Scottish Parliament Region: Lothian

Case 200502808: Lothian NHS Board

Summary of Investigation

Category

Health: Hospitals; Care of the Elderly; Clinical treatment; Communication; Complaints handling

Overview

The complainant (Mrs C) was unhappy with the treatment her mother (Mrs A) had received at St John's Hospital (the Hospital) on 16 July 2005, that certain questions she had raised with Lothian NHS Board (the Board) during the complaints process had not been answered, that the staff at the Hospital failed to act in a professional manner and that, though the Board had admitted that the date of Mrs A's death was recorded incorrectly, they had not arranged for the death certificate to be corrected.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs A's care and treatment at the Hospital on 16 July 2005 was inadequate (*not upheld*);

(b) staff at the Hospital did not act in a professional manner towards Mrs A or her family (*not upheld*); and

(c) the response from the Board to Mrs C's complaints contained inaccuracies and did not address all the issues she raised (*not upheld*).

Redress and recommendation

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. In January 2006 the Ombudsman received a complaint from the complainant (Mrs C). Mrs C stated that she was unhappy with the treatment her mother (Mrs A) had received at St John's Hospital (the Hospital) on 16 July 2005, that certain questions she had raised with Lothian NHS Board (the Board) during the complaints process had not been answered, that the staff at the Hospital failed to act in a professional manner and that, though the Board had admitted that the date of Mrs A's death was recorded incorrectly, they had not arranged for the death certificate to be corrected.

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

(a) Mrs A's care and treatment at the Hospital on 16 July 2005 was inadequate;

(b) staff at the Hospital did not act in a professional manner towards Mrs A or her family; and

(c) the response from the Board to Mrs C's complaints contained inaccuracies and did not address all the issues she raised.

3. During consideration of Mrs C's complaints I made enquiries of several public bodies, including the Procurator Fiscal service and the General Register Office for Scotland as to the process for amending death certificates and passed this information on to the Board. The Board then made the appropriate arrangements to amend Mrs A's death certificate with the General Register Office.

Investigation

4. The investigation of this complaint involved obtaining and reading all the relevant documentation, including communication between Mrs C and the Board and notes of the Board's investigation of Mrs C's complaints. I examined the relevant medical records and sought the views of a medical adviser to the Ombudsman (the Adviser). I have set out my findings of fact and conclusion. 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.

5. Mrs A was a 93-year-old resident of a nursing home. She had been unwell for a few days prior to 16 July 2005, being increasingly breathless,

having a poor appetite, and being confused and agitated. She was known to have moderate dementia and, though she required assistance with personal care, was mobile enough to move around unaccompanied. On 16 July 2005 staff at the nursing home found Mrs A in some distress, short of breath and very agitated. An emergency call was made to the ambulance service who took Mrs A to the Accident and Emergency Department of the Hospital.

6. Mrs A was assessed by a doctor (Doctor 1) at 12:00. He made a diagnosis of sepsis (see Annex 2) on the basis of fast pulse and poor air entry into the lungs.

7. Mrs A was reviewed by a Registrar (the Registrar) at 14:15. He found that Mrs A had wheezing in both lungs and made a diagnosis of a probable chest infection and possibly a urine infection. He prescribed intravenous fluids, antibiotics and nebulisers and arranged for her admission to a medical ward.

8. Mrs A was admitted to the medical ward at 15:30, and Mrs C's son (Mrs A's grandson) arrived shortly afterwards. Mrs C told me that her son was asked to wait outside Mrs A's room until she was settled. After 20 minutes no-one had approached him and he entered the room. Shortly afterwards a nurse entered the room. Mrs C's son felt that the nurse was annoyed that Mrs A was constantly repeating herself, and that on seeing Mrs C's son the nurse excused herself and left. Around 15 minutes later a nurse entered the room and fitted an oxygen mask to Mrs A. During his time with his grandmother, Mrs C's son noted that a member of the medical staff said that he was not getting any response from the equipment attached to Mrs A (the intravenous drip and a monitor) and that the staff kept tapping the equipment to obtain a response from it. Mrs C's son left at 16:30 having been satisfied that his grandmother was settled.

9. At 16:00 the nursing staff recorded that Mrs A was agitated and had a 'Standard Early Warning System' (SEWS) (see Annex 2) score of 6, indicating severe ill health. The nursing staff noted that a doctor was informed of this.

10. At 18:00 Mrs A's SEWS score was again noted as 6 and a doctor was again informed of this. The Registrar completed a 'Do Not Attempt Resuscitation' (DNAR) form, and this was signed by him at 18:15.

11. Mrs C's son returned to the Hospital with his father, Mr C, at around 19:00. Mrs C said they were approached by a doctor who wanted to discuss possible resuscitation of Mrs A in the event of heart failure. Mr C and his son stated that as Mrs C was the next-of-kin the doctor should discuss it with her. Mrs C told me that at around 19:10 Mr C and his son left the Hospital to contact Mrs C.

12. From 12:00 Mrs A's blood pressure was taken 13 times, ten times in the Accident and Emergency Department and three times in the medical ward, at 16:00, 17:40 and 19:30. At 19:45 a nurse found that Mrs A had passed away, a doctor was informed and the family were contacted.

13. Mr C and his son returned to the Hospital and were told Mrs A had had a heart attack and that if they waited, a death certificate would be issued. 20 minutes later they were told that as the Hospital was very busy it was unlikely that the death certificate would be completed soon, and that if they returned in the morning they could collect it.

14. At 01:35 on 17 July 2005 a doctor confirmed Mrs A's death. When the death certificate was issued the time of death was recorded as 01:35 on 17 July 2005 and the cause of death recorded as: 'I : (a) Myocardial ischemia, (b) Severe coronary artery atheroma, (c) Atherosclerosis. II : Dementia'.

15. On 21 August 2005, Mrs C wrote to the Board complaining about Mrs A's care and treatment and the attitude of medical staff towards her family. She noted her belief that the monitor and drip that had been attached to Mrs A were faulty, that an examination of Mrs A by her GP on 15 July 2005 had not resulted in the diagnosis of a chest infection and that the death certificate did not mention a chest infection. She asked why antibiotics were administered and whether these had any effect on Mrs A's heart. Mrs C recounted her son's view of what had happened in the afternoon and asked if the oxygen mask should have been fitted to her mother when she was first admitted to the ward. Mrs C noted that the medical staff had not given her son any indication that Mrs A's death was imminent and that when her husband and son returned to the Hospital following Mrs A's death they were given no explanation of what had happened. She noted the discrepancy between her understanding of the time of Mrs A's death (between 19:30 and 19:45 on 16 July) and the time recorded on the death certificate (01:35 on 17 July). Mrs C asked for a step-by-step account of all action taken up to the time of Mrs A's death and an indication of what drugs were administered. Finally she noted that the medical staff's

behaviour and attitude had left her son with the impression that they felt Mrs A's presence on the ward was a nuisance and that on previous occasions when Mrs A was admitted to the Hospital the staff had also seemed indifferent to her well-being.

16. Mrs C's complaint was acknowledged on 24 August 2005 and a full response was sent on 6 September 2005. The response advised Mrs C of the sequence of events following her mother's arrival at the Accident and Emergency Department. The Board noted that there had been a breakdown in communication and medical staff had not been aware who Mrs C's son was and this had resulted in him waiting outside the room. The Board apologised for this oversight. The Board stated that it was documented that discussion took place between Mrs C's family and medical staff in relation to Mrs A's poor prognosis, her frail condition and the implications of resuscitation. The Board noted that it would have been very difficult for staff to predict imminent death. In relation to the death certificate, apologies were offered that Mrs C's family were not informed that the death certificate could only be completed after referral to the Procurator Fiscal because the medical staff were unsure of the cause of death. The Board stated that the time of death was not officially certified by medical staff until 01:35 and it was this time that was 'erroneously recorded' and explained that this delay was due to the ward having been busy that evening. The Board also stated that 'a staff nurse spent the majority of her shift caring for your mother and at no time was your mother regarded as being a nuisance'. Finally, a meeting was offered to Mrs C to discuss the issues if she wished and condolences were offered.

17. Mrs C complained to the Ombudsman on 11 January 2006. She explained that she was not satisfied with this response as she felt it did not address the concerns she had raised in her letter. She took issue with the Board's statement that 'a staff nurse spent the majority of her shift caring for [Mrs A]' and felt that further action should have been taken about the inaccurate death certificate. She also explained that she was not able to take up the offer of a meeting due to family circumstances.

(a) Mrs A's care and treatment at the Hospital on 16 July 2005 was inadequate

18. Mrs C raised her belief that the drip and monitor that Mrs A was attached to were faulty (see paragraphs 8 and 15). The Board did not address this point in their response to Mrs C. I asked the Board about this concern and they

advised me that there was no mention in the case notes of any equipment used in the care and treatment of Mrs A being faulty. The staff nurse who cared for Mrs A was contacted and she had no recollection of any faulty equipment. The Board advised that a pump was used for the administration of intravenous fluids to Mrs A. The Board advised that this equipment is sensitive and at times it can alarm if a patient has poor venous access or positional sensitivity, as these can interfere with fluid delivery. In response to Mrs C's concern about the staff tapping the equipment the Board stated that small air bubbles can trigger the pump alarm, and staff would respond to this by tapping the bubble out of the tube. As this action would not normally be documented by staff the family may have perceived it as being indicative of the pump being faulty.

19. Mrs C raised her concern that Mrs A had been diagnosed with a chest infection when her GP had not diagnosed this on 15 July 2005. I sought the opinion of the Adviser on this issue. He advised me that it is common in dealing with acute infection in older people that the expected symptoms are subtle or absent and that it is not surprising that Mrs A's GP may not have seen anything out of the ordinary on 15 July. He stated that 'It is a well attested fact that elderly people can develop life-threatening infections within hours and not show any defining physical signs for some hours.' He also stated his opinion that Doctor 1 and the Registrar acted reasonably in their diagnosis.

20. Mrs C was concerned about when an oxygen mask was fitted to Mrs A (see paragraphs 8 and 15). In their response to Mrs C the Board noted that 'At the time of [Mrs A]'s transfer to the medical ward, it was noted [that her] oxygen saturation levels were normal, however, after a short period of time her oxygen saturation levels dropped, therefore, she was given oxygen'. I sought the opinion of the Adviser on this point. He noted that no nursing notes were made relating to oxygen being supplied to Mrs A in the medical ward and consequently it cannot be ascertained for certain what occurred or for what reason. Mrs A had oxygen supplied at 6 litres per minute on admission to the Accident and Emergency Department, this was raised to 15 litres per minute at 12:40. The oxygen supply was not noted at 15:00 (the final record before Mrs A was transferred to the medical ward) but at 16:00 it was noted as 8 litres per minute. The Adviser told me that he 'did wonder whether changing the delivery system from nasal prongs to mask (to obtain a higher percentage of oxygen)' may have been what Mrs C's son witnessed but, in the absence of nursing notes relating to this, it could not be ascertained with any certainty.

(a) Conclusion

21. I agree with the Adviser's conclusion that Doctor 1 and the Registrar acted reasonably in their diagnosis of Mrs A as having a chest infection and accept the Board's explanation that the drip and monitor that Mrs A was attached to were not faulty. There are no nursing notes relating to the method of supply of oxygen to Mrs A on the medical ward, so it is not possible to reach a conclusion on whether the oxygen mask had replaced nasal prongs, as the Adviser suggests it may have been. However, on the balance of the evidence available, I do not uphold the complaint.

(b) Staff at the Hospital did not act in a professional manner towards Mrs A or her family

22. As noted in paragraph 16, the Board explained to Mrs C that there had been a breakdown in communication resulting in her son not being spoken to about his grandmother and they apologised for this. As part of the Board's investigation of Mrs C's complaints, the Assistant General Manager, Medical Services was asked to comment on the nursing element of the complaint. With reference to the nurse entering Mrs A's room and seeming annoyed, she explained that none of the staff have any recollection of this, but offered apologies if Mrs A's grandson had felt this was the case. These apologies were not specifically given in the Board's response to Mrs C's complaints.

23. The Assistant General Manager, Medical Services also commented that there can be difficulties in predicting even very imminent death. The Registrar noted that he had discussed Mrs A's poor prognosis with her grandson.

(b) Conclusion

24. The Board properly acknowledged and apologised for the breakdown in communication that led to Mrs A's grandson not being spoken to about his grandmother by ward staff. Although the Assistant General Manager explained the staff's views on the issue of the nurse entering Mrs A's room and offered apologies, this was not specifically stated in the Board's response to Mrs C's complaints. The Registrar had noted that he had spoken to Mrs A's grandson about her poor prognosis, but the note is no more detailed than that a discussion took place. As the Assistant General Manager stated, it can be very difficult to predict imminent death, even in those who are very ill. On the balance of the evidence, I do not uphold the complaint.

(c) The response from the Board to Mrs C's complaints contained inaccuracies and did not address all the issues she raised

25. The Assistant General Manager's comments on the nursing aspects of Mrs C's complaints stated that a staff nurse spent 'the majority of her shift' with Mrs A. There are three separate nursing notes for the period Mrs A was in the ward, and all three, timed at 16:00, 18:00 and 19:45, were written by the same nurse.

26. In their response to Mrs C's complaints, the Board wrote that Mrs A was treated with intravenous antibiotics 'due to her acute confusion, which was probably secondary to an underlying infection'. Mrs C was unhappy with this, and she stated that Mrs A's confusion was due to dementia.

27. As part of my investigation I received the response from a consultant in the Accident and Emergency Department who had been asked to comment on Mrs A's treatment there. The consultant's response made clear that the staff were aware of Mrs A's history of dementia.

28. I sought the opinion of the Adviser on this point. He told me that Mrs A's increased confusion was entirely compatible with the onset of infection in an older person already suffering from dementia and that it was, therefore, reasonable for the medical staff to conclude that Mrs A's acute confusion was probably secondary to an underlying infection.

29. In her letter of 21 August 2005, Mrs C asked the Board why antibiotics were administered and whether these had any effect on Mrs A's heart (see paragraph 15). The Board's response did not directly address this question.

30. As part of the Board's investigation of Mrs C's complaints, a locum consultant was asked to comment upon the medical treatment Mrs A received. He submitted two letters to the investigation, and the second letter explained that because Mrs A was thought to have an infection when she was admitted and was given antibiotics as part of the care treatment for this. He stated clearly that 'the antibiotics would have helped [Mrs A]'s chest and they would not have affected her heart'.

31. The second letter from the locum consultant was dated after the response sent to Mrs C of 6 September 2005. I asked the Board why the response had been written before the locum consultant had provided this information and why

they had not contacted Mrs C following receipt of the second letter from the locum consultant. The Board told me that there was no indication in the locum consultant's first letter that any subsequent letter should be expected and that the Board had hoped that Mrs C would take up their offer of a meeting to discuss the issues raised in her complaint and it was planned that additional information could then be provided to her. The Board apologised that, as Mrs C had declined the offer of the meeting, the information about the antibiotics was not passed on to her.

32. In her letter to the Ombudsman, Mrs C said that she was unsure whether or not resuscitation of Mrs A had been attempted at any stage and noted that she had not been given the opportunity to state her wishes about resuscitation as Mrs A's next-of-kin. Mrs C had not made her wish for this information clear in her letter of 21 August 2005.

33. A DNAR order was signed by the ward Doctor at 18:15. No member of Mrs A's family had been consulted at this point, and, as noted in paragraph 11, when Mrs C's husband and son arrived at the Hospital at 19:00 they were asked about resuscitation of Mrs A. They told the staff that Mrs C was the appropriate next-of-kin to consult on that point. As noted in paragraph 13, by the time the family returned to the Hospital, Mrs A had passed away.

34. I asked the Board whether a resuscitation of Mrs A had been attempted. They told me that no attempt had been made.

35. I sought the opinion of the Adviser on this issue. He advised that when a decision has to be made on the resuscitation of a mentally incapacitated patient and relatives cannot be contacted for discussion the decision on resuscitation has to be made by the doctor for the patient's benefit. It is considered good medical practice to try to reach an agreement between the parties on this issue but, ultimately, it is the doctor's duty to reach a decision rather than the relatives' right to do so. The Adviser commented that full cardiac and respiratory resuscitation would have been perverse in the case of Mrs A, who was frail, seriously ill and suffering from dementia and that, regardless of this, by the time that the nurse checked Mrs A at 19:45 there would have been no reasonable prospect of any resuscitation being successful.

(c) Conclusion

36. Clearly there is disagreement between Mrs C and the Board about how long the staff nurse spent with Mrs A. Based on the available evidence it is not possible to verify how long the nurse spent with Mrs A, nor, therefore, what proportion of her shift this represented. However, it is clearly true that Mrs A was under the care of the nurse throughout her shift and, given that, I do not uphold the complaint. It is clear to me that the medical staff were aware of Mrs A's dementia and that their conclusion that her increased confusion was secondary to an underlying infection was reasonable. Therefore, I do not uphold that part of Mrs C's complaint. Mrs C stated very clearly that she wished to understand why antibiotics had been given to Mrs A and what affect these would have had on her heart. The Board did not address this in their response and they did not inform Mrs C of the information the locum Consultant had subsequently supplied. However, this information was received very shortly after the Board had sent their response to Mrs C's complaint which contained an invitation for Mrs C to meet with relevant staff to discuss the issues. In my opinion, it was reasonable for the Board to plan to decide to give this information to Mrs C at the proposed meeting. Mrs C did not advise the Board that she did not wish to take up the invitation and, instead approached the Ombudsman. Given this, I do not uphold this part of Mrs C's complaint. Finally, in relation to Mrs C's complaint that she had not been consulted about Mrs A's resuscitation and was not aware whether or not resuscitation had been attempted, I note that Mrs C did not raise this complaint directly with the Board, but I am satisfied that they acted correctly and in the best interests of Mrs A in concluding that resuscitation would not be appropriate. Therefore, I do not uphold this part of Mrs C's complaint or the overall complaint.

(c) Recommendation

37. The Ombudsman has no recommendations to make.

19 December 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mrs A	The complainant's mother
The Hospital	St John's Hospital
The Board	Lothian NHS Board
The Adviser	A medical adviser to the Ombudsman
Doctor 1	The Doctor who examined Mrs A in the Accident and Emergency Department
The Registrar	The Registrar who reviewed Mrs A in the Accident and Emergency Department
SEWS	Standard Early Warning System
DNAR	Do Not Attempt Resuscitation form
Mr C	Mrs C's husband

Annex 2

Glossary of terms

Atherosclerosis	A disease affecting arterial blood vessels
Coronary artery atheroma	Blocking of the arteries of the heart
Myocardial ischemia	Loss or reduction of blood flow to the heart
Nebulisers	A device used to pump oxygen through a liquid medicine to turn it into a vapour inhaled by the patient
Sepsis	A medical condition characterised by a whole-body inflammatory state caused by infection
Standard Early Warning System (SEWS)	System used to estimate the level of care required by a patient