Scottish Parliament Region: South of Scotland

Case 200601141: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; General medical; Clinical treatment/diagnosis

Overview

Mrs C complained that there had been a significant delay in diagnosing her late husband (Mr C)'s kidney condition and, further, that he had not been told he was suffering from kidney problems for some months. Mr C had been treated as an emergency by Crosshouse Hospital in February 2005. He was then investigated over several months as an out-patient at a urology clinic and admitted as an in-patient to Ayr Hospital (Hospital 2) on 19 January 2006 and, sadly, died there on 30 January 2006. Mrs C had concerns about the treatment provided to Mr C during this period of admission. She said she believed that his medication was withdrawn prior to this death and that, during the weekend prior to his death, a nursing care plan was not followed. Mrs C said that during this period of admission Mr C was not treated with appropriate dignity and respect and, in particular, he had died unobserved and been found by a cleaner on 30 January 2006.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was a delay in diagnosing Mr C's kidney condition and his treatment for this was inadequate (*upheld*);

(b) information about Mr C's kidney condition was not appropriately communicated to him (*upheld*);

(c) medication was withdrawn inappropriately during the last few days of Mr C's life (*not upheld*);

(d) nursing care was inadequate and, in particular, the care plan not adhered to over the last few days of Mr C's life (*upheld*); and

(e) Mr C was not treated with appropriate dignity and respect while in Hospital 2 (*no finding*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mrs C for the delays identified in diagnosing Mr C's condition and, as a result, failing to inform him that he was suffering from severe impairment of kidney function following the ultrasound taken in June 2005;

(ii) ensure that the clinical team involved in Mr C's care consider the lessons to be learned as a result of the failings identified in this report;

(iii) review a random sample of the results of ultrasounds taken, to ensure that they are being followed up appropriately;

(iv) review their procedures for arranging urgent IVPs, to ensure that the delay identified in this case is prevented in the future where possible;

(v) undertake a short, focussed audit of letters issued by the Urological Unit to GPs and provide evidence of the results and any action flowing from this;

(vi) the Consultant should share this case with his appraiser at annual appraisal if this has not already been done;

(vii) use this complaint as a case study with complaints handling staff, to demonstrate the importance of answering clearly the concerns raised with appropriate information;

(viii) apologise to Mrs C for the failure to provide an acceptable standard of nursing care to Mr C during the weekend of 28 to 30 January 2006;

(ix) undertake a selective audit of nursing records for this ward for weekends and provide her with a copy of the results;

(x) apologise to Mrs C for the failures in record keeping; and

(xi) ask the Consultant to reflect on how his approach may be perceived.

Main Investigation Report

Introduction

1. Mr C was admitted to Crosshouse Hospital (Hospital 1) as an emergency admission in February 2005. He was found to have traces of blood in his urine at a level that would not be detectable to the eye. Mr C's GP referred him for further tests to the Urological Clinic (the Clinic) at Ayr Hospital (Hospital 2) and he attended there in May 2005. In June 2005, Mr C had an ultrasound examination at East Ayrshire Community Hospital (Hospital 3). Mr C had further investigations at Hospital 3 in December 2005 and at Hospital 2 in January 2006. He was then admitted to Hospital 2 on 19 January 2006 and, sadly, he died there on 30 January 2006.

2. In September 2006, Mrs C complained in detail about her late husband (Mr C)'s care and treatment to Ayrshire and Arran NHS Board (the Board). In summary, she said there had been a ten-month delay in informing her husband that he was suffering from a kidney condition, following his initial presentation in February 2005. She said she was also aware that Mr C had been diagnosed with kidney failure in June 2005 but he had not been informed of this. Mrs C also had concerns about his care while he was in Hospital 2 in January 2006. She said medication had been withdrawn and a care plan not followed in the last few days of his life. She felt Mr C had not been treated with appropriate respect and dignity while in Hospital 2. She said, in particular, she was unhappy with the attitude of one consultant and she complained that Mr C had died unobserved and had been found by a cleaner.

3. In their response of 1 November 2006, the Board said Mr C had received all appropriate investigations and follow-up. Medication was not stopped in the period prior to his death and there was no change in the level of nursing care provided at weekends.

4. Mrs C complained to the Ombudsman's office on 11 January 2007 about both the Board and Mr C's GP Practice (the Practice). The complaints about the GP Practice have been dealt with in a separate report number 200603770.

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

(a) there was a delay in diagnosing Mr C's condition and his treatment for this was inadequate;

(b) information about Mr C's kidney condition was not appropriately communicated to him;
(c) medication was withdrawn inappropriately during the last few days of Mr C's life;
(d) nursing care was inadequate and, in particular, the care plan not adhered to over the last few days of Mr C's life; and
(e) Mr C was not treated with appropriate dignity and respect while in Hospital 2.

Investigation

6. In investigating this complaint, I have obtained the background documentation relating to the complaint and Mr C's medical records from the Board and the Practice. Advice was also obtained from Hospital and Nursing advisers to the Ombudsman, (Advisers 1 and 2 respectively) and specialist Urological advice sought from an external adviser (Adviser 3).[1] The abbreviations used in the report are explained in Annex 1 and the medical terms used in the report are explained in Annex 2.

7. 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.

Background

8. Mr C died aged 76 years on 30 January 2006 in the Urological Unit of Hospital 2. His death certificate recorded myocardial infarction and coronary artery disease as the primary causes of death. Chronic renal failure was listed as a secondary cause.

9. Mr C had been admitted as an emergency admission to Hospital 1 on 28 February 2005 following a telephone call to NHS24. There was some concern that blood and protein were present in his urine. Mr C had been noted to have had similar results in 2003. The results were forwarded to his GP, who repeated the tests and referred Mr C to Hospital 2. Mr C attended a urology clinic there on 24 May 2005 where he was seen by a staff grade surgeon (the

[1] The standard used in this report for assessing the actions of medical staff is whether the actions were reasonable. By reasonable, I mean the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical profession in terms of knowledge and practice at the time.

Surgeon). He was noted to have an enlarged prostate and a reduced urine flow. Mr C began to receive treatment for an enlarged prostate and a follow-up appointment for the Clinic was made for 18 November 2005. Mr C was also referred for an ultrasound scan. The ultrasound scan was taken on 21 June 2005.

10. On 2 September 2005 Hospital 3 wrote to Mr C to say that the appointment for the Clinic would be rescheduled for 9 September 2005. Mr C cancelled this appointment as he was unable to attend and he subsequently attended the Clinic at Hospital 3 on 2 December 2005.[2]

11. At the appointment on 2 December 2005, Mr C reported a further episode of blood in his urine (see paragraph 1) but that the flow had improved. The Consultant he saw that day (the Consultant) noted in a letter subsequently sent to Mr C's GP that the ultrasound scan showed dilation of the right kidney. He said that he decided to do further x-rays of the kidney (a procedure known as an intravenous pyelogram – IVP) and that this had been noted as urgent.

12. Mr C attended again at the Clinic on 29 December 2005, when he was seen by the Surgeon. The Surgeon commented on a marked dilation on the left side and an urgent IVP was requested and booked for 10 January 2006. At his subsequent Clinic appointment on 19 January 2006 the decision was made to admit Mr C to Hospital 1.

13. Following this admission, on 20 January 2006, Mr C had a tube inserted to the right kidney to improve urine flow. The next day he was noted to be unwell and intravenous antibiotics and fluids started. These were increased when blood tests showed evidence of infection. By 24 January 2006 the records noted that Mr C's kidney function and infection were improving but he was suffering from pain in his hands and feet, which were thought to be a recurrence of gout. A CT scan was carried out on 26 January 2006 and on 27 January a tube inserted into Mr C's left side. A decision was also made to carry out further x-ray tests.

14. A morning ward round by a member of the medical team on 30 January 2006 did not note anything significant. However, Mr C was found

[2] In response to a draft of this report, Mrs C explained that, given his reliance on public transport, the time of the original appointment meant it was impossible for Mr C to attend.

later that day to be unresponsive by a housekeeper, a cardiac arrest call was made and the team arrived at 13:34. Resuscitation measures were unsuccessful and Mr C was pronounced dead at 13:43.

(a) There was a delay in diagnosing Mr C's kidneycondition and his treatment for this was inadequate; and (b) Information about Mr C's kidney condition was not appropriately communicated to him

15. Between the period following his initial emergency admission to Hospital 1 in February 2005 and his death in January 2006, Mr C attended the Clinic as an out-patient at two separate locations and, finally, was treated as an in-patient at Hospital 2. Adviser 3 considered in detail the care Mr C had received from a urological perspective. Adviser 3 said that in May 2005 a clear history was taken by the Surgeon and prompt investigations undertaken. However, the Surgeon wrote to Mr C's GP to say he would review Mr C in six month's time, before receiving the results of the biochemical tests or the scan carried out in June 2005 (see paragraphs 9 and 17). Adviser 3 had not seen the results of the laboratory tests, as these were not with Mr C's medical records (see paragraph 26). However, the complaint response letter from the Board to Mrs C said that Mr C's creatinine level was 139 umol/l[3] and that this 'would not have been regarded as unusual in a man of his age and physical status'. Creatinine is a waste molecule which is generated as a by-product of energy production in muscles. This is processed by the kidneys and if the kidneys are impaired the level of creatinine in the blood will rise. As a result, the levels of creatinine present in the blood have been found to be a fairly reliable indicator of kidney function.

16. The letter from the Board continued, 'on the basis of the report from the ultrasound this would not require any further investigation than occurred'. Adviser 3 questioned these statements. He said that the top of the normal range for creatinine seen in most labs would be 133 umol/l and a man with a creatinine level of 139 umol/l must be regarded as possibly having impaired renal function unless proved otherwise, regardless of his age.

17. Adviser 3 also considered the scan undertaken in June 2005 in detail. He said that this showed Mr C had a grossly abnormal urinary tract, which appeared to be significantly obstructed. Adviser 3 said that, if this had been checked at the time, the significance of the 139 umol/l figure would have been

[3] A standard measurement referring to micromoles per litre

clear. However, it appeared that, following the decision to refer him to the Clinic in six months, the tests which had been ordered in June were not reviewed. In response to comments made by the Board to a draft of the report, Adviser 3 said that while, given Mr C's age and physical condition, the creatinine level alone may not have generated further investigation, this combined with the ultrasound scan results, should have instituted a full and comprehensive radiological and biochemical investigation as a matter of urgency. In his view, the failure to do any further investigation was to provide Mr C with management below the standard he was reasonably entitled to expect.

18. At the rescheduled Clinic appointment of 2 December 2005, Mr C's urine flow was measured. The tests showed he had a maximum flow rate of 12 mls/sec[4], an average of 7 mls/sec and a residual urine of 88 mls. Adviser 3 has said the flow rates were both abnormally low and the residual urine elevated. In his view, these results showed clear evidence of significant bladder outflow obstruction. Mr C was reviewed by the Consultant at the Clinic and the Consultant dictated a letter to Mr C's GP on that day. This was then typed on 6 December 2005. Adviser 3 reviewed this letter in detail and said he was concerned that this did not correlate to the clinical record made available. The Consultant referred to an improvement in both the flow and the residual urine but there were no records of previous measurements having been taken. Adviser 3 described the flow recorded on 2 December 2005 as grossly reduced. The Consultant also referred to some dilation on the ultrasound (carried out on 21 June 2005) on the right side but Adviser 3 noted there was also dilation on the left side which was not noted. The Consultant said he was reassured that Mr C's symptoms had improved and he noted Mr C was not suffering from continual bleeding but, according to Adviser 3, Mr C had no symptoms originally and continual bleeding was not a usual presentation of urinary tract tumours. Adviser 3 found no evidence that his creatinine level was measured by the Clinic but the GP notes recorded a level of 279 umol/l on 12 December 2005, which indicated Mr C was in significant renal failure. The GP had seen Mr C on 9 December 2006 when these tests were taken.

19. Adviser 3 said that on 2 December 2005 the Consultant had seen a five-month-old ultrasound scan which, in his opinion, showed 'very serious and potentially life-threatening changes' in Mr C's urinary tract. He considered Mr C should have been admitted as an emergency in early December 2005. He

[4] A standard measurement indicated millilitres of flow per second

noted the 'urgent' IVP took over a month to be performed. Even given this was the holiday season, Adviser 3 felt this was poor performance. He said again that, in his view, this was management to a standard below which Mr C was reasonably entitled to expect.

20. The Surgeon saw Mr C on 29 December 2005 and this was noted in a letter to his GP dictated on 11 January 2006. The Surgeon noted that the ultrasound showed marked dilation on the left kidney and mild dilation on the right kidney and that the second IVP should have been carried out on 10 January 2006 (see paragraph 12). Adviser 3 said that, given this was dictated a day later, he thought the Surgeon should have checked whether this was the case.

21. According to Adviser 3, the results of the IVP of 10 January 2006 demonstrated that Mr C's left kidney no longer functioned and that the right kidney was showing signs of seriously impaired function, due to obstruction of the ureter. Taking into account the creatinine level reported in the GP records, Mr C's overall renal function was, by this time, seriously impaired.

22. Mr C was seen again at the Clinic on 19 January 2006. No clinical note was available but the Consultant wrote to Mr C's GP about this. Adviser 3 commented about the quality of this letter, which had a series of uncorrected secretarial errors and was, at times, badly expressed. In particular, Adviser 3 was confused by a statement that evidence of a bladder lesion was present and felt it was likely the Consultant should have said 'not' present and a cystoscopy was referred to which did not appear to be recorded in the notes. A reference to 'interior cherry bar' was likely to mean 'interureteric bar'. He was also concerned about the Consultant's interpretation of the IVP, which he felt underestimated the extent of Mr C's renal impairment and did not match his own reading of this. However, he concluded that it was reasonable[5] for the Consultant to conclude that Mr C likely had a retroperitoneal cause for the obstruction; that his renal function was impaired; the right kidney needed to be drained; and a CT scan undertaken. Mr C was admitted to Hospital 2 on the same day as this Clinic appointment (19 January 2006).

[5] When reasonable is used in this report it should be taken to mean the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical profession in terms of knowledge and practice at the time.

23. Adviser 3 noted that, following the insertion of the first drain on 20 January 2006, Mr C's creatinine levels showed improvement over the next few days from 503 umol/l on 20 January 2006 to 296 umol/l on 26 January 2006. The CT scan on 26 January 2006 showed no obvious reason for the obstruction. A second drain was inserted to the left side on 27 January 2006 but showed only minimal amounts of urine on 29 January 2006. Adviser 3 said that, given the gross lack of function shown on the IVP, this was to be expected. He said that, given this, the left drain was likely to have been an ineffective therapeutic manoeuvre.

24. Adviser 1 also reviewed Mr C's care and treatment while in Hospital 2 and as an out-patient. It was his initial concerns about a possible delay in diagnosis which led to advice being sought from Adviser 3. Adviser 1 also commented on whether the renal problem could have increased the risk of Mr C suffering a heart attack. He said that, on balance, he did not consider this was the case but that, clearly, as Mr C became more ill and a diagnosis was not yet made, this would have increased his anxiety. It was not possible to define how this would have affected his predisposition to a heart attack.

25. Furthermore, Adviser 1 agreed that it was unclear that anyone had seen the ultrasound scan of June 2005 prior to December 2005 but it was clear that the results of this were not communicated to the GP or the patient or dealt with appropriately. He also noted the Consultant's failure to comment on the left obstruction of the kidney evident in this scan in December 2005. In addition, Adviser 1 also supported Adviser 3's comments on the quality of the letter of 19 January 2006, which he said was poor and confusing.

26. In reviewing the care received while in Hospital 1, Adviser 1 added that, from a medical point of view, Mr C's care was adequate. Medical notes were recorded daily. Blood tests were taken regularly and radiological investigations requested, undertaken and recorded correctly. In response to concerns about joint pain, medical opinion was sought appropriately from the rheumatology team and prompt treatment given when an infection occurred. However, Adviser 1 also noted that some tests that were noted to have been taken were not present in the files. After enquiries, the Board confirmed that all records had been sent. Adviser 1 remained concerned about the incomplete state of the notes but said that the investigations which were missing had been noted in the medical records and did not indicate that further follow-up had been required.

27. In response to my enquiries, the Board commented on the delay between the request for an urgent IVP made on 2 December 2005 and the procedure being carried out on 10 January 2006. They explained that the request was assessed by a Consultant and passed for booking of an appointment on 13 December 2005. They said they would normally expect to complete this within one working week and the timescale for the appointment from the booking time would have been two weeks. However, there was a reduction in IVP sessions available at this time due to the public holiday periods, resulting in an appointment offer of 6 January 2006. This was rescheduled to 10 January 2006 on Mr C's request.

(a) and (b) Conclusion

28. In her letter of complaint, Mrs C referred to the Board's own statement of patient rights and said she felt that the Board had breached these on a number of significant points in relation to Mr C's care, including failure to inform and failure to be treated within a reasonable length of time. Given the advice I have received from Adviser 3, it is difficult to disagree with these statements.

29. Adviser 3 has highlighted a number of significant failures. There is no evidence the ultrasound taken on 21 June 2005 was reviewed: this meant that information sent to Mr C's GP was not accurate and both the GP and Mr C were not given the correct information about his condition. Adviser 3 was also of the view that the results of the ultrasound, combined with Mr C's creatinine level, should have meant urgent further investigations. He has advised that, when the ultrasound was reviewed at the Clinic in December 2005 (see paragraph 18), its full implications were not noted or appreciated and there was then a delay in carrying out an IVP, despite it being noted as urgent. The Board have explained the circumstances for this last delay (see paragraph 28) and I accept the Christmas/New Year break can cause difficulties. However, on the basis of the advice I have received, I uphold both complaints in full and the Ombudsman is making a number of recommendations for review and audit as a result of these complaints.

30. Adviser 1 has said that the medical aspects of Mr C's treatment during his period as an in-patient do not raise concern. However, he has noted that the medical records were incomplete and that not all test results were made available. While the notes of the results which were present in the handwritten medical notes did not raise cause for concern, all test results should be kept with the notes. This is of particular concern given that Adviser 3 also noted test

results were not available with the notes provided. I am critical of this poor practice and, therefore, draw it to the Board's attention.

(a) Recommendation

31. The Ombudsman recommends that the Board:

(i) apologise to Mrs C for the delays identified in diagnosing Mr C's condition and, as a result, failing to inform him that he was suffering from severe impairment of kidney function following the ultrasound taken in June 2005;

(ii) ensure that the clinical team involved in Mr C's care consider the lessons to be learned as a result of the failings identified in this report;

(iii) review a random sample of the results of ultrasounds taken, to ensure that they are being followed up appropriately;

(iv) review their procedures for arranging urgent IVPs, to ensure that the delay identified in this case is prevented in the future where possible;

(v) undertake a short, focussed audit of letters issued by the Urological Unit to GPs and provide evidence of the results and any action flowing from this; and

(vi) the Consultant should share this case with his appraiser at annual appraisal if this has not already been done.

(c) Medication was withdrawn inappropriately during the last few days of Mr C's life

32. In her complaint to the Board, Mrs C said that she was concerned that, during the last days of Mr C's life, it appeared medication was withdrawn. In their response letter of 1 November 2006, the Board said that a course of antibiotics had been completed on 21 January 2006 and a second course of medication was stopped on 22 January 2006 because Mr C's blood pressure was low. They said they felt all medication given throughout Mr C's stay was appropriate.

33. Adviser 1 reviewed the medication given. He said that the drugs charts showed that antibiotics had been continued until the morning of Mr C's death. Other drugs for a variety of symptoms and conditions, including antihypertensives, prostate treatment and laxatives, were all given regularly up to and including the date of Mr C's death.

34. Adviser 2 also noted that oral antibiotics were given up until 30 January 2006 and noted that, in her letter to the Board, Mrs C had been concerned about the timing of medication that was given. Adviser 2 said that it

was accepted and standard practice that medication rounds would start prior to prescription times given on charts, to ensure all patients received medication at appropriate intervals. This would not have impacted on Mr C's care. Adviser 2 noted that this concern had not been dealt with in the response from the Board to Mrs C's complaint (see paragraph 3).

(c) Conclusion

35. It is clear that medication was not withdrawn, and, on this basis, I do not uphold this complaint. However, I am concerned about the response given by the Board to Mrs C's concerns on this point. The letter of 1 November 2006 does not explain what medication was still being given at the time of Mr C's death and simply refers to medication that had been stopped some time previously. Adviser 2 has also noted that no response was given to Mrs C's concerns about the way medication was administered. It would have been possible for the Board to have provided a fuller response on the details of Mr C's medication and reassurance about the practice of administering medication in hospitals. Therefore, while I am not upholding this complaint, the Ombudsman is making the following recommendation.

(c) Recommendation

36. The Ombudsman recommends that the Board use this complaint as a case study with complaints handling staff, to demonstrate the importance of answering clearly the concerns raised with appropriate information.

(d) Nursing care was inadequate and, in particular, the care plan not adhered to over the last few days of Mr C's life

37. Adviser 2 reviewed the nursing notes detailing care given to Mr C. She said there was evidence that Mr C was appropriately assessed on admission and a care plan put in place. The daily progress notes were relatively detailed. She added that she was satisfied with the regularity of entries over the first weekend and that this was supported by an observation chart which indicated an appropriate level of monitoring. This was particularly relevant, as Mr C became unwell on 21 January 2006.

38. However, Adviser 2 said that on the second weekend the regularity of monitoring dropped significantly. There was only a single set of observations on 28 January 2006 (a Saturday) and this consisted solely of a temperature reading. Only two observations were taken on 29 January 2006: one at 14:40, when Mr C's pulse was rather low but blood pressure was within acceptable

limits. A temperature reading was noted later that day. There were no notes of monitoring Mr C on 30 January 2006, the day of his death.

39. Adviser 2 said that, in her view, the level of nursing monitoring was of an acceptable standard until 28 January 2006. After this time, the level of monitoring fell significantly below the level she would have expected. Statements were made by nursing staff in response to Mrs C's complaint. These were internal documents used to generate the Board's response to Mrs C of 5 December 2006. In these it was said Mr C 'would have had regular watchful observation of him on all shifts' and 'the level of nursing care is no less at the weekend than during the week'. Adviser 2 said that this could not be substantiated from the available records. She did not doubt that nursing staff were often present and that Mr C was seen when medication was administered. However, documented observations and fluid balance were key interventions which should have been carried out. The care plan indicated these should be carried out with reasonable regularity and she said no rationale had been given by the Board for why the observations had suddenly been reduced so markedly. She said that any such alteration in the level of care should be clearly explained in the records and it was not. In the circumstances, Adviser 2 added, she understood Mrs C's concern.

(d) Conclusion

40. Adviser 2 said that, in her view, Mrs C was correct to have been concerned about a change in the level of care provided to Mr C over his second weekend while in hospital. She said that the level of monitoring fell below an acceptable standard. The Board have not explained why the level of monitoring was so different each weekend. On the basis of the advice I have received, I uphold this complaint.

(d) Recommendations

41. The Ombudsman makes the following recommendations that the Board:

(i) apologise to Mrs C for the failure to provide an acceptable standard of nursing care to Mr C during the weekend of 28 to 30 January 2006;

(ii) undertake a selective audit of nursing records for this ward for weekends and provide her with a copy of the results.

(e) Mr C was not treated with appropriate dignity and respect while in Hospital 2

42. In her complaint Mrs C had been concerned about the attitude shown towards her late husband. She said, in particular, that the Consultant had been dismissive and lacking in courtesy. She was concerned that, when he died, Mr C had initially been found by a cleaner and not a member of the clinical team. She said there was no time given in the notes detailing when the cleaner found her husband. She was concerned that he may have been left for some time and that the cardiac arrest team noted his pupils were fixed.[6]

43. In their response, the Board said that the Consultant was unaware that his attitude was perceived as dismissive and that he had made many attempts to communicate with Mr C during his stay. They said that, while there was no nurse present at the moment Mr C became unresponsive, there were nursing staff in the six bedded room all day. The housekeepers (the cleaners referred to in paragraph 42) were part of the team and had been present. They pulled the emergency cord and nursing staff were present within seconds. They confirmed that the entry relating to this in the records was made at 14:00 but that this was not the time the housekeeper had alerted staff but when the note was written.

44. Adviser 1 said there was nothing in the written evidence to show the Consultant had displayed a lack of courtesy. However, this was a subjective matter. Adviser 1 also considered comments made by the Consultant in response to Mrs C's concerns that Mr C had not been kept fully informed. The Consultant had said that he had many conversations and long discussions with Mr C. Adviser 1 said that there was little in the notes to support this statement. The in-patient notes recorded only one ward round by the Consultant and a discussion with Mrs C following her husband's death. Any other conversations which may have occurred were not documented.

45. Adviser 1 set out the circumstances surrounding Mr C's death from the record, which he described as brief but adequate. An entry had been made in the nursing records at 09:00 which showed no concern. The cardiac arrest call

[6] This head of complaint only deals with the concerns raised over the attitude of the Consultant and with the information given to Mrs C about the circumstances surrounding Mr C's death. Concerns over nursing care and monitoring which can relate to general aspects of dignity and respect are dealt with under heading (b).

was made at 13:34 and Mr C subsequently pronounced dead at 13:43. Adviser 2 also said the entry in the nursing records was brief and best practice would have been for the nurse to have clearly identified all timings. However, she was satisfied it was likely the housekeeper summoned nursing staff as soon as she discovered him, and that this occurred shortly before the arrest call was made by nursing staff at 13.34. She also noted that medications were administered around midday but, given there were no other documented events, it would be impossible to state exactly when Mr C collapsed before he was found. Adviser 2 also said she felt the response by the Board to Mrs C on this point was brief and did not fully explain the apparent conflict in the timings but appeared to assume Mrs C would understand how such unexpected events were recorded.

(e) Conclusion

46. In considering the advice I have received, I have no concerns about the actions taken following the discovery, by a member of the housekeeping staff, that Mr C had collapsed. I am aware that the concerns raised by Mrs C, that this was a non-clinical member of staff, relate to the inadequate level of nursing care that she felt he was receiving over this weekend from the nursing staff. I have already commented on this in detail under heading (d) and do not repeat those comments here. I have also made a recommendation under heading (c) in relation to the response to Mrs C's complaint.

47. I have considered carefully Mrs C's concerns about the attitude of the Consultant. The Board have commented that the Consultant was unaware that his attitude was perceived as dismissive and Adviser 1 found no evidence to show that the Consultant displayed a lack of courtesy. The Consultant feels his attitude was appropriate, while Mrs C clearly feels differently on this score.

48. Having examined all the evidence, I have been unable to substantiate either way Mrs C's concerns that Mr C was not treated with appropriate dignity and respect. Accordingly, on balance, I make no finding but given this is a subjective matter I have asked the Consultant to reflect on these concerns. Nevertheless, there is no note of any record of discussion with Mr C and the Consultant during his admission and I am critical of this, given the Consultant's position that he had made many attempts to communicate with Mr C. The Ombudsman, therefore, makes the following recommendations.

(e) Recommendation

49. The Ombudsman recommends that the Board:

(i) apologise to Mrs C for the failures in record keeping; and

(ii) ask the Consultant to reflect on how his approach may be perceived.

50. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The aggrieved, Mrs C's late husband
Hospital 1	Crosshouse Hospital
The Clinic	The Urology clinic, which was held at a number of separate locations
Hospital 2	Ayr Hospital
Hospital 3	Cumnock Hospital
Mrs C	The complainant
The Practice	Mr C's general medical practice
The Board	Ayrshire and Arran NHS Board
Adviser 1	Hospital Adviser to the Ombudsman
Adviser 2	Nursing Adviser to the Ombudsman
Adviser 3	Urological Adviser to the Ombudsman
The Surgeon	Staff grade surgeon who saw Mr C at the Urological clinic
The Consultant	Consultant who saw Mr C at the clinic and in Hospital 2

Annex 2

Glossary of terms

Creatinine	Creatinine is a waste molecule which is generated as a by-product of energy production in muscles. This is processed by the kidneys and if the kidneys are impaired the level of creatinine in the blood will rise.
CT scan	Computerized tomography scan: pictures of structures within the body created by a computer which takes the data from multiple x-ray images and turns them into pictures on a screen
Cystoscopy	A procedure to view the inside of the bladder and urethra in great detail, using a specialised endoscope (a tube with a small camera used to perform tests and surgeries) called a cystoscope
Interureteric bar	A fold between the opening of the two ureters
Intravenous pyelogram (IVP)	An x-ray of the kidneys and urinary tract: structures are made visible by the injection of a substance that blocks x-rays
Myocardial infarction	A heart attack
Renal	Relating to the kidneys
Retroperitineal	Situated or occurring behind the peritoneum
Ultrasound scan	Images of the internal organs, created from sound waves

Ureter	The tube which carries urine from the kidney to the bladder
Urology	The medical specialty which deals in the medical and surgical diseases of the kidneys and urinary tract