Scottish Parliament Region: Mid Scotland and Fife

Case 200601379: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; Cardiology

Overview

The complainant (Mr C) raised a number of concerns about the care and treatment provided to his late mother (Mrs A) at the Queen Margaret Hospital, Dunfermline (the Hospital) between 26 March 2006 and her death there on 21 May 2006.

Specific complaints and conclusions

The complaints which have been investigated are that Fife NHS Board:

(a) failed to provide appropriate care and treatment to Mrs A (*not upheld*);

(b) failed to ensure adequate communication with Mrs A and her family about Mrs A's condition and treatment (*not upheld*); and

(c) failed to adequately respond to Mr C's complaints (*not upheld*).

Redress and recommendations

The Ombudsman recommends that Fife NHS Board use the events of this case, in particular the differing perceptions of staff and family about these events, in staff training to consider how communication in these circumstances might be improved for the future.

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

Main Investigation Report

Introduction

1. On 11 August 2006 the Ombudsman received a complaint from Mr C about the care and treatment provided to his late mother (Mrs A) by Fife NHS Board (the Board) at Queen Margaret Hospital, Dunfermline (the Hospital) between her admission on 26 March 2006 and her death there on 21 May 2006. In particular Mr C complained that Mrs A had not received treatment appropriate to her condition and that despite attempts by the family to understand what was happening they were not given adequate explanations. Mr C also complained about a lack of robustness in the Board's responses to his complaint. Mr C first complained to the Board on 8 June 2006 and received a first response sent on 28 June 2006 and a final response sent on 11 September 2006.

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

(a) failed to provide appropriate care and treatment to Mrs A;

(b) failed to ensure adequate communication with Mrs A and her family about Mrs A's condition and treatment; and

(c) failed to adequately respond to Mr C's complaints.

Investigation

3. Investigation of this complaint involved obtaining and reviewing the relevant clinical records and the Board's complaint file. I have also sought the views of a medical adviser to the Ombudsman (the Adviser). 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 provide appropriate care and treatment to Mrs A

4. Mrs A was admitted to the Hospital on 26 March 2006, under the care of a consultant (the Doctor), by NHS 24 for investigation of the increased swelling in her legs and increased shortness of breath. Mrs A had previously undergone coronary bypass surgery and had a faulty valve in her heart replaced in 1998 and was undergoing regular treatment review from the cardiology team. On admission Mrs A was found to have congestive cardiac failure. The Adviser provided me with the following explanation of this condition:

> 'In this condition, both of the main chambers of the heart have been damaged and are unable to move the blood around their circulation sufficiently. Blood then dams back in the circulation causing swelling on

the right side, particularly of the lower limbs, due to accumulation of fluid in the tissues. On the left side of the circulation, the damming effect causes increased pressure in the veins of the lungs resulting in shortness of breath.'

5. Mr C complained that Mrs A's treatment did not help her and in fact made her excessively drowsy. Mr C considered that the side-effects of the drugs being given to Mrs A were excessive and Mrs A's wishes were being ignored. He considered she should have been given the opportunity to decide for herself whether or not she wished to endure the side-effects of treatment and that she had wanted to die at home.

6. The Adviser commented that the standard of medical and nursing notes in this case was good with clear records of consultations and considerations along with ward rounds and multi-disciplinary team meetings. There were clear records of all investigations undertaken by clinical staff and appropriate action plans in place as a result of such investigations.

7. The Adviser told me that Mrs A was treated promptly (and appropriately) on her admission with diuretic medication which were designed to relieve the strain on her heart by removing excess fluids. The Adviser noted that Mrs A's physical response to this treatment was not good and other alternative therapeutic approaches were also largely unsuccessful. As a consequence Mrs A developed low levels of sodium in her blood which in turn would have caused her to feel very unwell. The Adviser noted that opiate drugs (such as morphine) are used to improve symptoms and distress at the end stages of heart failure but have the side-effect of sedation and sleepiness which in the elderly will cause confusion. The Adviser told me that in his view this was true for Mrs A who was noted to be confused on 2 April 2006 not long after her admission. The Adviser noted that many of the difficulties experienced by Mrs A were side-effects of her end stage heart failure rather than the treatments.

8. The Adviser told me that in his view sadly Mrs A was in the end stages of heart failure at the time of her admission (following on from previously known damage caused by her heart disease) and was already receiving full treatment for this prior to her admission. The treatments offered by the Doctor and his team were entirely consistent with good practice and designed to relieve her of the very distressing symptoms of end stage heart failure. Despite attempts to

address the side-effects of her illness by a change in diuretic regime Mrs A did not improve. The Adviser told me that this is not uncommon in end stage congestive heart failure when the balance between reducing stress on the heart and increasing the workload of the kidneys is a difficult one and can often be impossible to achieve. All possible treatment alternatives were tried but Mrs A's failure to respond to these is, unfortunately, typical of end stage heart disease.

(a) Conclusion

9. Based on the very clear view of the Adviser about the suitability and purpose of treatments offered to Mrs A, I do not uphold this aspect of the complaint.

(b) The Board failed to ensure adequate communication with Mrs A and her family about Mrs A's condition and treatment

10. Mr C complained that despite many attempts by members of Mrs A's family to understand what was happening and to find out more about her condition and treatment plan, the Doctor did not explain what was going on. Mr C noted that he felt the Doctor was not sufficiently aware of Mrs A's condition and in fact could not offer an explanation because of his own lack of knowledge.

11. The clinical records make a number of references to communications with a number of members of Mrs A's family throughout the time of her admission. This included meetings between Mr C and the Doctor. I note that staff made reference more than once to their concern that the family did not understand the true nature and seriousness of Mrs A's condition.

12. The Adviser told me that, as is so often the case with complaints to the Ombudsman's office, communication lies at the core of Mr C's complaint. Unfortunately it is never possible to make an objective assessment of the quality of communications simply from the written records as much of day to day communication is not recorded in detail and cannot capture the importance of non-verbal communication such as tone, expression and body language. The Adviser noted that in general good communication is a two-way process that requires technical information to be appropriately given in a manner that enables it to be received and understood. I would add to that the need to check that the vital information has been meaningfully communicated. Clinical records will tend to provide details of only the factual content of conversations rather than whether or how this has been received.

(b) Conclusion

13. I am concerned that Mr C's complaint is in essence that no one was able to properly explain Mrs A's overall condition (and treatment for this) to her family while at the same time it is recorded on more than one occasion that staff did not feel the family were aware of the nature of Mrs A's illness. It may have been helpful, particularly in view of the recognised difference in understanding, to have arranged a meeting between appropriate members of staff, Mrs A and Mrs A's family to ensure that their was a common understanding of the nature of Mrs A's illness and her wishes. However, I also recognise that, in the Adviser's view, the frequency of and quality of recorded communications was reasonable in this case and that there are practical limitations and time constraints on the availability of a particular doctor or other member of staff. I conclude, therefore, that the communication with the family was of a reasonable quality but note that an opportunity was missed by staff who had identified the family's misunderstanding of Mrs A's condition. I do not uphold this aspect of the complaint but feel there is action than can usefully be taken to learn form this complaint.

(b) Recommendation

14. The Ombudsman recommends that the Board use the events of this case, in particular the differing perceptions of staff and family about these events, in staff training to consider how communication in these circumstances might be improved for the future.

(c) The Board failed to adequately respond to Mr C's complaints

15. Mr C first complained to the Board on 8 June 2006. He received a response sent on 28 June 2006. Mr C was not satisfied with the response which he felt had simply accepted the Doctor's view of events without question. He noted a number of specific concerns about the Doctor's response in a second letter of complaint and received a further response sent on 11 September 2006. Mr C remained unhappy about the level and quality of communication from the Doctor during Mrs A's admission and the apparent acceptance by the Board of all the Doctor had said.

16. Mr C's concerns included his view that the Doctor had told a number of members of the family that Mrs A's heart was not the problem yet she had died of heart failure but the Doctor had simply denied expressing this view in his response. Mr C also noted the response had come from a member of nursing

staff rather than a more senior doctor and accordingly there had been no proper independent review of Mr C's complaint or the Doctor's actions.

17. The NHS Complaint Process sets out a number of requirements for timescales and process for complaints review and response relevant to this complaint. The process followed by the Board in responding to Mr C's complaint adhered to these requirements; in particular I would note that for a response to be signed off by a Director of Nursing, a very senior member of the clinical team, is entirely appropriate.

(c) Conclusion

18. Mr C and the Doctor had a clear difference in view as to what had passed between them (and other family members) regarding Mrs A's heart condition. The Adviser told me that it was, in his view, inconceivable that the Doctor would not have been aware of Mrs A's heart problems or would have denied that such problems existed. The entries in the clinical records made by the Doctor are consistent with the views expressed in his response to the complaint. In light of the very clear views of the Doctor (and the evidence of the clinical records to support his view), I conclude that the Board's response was appropriate and sufficiently robust. The Board's response was entirely in-line with the relevant NHS procedures and guidelines. I do not uphold this aspect of the complaint.

19. The Board have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the Board notify her when the recommendation has been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs A	The aggrieved
The Board	Fife NHS Board
The Hospital	Queen Margaret Hospital, Dunfermline
The Adviser	A medical adviser to the Ombudsman
The Doctor	The consultant responsible for Mrs A's care during her final admission