but the ambulance desk later suggested that they could have done.

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[2] The paragraphs that follow summarise the concerns expressed and response given and do not include the full details of Miss C's complaints or the Board's response.

5. Miss C also said that, on the night when Mrs C died, the family had been given two different versions of events and treated insensitively.

6. The Board responded on 14 March 2006. They detailed the treatment received by Mrs C during her stay and apologised for the events on 13 and 14 November 2005. They said this matter would be discussed further with staff as the actions had not been in line with procedure. They also said that the information given by the ambulance help desk was inappropriate as, because of her frailty, Mrs C had required a nurse escort.

7. The Board said they considered the tests and treatment provided to Mrs C had been appropriate and necessary. They were not able to explain why Mrs C's family were unaware of the full extent of her condition and noted she had also said they had been informed that Mrs C was ill and would require chemotherapy. They said there could be a number of reasons why they were not fully informed, including patient choice.

8. On 16 May 2006 Mr C complained to the Ombudsman that the family did not consider any of their concerns had been fully addressed.

9. The complaints from Mr C which I have investigated are that:
(a) there was a delay in the initial diagnosis of Mrs C's condition;
(b) the treatment given to Mrs C was inappropriate; and
(c) there were significant failures of communication, concerning her treatment and care, both to Mrs C and her family and between the Hospital staff.

Investigation

10. The investigation of this complaint involved obtaining all the background documentation relating to the complaint and Mrs C's medical records. Advice was also obtained from medical and nursing advisers (Adviser 1 and 2, respectively) to the Ombudsman. As a result of the advice, further enquiries were made of the Board. The abbreviations used in the report are explained in Annex 1 and the medical terms used in the report are explained in Annex 2.

11. I have not included in this report every detail investigated but 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) There was a delay in the initial diagnosis of Mrs C's condition

12. Mrs C, who had a past history of cervical cancer and some episodes of heart failure, was first admitted to the Hospital on 21 October 2005 by her GP with suspected DVT. Mrs C had swelling in her legs and fluid accumulation in her abdomen and chest. She also reported weight loss over previous months. She underwent two tests on 21 October 2005 – a venometry (this measures venous blood pressure in a number of points) and a test for the presence of D-dimer in the blood. A D-dimer is a fragment of a blood clot.

13. No results were obtained from the venometry but the blood test showed an increased level of D-dimer and she was referred for an ultrasound scan to confirm whether this was an indication of DVT. Mrs C was told the next available appointment for the ultrasound was on 25 October 2005. In the interim Mrs C attended the Hospital each day to be given an anti-coagulant injection to thin her blood. The ultrasound showed there was no sign of a DVT but the presence of fluid in the abdomen was noted and the presence of tumours. The anti-coagulant injections were stopped.

14. A CT scan was carried out on 2 November 2005. This showed the presence of secondary malignancies on Mrs C's liver. (Secondary in this context means that the cancerous cells had not originated in the liver but had spread there.) On 3 November, Mrs C was seen by a Senior House Officer who examined her and, according to the clinical records, explained the results of the CT scan to Mrs C and Miss C who was also present. Mrs C was admitted to the Hospital on 4 November 2005. Tests on fluid extracted from her abdomen confirmed the presence of cervical cancer.

15. In reviewing the clinical records, Adviser 1 said that Mrs C's cervical cancer had been treated appropriately in 1996 and followed up. Given this, when Mrs C attended at the Hospital with a painful and swollen leg on 21 October 2005, it was entirely reasonable that the possibility of a DVT be excluded. Adviser 1 also pointed out that the symptoms caused by Mrs C's cancer would have predisposed her to a venous thrombosis and that, given the positive D-dimer test, one may indeed have been present.

16. However, Adviser 1 also noted that fluid in the abdomen was clearly present on the first admission. The distention of the abdomen was described as 'gross'. In the circumstances, Adviser 1 considered that the procedure to withdraw fluid (see paragraph 14) need not have waited until after the CT scan

but could have been done at this first admission. This would have led to a diagnosis of cancer at an earlier stage. Adviser 1 added that there were no significant delays in the scheduling of the other investigations and that any earlier diagnosis would not have materially affected the outcome.

17. Adviser 2 said that it was not clear whether the injections could have been carried out at home. Following further enquiries, the Board confirmed that this service was available. The Board also said that patients were always asked if attendance would be problematic and that Mrs C had not presented with mobility problems. Adviser 2 said she was encouraged this could be carried out at home but that it was not clear from the documentation that this had been offered to Mrs C and communicated to her family. In response to this draft report, Miss C said that she was certain Mrs C had never been asked about this.

(a) Conclusion

18. Adviser 1 has said that it was reasonable in the circumstances to consider a diagnosis of DVT and that the actions taken on this basis, including arranging anti-coagulant injections, were appropriate. However, he has also said that there was distention of the abdomen and that it would have been possible to test the abdominal fluid earlier. If this had occurred then the cancer would have been detected earlier. As DVT would still have remained a possibility, even given the likely diagnosis of cancer, this would not have necessarily prevented the need for Mrs C to have anti-coagulant injections prior to the CT scan.

19. Adviser 2 has commended the Hospital for ensuring injections can be carried out at home if there are problems with attendance. It is unfortunate, however, that it was not noted on Mrs C's records whether this was discussed with her or her circumstances were considered.

20. On the basis of the advice that there was a delay in diagnosing cancer and given that it is not possible, as it is not noted anywhere in the documentation, to confirm that the Hospital did consider whether Mrs C should have received injections at home, I am upholding this complaint in full. I have noted the advice that the delay in diagnosis did not have any material effect on the outcome. I am also aware that the diagnosis itself would not have prevented the need for the injections and these would likely have continued until the ultrasound confirmed DVT was not present (see paragraph 13).

(a) Recommendation

21. The Ombudsman recommends that the Board apologise to Mr C and his family for the delay in diagnosis and share this report with the clinical staff responsible for Mrs C's care.

(b) The treatment given to Mrs C was inappropriate

22. Under this head of complaint, I have considered two separate aspects of the treatment given to Mrs C: the investigations taken to provide further information following the diagnosis of cancer; and the use of morphine to treat Mrs C's pain. I deal with the investigations first.

23. From the clinical records, it is clear that, following the diagnosis of cancer, Mrs C underwent a number of further tests. X-rays were taken of her right shoulder and she was transferred to the Western Infirmary for a bone scan. Mammograms were taken, as well as a chest CT scan. The fluid in her abdomen was tested again and she had an x-ray of her lower abdomen. Mrs C was also scheduled for a bronchoscopy at the time of her death and had also been scheduled for a liver biopsy but this had been cancelled.

24. Adviser 1 said that, on the whole, the investigations undertaken were reasonable. Mrs C had complained of shoulder pain and x-rays and the bone scan were taken to clarify whether the cancer had spread to the bone. Mrs C also had fluid in her chest cavity and complained of severe lower abdominal pain and further investigations of these were appropriate. However, he was unsure why the mammograms were taken when an examination revealed no lump.

25. In commenting on the decision to cancel a liver biopsy, Adviser 1 noted that the decision whether or not this was needed was not a straightforward clinical one. There had been discussion amongst clinical staff on this point and the further testing of the abdominal fluid confirmed the first diagnosis that the primary cancer was cervical. Given Mrs C's condition was deteriorating and a liver biopsy would mean a further trip to another hospital, the decision not to go ahead was reasonable.

26. On 7 November 2005 Mrs C was prescribed a pain killer. On 14 November she was prescribed morphine. The prescription was changed to a different form of morphine on 17 November 2005. Mrs C's family were concerned and said she appeared to be in a drugged state. On

20 November 2005 they asked that this be reduced. The nursing records note that the family were told Mrs C had been on a lower dose the week before and that she was often in pain. The family said that they felt the current dose was causing excessive drowsiness. A doctor was consulted and the dose reduced. On 21 November 2005 Mrs C refused further morphine and her family said they did not wish her to receive this. Mrs C was described as being in significant pain later that evening and again given morphine. Mrs C died in the early hours of 22 November 2005.

27. In their letter of 14 March 2006, the Board said that Mrs C was given increased dosage in response to her need for regular pain relief. They also said that there was no evidence that morphine weakened the heart and that it was often given towards the end of life when patients were in organ failure. It, therefore, had to be used with care but could not be completely avoided.

28. Adviser 1 said that it was a common experience, particularly when treating the frail elderly, that the dosage required to achieve pain relief caused problems with drowsiness. Ideally, this would be adapted so that the patient would be settled and alert enough to enjoy her visitors. However, this was not always achieved, especially when there was a short time frame to adjust the dosage. Adviser 1 added that the dosage would have reduced Mrs C's respiration and raised the risk of infection but, again, that this was not an unusual outcome of the care of the terminally ill. This would have been the only effect that the dose would have had on her health.

29. Adviser 2, in reviewing the nursing documentation, said that the daily progress notes detailed Mrs C's gradual decline and her increasing shoulder and abdominal pain. The entries in the notes directly related alterations in the pain relief prescriptions to increase in pain and she had no doubt that attempts were made to ensure the pain relief medication was appropriate to the level of distress experience caused by Mrs C. She did note, however, that although the daily records were good, there was no evidence of regular, formal pain assessment and sedation scoring. There was room for this on the observation chart.

30. Adviser 2 was concerned that Mrs C was not assessed by a member of the pain or palliative care teams. She also said that, from the notes and the Board's response, it was not clear whether Mrs C and her family had full explanations and counselling to enable them to understand how pain relief was

being used to help Mrs C and the possible side effects. Although a nurse did provide a reasonable explanation of Mrs C's increased need for pain relief on 20 November 2005 (see paragraph 26), opportunities were generally missed to provide further information and she felt more detailed explanations of the reasoning behind the staged increase of pain relief and the nature of pain might have assisted Mrs C and her family to understand that staff were trying to achieve a pain-free situation with minimal drowsiness.

(b) Conclusion

31. Advisers 1 and 2 have both said that, in general, the treatment given was appropriate. Although I have noted Adviser 1 has some concerns about the need for the mammogram, Mrs C was displaying complex symptoms and the advice I have received is that the overall treatment was appropriate. (I have already recommended at paragraph 21 that the report be shared with clinical staff and expect the issue of the mammogram also to be shared.)

32. Nevertheless, I am concerned that, while the use of morphine was appropriate, the only evidence of this being discussed with Mrs C or her family in detail followed complaints by her family several days after morphine had been prescribed. There was no evidence of specialist pain management or palliative support being made available to support Mrs C, her family and staff in dealing with her pain. The failure to communicate the reasons behind the use of morphine or to discuss pain management with Mrs C and her family contributed to Mrs C's refusal to take pain relief and may have led to her experiencing pain and discomfort unnecessarily. Adviser 2 has also found that there was no evidence of regular, formal pain assessment and sedation scoring. I, therefore, partially uphold this complaint to the extent that, although in general appropriate, the failure to fully communicate to Mrs C and her family about the pain management regime and lack of documentation mean that it is difficult to conclude that at all times the treatment Mrs C received for her pain was adequate.

(b) Recommendation

33. The Ombudsman recommends that the Board:

(i) review their pain assessment and management procedures and ensure that these include a full explanation of the role and involvement of specialist or palliative care teams in the care of patients with non-surgical pain; and

(ii) apologise to Mr C and his family for not fully explaining Mrs C's pain management regime and for any unnecessary pain that Mrs C suffered as a result of this.

(c) There were significant failures of communication concerning her treatment and care, both to Mrs C and her family and between the Hospital staff

34. Under this head of complaint, I have considered general issues of communication as well as reviewing particular concerns about: nutrition, the time taken to issue a prescription on discharge and the information given to Mrs C's family about the circumstances surrounding her death.[3] I deal with communication in general first.

35. In considering the overall communication, Adviser 2 reviewed the nursing records of Mrs C's care.[4] As noted in paragraph 29, daily progress notes were kept and were of good quality. Care plans were also completed for her abdominal distension, poor appetite and constipation. Adviser 2 noted the care plans were only reviewed once during Mrs C's stay and that the reviews were undated. She also felt that the initial assessment was limited.

36. Adviser 2 also noted that there was very little documentation about what was communicated to Mrs C and her family. Adviser 1 added that there was no evidence that anyone had explained to Mrs C or her family the reason for the investigations or her prognosis during Mrs C's first admission (prior to 14 November 2005).[5] The nursing notes simply stated that on the initial admission Mrs C and her family were 'aware of her condition'. The next relevant entry was dated 18 November 2005, which said Mrs C was informed about the results of specific tests and why more tests would be needed.

37. Turning to the nutritional support given to Mrs C: Mrs C was assessed on 4 November and 20 November 2005 and both assessments showed Mrs C to be at risk of malnutrition. Mrs C was referred to a dietician and she was

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[3] The Hospital have already accepted fault for the communication surrounding other aspects of events on 13/14 November 2005 and surrounding the transfer of Mrs C to the Western Infirmary for tests (paragraph 6). I do not comment on these further.

[4] Adviser 2's concerns about the recording of pain management have been dealt with in paragraph 29 and are not repeated here.

[5] Paragraph 14 notes there was some discussion at the meeting prior to admission about the diagnosis of cancer.

assessed by a dietician on 8 November and 15 November 2005. This second assessment followed concerns expressed by Mrs C's family about her food intake. At the first assessment the dietician advised a high protein, low salt diet and a prescription of a high–calorie drink. On 15 November 2005 it was noted that Mrs C had managed some of the drink and was taking snacks when she could manage. Throughout, nursing records indicate that Mrs C's diet continued to be poor.

38. In response to further questions the Board said that the meals were ordered but that they could not confirm whether these were delivered. They said the ward sister had confirmed Mrs C was always offered a meal at meal times. Adviser 2 noted that this was not evidence that these arrived or of what Mrs C ate and that, given the concerns over her diet, she felt that the use of a food chart would have been helpful and informative.

39. Adviser 1 and Adviser 2 both said that given she was terminally ill, further intervention (eg, by tube feeding) would have been inappropriate. Adviser 2 added that it was generally accepted as being in the patient's best interest from the perspective of comfort and dignity not to persist with aggressive nutritional measures and to only encourage oral intake when the patient was able to accept it. This was because tube feeding could be very distressing for a deteriorating patient who was not likely to be able to tolerate it.

40. Adviser 2 also requested further information about the issuing of prescriptions to patients being discharged on Fridays and the Board's policies on privacy and dignity.

41. In their response, the Board said that for small, uncomplicated prescriptions, a pharmacy label printer was now available at ward level but Fridays did remain busy. They said Mrs C was given a single room within the ward when her condition deteriorated suddenly on the evening of the 21 November 2005 and staff did attempt to prevent patients being disrupted by the behaviour of other patients and relatives.

42. In reviewing the response, Adviser 2 remained concerned that the Board had not responded to the question about their broader privacy and dignity improvement initiatives or given further information about how discharges were anticipated and predicted so that delays were kept to a minimum.

43. In her letter to the Board of 19 December 2005, Miss C had described the family's experiences on the night of Mrs C's death. She said that they had been called to the Hospital in the early hours of the morning of 22 November 2005. While with Mrs C, a doctor had examined her and a nurse told them that it had been decided treatment to help her move her bowels would make her more comfortable. The family were asked to leave the room. After a wait, they returned to find the door open and Mrs C on her own. She was not breathing and they pressed the panic button. The doctor appeared and then other members of staff. The family left the room and were subsequently told that Mrs C had died. They approached a nurse for further information and were told that Mrs C had been alive after the treatment had been completed. They approached a second nurse and were told that Mrs C had not been alive when they (nursing staff) had left the room and that resuscitation had been attempted although this was unusual in the case of a patient with terminal illness.

44. The Board's letter to the family of 14 March 2006 said that the nursing records showed that she had complained of pain at 23:30 and given pain relief. Mrs C then deteriorated and the family and a doctor were called. As Mrs C complained of abdominal pain and was found to be constipated, she was given suppositories, she was then bathed and left in her bed. They were later alerted by the family that her condition had further deteriorated and a doctor called who decided that resuscitation was not appropriate.

45. Adviser 2 said that despite the Board's letter this was not the version recorded in the nursing records. She said that while the nursing records did not accurately record the timing of events they seemed to suggest that Mrs C had collapsed immediately following the suppository administration and it seemed the nurse was present and instigated a cardiac arrest call. This suggested that when Mrs C's family found her she had already died but they had not been informed.

46. In their response, the Board said they had discussed this with the nurse who was present at the time. She repeated the description of events given in the letter (see paragraph 44) but confirmed that resuscitation had begun and was only stopped after the Senior House Officer who had responded to the call had analysed the situation.

47. Adviser 2 said there was now clear discrepancy between the accounts of staff and Mrs C's family and that the version from the Board still did not reflect

the nursing records. She said she could make no further judgement other than to say that she understood the family's concerns in the light of this.

48. In reviewing the relevant section of the nursing and clinical records, I noted the clinical records record that the Senior House Officer who was called was told that the family had found Mrs C not breathing and staff had begun CPR. He stopped this as it was inappropriate, given Mrs C's condition. The nursing notes recorded the following:

> 'Glyn Supp given. Respirations ceased suddenly. Arrest call made by [Dr X]. Resuscitation commenced. [Dr Y] attended ward. CPR inappropriate same stopped.'

(c) Conclusion

49. In reviewing the records both Advisers were concerned by a number of communication failures. They have identified a failure to ensure documentation was correctly completed and regular assessments taken of Mrs C's condition (see paragraph 35); a failure to communicate with Mrs C and her family about her condition or to document this (see paragraph 36); and a failure to document the provision of specialist meals (see paragraph 39).

50. Adviser 2 has also criticised the failure of the Board to provide details of their privacy and dignity initiatives or about any steps taken to improve discharge procedures (see paragraph 42).

51. Although the Board have admitted to some failings of communication in their letter to Miss C of 14 March 2006, I feel that the communication in this letter was not as careful and sensitive as it should have been. An example of this can be seen in paragraph 7, where I have repeated a passage from the letter to Miss C which stated that there could be a number of reasons why they were not fully informed, including patient choice. While this is true in general, it did not respond to Miss C's concerns why she and her family were not informed and certainly does not reflect the fact that the clinical records show that communication not only to the family but to Mrs C about her condition was inadequate. It also wrongly gives the impression that Mrs C may have made a request that her family be denied information when there is no evidence of this. It is, therefore, highly inappropriate.

52. On this point, it is also notable that in response to my own questions, the Board did not take the opportunity to provide full, detailed responses. For

example, in response to a direct question on the privacy and dignity initiatives used by the Board, I was given a reply which simply repeated statements made in responding to the details of Miss C's complaint (see paragraph 41). I appreciate it is never pleasant to receive complaints but responses should, wherever possible, answer the points raised and, where a bereavement has occurred, be phrased with sensitivity and care.

53. Turning to the circumstances surrounding Mrs C's death, it is clearly a matter of concern that the nursing notes do not provide a definitive answer to what occurred and that Adviser 2 was unable to make a valid judgement on this. The situation has been made worse by the fact that Mrs C's family appear to have been given two versions of the events on the night she died. I am also concerned that resuscitation was attempted. Mrs C was clearly terminally ill and this could have caused unnecessary distress. The Senior House Officer who attended correctly described this intervention as inappropriate and this should not only have been clearly stated on her records but, given she was clearly deteriorating, discussed in advance with Mrs C and her family.

54. Given all the above, I have no hesitation in upholding this complaint in full.

(c) Recommendation

55. Since the events described in this report occurred, the Ombudsman has made recommendations that the Board review their record-keeping (report number 200501786), discharge policies (report number 200500930) and complaints procedure (report number 200400662). The Board have provided evidence of action taken in these areas and this is reflected in the recommendations made below.

56. The Ombudsman recommends that the Board:

(i) review their policies and procedures to ensure that there is suitable monitoring of nutritional care and management;

(ii) provide evidence that standards of communication have improved and, in particular, that there are policies and procedures in place to ensure that patients who are terminally ill and their families are fully supported and treated with appropriate dignity;

(iii) emphasise to staff responsible for responding to complaints the importance of doing so in a non-defensive and open manner; and

(iv) apologise to Mr C and his family for all the failures identified in record keeping and communication; for failing to provide adequate support to

them and Mrs C during her final illness; for the confusion about the circumstances surrounding Mrs C's death, and for failing to respond with appropriate care and sensitivity to the concerns raised by Miss C on their behalf.

57. 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.

22 August 2007

Annex 1

Explanation of abbreviations used

Mrs C	Mr C's late wife
The Hospital	Inverclyde Royal Hospital
DVT	Deep Vein Thrombosis
Miss C	Mr and Mrs C's daughter
The Board	Prior to 1 April 2006, Argyll and Clyde NHS Board and, after that date, Greater Glasgow and Clyde NHS Board
Mr C	The complainant and husband of Mrs C
Adviser 1	Medical adviser to the Ombudsman
Adviser 2	Nursing adviser to the Ombudsman
CT	Computerised tomography
CPR	Cardiopulmonary resuscitation

Annex 2

Glossary of terms

Anti-coagulant	any agent used to prevent the formation of blood clots
CT scan	computerised tomography scan: pictures of structures within the body created by a computer that takes the data from multiple x-ray images and turns them into pictures
D-dimer	a fragment of a blood clot, the presence of which can indicate DVT
Cardiopulmonary resuscitation	the emergency substitution of heart and lung action to restore life to someone who appears dead
Deep Vein Thrombosis	a blood clot (thrombus) that develops in a deep vein, usually in the leg
Enema	treatment to relieve constipation
Malignancy	a tumour that can invade and destroy nearby tissue and that may spread to other parts of the body
Morphine	a powerful drug with strong painkilling action (it can cause severe drowsiness)
Ultrasound/Doppler scan	a form of ultrasound that can detect and measure blood flow
Venometry	a test for DVT that involves testing venous blood pressure at a number of separate points

X-rays	High-energy radiation with waves shorter than those of visible light