Scottish Parliament Region: North East Scotland

Case 200601247: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant, Mr C, raised a number of concerns about the care and treatment of his sister, Miss A, during an admission to Ninewells Hospital (the Hospital) in the 13 days leading up to her death. Mr C believed that had failures in Miss A's care and treatment not occurred, the outcome might have been different for her.

Specific complaints and conclusions

The complaints which have been investigated are that Tayside NHS Board (the Board):

(a) failed to make an urgent and correct diagnosis of Miss A's condition when she was admitted to hospital (*not upheld*);

(b) failed to provide urgent and appropriate treatment to Miss A (*upheld*);

(c) failed in their duty of care towards Miss A (*upheld*);

(d) failed to treat Miss A without delay due to holidays and staff not being available and, in particular, delayed in arranging a second Computerised Tomography scan (CT scan) (*upheld*);

(e) might have saved Miss A's life had they not failed to provide her with urgent and appropriate treatment (*not upheld*);

(f) stigmatised Miss A in relation to her alleged alcohol abuse and this affected the nature and urgency of the treatment she received (*not upheld*);

(g) failed to explain to Mr C how the figure of 70 units of alcohol a week was noted as Miss A's alcohol intake on admission (*not upheld*);

(h) failed to explain to Mr C why Miss A was unconscious during the first few days of her admission (*upheld*); and

(i) failed to have a single doctor in charge of Miss A's care, which made communication with Mr C very difficult (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board inform ward staff and relatives of the named consultant in charge of a patient's care either in the form suggested by the Adviser at paragraph 56 or similar.

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

I am also pleased that the Board, in response to my investigation, have repeated their apology to Mr C and his family for the failings in Miss A's care. I am also satisfied that the recommendations the Board put in place when initially responding to the complaint (see paragraphs 13 to 14 above) adequately address the central failings highlighted in complaints (b), (c) and (d), as they will ensure appropriate medical management and review and better care planning. It is unfortunate that, while the Board put appropriate recommendations in place in response to Mr C's complaint, they did not sufficiently acknowledge the nature and seriousness of the problems that occurred in this case when they wrote to Mr C. This has led to an unusual situation whereby the Board did not fully explain and acknowledge problems that occurred when responding to the complainant's complaint, but nevertheless put in place recommendations that, as it happens, adequately address the issues and failings that have been highlighted in this report. Consequently, while there have been serious failings in relation to Miss A's care and treatment, I have no recommendations regarding complaints (b), (c), and (d) because measures have already been taken by the Board that appropriately remedy the complaints.

Main Investigation Report

Introduction

1. On 27 July 2006, the Ombudsman received a complaint from a man, referred to in this report as Mr C, about the care and treatment of his sister, Miss A, during an admission to Ninewells Hospital (the Hospital) in the 13 days leading up to her death. Miss A was a 59-year-old woman at the time of her admission to the Hospital, following a seizure, on 28 March 2006. Sadly, on 9 April 2006, Miss A died, with the primary cause of death recorded as a spontaneous subarachnoid haemorrhage (a type of brain haemorrhage) and a secondary cause recorded as alcohol excess.

2. The complaints from Mr C which I have investigated are that Tayside NHS Board (the Board):

(a) failed to make an urgent and correct diagnosis of Miss A's condition when she was admitted to hospital;
(b) failed to provide urgent and appropriate treatment to Miss A;
(c) failed in their duty of care towards Miss A;
(d) failed to treat Miss A without delay due to holidays and staff not being available and, in particular, delayed in arranging a second Computerised Tomography scan (CT scan);
(e) might have saved Miss A's life had they not failed to provide her with urgent and appropriate treatment;
(f) stigmatised Miss A in relation to her alleged alcohol abuse and this affected the nature and urgency of the treatment she received;
(g) failed to explain to Mr C how the figure of 70 units of alcohol a week was noted as Miss A's alcohol intake on admission;
(h) failed to explain to Mr C why Miss A was unconscious during the first few days of her admission; and
(i) failed to have a single doctor in charge of Miss A's care, which made communication with Mr C very difficult.

Investigation

3. The investigation of this complaint involved obtaining and reading the complaint correspondence between Mr C and the Board and Miss A's clinical records. I made two written enquiries of the Board. In addition, I sought the advice of one of the Ombudsman's medical advisers (the Adviser) who advised me on 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. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to make an urgent and correct diagnosis of Miss A's condition when she was admitted to hospital

5. Mr C, in his letter of complaint to the Board dated 3 May 2006, expressed concern that the Board had not done enough to diagnose Miss A's condition and stated that he had not been given any diagnosis regarding the attack that brought Miss A into hospital in the first place.

6. The Board, in their letter responding to the complaint dated 20 June 2006, stated that Miss A experienced a tonic clonic seizure (this is a seizure that induces epileptic activity in the brain) and that such seizures were often associated with alcohol withdrawal. The Board confirmed that a diagnosis of seizures associated with alcohol withdrawal was made and that this diagnosis was supported by Miss A's later symptoms of hallucination and confusion, which were indicative of withdrawal.

7. I asked the Adviser whether the diagnosis made by the Board when Miss A was admitted to the Hospital was reasonable. His comments are summarised at paragraphs 8 and 9 below.

8. An immediate definitive diagnosis would not have been possible. The differential diagnosis (this is an initial diagnosis which proposes a range of likely options to explain a problem) made by the admitting doctor on 28 March 2006 of stroke, hemiplegic migraine or brain tumour were very reasonable attempts at identifying what might have gone wrong. The review that same evening by a consultant surmised that an alcohol-related seizure was more likely and, although not recorded as a diagnosis, this clearly formed the reason for starting pabrinex (this is vitamin B1 – thiamine – for reducing the liver damage caused by alcohol) and 'diazepam as per protocol' (a medication protocol for dealing with agitation and hallucinations associated with alcohol withdrawal).

9. Miss A exhibited signs of agitation, confusion and hallucinations which were compatible with alcohol withdrawal. Seizures in previously unaffected people who are alcohol dependent to any significant degree are almost invariably due to withdrawal, rather than the actual effect of alcohol itself. The diagnosis made on admission was the most logical one to make and no other

explanation of the history, signs and symptoms would have been plausible. The treatment of alcohol withdrawal with benzodiazepines like diazepam is well recognised as being necessary because this condition can be fatal.

(a) Conclusion

10. In light of the Adviser's comments, which I accept, I conclude that the diagnosis made when Miss A was admitted was correct and timely. I also note the Adviser's comments that the treatment instituted following this diagnosis was appropriate and necessary given the risks associated with alcohol related seizures. Consequently, I do not uphold this complaint.

(b) The Board failed to provide urgent and appropriate treatment to Miss A; (c) the Board failed in their duty of care towards Miss A; (d) the Board failed to treat Miss A without delay due to holidays and staff not being available and, in particular, delayed in arranging a second CT scan; and (e) the Board might have saved Miss A's life had they not failed to provide her with urgent and appropriate treatment

11. Mr C, in bringing his complaint to the Ombudsman's office, said he was concerned that, although the Board had recognised that there had been some problems, they had not related these to specific failings in Miss A's care and had not acknowledged that they had had an impact on the outcome for Miss A. Mr C was particularly concerned that there was a lack of urgency in arranging a second CT scan after the first one (carried out on admission) had not proved to be conclusive. Mr C considered that the Board's response focused on issues of communication and ignored more important issues relating to Miss A's care. Mr C stated that the fact that the Board had felt it necessary to make six recommendations for change following the complaint showed that, more than just involving failures in communication, there were failures in the Hospital's management system that must have adversely affected Miss A's care and might well have contributed to her death.

12. The Board's response to Mr C's complaint, dated 20 June 2006, did largely focus on communication issues, although in their conclusions and recommendations the Board did make some reference to failings relating to Miss A's care and treatment. In concluding their letter to Mr C the Board stated:

> 'In conclusion, it is very clear that there has been a lack of consistent and systematic co-ordinated approach to the clinical care and treatment following [Miss A]'s admission to hospital. A variety of contributory factors have been identified which involves poor record-keeping and lack of

documented evidence based clinical practice such as routine monitoring, inaccurate and lack of treatment and care planning, use of evidence based tools, poor communication between professionals, training and education of staff, inadequate skill mix, policies and procedures and in particular poor communication with relatives or carers.'

13. In the same letter, the Board highlighted six recommendations which would be put in place as a result of Mr C's complaint:

- an urgent review of the present nursing documentation in line with Nursing and Midwifery Council guidelines for records and record-keeping which will involve an audit programme, in order to assess the standard of the nursing records and identify areas for development;
- to implement the Named Nurse system within Ward 4 which is an evidence based and co-ordinated systematic approach to nursing practice which enhances care delivery and clinical practice involving patient allocation whereby a named person or persons are responsible for the pathway of care and treatment interventions of specific allocated patients;
- to review and establish more effective communication systems with carers and their relatives and in particular implementation of a carer's communication care plan. To establish a system whereby relatives and/or carers are involved in care planning and delivery of care and given the opportunity to discuss their concerns or the care of their relative with the most appropriate professional;
- to identify training and educational needs of nursing staff within Ward 4 so that all staff have the necessary knowledge and skills to care for patients who have suffered a cerebral haemorrhage;
- to ensure that appropriate skill mix and senior nurse support is available in relation to the care of acutely ill patients and overall patient dependency and clinical workload is considered when planning duty rosters and patient allocation; and
- to review the policy/procedure in place in relation to medical cover and medical management, and ensure that a clear process is in place which identifies a clear medical management plan involving medical reviews and identifies overall medical responsibility for individual patients.

14. As part of the investigation, I asked the Board to provide me with an update on the implementation of the recommendations contained in their response to Mr C. In a letter dated 21 March 2007, the Board told me:

- within Ward 4 there is now an established training programme for the nursing staff involving a number of the issues raised in [Mr C]'s initial complaint. This involves guidelines on record-keeping observation and monitoring pain control and fundamental nursing care. This training is continually reviewed and will go on to encompass more specialised subjects around the care of a patient following an acute stroke;
- a full review of the nursing documentation across the organisation is underway and any improvements identified from this will be fully implemented;
- the nursing team have implemented a dedicated patient/carer communication care plan to ensure the lines of communication between the staff and the patient and family members are more robust;
- there are also now more robust measures in place in order for patients and their families to discuss care and treatment with the appropriate member of the medical/nursing team;
- admission, nutrition and pain care plans are also at present being reviewed to establish how these areas can be improved;
- the named nursing concept was adopted in Ward 4, however, this has evolved into a team approach. Each patient is allocated a team leader who will co-ordinate the care and communications required for the patient. This has improved communication both with patients and carers and within the healthcare teams. Again, this is continually being reviewed;
- skill mix and the shift patterns of the nursing staff has been reviewed and is now organised based on measuring clinical workload to ensure adequate appropriately trained staff are on duty to address the workload and to ensure that support of all staff is available;
- the difficulties in identifying which consultant is responsible for each patient occurs when they move from one ward to another due to bed shortages. Each consultant has a base ward, however, if there are insufficient beds in this ward the patient will be moved to another ward. However, the line of responsibility for the patient remains that of the designated consultant irrespective of the ward they are in. It can be difficult for the nursing staff to identify which consultant and team are responsible and this is the area of review. It is planned that there will be changes to the way patients are managed when they are boarded to another ward. This review is to look at reducing the number of patients who are boarded which will address this issue … . The importance of establishing the correct line of responsibility for each patient has been reiterated to all staff; and

- a monitoring tool has been in operation in [the Hospital] for some time and this tool identifies when a more senior review requires to take place given the condition of a patient. This is audited on Ward 4 on a weekly basis and any identified areas of improvement are actioned. Ward 4 is also at present piloting a 'rapid response' algorithm whereby a senior nurse will respond to those patients identified as requiring more senior review.

15. I asked the Adviser, based on his consideration of the clinical records, for his comments regarding whether Miss A was provided with urgent and appropriate care and treatment and whether any failure in providing care and treatment could be linked to Miss A's death. Paragraphs 16 to 24 below summarise the Adviser's comments.

16. The notes record that Miss A suffered from agitation, confusion and hallucinations over night on 29 March 2006 which would be typical of alcohol withdrawal and the dosage of diazepam was reasonably increased from 15mg in the protocol to 20mg because she did not settle on the lower dose. By 30 March 2006, Miss A was alert and walking independently, although still agitated. She developed drowsiness on 31 March 2006, which may have been due to successive doses of 20mg of diazepam given over the night of 29/30 March 2006. The drug charts show that Miss A had Lorazepam 1.5mg (a moderate dose of tranquiliser) at 01:15 on 30 March 2006 and her last doses of diazepam 20mg on 30 March 2006 at 04:40 and 06:50. Diazepam is quite a long acting drug and that may help explain Miss A's drowsiness.

17. However, it is unfortunate that the medical records show a gap in entries between 30 March 2006 and 3 April 2006, and this indicates a lack of medical review. It is more likely that the drowsiness which developed over the period 30 March 2006 to 3 April 2006 was a manifestation of a large brain haemorrhage rather than the cumulative effect of diazepam. During this period, Miss A's drowsiness needed review and some monitoring but this was ignored by medical and nursing staff. It is assumed from the medical records, although this is not stated, that it was Miss A's continued drowsiness which led to the doctor's order of the second CT scan on 5 April 2006.

18. The point is that Miss A's level of consciousness was deteriorating over the holiday and weekend (1 April 2006 to 3 April 2006) and yet this gave rise to no recorded investigative or remedial action from nurses or doctors. It would have been expected that nurses would have been monitoring Miss A regularly

over the weekend and public holiday, as over any other days, and recognised the deteriorating levels of consciousness and alerted on-call doctors to review her. Instead, the nursing records show Miss A developing drowsiness (for example: 1 April 2006 'remains very drowsy'; 2 April 2004 'remains very drowsy'; 4 April 2004 'remains in bed due to lethargy') and a deterioration in Miss A's level of consciousness which was increasingly unlikely to be able to be explained away as over sedation but for which no doctor was asked to review her.

19. The gap in the medical notes between 30 March 2006 and 3 April 2006 indicates that no doctor reviewed Miss A during that critical period. The doctor who saw Miss A on 3 April 2006 only saw her because the nurses were concerned about blood pressure. No doctor was asked to see Miss A on 4 April 2006, yet by 5 April 2006 she was unconscious. It is unlikely from the continuous period of drowsiness over four days progressing to a coma noticed on 5 April 2006 that the subarachnoid haemorrhage (from which Miss A ultimately died) only occurred on the morning of 5 April 2006.

20. While there should have been medical review during the period 30 March 2006 to 3 April 2006, it would be speculative to suggest that, in the presence of a massive bilateral brain haemorrhage, had the change in Miss A's condition been more apparent to medical staff and had a CT scan been performed over the period 30 March 2006 to 3 April 2006, neurosurgical treatment would have changed the outcome. There is no clear-cut causal link between the failures in providing a reasonable level of care to Miss A and the likelihood of changing the outcome of Miss A's illness. Had a diagnosis of subarachnoid haemorrhage been made earlier and curative surgical treatment instituted immediately there might have been a difference in outcome but that was unlikely and it cannot be known either way.

21. What can be said is that the lack of good quality nursing care planning and documentation as well as appropriate medical reviews, particularly over the weekend and public holiday period 1 April 2006 to 3 April 2006, meant that Miss A received less care and monitoring than she should have done. While it is acceptable that there was likely to be less clinical activity and possibly less available medical staff over the weekend and public holiday, the medical and nursing care of such a critically ill patient should not have been compromised during this time. That the Board, in their response to Mr C, expected him to accept the holiday as an explanation for the lack of communication or delay in

investigation is astonishing. Mr C, in commenting on a draft of this report, said he had met with a doctor at Miss A's bedside on 31 March 2006 and raised concern about the fact that she remained unconscious but that no action was taken (Mr C's perception and that of the records are at odds here as the records note her condition as being 'drowsy' rather than 'unconscious'). The Adviser, whom I asked to comment on this point, told me that the information provided by Mr C, while not present in the clinical records, strengthened his view that the Board's staff failed to accord Miss A's continued drowsiness significance and to institute a review of her condition.

22. Other failures in care planning and execution are highlighted by Miss A's fluid charts which show that Miss A only had one litre of intravenous fluid in the interval between 14:10 on 1 April 2006 and 14:00 on 4 April 2006. The fluid charts for that period are incompletely filled in with no oral intake recorded at all and only incontinence recorded five times as urine output in that time. This suggests that Miss A's fluid balance was totally inappropriately managed for those days when she was drowsy and presumably taking nothing orally.

23. Mr C, in his complaint to the Board, highlights an incident where he was told by nursing staff that Miss A was sitting up in a chair, which gave him the impression that there had been an improvement in her condition, but he was then told by friends of the family that Miss A was put in a support chair and was not properly alert or conscious. The Board's response to Mr C on this point was rather superficial and erroneous in stating that Mr C had been given incorrect information and apologising for that. It is suspected that Mr C's assessment was correct and that, in line with Miss A's drowsiness all day, she was sitting but was likely to have been slumped in a chair all day rather than alert. Sitting Miss A in a chair if she was that drowsy would have been inappropriate, although not related to her death. However, it is another indication of the lack of proper assessment, care planning and evaluation which should have taken place.

24. In responding to Mr C's complaint, the Board failed to recognise several shortfalls in medical and nursing care. These went beyond poor recording or assessment. The lack of recording was part of the manifestation of a poor quality of care but, more importantly, indicated a much more serious level of clinical unawareness and inaction.

25. The Board, in commenting on the Adviser's criticisms, told me that there clearly were significant failings during the time Miss A was a patient at the Hospital. They acknowledged that the change in Miss A's condition appeared to have given rise to little in the way of investigative or remedial action from either nursing or medical staff. The Board said that nursing staff did remember requesting medical review, but that this was not documented in the records, which they accepted was unsatisfactory. The Board agreed that there had been a lack of systematic and consistent co-ordination of care between the clinicians involved in Miss A's care. The Board said they would again wish to offer Mr C and his family their sincere apologies for that.

(b) (c) and (d) Conclusion

26. I accept the Adviser's comments in their entirety and welcome the Board's acknowledgment of the failings that have been identified at paragraphs 16 to 24 above. It is clear that Miss A was not provided with urgent and appropriate care and treatment and that this was largely due to a lack of medical review during the critical period between 31 March 2006 and 3 April 2006. Mr C has stated that he spoke with a doctor at Miss A's bedside on 31 March 2007 and, although this conversation is not recorded in the clinical records, it strengthens the view that the Board's staff did not accord enough significance to Miss A's drowsiness, as the conversation did not lead to any further investigation of her condition. Indeed, it is clear that a medical review of Miss A's condition should have taken place and that nursing staff should have taken note of Miss A's drowsiness and requested that a review take place. I note that nursing staff remember making such a request, but because this is not documented in the clinical records, I must assume that no request was made.

27. In light of my comments at paragraph 26 above, I uphold complaints (b), (c) and (d), as it is evident that there were delays in investigating and treating Miss A's condition and in arranging for a CT scan to take place.

(e) Conclusion

28. However, while serious failures have been identified in the care provided to Miss A, the Adviser's comments are very clear in stating that no causal link can be made between these failures and Miss A's death. The Adviser's view, which I accept, is that it is unlikely that diagnosing Miss A's brain haemorrhage earlier and instituting curative surgical treatment immediately would have led to a different outcome.

29. I do not uphold complaint (e), which refers to there being a direct link between failings in care and Miss A's death, because such a connection cannot be established.

(b) (c) (d) and (e) Recommendation

30. I am pleased that the Board, in response to my investigation, have repeated their apology to Mr C and his family for the failings in Miss A's care. I am also satisfied that the recommendations the Board put in place when initially responding to the complaint (see paragraphs 13 to 14 above) adequately address the central failings highlighted here, as they will ensure appropriate medical management and review and better care planning. It is unfortunate that, while the Board put appropriate recommendations in place in response to Mr C's complaint, they did not sufficiently acknowledge the nature and seriousness of the problems that occurred in this case when they wrote to Mr C. This has led to an unusual situation whereby the Board did not fully explain and acknowledge problems that occurred when responding to the complainant's complaint, but nevertheless put in place recommendations that, as it happens, adequately address the issues and failings that have been highlighted in this report. Consequently, while there have been serious failings in relation to Miss A's care and treatment, I have no further recommendations regarding complaints (b), (c), and (d) because measures have already been taken by the Board that appropriately remedy the complaints.

(f) The Board stigmatised Miss A in relation to her alleged alcohol abuse and this affected the nature and urgency of the treatment she received

31. Mr C was concerned that, from the moment Miss A was admitted to hospital, nursing and medical staff made reference to her condition being related to alcohol. While he accepted that Miss A had a history of alcohol dependency, he felt that the emphasis put by staff on Miss A's alcohol consumption as being a cause of her condition meant that she was stigmatised and received poorer care than she would otherwise have received. Mr C pointed out that Miss A's friends, who were with her when she was admitted to hospital, had detected no sign that Miss A had been drinking.

32. The Board, in responding to Mr C in their letter dated 20 June 2006, explained that asking friends and relatives about alcohol consumption when a patient was admitted to hospital was standard practice. As already stated above, they considered that the seizure Miss A had suffered was due to alcohol withdrawal.

33. I asked the Adviser whether there was any sign in the clinical records that Miss A had been stigmatised as a result of her alcohol intake. The Adviser's comments are summarised at paragraphs 34 to 35 below.

34. There is no evidence in the records of Miss A being treated differently or with any less urgency at any time because she had a history of alcohol dependency. It may have been helpful to provide Mr C with a fuller explanation of how alcohol related seizures occurred i.e. normally due to withdrawal of alcohol rather than direct alcohol consumption. This would have helped to soothe his concern that Miss A's friends had detected no smell of alcohol on Miss A either prior or while she was having a seizure on 28 March 2006 and why the fact that Miss A was not drinking on the day in question would not be relevant to the diagnosis of alcohol related seizures.

35. The records show that the initial diagnosis of alcohol-related seizures was made quickly and appropriate treatment was instituted within hours of admission. Diagnosing and treating the subsequent brain haemorrhage was not delayed due to Miss A's history of alcohol dependency but by the lack of medical and nursing awareness of Miss A's deteriorating medical condition.

(f) Conclusion

36. I accept the Adviser's view that there is no evidence to show that Miss A was stigmatised as a result of her alcohol consumption or that her care suffered as a result. Consequently, I do not uphold this complaint.

(g) The Board failed to explain to Mr C how the figure of 70 units of alcohol a week was noted as Miss A's alcohol intake on admission

37. Mr C was concerned that Miss A's alcohol intake was recorded in the clinical notes as being 70 units per week. He said that the figure was not consistent with what he knew of Miss A's alcohol consumption and he was concerned that he had been given no explanation regarding how the figure had been arrived at. He said he had asked the Board to substantiate the figure in a letter to them dated 26 May 2006 (which should have been dated 26 July 2006), but that he had received no reply.

38. The copy of the complaints file I obtained from the Board contained a copy of a letter from the Board to Mr C dated 23 August 2006, which acknowledged his letter of 26 July 2006. The letter noted that Mr C had said he would be

taking his complaint to the Ombudsman, but asked for clarification regarding whether he wanted the Board to carry out a further investigation of the points raised in his letter dated 26 July 2006 beforehand. The letter invited Mr C to contact the Board with clarification.

39. In commenting on a draft of this report, Mr C said that he had not replied to the Board's letter because he had already sent a complaint to the Ombudsman and because he did not consider the letter from the Board as an invitation for him to ask them to pursue a further investigation.

40. In response to my investigation, in a letter dated 21 March 2007, the Board told me that the information regarding Miss A's alcohol intake was noted on the admission sheet as being 70 units per week and that there was no record of who had provided that information.

41. I asked the Adviser to comment on whether the clinical notes provided any clue as to who had provided the information regarding Miss A's alcohol intake. I also asked him to tell me what he would have expected normal practice to have been in such circumstances. The Adviser's comments are summarised at Paragraphs 42 to 45 below.

42. Although it is not specifically recorded in the records, the Adviser has speculated that the figure of 70 units per week was given by the friends of Miss A who were with her on admission. This speculation is based on the fact that Miss A was recorded as having slurred speech, vagueness and confusion and might not have been able to provide a figure herself. It is the usual practice to record in units an estimation by the patient or relative of the amount of alcohol drunk. No source for the information is given in the clinical notes. Mr C, in commenting on a draft of this report, stated that Miss A's friends recollected that Miss A, when asked on admission what her alcohol intake was, answered herself and stated that she drank half a bottle of wine a day.

43. Other entries in the records show alcohol intake being consistent with the recollection of Miss A's friends. The nursing admission documents show that against the question 'Does the patient drink alcohol everyday?' the answer was written '1/2 bottle of red wine'. There is a possibility that this answer was merely copied from documentation relating to an earlier admission as the phrasing was very similar. The documents also showed that 'no' was ticked against the question 'does the patient drink more than five alcoholic drinks a day?' Again, it

is impossible to know, based on the documentary evidence, whether the nurse asked Miss A or whether this answer was estimated on the basis of information previously recorded in the notes.

44. It would be extraordinary for the admitting doctor to order a course of pabrinex if the history of excessive alcohol was fictitious. It is difficult to believe that Miss A's alcohol intake was either deliberately invented by the admitting doctor or exaggerated from any information given by Miss A or her friends. It was noted, however, that liver function tests that were carried out did not show significant damage to Miss A's liver which made it more likely that that her intake was less than 70 units of alcohol per week, as that would have almost certainly caused measurable damage.

45. In any event, while the origin of the figure of 70 units of alcohol a week cannot be determined, even the lower alcohol intake recorded in the notes of half a bottle of wine daily is equivalent to 21 units weekly and is a third over the upper limit for a young woman. Even this relatively much smaller amount than 70 units weekly is a possible hazard for a thin elderly woman and might be associated with symptoms if alcohol was withdrawn suddenly.

(g) Conclusion

46. I note that it is not possible to determine who provided the figure of 70 units of alcohol per week, but I hope that Mr C will be reassured by my Adviser's comments that, regardless of whether the 70 units or 21 units figure was correct, the initial diagnosis and care provided to Miss A was appropriate.

47. With regards to the crux of the complaint, and the alleged failure by the Board to provide Mr C with an explanation, it appears that, rather than failing to provide Mr C with more details regarding the figure of 70 units of alcohol a week, the Board did write to Mr C to clarify how he wished to proceed with his complaint. Mr C wrote to the Board asking for clarification regarding the 70 units of alcohol figure on 26 July 2007 and in the same letter said he would be referring his complaint to the Ombudsman. It is accepted practice for bodies not to carry out further investigation if a complaint has exhausted internal complaints procedures and if the matter has been referred to the Ombudsman. In this case, the Board offered Mr C the opportunity to return to them to carry out further enquiries or to pursue his complaint with the Ombudsman. Mr C chose the latter.

48. Given that Mr C chose to bring his concerns to the Ombudsman, rather than allow the Board to respond to the further concerns he had raised in his letter dated 26 July 2006, it cannot be said that the Board failed to provide an explanation regarding the source of the 70 units of alcohol a week figure as, in effect, they were not given an opportunity to do so.

49. Therefore, I cannot conclude that the Board failed to provide Mr C with information and I do not uphold this complaint.

(h) The Board failed to explain to Mr C why Miss A was unconscious during the first few days of her admission

50. Mr C was concerned that no explanation had been provided to him by the Board regarding why Miss A was unconscious following her admission. In his complaint to the Board, he stated that he was aware that Miss A had initially been prescribed diazepam but that this treatment had stopped after 30 March 2006, and this medication could not, in his view, account for the fact that Miss A was unconscious thereafter.

51. The Board responded to Mr C's concerns by stating that, while it would not be impossible for the sedatory effects of diazepam to have lasted after 30 March 2006 it would be unusual for that to be the case. The Board stated that they would have expected Miss A to have been more alert by the beginning of the week following her admission.

(h) Conclusion

52. The Board's response, while it noted that they expected Miss A to have been more alert and that it was unlikely her lack of alertness could be ascribed to the diazepam she had previously been prescribed, did not provide an adequate explanation regarding Miss A's drowsiness. As stated above, in relation to complaints (b), (c) and (d), the likely reason for her drowsiness was the fact that a brain haemorrhage was developing. I would have expected the Board, on reviewing their actions in response to Mr C's complaint, to have acknowledged this and to have provided Mr C with an explanation regarding the likely cause of Miss A drowsiness. That did not happen and, consequently, I uphold the complaint.

(i) The Board failed to have a single doctor in charge of Miss A's care, which made communication with Mr C very difficult

53. In responding to Mr C's complaint, the Board apologised that a doctor had not been able to meet with Mr C when he arrived from England to visit Miss A on 30 March 2006, despite being told on the telephone that a doctor would be available. The Board stated that normally there were measures in place to ensure that relatives could contact a member of senior medical staff to discuss the care of a patient and they apologised that that did not happen for Mr C. The Board said that, during the period 1 April 2006 and 8 April 2006, nursing staff had repeatedly tried to contact medical staff to discuss Miss A's condition with her family but that as that period of time involved a bank holiday weekend and as there was no confirmation of the Consultant responsible for Miss A's care, that proved very difficult. The Board accepted that the situation was unacceptable and apologised to Mr C.

54. In response to this particular complaint, the Board formulated the following recommendations:

- to review and establish more effective communication systems with carers and their relatives and in particular implementation of a carer's communications care plan. To establish a system whereby relatives and or carers are involved in care planning and delivery of care and given the opportunity to discuss their concerns or the care of their relative with the most appropriate professional; and
- to review the policy/ procedure in place in relation to medical cover and medical management, and ensure that a clear process is in place which identifies a clear medical management plan involving medical reviews and identifies who has overall medical responsibility for individual patients.

55. In response to my investigation, the Board told me that difficulties in identifying which consultant was responsible for each patient often occurred when patients were moved due to bed shortages. The Board said that each consultant had a base ward but that, if there was a shortage of beds a patient under that consultant's care might be moved to another ward. The Board said that it could be difficult for nursing staff to know which consultant was responsible for a patient's care and that was an area they were reviewing.

56. I asked the Adviser whether the recommendations put in place by the Board to remedy the failures they had identified went far enough. The Adviser told me that he considered that a better system for communicating to ward staff,

patients and carers who was responsible for patients' care was required. He suggested that this could take the form of having the consultant's name written over the patient's bed and the consultant's name appearing at the top of documentation on the nursing and medical records.

(i) Conclusion

57. It is clear that communication with Mr C was poor and that he was not able to speak with the Consultant responsible for Miss A's care. Consequently, I uphold the complaint.

(i) Recommendation

58. Although the Board have made efforts to remedy this complaint, I recommend that the Board inform ward staff and relatives of the named consultant in charge of a patient's care either in the form suggested by the Adviser at paragraph 56 or similar.

59. 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.

60. I am also pleased that the Board, in response to my investigation, have repeated their apology to Mr C and his family for the failings in Miss A's care. I am also satisfied that the recommendations the Board put in place when initially responding to the complaint (see paragraphs 13 to 14 above) adequately address the central failings highlighted in complaints (b), (c) and (d), as they will ensure appropriate medical management and review and better care planning. It is unfortunate that, while the Board put appropriate recommendations in place in response to Mr C's complaint, they did not sufficiently acknowledge the nature and seriousness of the problems that occurred in this case when they wrote to Mr C. This has led to an unusual situation whereby the Board did not fully explain and acknowledge problems that occurred when responding to the complainant's complaint, but nevertheless put in place recommendations that, as it happens, adequately address the issues and failings that have been highlighted in this report. Consequently, while there have been serious failings in relation to Miss A's care and treatment, I have no recommendations regarding complaints (b), (c), and (d) because measures have already been taken by the Board that appropriately remedy the complaints.

19 December 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Miss A	The aggrieved, the complainant's sister
The Hospital	Ninewells Hospital
The Board	Tayside NHS Board
CT scan	Computerised Tomography scan
The Adviser	The Ombudsman's medical adviser

Annex 2

Glossary of terms

Benzodiazepines	A class of drugs that act as tranquilisers
Computerised Topography scan (CT scan)	A scan using a special type of x-ray scanner
Diazepam	A tranquiliser
Differential diagnosis	An initial diagnosis where a range of likely options to explain a problem are proposed
Hemiplegic migraine	A condition whose symptoms can include: temporary paralysis down one side of the body, which can last for several days; vertigo or difficulty walking, double vision or blindness, hearing impairment, numbness around the mouth leading to trouble speaking or swallowing
Lorazepam	A tranquiliser
Spontaneous subarachnoid haemorrhage	A type of brain haemorrhage
Toni clonic seizure	A seizure that induces epileptic activity in the brain