Scottish Parliament Region: Glasgow

Case 200501476: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category

Health: Clinical treatment

Overview

The complainant (Mrs C) raised a number of concerns about the care her late brother (Mr A) received in the days before he died.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs C was not kept properly informed about Mr A's condition (*upheld*);

(b) Mr A's condition was not adequately monitored on the night he died (*not upheld*);

(c) the way Mr A's death was communicated to the family was inappropriate (*not upheld*);

(d) a member of the nursing staff was rude to the family (*upheld*); and

(e) some of Mr A's personal belongings were lost during his stay in hospital (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Greater Glasgow and Clyde NHS Board (the Board):

(i) apologise to Mrs C for shortcomings in communications about Mr A's condition;

(ii) take further action to ensure that a proactive approach is taken to establishing good communication with relatives;

(iii) use this complaint as a case study to illustrate the importance of good communication with relatives, especially when the hospital are aware that the patient is unlikely to survive; and

(iv) apologise to Mrs C formally for the conduct of a member of nursing staff and also give consideration to providing to staff dealing with patients and their families a more focussed reinforcement of the importance of good customer care through, for example, appropriate training.

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

Main Investigation Report

Introduction

1. Mrs C's husband telephoned the Ombudsman's office on 2 September 2005 to complain about the treatment his brother-in-law (Mr A) had received at the Royal Alexandra Hospital (the Hospital) in Paisley. Mrs C followed this up by submitting a statement of her complaint and copies of the complaint correspondence received from the Greater Glasgow and Clyde NHS Board (the Board). This was received on 12 September 2005.

2. Mr A had been admitted to the Hospital on 21 June 2004 after collapsing at home. He had a history of alcohol related liver disease and was very jaundiced on admission to the Hospital. Laterally, Mr A was moved to a single room to allow better observation. Mrs C and her family sought advice on the seriousness of Mr A's condition so that they could decide how important it was to travel to see him. Mrs C did not visit Mr A and he died at the Hospital on 2 July 2004 of decompensated alcohol related liver disease, staphylococcal bacteraemia and acute renal failure.

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

(a) Mrs C was not kept properly informed about Mr A's condition;
(b) Mr A's condition was not adequately monitored on the night he died;
(c) the way Mr A's death was communicated to the family was inappropriate;
(d) a member of the nursing staff was rude to the family; and
(e) some of Mr A's personal belongings were lost during his stay in hospital.

Investigation

4. To investigate Mrs C's complaint, I reviewed Mr A's medical records, including the nursing notes relating to his stay at the Hospital. I also reviewed correspondence relating to the complaint made to the Board and took advice from an independent clinical adviser (the Adviser). The Board arranged for a meeting between NHS staff, Mrs C and other members of her family and this took place on 18 April 2005. I have seen the notes of this meeting and the follow-up letter sent to Mrs C on 24 May 2005. Additionally, I made inquiry of the Board on 14 February 2006 and a response was sent on 21 March 2006.

5. 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 an opportunity to comment on a draft of this report.

(a) Mrs C was not kept properly informed about Mr A's condition

6. Mrs C complained that she and her family had received contradictory advice about the seriousness of Mr A's condition after his admission to the Hospital. Mrs C telephoned the Hospital on 30 June 2004 to ask whether Mr A's condition was serious enough for her to visit him immediately. She was advised that his condition was stable and that it was not necessary for her to visit immediately. Other family members also contacted the Hospital on 30 June 2004 and felt reassured that Mr A's condition was not serious. However, during an afternoon visit the previous day, Mrs C's sister had been advised by the ward sister that they were 'taking it day by day' and she took this as an indication that Mr A's condition was, indeed, poor.

7. During the investigation, Mrs C told the Ombudsman's office that the conversation between her sister and the ward Sister on 29 June 2004 was the first indication the family had received that Mr A's prospects may not be good.

8. Mr A's nursing notes record only that the family had been updated on 27 June 2004. The advice I have received from the Adviser is that it is likely that if other updates were offered, this was on request by family members.

9. The Board's response to this complaint was that Mrs C had been advised by telephone that she would receive a fuller update on Mr A's condition if she spoke to other family members because it would be difficult to give detailed information on the telephone. At the meeting with Mrs C on 18 April 2005, the Board further commented that, although it can be difficult to keep a large family informed of a relative's progress, staff should have explained to the family that a single point of contact may have facilitated better communications.

10. In response to my inquiry on 14 February 2006, the Board confirmed that, while there is no formal policy on giving sensitive information to relatives by telephone, their normal practice is to give only limited information by telephone (see paragraph 23). However, there are now arrangements for keeping relatives who live at a distance updated by telephone by requesting a single nominated contact person for each patient. This request features on a handout given to new patients and is backed up with advice to staff on responding to requests for information by telephone.

11. In reviewing the communications between the Hospital and Mrs C's family, the Adviser said:

> 'It surprises me that an appointment does not seem to have been made with the relatives to discuss Mr A's condition and prognosis given his previous admission history and his current history. Such a proactive approach would have cut the risk of inconsistent messages being given to relatives.'

(a) Conclusion

12. Mrs C complained that communications from the Hospital had not prepared her or other family members for the possibility that Mr A's condition may worsen. Because of this, she said she, and other family members including Mr A's daughter, did not believe it was necessary to make arrangements to visit Mr A and as a result did not have the chance to see him before he died.

13. The advice I have received is that it is clear from Mr A's medical history that there was a strong possibility that his health would deteriorate. From the evidence I have seen, this possibility does not seem to have been communicated to Mrs C. If better communications had been established earlier on, Mrs C may have been better prepared for the news of Mr A's death. I, therefore, uphold this complaint.

(a) Recommendation

14. I note that the Board have taken action to improve communication at a distance and with larger families and I commend them for this action. However, I recommend that they:

(i) apologise to Mrs C for shortcomings in communications about Mr A's condition; and

(ii) take further action to ensure that a proactive approach is taken to establishing good communication with relatives.

(b) Mr A's condition was not adequately monitored on the night he died

15. On 23 June 2004, Mr A was moved to a different ward and shortly after that he was moved from the open ward to a side room close to the nurses' station. The reasons given to the family for this were that Mr A was confused and needed closer observation.

16. On the night of 1 July 2004, it is noted in Mr A's records that a nurse checked on his condition at around midnight. When he was checked again at 01:40 he was found to have no respirations and no pulse was felt. A doctor was called and Mr A's death was confirmed at that time.

17. Mrs C complained that Mr A had not been adequately monitored because no one had noticed that he had died until some time later. She further complained that the curtains on the window of Mr A's room had been drawn so he could not have been observed from outside. The Board acknowledged that this should not have happened and said they would raise this issue with the nursing staff on the ward.

18. The Adviser noted that '… both the medical and nursing notes indicate that doctors and nurses were vigilant and responsive to [Mr A]'s changing needs' and did not regard a one and a half hour gap between observations on the night of Mr A's death as unreasonable. However, she also noted that the care plan that had been completed shortly after admission was 'very limited' and did not appear to have been updated in the course of Mr A's stay. This issue was raised at the meeting held between family members and NHS staff on 18 April 2005 and, again, it was noted that this issue would be addressed with nursing staff in the ward. Furthermore, the Board, in its submission to the Ombudsman's office of 21 March 2006, advised that the regular updating of care plans was now established.

(b) Conclusion

19. Although the Board has acknowledged that some aspects of the way Mr A's condition was monitored were not as good as they should have been, these areas have now been addressed and I commend the Board for this action. In addition, the records demonstrate that the staff involved in Mr A's care had been attentive and responsive to the changes in his condition. I, therefore, do not uphold this complaint.

(c) The way Mr A's death was communicated to the family was inappropriate

20. As stated above, on the night of 1 July 2004, a nurse checked on Mr A's condition at around midnight. When he was checked again at 01:40, he was found to have no respirations, and no pulse was felt (see paragraph 16). The nursing notes confirm the family's reports that they were contacted some time after 01:40 and told that Mr A's condition had worsened.

21. When family members arrived at the Hospital, they were informed that Mr A had died, and when they went in to see him, they were distressed that he seemed to have died some time previously. They felt aggrieved that they were told that Mr A's condition had worsened at the time when he had already passed away.

22. In their response to the family's complaint about this, the Board said that they prefer to be able to support family members when giving the news of the death of a loved one, and this is why they were not informed by telephone that Mr A had died.

23. The Board confirmed with the Ombudsman's office that their normal practice is to give only limited information by telephone both to preserve the patient's right to confidentiality and to ensure that appropriate support is available if it is necessary to communicate difficult or sensitive information.

(c) Conclusion

24. The decision not to inform Mr A's family of his death by telephone was taken for good reasons and the Adviser has confirmed that this is in keeping with usual practice. I, therefore, do not uphold this complaint. However, because the family had not been prepared for the possibility of Mr A's condition worsening severely (see paragraph 13), their distress at receiving the news of his death was all the more acute.

(c) Recommendation

25. Although I do not uphold this complaint, because of the concerns about communication highlighted above (see paragraph 14), I recommend that the Board use this complaint as a case study to illustrate the importance of good communication with relatives, especially when the hospital are aware that the patient is unlikely to survive.

(d) A member of the nursing staff was rude to the family

26. Mrs C complained that a member of the nursing staff on the ward where Mr A was being cared for was 'abrupt, rude and unsympathetic' and a note written by her sister about visits to the ward reiterates this. In a letter to the family of 5 October 2004, the Board apologised if any members of staff were rude and gave assurances that the issue would be addressed with nursing staff.

27. The notes of the meeting with the family on 18 April 2005 record that an apology was offered for the attitude of a member of the nursing staff, but this is not mentioned in the letter sent on 24 May 2005 which summarised the outcomes of the meeting. The Board further informed the Ombudsman's office on 21 March 2006 that all staff had been reminded that they should always be considerate to patients and their families and that the member of staff in question had left the organisation.

(d) Conclusion

28. Although it is very difficult to adjudicate between different perceptions of the attitude of a member of staff, the Board have not contradicted Mrs C's complaint of inappropriate behaviour and have, indeed, given reassurances that the issue would be addressed. However, although an apology has been offered, it is not clear that the apology has been made formally and the manner in which staff have been reminded of the need to be considerate to patients and their families is unclear. In these circumstances, and on the balance of probabilities, I uphold this complaint.

(d) Recommendation

29. Although the Board said that the issue of staff attitude would be addressed, I recommend that they apologise to Mrs C formally and also give consideration to providing to staff dealing with patients and their families a more focussed reinforcement of the importance of good customer care through, for example, appropriate training.

(e) Some of Mr A's personal belongings were lost during his stay in hospital

30. After Mr A's death, the family received the belongings that he had with him in the ward. Mrs C complained that many personal items, including clothes, photographs of Mr A's daughter and grandchildren, and pictures by his granddaughter, were missing.

31. The Board addressed this issue in their letter of 5 October 2004 and at the meeting with the family of 18 April 2005. They recognised the family's distress and confirmed that all items in Mr A's room at the time of his death were returned to the family. They were not able to account for the missing items.

32. The Board further reassured the family that their policy and procedures for handling patients' valuables and personal belongings was being reviewed. In

their submission to the Ombudsman's office, the Board included copies of a disclaimer displayed in the wards and a flowchart for the safekeeping of patients' valuables. They noted that it is not possible to make an inventory of all patients' personal belongings.

(e) Conclusion

33. The Board have provided evidence that they have addressed the issue of the care of patients' belongings and the advice that I have received is that their approach is acceptable. Although the family feel understandable distress at the loss of Mr A's personal items, it was not the Board's responsibility to ensure their safekeeping. I, therefore, do not uphold this 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.

19 December 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	Mrs C's brother
The Hospital	The Royal Alexandra Hospital, Paisley
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	The Ombudsman's independent medical adviser