Scottish Parliament Region: Central Scotland

Case 200600942: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment of her late mother (Mrs A) during an admission to Monklands Hospital (the Hospital) between 5 April 2005 and 26 June 2005.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Lanarkshire NHS Board (the Board) inappropriately refused to admit Mrs A to the Hospital on 4 April 2005 (*not upheld*);

(b) two doctors were rude to Mrs A when they saw her in Accident and Emergency on 5 April 2005 (*not upheld*);

(c) the Board failed to supervise Mrs A when going to the toilet and did not do enough to prevent her from falling over (*upheld*);

(d) the Board failed to ensure that Mrs A was eating and failed to consider nasal tube feeding (*not upheld*);

(e) the Board failed to supervise Mrs A's drug-taking, failed to correctly record drug-taking and failed to ensure that the right medication was given to the right patient (*partially upheld to the extent that the Board failed to supervise Mrs A's drug-taking and failed to ensure that the right medicine was given to the right person*);

(f) the Board failed to introduce a care package for Mrs A despite promises to do so and refused to allow Mrs C to take Mrs A home in the last few days of her life (*not upheld*);

(g) the Board failed to diagnose and treat an infection that Mrs A contracted while in the Hospital, which led to additional discomfort and pain and which Mrs A's family believe contributed to her death (*not upheld*);

(h) the Board failed to record sepsis as a cause of death on the death certificate (*not upheld*);

(i) the Board failed to carry out a post-mortem even though Mrs A had died sooner than expected (*not upheld*);

(j) the Board did not provide sufficient nursing care to Mrs A and did not help bring Mrs A's temperature down or remove her teeth and only checked up on her occasionally (*upheld*);
(k) the Board's nursing staff were unable to fit a syringe driver because a nurse was on her break (*not upheld*);
(l) a physiotherapist said that she could not help Mrs A because she was not co-operating, which was inappropriate (*not upheld*);
(m) nursing staff did not inform Mrs C or her brother that Mrs A was dying when they re-entered the room Mrs A was in (*not upheld*);
(n) no attempt at resuscitation was made and the family were not asked if they wanted it (*not upheld*);
(o) an empty syringe driver contributed to Mrs A's death (*not upheld*);
(p) Mrs A had to wait a long time on both occasions when a doctor was called on 26 June 2005 (*not upheld*); and
(q) the clinical records were inadequate, because they contained no observations for 25 June 2005 and no fluid charts (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) emphasise to staff the importance of adjusting care plans in line with risk assessments, especially in relation to supervision needs, and ensure that staff fully understand the importance of, and the procedure for, incident reporting;
(ii) ensure that measures are put in place to monitor compliance with the Medicines Code of Practice;
(iii) reflect on this complaint and consider whether guidance or training is needed to ensure that patients' families feel appropriately supported when they decide to take an active role in caring for a relative; and
(iv) put measures in place to ensure that, where appropriate, fluid charts are filled out for patients and observations are recorded.

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

Main Investigation Report

Introduction

1. On 21 June 2006, the Ombudsman received a complaint from a woman, referred to in this report as Mrs C, about the care and treatment provided to her late mother (Mrs A) during an admission to Monklands Hospital (the Hospital) between 5 April 2005 and 26 June 2005. Sadly, Mrs A died of lung cancer while at the Hospital on 26 June 2005.

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

(a) Lanarkshire NHS Board (the Board) inappropriately refused to admit Mrs A to the Hospital on 4 April 2005;

(b) two doctors were rude to Mrs A when they saw her in Accident and Emergency on 5 April 2005;

(c) the Board failed to supervise Mrs A when going to the toilet and did not do enough to prevent her from falling over;

(d) the Board failed to ensure that Mrs A was eating and failed to consider nasal tube feeding;

(e) the Board failed to supervise Mrs A's drug-taking, failed to correctly record drug-taking and failed to ensure that the right medication was given to the right patient;

(f) the Board failed to introduce a care package for Mrs A despite promises to do so and refused to allow Mrs C to take Mrs A home in the last few days of her life;

(g) the Board failed to diagnose and treat an infection that Mrs A contracted while in the Hospital, which led to additional discomfort and pain and which Mrs A's family believe contributed to her death;

(h) the Board failed to record sepsis as a cause of death on the death certificate;

(i) the Board failed to carry out a post-mortem even though Mrs A had died sooner than expected;

(j) the Board did not provide sufficient nursing care to Mrs A and did not help bring Mrs A's temperature down or remove her teeth and only checked up on her occasionally;

(k) the Board's nursing staff were unable to fit a syringe driver because a nurse was on her break;

(l) a physiotherapist said that she could not help Mrs A because she was not co-operating, which was inappropriate;

(m) nursing staff did not inform Mrs C or her brother that Mrs A was dying when they re-entered the room Mrs A was in;
(n) no attempt at resuscitation was made and the family were not asked if they wanted it;
(o) an empty syringe driver contributed to Mrs A's death;
(p) Mrs A had to wait a long time on both occasions when a doctor was called on 26 June 2005; and
(q) the clinical records were inadequate, because they contained no observations for 25 June 2005 and no fluid charts.

Investigation

3. The investigation of this complaint involved obtaining and reading copies of all correspondence between Mrs C and the Board. I also obtained copies of Mrs A's clinical records and met with staff of the Board. In addition, I sought the advice of one of the Ombudsman's clinical 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. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Complaint-handling background

5. Mrs C initially complained to the Board on 17 May 2005 and the Board received confirmation that Mrs A was happy for Mrs C to pursue the complaint on her behalf on 26 May 2005. The complaint focussed on alleged problems with Mrs A being admitted on 4 and 5 April 2005. The Board responded on 23 June 2005 acknowledging that a mistake had been made and offering an apology.

6. Mrs C and her brother, Mr B, took up the offer of a meeting, held on 2 August 2005, at which they listed 27 questions they wanted answers to (the complaint, at this time, had extended to the other matters relating to Mrs A's care that are dealt with in this report). Very full and detailed notes of the meeting, listing the Board's answer to each question, were sent to Mrs C on 23 August 2005 along with a cover letter answering other points that the Board had not been in a position to respond to at the meeting on 2 August 2005. A second meeting took place on 24 October 2005, during which Mrs C and Mr B's outstanding concerns were discussed. Again, very full and detailed notes of the meeting were subsequently provided to Mrs C.

7. The responses provided by the Board show that a number of failings were acknowledged and apologised for and that they adopted an open-minded and learning approach to the complaint. While Mrs C and Mr B clearly remained unhappy, and while there were failures in Mrs A's care (as this report makes clear), the way the Board handled Mrs C's complaint was commendable. Indeed, the time and effort they put in to trying to resolve matters to Mrs C's satisfaction and fully explain what had happened, along with the detailed and comprehensive nature of the responses they provided, were exemplary. This does not take away from the failings that have been identified below, but I consider that the Board should be given credit for the quality of their complaint handling in this case.

8. In commenting on a draft of this report, Mrs C strongly disagreed that the Board had handled her complaint properly. She said the meetings held with the Board had been dreadful for her family and that the Board's representatives had been intimidating, rude, unsympathetic and unresponsive. Mrs C said the Board had rebuked her for making a complaint in the first place.

9. While I note Mrs C's comments, my view on the quality of the Board's complaint handling is based on the documentary evidence I have been provided with, which, as mentioned above, demonstrates a good degree of responsiveness and detailed attention to the complaint. The documentary evidence provides no indication of the attitude which Mrs C ascribes to the Board's representatives. Therefore, while I have recorded Mrs C's view in this report, my view remains that the evidence available to me shows that the Board's handling of the complaint was commendable.

(a) The Board inappropriately refused to admit Mrs A to the Hospital on 4 April 2005; and (b) Two doctors were rude to Mrs A when they saw her in Accident and Emergency on 5 April 2005

10. On 4 April 2005, Mrs A, a 76-year-old woman, fell ill and was visited at home by her General Practitioner (GP 1). GP 1 advised Mrs A to go to the Accident and Emergency Department of the Hospital and gave her a letter to take with her. GP 1's letter stated:

> 'Thank you for seeing this lady who awaits outpatient assessment … unfortunately she is not due to be seen soon and she has become increasingly frail … I feel she needs in-patient assessment'.

11. Mrs C was concerned that the doctor who saw Mrs A in the Accident and Emergency Department (Doctor 1) refused to admit her despite symptoms which included sickness, diarrhoea and rapid weight loss and despite the letter from GP 1. Mrs C said that Doctor 1 had put the symptoms down to depression caused by the recent death of Mrs A's dog. Doctor 1 had said that tests showed nothing unusual and that Mrs A should go home.

12. On 5 April 2005, Mrs C was seen at home by another GP from her practice (GP 2). He gave Mrs A another letter to take to the Accident and Emergency Department. GP 2's letter stated:

> 'This lady was referred yesterday and discharged … she needs admitted for further investigation.'

13. Mrs C said that when she, Mr B and her late mother returned to the Hospital on 5 April 2005, a junior doctor who saw Mrs A said she would probably need to be admitted but wanted to check with Doctor 1. Mrs C stated that when Doctor 1 arrived she said:

> 'I told you yesterday to take [Mrs A] home, there is nothing wrong with her, this is a social issue and I will be telephoning your mother's GP.'

Mrs C stated that another doctor (Doctor 2) then came into the room. Mrs C stated that her manner was not pleasant and she told Mrs C that she was not happy with having been sent a 'cheeky' letter from Mrs A's GPs. Mrs C stated that Doctor 2 said there was an infection in the Hospital and that it would be better if Mrs A was not admitted. Mrs C said that she and Mr B had to beg for Mrs A to be admitted and Doctor 2 eventually agreed. However, Mrs C stated that Doctor 2 said:

> 'If I admit her she will not be getting any preferential treatment, she will wait until it would have been her turn to be seen by a Consultant.'

14. In response to Mrs C's complaint, the Board acknowledged that Mrs A should have been admitted on 4 April 2005. The Board said they could not condone Doctor 1's decision to refuse admittance. They said that Doctor 1 had committed an error of judgement, in that she had misinterpreted the picture and thought she was dealing with a social depressive illness rather than a clinical illness. The Board acknowledged that Doctor 1's view may have carried over onto 5 April 2005. The Board also confirmed that Doctor 1 should have acted on GP 1 and GP 2's letters. The Board issued an apology to Mrs C for their failure to admit Mrs A.

15. With regard to Mrs C's view that Doctor 1 and Doctor 2 had been rude, the Board accepted that the remarks they were reported as saying were 'unacceptable' and represented 'very bad behaviour'. The Board said they would discuss these concerns with Doctor 1 and Doctor 2.

(a) Conclusion

16. The Board have acknowledged that Mrs A should have been admitted on 4 April 2005 and that this did not happen. The Board were clearly at fault in this respect. In line with the Ombudsman's normal practice, however, I do not uphold this complaint. That is because fault was acknowledged and, in our opinion, remedied prior to a complaint being made to the Ombudsman. When this is the case, while fault is noted, complaints are not upheld.

(b) Conclusion

17. The Board have accepted that Doctor 1 and Doctor 2 were rude on 5 April 2005, when the possibility of Mrs A's admission was being discussed. I note that Doctor 1 and Doctor 2 have been spoken to by the Board regarding this incident. I also note the Board's apology and full acknowledgements regarding the unacceptability of Doctor 1 and Doctor 2's behaviour in the notes of the meeting in August 2005 (see paragraph 6) between Mrs C, Mr B and the Board. For example, the Board are recorded as having:

> 'said this was very bad behaviour … said these were inappropriate and apologised … said that the comments were unacceptable'.

Mrs C was sent a copy of the meeting notes at the time. There is no record on file of her having disputed that the above statements were made. Therefore, I conclude that fault was appropriately acknowledged and remedied prior to a complaint being made to the Ombudsman. As explained at paragraph 16, that means I do not uphold complaint (b).

(c) The Board failed to supervise Mrs A when going to the toilet and did not do enough to prevent her from falling over

18. Mrs C was concerned that not enough had been done to prevent Mrs A from falling while at the Hospital. She said that Mrs A had had two falls while in Hospital. The first fall happened when Mrs A was trying to get back to bed after having been to the bathroom. Mrs C felt that someone should have escorted her, especially since she had very low blood pressure at this time. The second fall happened when Mrs A went to the toilet and fell while she was in there.

Mrs C said that Mrs A had to wait a long time for anyone to come in and help her up.

19. In response to Mrs C's complaint to them, the Board stated that a 'Falls Risk Assessment' had suggested that Mrs A did present a high risk of falling. They said it was noted that Mrs A had a fall at home prior to admission. They said, however, that as her condition deteriorated and she became more confused, Mrs A was moved to a single room nearer the nurses' station to improve her direct observations. In commenting on a draft of this report, Mrs C said that although Mrs A had been moved near to the nurses' station, nurses were rarely there.

20. The Board said that when Mrs C had her second fall she had been assisted to the bathroom. The Board said there was no suggestion that she was unable to be left, and in order to maintain a patient's privacy staff routinely left patients who were deemed safe to be alone. The Board said that it had been noted by the doctor who reviewed Mrs A after the fall, that nursing staff suggested that she appeared to slide down the wall. The Board said the doctor found no obvious injury and Mrs A denied any preceding symptoms or any injury. In commenting on a draft of this report, Mrs C said that Mrs A had suffered injury as a result of this fall and that there was substantial bruising on her face and back.

21. I sought advice from the Adviser about this point of complaint. The Adviser told me the clinical records showed that a Falls Risk Assessment was completed on 11 June 2005 and the risk was estimated as high. The Adviser said there was an error in the completion of the form as it indicated that Mrs A had no falls in the previous year, whereas the assessment completed on 12 April 2005 indicated that she had fallen in the period prior to that admission.

22. The Adviser told me that the care plan completed on 11 June 2005 was not comprehensive and stated 'supervision at times' against the heading 'mobilising', which the Adviser considered was out of line with the high risk assessment.

23. The Adviser said there was no adjustment to the risk assessment or the care plan either in direct response to the fall on 11 June 2005 or to reflect any general change in condition. The Adviser noted that Mrs A was recorded as having low blood pressure on several occasions and as experiencing dizzy

spells. The Adviser said that she could find no evidence that these factors were taken account of when planning how to keep Mrs A as safe as possible.

24. The Adviser said that the clinical records did not contain any incident reports in relation to the falls on 11 and 23 June 2005. In commenting on a draft of this report, the Board said they did not consider that incident forms formed part of the clinical records. They acknowledged, however, that if an incident occurred, a note of the incident should be included in the clinical records along with a note that an incident record form had been filled out. They said that although this happened on 11 June 2005, it did not happen on 23 June 2005. The Adviser, responding to the Board's comments, accepted that incident forms did not have to form part of the clinical records. She noted, however, that it was disappointing that the Board had not followed their normal practice in relation to the incident on 23 June 2005.

25. With regard to the incident when Mrs A fell while in the toilet, the Adviser considered that it was appropriate for her to have been left to go to the toilet in privacy once she had been escorted there. She noted that good practice in such cases would be to check up on patients after a reasonable amount of time to make sure they were alright. The Adviser said that in this case there was no evidence available to suggest that Mrs A had been left alone for too long. In addition, I note that, although Mrs C disagrees, the clinical records showed no indication that Mrs A suffered any injury as a result of this fall.

26. With regard to Mrs A's second fall (see paragraph 20 above) the Adviser commented that it was possible that the bruising to which Mrs C referred developed after Mrs A was seen by the doctor. The Adviser told me that this would explain why the doctor did not note any bruising, even though Mrs A's family noticed bruising when they saw her. The Adviser told me, however, that the presence of bruising would not impact on a patient's treatment and that, whether there was bruising or not, no different treatment would be prescribed.

27. The Adviser said, however, that the progress notes showed that staff were vigilant to the best of their ability; for example, Mrs A was moved to a single room near the nurses' station to make observation easier.

28. The Adviser summed up by telling me that the high risk assessment was accurate but that there were factors that should have been documented as

having a bearing on Mrs A's care plan and which may have influenced things like toileting.

(c) Conclusion

29. The Board's assessment of Mrs A as being at high risk of falling was correct, although the Adviser has pointed out several deficiencies. In particular: the Falls Risk Assessment was not filled in accurately; the Falls Risk Assessment was not updated to reflect falls Mrs A had in the Hospital; and Mrs A's care plan did not reflect the fact that Mrs A was at a high risk of falling. Consequently, while I note the Adviser's view that staff did their best to be vigilant, I uphold the complaint.

(c) Recommendation

30. I recommend that the Board emphasise to staff the importance of adjusting care plans in line with risk assessments, especially in relation to supervision needs, and ensure that staff fully understand the importance of, and the procedure for, incident reporting.

(d) The Board failed to ensure that Mrs A was eating and failed to consider nasal tube feeding

31. Mrs C said that Mrs A was not eating while at the Hospital and that nothing the family tried to do could encourage her to eat. Mrs C said that when she looked over Mrs A's clinical records she saw an entry where the possibility of nasogastric feeding (delivering liquid nutrients through a tube passing through the nose and into the stomach) was suggested. Mrs C said this was never followed up.

32. In responding to the complaint made to them, the Board said that a tube would be used as a last resort and only if there were clinical signs of a patient being undernourished.

33. The Board said that Mrs A was referred to a dietician (the Dietician) on 8 June 2005 and was prescribed appetite enhancers to improve her nutritional intake. On 10 June 2005, Mrs A was reviewed by the Dietician and it was noted that her oral intake was very poor and there was a suggestion as to whether nasogastric feeding was an option. The Board said that, on 14 June 2005, a doctor noted that Mrs A's appetite had improved slightly. The Board said that Mrs A had been provided with dietary supplements.

34. I asked the Adviser for advice on this point of complaint. She told me that there was evidence in the clinical records that the Dietician was involved, appropriately, in Mrs A's care on 8 June 2005 and again on 10 June 2005 when she raised the possibility of introducing nasogastric feeding. The Adviser said there were comments in the clinical records that described attempts made by staff to tempt Mrs A to eat by offering a variety of options, and that they indicated concern that she was not eating well, other than on a few occasions.

35. The Adviser said that the records showed that, in addition to Mrs A's low mood, she was confused and agitated much of the time. The Adviser said that, although not stated in the clinical records, she considered that those factors, together with her general condition, influenced the decision not to commence tube feeding, especially when the decision was taken to keep her comfortable and to try to reduce the level of agitation.

36. The Adviser told me that, in her view, it was reasonable not to commence Mrs A on nasogastric feeding.

(d) Conclusion

37. I accept the Adviser's comments. The clinical records indicate that, given Mrs A's clinical condition at the time, it was reasonable for the Board not to pursue the option of nasogastric feeding. Consequently, I do not uphold this complaint.

(e) The Board failed to supervise Mrs A's drug-taking, failed to correctly record drug-taking and failed to ensure that the right medication was given to the right patient

38. Mrs C said that Mrs A was having trouble swallowing medication and she was keeping tablets in a handkerchief and asking Mrs C to put them in the bin. Mrs C said that she brought this to the attention of the nursing staff and asked them whether they would consider giving Mrs A medication in a different way, but that they only answered 'maybe'. Mrs C said that medication was often left at the side of Mrs A's bed. Mrs C said that Mrs A's clinical records indicated that medication had been administered but that she was often not taking the pills. Mrs C said she should have been supervised. Mrs C said that on one occasion, when Mr B was visiting Mrs A, a nurse came up to Mrs A and tried to give her another patient's medication.

39. In response to Mrs C's complaint to them, the Board said that normal practice would be that nursing staff would witness a patient taking the medication. The Board said that the information provided by Mrs C suggested that that did not always happen and the Board apologised for that. The Board said that they would remind nursing staff of the importance of monitoring patients taking their medication.

40. The Board said that when medications were given, nursing staff should routinely check the patient's identity from their name band and compare it to their prescription chart. The Board said that, clearly, that did not happen on this occasion and they apologised for the upset it may have caused.

41. The Board acknowledged that there were some areas of less than ideal practice with regard to the administration of medicines and said staff should have made sure that Mrs A had taken her medication. The Board said they had spoken with nursing staff regarding the administration of drugs.

42. I asked the Adviser for advice on this complaint. The Adviser noted that the Board accepted that all aspects of the procedure for the administration of medication, especially the supervision of medicines being swallowed, had not always happened in line with their policy. The Adviser noted that the Board had apologised for this.

43. The Adviser pointed out that the Board's Medicines Code of Practice (the Code) contained guidance on what should happen when medication was being administered and she said that the Code was in line with all available guidance. The Adviser said that the problem in this case was that the guidance in the Code had not been complied with.

44. The Adviser said that all aspects of medicines practice were associated with patient safety and so should feature in risk assessment and clinical governance deliberations; she said that the Board should, therefore, monitor compliance with the Code.

45. The Adviser confirmed that the clinical records demonstrated appropriate recording of drugs that were given out to Mrs A. She said the problem was not that Mrs A was not given drugs, or that this was not recorded, but rather the problem was that adequate supervision did not take place.

46. In relation to Mrs A being unable to swallow the pills she was being given, the Adviser commented that the clinical records showed no indication that this issue had been raised by Mrs C or that Mrs A was unable to swallow medication. The Adviser said that if such an issue was brought to a nurse's attention good practice would have been to consider alternatives such as looking into the availability of drugs in liquid form and whether or not it would have been appropriate to crush any of the medication. However, the Adviser made clear that there was no evidence that Mrs A had a problem swallowing medication and, therefore, she had no criticism to make of the Board in that regard.

(e) Conclusion

47. It is clear that the clinical records were properly filled out in terms of recording medicines that had been provided to Mrs A. Consequently, I do not uphold that part of the complaint.

48. However, the Adviser's comments, which I accept, show that the Board clearly failed to fulfil the requirements of the Code by failing to supervise Mrs A actually taking the drugs and failing, on one occasion, to confirm Mrs A's identity before trying to give her drugs. Consequently, I partially uphold this complaint.

(e) Recommendation

49. I recommend that the Board ensure that measures are put in place to monitor compliance with the Code.

(f) The Board failed to introduce a care package for Mrs A despite promises to do so and refused to allow Mrs C to take Mrs A home in the last few days of her life

50. Mrs C said that, about a week before 22 June 2005, she was told that Mrs A would be able to go home and that a care package, provided in conjunction with Social Services, was in place. Mrs C said that Mrs A was told she could go home the following Wednesday and this 'perked her up' a little. Mrs C said that on 21 June 2005 she received a telephone call from the Hospital advising that they had carried out a risk assessment and decided that it would not be possible for Mrs A to go home. Mrs C said she was told that Social Services could not provide the level of care Mrs A required and, even though Mrs C said that her family could help, the Hospital said it would not be possible to allow Mrs A home in the circumstances. Mrs C believed that it was cruel to promise a care package to Mrs A when it could not be delivered. In

commenting on a draft of this report, Mrs C added that she had been given no indication when the care package was first mentioned that it might be withdrawn if Mrs A's condition changed. Mrs C said that Mrs A not being able to go home was particularly distressing because it left her with the impression that her family did not want her to come home, which was not the case. Mrs C said the Board had not handled the situation professionally and sympathetically.

51. In response to the complaint made to them, the Board explained that plans were initiated for Mrs A to be discharged home with a full package of care. They said she was referred to a physiotherapist (the Physiotherapist) and to an occupational therapist (the Occupational Therapist) on 14 June 2005 for a full discharge assessment and she was also referred to Social Work for a care package. They said the Occupational Therapist assessed Mrs A and noted that she required supervision with one person regarding transfers, for example from her bed, or from a chair.

52. The Board said that, on 15 June 2005, Mrs A was seen by the Physiotherapist and it was noted that she required supervision and the assistance of one person to mobilise. It was also noted that Mrs A had occasional loss of balance.

53. The Board said that, on 16 June 2005, the Occupational Therapist discussed Mrs A's occupational therapy assessment with family members. The Board said that the Occupational Therapist had advised that a washing and dressing assessment would be carried out on 20 June 2005.

54. The Board said that on 17 June 2005 a nurse had written in the clinical records:

> '... possible transfer to [a hospice], but [Mrs A] was adamant she did not want this. She was certainly not confused. The plan is to allow [Mrs A] home on Wednesday with maximum home support ...'

The Board said that the plan was made for Mrs A to go home and this plan was made in good faith, but circumstances prevented it from happening.

55. The Board said that the Occupational Therapist noted, on 20 June 2005, that Mrs A was able to wash with very close supervision and that she required some assistance to maintain a standing balance. It was also noted that she would require some assistance with this task once she was at home. The

Board said that, on 21 June 2005, the Occupational Therapist spoke with Mrs C and explained that Mrs A would require someone with her at all times at home to ensure safety with transfers and mobility and to address her general needs.

56. The Board said, therefore, that following assessment, the Occupational Therapist, the Physiotherapist and nursing staff did not feel that Mrs A would be safe in her home without 24-hour care. The Board said that, instead, in-patient specialist palliative care at St Andrew's Hospice (the Hospice) was suggested. The Board said that Mrs A was first seen by a specialist palliative care team from the Hospice on 20 June 2005 and it was noted that she had no major symptom issues, but that she indicated that she did not want to go to the Hospice. On 21 June 2005, a nurse spoke to both Mrs C and Mrs A to try and encourage her to go to the Hospice as an initial discharge from hospital.

57. The Board said that Mrs A agreed to the transfer on 22 June 2005 and a formal request was made to the Hospice for admission.

58. The Board said they tried to give indicative discharge dates to patients and their families, as they had done in this instance, but that when patients' conditions changed they had to revise their plans. The Board said that the assessments of Mrs A showed that the care package that had been arranged was not sufficient and, therefore, Mrs A's discharge had to be delayed. The Board apologised for this.

59. I asked the Adviser for advice on this complaint. She told me that the clinical records showed that communications between staff and the family were frequent and informative. However, the Adviser said it appeared that the information was not always being received and interpreted by the relatives in a way that was meant. The Adviser said this seemed to be the case in relation to discharge planning.

(f) Conclusion

60. I note that the Board initially told Mrs C that Mrs A would be discharged on 22 June 2005 and that the plan was for her to be given a full care package. Subsequent assessment by the Physiotherapist and the Occupational Therapist found, however, that Mrs A would not be able to cope at home without 24-hour care. In the circumstances, I consider it was appropriate to revise the plan for discharge. Certainly, sticking to a discharge plan that had become inappropriate would not have been acceptable.

61. The key issue here appears to be one of communication. Mrs C had the impression that the care package and Mrs A's discharge date were set in stone and would not be subject to change. Consequently, she was surprised, and Mrs A was upset, when discharge was delayed and the idea of discharging Mrs A to a hospice was agreed instead.

62. I note the Adviser's comments that the clinical records show that communication with Mrs A's family was frequent and informative and that information may, at times, not have been received in the way it was meant. In the circumstances, at this distance from events, I cannot say whether there was any failure on the Board's part to communicate effectively with Mrs A's family about the process of arranging a care package and the fact that discharge would be dependent on Mrs A's condition being amenable to being discharged. Had this been properly explained to, and properly understood by, Mrs C and Mrs A, then the latter would not have been surprised if a change to the plan occurred. However, I cannot determine, based on the evidence available, whether it was the Board's explanation or the complainant's understanding that was at fault in this case.

63. Although I cannot determine exactly what happened in this case and while I make no criticism of the Board, I consider that good practice in such situations would be to make clear to patients and their families that any indicative discharge date given is not definitive and could be subject to change. In order to ensure good practice, the Board may wish to consider highlighting this issue to their staff to avoid potential situations where patients and families are upset and disappointed as a result of changes to discharge arrangements. While this suggestion does not represent a formal recommendation and while, as I make clear above, the facts of the case in terms of communication cannot be fully established, the Board may find this a useful opportunity to remind staff of good practice in relation to providing patients with discharge dates.

64. Ultimately, while I appreciate that Mrs C and Mrs A would have been disappointed that Mrs A was not discharged and was not able to spend her last few days at home, the Board made their decision on the basis that Mrs A's deteriorating condition meant that she required 24 hour care. In the circumstances, the Board considered that discharge to the Hospice would be more appropriate and I am satisfied that this was reasonable.

65. In light of my comments above, I do not uphold this complaint.

(g) The Board failed to diagnose and treat an infection that Mrs A contracted while in the Hospital, which led to additional discomfort and pain and which Mrs A's family believe contributed to her death

66. Mrs C said that, on 26 June 2005, she and Mr B were called by the Hospital who told them that Mrs A's condition had deteriorated. When they arrived they said they found Mrs A moaning, groaning and rolling about in bed. Mrs C said that Mrs A was scarlet red and there was a rattling sound coming from her chest. Mrs C said a doctor (Doctor 3) spoke to Mrs C and said that Mrs A appeared to have some sort of infection and she asked whether the family wanted any investigations done to see what the infection might be. Mrs C said that she told Doctor 3 that no more investigations should be done. Mrs C said that when she complained, subsequently, the Board had told her that the infection might have contributed to Mrs A's death.

67. In response to the complaint made to them, the Board said that Doctor 3 had clearly noted that she discussed investigating and treating Mrs A's symptoms with the family but that it was noted the family only wanted symptom control. Doctor 3 also noted that Mrs C asked how long Mrs A had to live and she suggested a couple of days at most, but maybe less.

68. The Board said that, on reviewing the clinical records, there were indications that Mrs A had become agitated and flushed, with a raised white blood cell count. The Board said that this may have been the sign of a chest infection. However, the Board said there was no definite proof of this and that steroids could also cause an increase in white blood cell count. The Board said that infections were common in patients with advanced lung cancer, that they could progress rapidly and were a common final cause of death.

69. I asked the Adviser for advice on this point of complaint. She said that she endorsed the comments made by the Board.

(g) Conclusion

70. Mrs C admits that Doctor 3 told her there was a possibility of infection and had asked the family whether they wanted this to be investigated. Mrs C has clearly stated that the family did not want further investigations. This is in accord with Doctor 3's note of the conversation in the clinical records.

71. The Adviser has endorsed the Board's comments that the presence of an infection cannot be proven but that infection is a common final cause of death for people who are very ill.

72. In the circumstances, given the clearly expressed wishes of the family, I consider the Board's actions in not investigating a possible chest infection were reasonable. Consequently, I do not uphold the complaint.

73. While I do not uphold the complaint, I am pleased to note that the Board have introduced a new Integrated Care Pathway for the Terminal/Dying Phase (the Pathway) on the ward to which Mrs A was admitted. Patients are placed on the Pathway after discussion with doctors, nurses and relatives. The Pathway will ensure that, amongst other things, there is a specific record that the care plan for the management of a dying patient (including the extent of any investigations or treatment) has been discussed with, and understood by, relatives. This should ensure that any potential for confusion is avoided.

(h) The Board failed to record sepsis as a cause of death on the death certificate

74. Mrs C said that, if the actual cause of Mrs A's death had been sepsis (a type of infection), then this should have been recorded on Mrs A's death certificate.

75. The Board said that the main cause of death was lung cancer, as was correctly recorded on the death certificate. The Board said that, with hindsight, the clinical records showed it was likely that the reason why Mrs A had deteriorated so rapidly on 26 June 2005 was due to a chest infection. However, the Board said that there was no proof of this.

76. I asked the Adviser for advice on the complaint. She considered that sepsis should only have been recorded as a cause of death on the death certificate if this had been a diagnosis at the time. The Adviser confirmed that many people with terminal cancer develop chest infections, but the essential cause of death was the untreatable cancer.

(h) Conclusion

77. With hindsight, the Board have come to the view Mrs A may have had a chest infection, although there is no proof this was the case. The Adviser, whose advice I accept, has stated that she considers that it was reasonable for

sepsis not to be recorded on the death certificate. Consequently, I do not uphold this complaint.

(i) The Board failed to carry out a post-mortem even though Mrs A had died sooner than expected

78. Mrs C, responding to a statement made by the Board that Mrs A died more quickly than expected and that that was presumably due to sepsis, said that a post-mortem should have been carried out given that death had come quicker than anticipated.

79. In response to the complaint made to them, the Board said that while up to a third of hospital deaths underwent a hospital post-mortem previously, they were carried out much less frequently now. They said this was largely due to public perceptions and the wishes of families. The Board said it would now be unusual to perform a post-mortem if the main cause of death was clear, as was the case here (inoperable lung cancer), to avoid causing further distress to the family.

80. I asked the Adviser for advice on the complaint. She said she did not consider that a post-mortem was necessary in this case. She pointed out that Mrs A had an inoperable lung cancer that significantly decreased her life expectancy. She said that, in the circumstances, any additional diagnosis that might have been provided by a post-mortem would not be necessary and would not be a good use of resources.

(i) Conclusion

81. The Adviser's view, which I accept, is that a post-mortem was not necessary in this case. Consequently, I do not uphold this complaint.

(j) The Board did not provide sufficient nursing care to Mrs A and did not help bring Mrs A's temperature down or remove her teeth and only checked up on her occasionally

82. Mrs C was concerned about what she saw as a lack of nursing care being provided to Mrs A on 26 June 2005. Mrs C said that Mrs A had a temperature and that her family had started a chain, wetting paper towels to try to bring the temperature down. Mrs C said Mrs A was so overheated that her face was scarlet. Mrs C said that no nursing staff attended or tried to help. Mrs C said that nurses were not helpful and that when she asked a nurse to help remove Mrs A's teeth she was asked whether Mrs C could do it.

83. In responding to the complaint made to them, the Board explained that staff were happy if family members wanted to help in the care of their relatives and that sometimes it was good that the family did that rather than the nursing staff. However, the Board confirmed that nursing staff should have been on hand to help. The Board also confirmed that using paper towels was not appropriate.

84. The Board said that when patients were at the end stage of their life and surrounded by their loved ones nurses did their utmost not only to maintain patient comfort and dignity, but also to afford families privacy. The Board acknowledged that this could sometimes lead to situations where families felt that nursing staff were not in attendance as often as they should be.

85. The Board pointed out there was no evidence to support the view that, on the day in question, Mrs A had a raised temperature. They said, however, that Mrs A may have appeared warmer than normal due to the exceptionally warm weather at the time. The Board said that, for that reason, a fan was made available in Mrs A's room. The Board apologised if Mrs C felt that nursing staff were not as attentive as she would have liked, but confirmed that that would not have been their intention.

86. I asked the Adviser for advice on the complaint. She told me that she agreed that the use of paper towels, while acceptable in an emergency until a more appropriate means could be found, was not acceptable in the circumstances described. The Adviser said that, while she accepted that nursing staff would wish to maintain the family's privacy and would encourage the family to be involved in caring for a dying relative, she considered that staff should have assessed Mrs A and agreed with the family who would deliver necessary care to her. The Adviser said that, if the decision had been taken between the family and nursing staff that relatives would deliver direct care, then nursing staff should still have checked that all was well at regular intervals.

(j) Conclusion

87. The Board have explained that their staff wish patients and their families to maintain their privacy, particularly when the patient is nearing death. However, the Adviser, whose comments I agree with, is critical of the fact that no discussion occurred between nursing staff and the family about who would provide what care. In this case, such a discussion would have helped the family

feel supported, while at the same time allowing them to care for, and spend time with, Mrs A. It is also clear that the use of paper towels was not acceptable in the circumstances. In light of the Adviser's criticisms, I uphold the complaint.

(j) Recommendation

88. The Ombudsman recommends that the Board reflect on this complaint and consider whether guidance or training is needed to ensure that patients' families feel appropriately supported when they decide to take an active role in caring for a relative.

(k) The Board's nursing staff were unable to fit a syringe driver because a nurse was on her break

89. Mrs C said that Doctor 3 had told her that a syringe driver would be put in place to calm Mrs A down. Mrs C said that there was then a delay in having the syringe driver put in place as it took two nurses to fit the device and one nurse was on her break.

90. In responding to the complaint made to them, the Board said that two nurses were required to check and administer the syringe driver, which was prescribed to reduce Mrs A's agitation. The Board said that, as Mrs A was given a sedative at 09:15 and the syringe driver was set up by the two members of nursing staff at 11:00, the staff made the judgement that Mrs A's condition did not require the task to be carried out immediately.

91. I asked the Adviser to comment on this complaint. She said that she was unable to establish whether a nurse being on her break was the reason why the syringe driver had not been set up immediately. However, she said that since a sedative had been administered at 09:15 it was reasonable for the syringe driver not to be set up for two hours. She confirmed that this was appropriate in the circumstances.

(k) Conclusion

92. Although I cannot establish whether the syringe driver was not put in place sooner because a nurse was on her break, I am satisfied that the Board's actions were clinically appropriate in the circumstances. Given that Mrs A had been administered a sedative at 09:15, the Adviser, whose advice I accept, considers that it was reasonable for the syringe driver not to be set up until 11:00. In light of this, I do not uphold this complaint.

(l) A physiotherapist said that she could not help Mrs A because she was not co-operating, which was inappropriate

93. In response to Mrs C's complaint to them, the Board stated that the Physiotherapist attempted various treatments to alleviate Mrs A's distress. The Board said that, unfortunately, due to her agitation she was unable to give the co-operation required for these treatments. The Board acknowledge that the use of the phrase 'not co-operating' by the Physiotherapist was unfortunate. The Board pointed out, however, that it was routine terminology used where treatments had not been effective. Nonetheless, the Board apologised for the distress this caused.

(l) Conclusion

94. The phrase used by the Physiotherapist is a commonly used term in the medical setting to describe situations where patients do not respond well to treatment. While the term perhaps lacks sensitivity, I do not consider that its use is in itself inappropriate; much would depend on how it was said and what context it was said in. Therefore, while I consider the Board acted appropriately by apologising for any distress caused by the use of the phrase, I do not feel that the Physiotherapist's choice of words amounts to maladministration or service failure. Consequently, I do not uphold the complaint.

(m) Nursing staff did not inform Mrs C or Mr B that Mrs A was dying when they re-entered the room Mrs A was in

95. Mrs C said that at 18:50 on 26 June 2005, nurses asked the family to leave the room in order to 'freshen up' Mrs A. At 19:00 a nurse told the family that they could go into the room. Mrs C said that when they entered they found that Mrs A was dying. Mrs C said that the family asked the nurses why they had not mentioned Mrs A was dying and were told that they did not know. In commenting on a draft of this report, Mrs C said that a member of Mrs A's extended family, who was a nurse at the Hospital (Mrs D), was appalled by the lack of proper procedure on the ward and by the way Mrs A was treated. Mrs C also said that when she entered Mrs A's room equipment had already been disconnected, which showed that Mrs A was already dead before the nurses allowed the family back into the room.

96. An entry in the clinical records written by a nurse stated:

> 'Family asked to leave room to make pt comfortable. S/c line for syringe driver dislodged, the same to be resited. Family allowed back into room, on entering room pt condition had deteriorated badly. Family + [Mrs D]

present. [Mrs D] complained that family have not been properly prepared for their mother's death. Family spoken to by staff nurse in charge + myself with regards condition changing so quickly. [Mrs D] still unhappy with events'.

97. An entry in the clinical record written after the incident by a doctor stated:
'[Mrs D] requesting to speak to me. She is angry that family were brought in to see [Mrs A] while she was dying without being warned of [Mrs A's] condition'.

98. A minute of a meeting between the Board and Mrs C to discuss her complaint stated:
'[The Board] explained that the nursing auxiliary had gone into [Mrs A's] room to make her more comfortable and had asked the family to step outside. The nursing staff then realised that [Mrs A] was taking her last breaths and called the family back in as they were anxious that her family was with her at this time. [Mrs C] said that they were only told they could go back into the room by the nursing staff, what she did not realise was that her mum was dead. [The Board] explained that staff had one recollection and the family had another. [Mrs C] said it was not her recollection, it was a fact, and the family had a witness that the nursing staff were lying ... [The Board] explained that nursing staff had given their recollection of events.'

99. A minute of a meeting between the Board and Mrs D stated:
'[Mrs D said] Nursing staff (staff nurse and auxiliary) went to the room to attend her aunt. The nursing staff came out after a short while and said that the family could return to the room. [Mrs D] said that she saw her aunt's hand and knew that she was dead.

[The Board] said that [the family] had asked how long their mother had and had been told that she could have a couple of days, or it could be sooner. Mrs D said that she appreciated what [the Board] was saying, as she was very aware that nursing staff could be attending and turning a patient and they could just go. [The Board] said the nursing staff had realised that [Mrs A] was taking a turn for the worse. [Mrs D] said that the family had not known that their mother was going to die'.

100. In commenting on this point of complaint in response to my investigation the Board stated:

> 'The issue was covered at both meetings. I can only apologise that the family feel they were not prepared by nursing staff: I realise that this must have been a very distressing time for them.'

101. At interview, the clinical support worker (the Support Worker) who told Mrs A's family that they could re-enter the room, said that she was not one of the members of the Board's staff who had been in the room with Mrs A at the time. She said that she was passing and looked into the room, at which point another clinical support worker and a student nurse - who were turning Mrs A - told the Support Worker to bring the family into the room. The Support Worker said that she did not give the family any information about Mrs A's state of health at that time. She said that she had simply advised them to go back into the room. The Support Worker said that she did not think it was for her, as a clinical support worker, to give information about whether a patient was dying.

102. At interview, the nurse in charge of the part of the ward Mrs A was in (the Nurse) said that he had gone off to get medication to ease Mrs A's chest problems and that when he returned he witnessed the Support Worker telling Mrs A's family that they could re-enter the room. The Nurse said that he did not know the exact state of Mrs A's health at the time, as he had just returned. The Nurse confirmed that the Support Worker had only asked the family to go back into the room and had not provided any information about Mrs A's health at that point. The Nurse confirmed that the Support Worker had wanted to get the family back into the room as quickly as possible.

103. Following the interviews described at paragraphs 101 and 102 above, I discussed this point of complaint with the Ward Manager of the ward in question and other members of the Board's staff. They told me that the events at the time of Mrs A's death should be seen in the context of her final day as a whole. They said that Mrs A's family had been seen by a doctor and been told that she did not have long to live. The family also knew that Mrs A had an inoperable and terminal lung cancer. They said that the family had been there all day and, therefore, in the view of staff, were fully aware of Mrs A's deteriorating condition and the fact that she was nearing the end of her life. They said Mrs A's family should not have been surprised, given the information they had been provided with during the day. They also said that it was not a clinical support worker's role to express an opinion as to whether a patient was dying.

(m) Conclusion

104. It is clear from the evidence set out above that Mrs A's family were not specifically told by the Board's staff that she was dying when they were asked to re-enter her room. This is in accord with Mrs C's recollection of events.

105. The question for this office is whether the fact that no specific information was provided regarding Mrs A's imminent death was reasonable in the circumstances. I have concluded that the Board's actions were reasonable and I explain why below.

106. An important factor in considering this complaint relates to the Support Worker's level of experience and the nature of responsibilities she could be expected to fulfil. Clinical support workers are not registered clinical professionals such as nurses or doctors. The Adviser has confirmed that, while they can perform a number of tasks on the ward, they would not normally be expected to provide relatives with information regarding a patient's health as this would be a matter for doctors or nurses. In this case, therefore, I consider that the Support Worker went as far as she could be expected to go by simply asking the family to return to Mrs A's room, rather than providing information about Mrs A's deteriorating state of health.

107. In this case I note that, even if providing such information had been within the scope of the Support Worker's responsibilities, the information available to the Support Worker herself was limited. Indeed, the Support Worker was not fully aware of Mrs A's condition given that she was just passing the room and had not been one of the staff looking after Mrs A at the time.

108. In relation to the Nurse, he had been to get medication and was, therefore, not aware of any further deterioration in Mrs A's condition and, therefore, could not have been expected to provide any information to the family.

109. While I can appreciate that it was extremely distressing for Mrs A's family to return to the room to find her dying, I am satisfied that in the particular circumstances described above, the actions of the Board's staff were reasonable.

110. I understand that Mrs A's family would have wanted to be warned of the further deterioration in her condition and that - despite their conversation with a

doctor earlier in the day - Mrs A's death nevertheless came as a surprise. In an ideal situation, a warning would have been helpful and would have perhaps helped to mitigate the distress felt by the family when they returned to see Mrs A in her final moments.

111. However, the staff member who asked the family to go back into the room was not qualified to provide that information, even if she had known the full details of Mrs A's situation. In the circumstances, therefore, while I fully understand how distressing this situation was for the family, I cannot fault the actions of the Board's staff. Consequently, I do not uphold this complaint.

(n) No attempt at resuscitation was made and the family were not asked if they wanted it

112. In responding to the complaint made to them, the Board stated that it was well documented in the notes by Doctor 3 that she had spoken with Mrs A's family on the morning of 26 June 2005, as Mrs A had deteriorated clinically. The Board said that, at that stage, Mrs A's family indicated that they did not wish anything to be done to prolong her suffering.

113. The Board said that whilst Doctor 3 had not directly discussed resuscitation, they had quite clearly discussed the overall care plan for Mrs A and it had been agreed that this should be based on keeping her comfortable rather than making any attempts to prolong her life.

(n) Conclusion

114. The Board did not specifically mention resuscitation with the family. I consider, however, that it was reasonable for the Board to extrapolate from the discussion between Mrs C and Doctor 3, that resuscitation was not an option the family wanted, given that the preference had been indicated for control of symptoms only, rather than treatment or investigation. Consequently, I do not uphold this complaint.

115. While I do not uphold the complaint, I note that the Pathway requires that resuscitation should be specifically discussed with relatives and that this discussion should be recorded in the notes. I welcome this improvement in the Board's practice.

(o) An empty syringe driver contributed to Mrs A's death

116. Mrs C said that when she and her family re-entered Mrs A's room at 19:00 on 26 June 2005, they found the syringe driver lying out of its casing with no fluid in it. Mrs C questioned whether the empty syringe driver had anything to do with the fact that Mrs A died so quickly.

117. In responding to the complaint made to them, the Board stated that there was evidence in the clinical records to suggest that Mrs A's condition was deteriorating. They said that, at the time, the doctor was requested to attend and Mrs A's family were asked to leave the room to allow nursing staff to make Mrs A as comfortable as possible. The Board said that nursing staff noted that the syringe driver had become dislodged. They said this explained why the syringe driver was lying outside its casing. The Board said, however, that the nurses were very anxious given the rapid deterioration of Mrs A's condition to allow the family back into the room.

118. The Board explained that the medication being administered by the syringe driver was Haloperidol 10 mg over 24 hours subcutaneously and this was commenced at 11:00. They explained that Haloperidol is an anti-psychotic drug used to alleviate anxiety. They said, however, that in Mrs A's case it was used to reduce agitation. The Board said that the dose prescribed was a low dose and was being given subcutaneously, which was the slowest route for absorption.

119. I asked the Adviser to comment on the complaint. She said she supported the view given by the Board in respect of the appropriateness of the choice and dosage of the medication prescribed.

120. The Adviser said she had no reason to believe that the syringe driver was other than disconnected by accident when the final nursing care was being provided, but she confirmed that there was no way of proving that. The Adviser said there was no evidence of an over-infusion of medication that contributed to the final deterioration of Mrs A.

(o) Conclusion

121. While it cannot be known exactly how the syringe driver came to be dislodged, the Adviser, whose comments I accept, has stated that, in her view, Mrs A's final deterioration was not due to an over-infusion of medication from the syringe driver. Consequently, I do not uphold this complaint.

(p) Mrs A had to wait a long time on both occasions when a doctor was called on 26 June 2005

122. In response to the complaint, the Board said that staffing levels were reduced at weekends and the doctors could be responsible for large numbers of patients.

123. The Board said that, from the clinical records, there was evidence that Mrs A was seen on two occasions by medical staff on 26 June 2005. The first occasion was around 09:00 at which time the family were spoken to by Doctor 3. The Board said there was another medical entry at 11:50 and in addition there were regular entries from the Physiotherapist and nursing staff.

124. I asked the Adviser for her comments on this complaint. She said the level of medical review received by Mrs A and the speed with which she was attended, while not perfect, were reasonable.

(p) Conclusion

125. The Adviser's view is that the level of medical review and the speed with which Mrs A was attended were reasonable. I accept her advice and, consequently, I do not uphold this complaint.

(q) The clinical records were inadequate, because they contained no observations for 25 June 2005 and no fluid charts

126. Mrs C, when looking over Mrs A's clinical records, noticed that they showed no observations had been taken and no fluid charts existed for 25 June 2005.

127. In response to my investigation, the Board accepted that there were no fluid balance charts in the records and accepted that it would have been beneficial to have such a chart in place for Mrs A.

128. I asked the Adviser to comment on this complaint. She told me that, in addition to the missing fluid charts, the Modified Early Warning Score (MEWS – a system used to determine when patients are at risk of deterioration) showed no observations for 25 June 2005.

(q) Conclusion

129. The Board failed to put in place fluid charts for Mrs A or to record any observations on 25 June 2005. Consequently, I uphold this complaint.

(q) Recommendation

130. I recommend that the Board put measures in place to ensure that, where appropriate, fluid charts are filled out for patients and observations are recorded.

131. 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.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mrs A	The aggrieved
The Hospital	Monklands Hospital
The Board	Lanarkshire NHS Board
The Adviser	One of the Ombudsman's clinical advisers
Mr B	Mrs A's son, Mrs C's brother
GP 1	One of Mrs A's GPs
Doctor 1	A doctor who saw Mrs A at Accident and Emergency on 4 and 5 April 2005
GP 2	Another of Mrs A's GPs
Doctor 2	A doctor who saw Mrs A at Accident and Emergency on 5 April 2005
The Dietician	A dietician involved in Mrs A's care
The Code	The Medicines Code of Practice
The Physiotherapist	A physiotherapist involved in Mrs A's care
The Occupational Therapist	An occupational therapist involved in Mrs A's care
The Hospice	St Andrew's Hospice

Doctor 3	A doctor who attended Mrs A on the day of her death
The Pathway	The Board's Integrated Care Pathway for the Terminal/Dying Phase
Mrs D	A member of Mrs A's extended family who was also a nurse at the Hospital
The Support Worker	A clinical support worker who was involved in the events of Mrs A's death
The Nurse	A nurse who was involved in the events of Mrs A's death