Scottish Parliament Region: Glasgow

Case 200702258: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Clinical treatment/Diagnosis

Overview

The complainant (Miss C) raised a number of concerns about the care and treatment received by her mother (Mrs A) in Stobhill Hospital (the Hospital) prior to her death on 11 July 2007.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) despite having suffered Transient Ischaemic Attacks (TIA), Mrs A was discharged without having had a scan to determine the exact cause of her symptoms; in particular, she should not have been discharged after her second TIA *(not upheld)*;

(b) Mrs A was prescribed aspirin, which Miss C said was unsafe *(not upheld)*; and

(c) there was a delay in the Greater Glasgow and Clyde NHS Board (the Board) informing the family that Mrs A had contracted MRSA *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) stress to nursing staff the importance of comprehensive note taking;

(ii) formally apologise to Miss C for the delay in advising that Mrs A had contracted MRSA; and

(iii) emphasise to staff the importance of good communication in keeping family members advised of a patient's changing condition and of recording such conversations in the appropriate clinical notes.

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

Main Investigation Report

Introduction

1. On 27 November 2007, the Ombudsman received a complaint from the complainant (Miss C) about the care and treatment her mother (Mrs A) received when attending Stobhill Hospital (the Hospital)'s Accident and Emergency (A and E) department on 11 May 2007 after suffering a stroke. She also complained about the Hospital's delay in advising that Mrs A had contracted MRSA.

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

(a) despite having suffered Transient Ischaemic Attacks (TIA), Mrs A was discharged without having had a scan to determine the exact cause of her symptoms; in particular, she should not have been discharged after her second TIA;

(b) Mrs A was prescribed aspirin, which Miss C said was unsafe; and

(c) there was a delay in the Greater Glasgow and Clyde NHS Board (the Board) informing the family that Mrs A had contracted MRSA.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Miss C and the Board. I have also had sight of Mrs A's relevant clinical records and the Board's complaints file. In relation to this complaint, I sought advice from an independent medical adviser (the Adviser) and, on 8 February 2008, I made a formal enquiry of the Board. They responded to me on 11 March and 28 March 2008.

4. While I have not included in this report every detail investigated, I am satisfied that no matter of significance has been overlooked. Miss C and the Board were given an opportunity to comment on a draft of this report.

(a) Despite having suffered TIAs, Mrs A was discharged without having had a scan to determine the exact cause of her symptoms; in particular, she should not have been discharged after her second TIA

5. Miss C said that on 11 May 2007 she accompanied Mrs A, who was 85-years-old, to the Hospital's A and E department because she had suffered a stroke. Miss C said that after Mrs A was seen, she was asked to obtain her medication from the pharmacy. When Miss C returned, the nurse, who had

stayed with Mrs A and helped her use the commode, told her she had had another stroke. Despite this, Miss C said the advice was that Mrs A was to be discharged. Miss C said that she and Mrs A were then taken to the ambulance room to wait for transport home but she stated that Mrs A had a further stroke in the lavatory there. At that point, it was decided to admit Mrs A. Miss C said that Mrs A had a scan the next day which, she said, showed that Mrs A had bleeding in the brain. Mrs A stayed in hospital but, regrettably, on 11 July 2007, she died of stroke related problems.

6. It is Miss C's contention that the plans for Mrs A's discharge should have been changed immediately when it was known that she had had another stroke whilst Miss C went to the pharmacy. In commenting on this aspect of the complaint, the Board have told me that it is their practice that, if a patient has had a TIA which is fully resolved, the patient would be allowed home with a referral to the TIA clinic and that these patients were normally seen within a week of referral. If patients have more than one TIA, the Board said that they are admitted to hospital. In Mrs A's case, they said there was no record in her casualty notes of the second set of symptoms described by Miss C (see paragraph 5) but that Mrs A was admitted (on 11 May 2007) after the Hospital recorded her second attack which, they said, was in the ambulance waiting room. The Board advised me that guidelines for acute stroke recommend a CT/MRI scan within 24 hours of admission to hospital and that a CT scan was, therefore, arranged for Mrs A on 12 May 2007. In this connection, the Adviser told me that National Clinical Guidelines for Stroke published by the Royal College of Physicians in June 2004 stated that a strategy for prevention of stroke should be implemented within seven days of acute stroke or TIA and patients with TIA should be assessed by a specialist service within seven days. It also stated that patients with more than one TIA within a week should be admitted.

7. The Adviser considered Mrs A's clinical records and told me that they showed that Mrs A arrived at A and E at 11:10 on 11 May 2007. She was seen by a doctor at 13:05, when no neurological abnormalities were found, but it was noted that she had an irregular heart beat. Mrs A's ECG was then compared to previous records but found to be unchanged. It was observed that she had been admitted two months earlier and received blood transfusions for anaemia and that she had a previous history of TIA. The Adviser said that the records noted that the medical team were consulted and they advised that Mrs A be discharged, recommending that she be given aspirin and omperazole (to

counteract the irritant effect of aspirin in the light of Mrs A's history of oesophageal ulceration and bleeding).

8. However, the Adviser identified that there was a further entry in the A and E record at 11:25, describing an episode of slurred speech and facial weakness on mobilising to the toilet but that it was described as resolving quickly. He commented that the crux of the decision upon whether to admit Mrs A at this stage, therefore, rested upon whether this episode of slurred speech and facial weakness was part of the initial TIA or a separate event. He said that his own feeling was that, since the doctor examined Mrs A two hours after this (see paragraph 7), and found no signs of a stroke, it was not unreasonable to attribute the signs described by the nurse as residual symptoms of the first TIA.

9. Records show that Mrs A was admitted to A and E at 16:15, after a further recurrence of symptoms in the ambulance waiting room. The Adviser said that these symptoms resolved on examination but that Mrs A's heart rate was noted to be faster (120). However, he said it was also noted that this was the third TIA in eight hours (but see paragraph 6). At 18:00, the Adviser said that Mrs A still had no neurological symptoms but the following day she had some further facial weakness and the CT scan which had been arranged showed infarction (tissue death due to obstructed blood supply) and not haemorrhage (bleeding) to be the cause of this.

(a) Conclusion

10. The Board said that they followed the established guidelines by admitting Mrs A to the Hospital after her further TIA in the ambulance waiting room (see paragraph 6) and the Adviser considered the fact that the second episode of slurred speech at 11:25, before Mrs A saw the doctor (see paragraph 7 and paragraph 8), was considered to be a continuation of her symptoms, to be reasonable. While Miss C maintained that this was a second separate TIA, I have to be guided by the advice I am given, which was that it was reasonable to consider this to be a continuance of the first episode. However, notwithstanding the Board's contention that there was no record of the second set of symptoms as described by Miss C (see paragraph 6), the Adviser pointed out to me that clinical records noted the episode. This illustrated some confusion and, the Adviser told me, a failure to document properly the fluctuating signs while Mrs A waited to see a doctor. Accordingly, he said, clinicians were denied information about the nature of the development of Mrs A's condition. Nevertheless, the

Adviser's prevailing opinion is that Mrs A's treatment was reasonable and I have concluded that, on the matter of admission, the Board acted in accordance with the appropriate guidelines.

11. Thereafter, Mrs A had a CT scan the next day and, again, this was in accordance with the Hospital's guidelines for acute stroke, which recommend that a CT/MRI scan occur within 24 hours of admission. Although Miss C believed that a scan should have been carried out prior to making a decision on discharge, this was not what the guidelines advised. Accordingly, in this respect, I am satisfied that Mrs A was treated correctly and I do not uphold the complaint.

(a) Recommendation

12. Although I do not uphold this aspect of the complaint, the Adviser identified that the clinical notes could have been improved upon (see paragraph 10). He commented to me that the nursing record of Mrs A's stay in A and E, over the course of about four hours before she was transferred to the ambulance waiting room, was confined to one set of observations at 11:10 and a nursing entry at 11:25. He said that he would have expected the final entry to have prompted a repeat set of observations. He is of the view that if Mrs A had been further observed, a variation of her condition may have been picked up sooner and thus avoided unnecessary anxiety. In the circumstances, the Ombudsman recommends that the Board stress to nursing staff the importance of comprehensive note taking and that they follow up any observed change in condition by careful charting of observations and onward referral to more senior or medical colleagues.

(b) Mrs A was prescribed aspirin, which Miss C said was unsafe

13. Miss C said that on being discharged, Mrs A was prescribed aspirin and she believed this to have been unsafe because, she said, Mrs A had suffered from bleeding in her brain. She thought that the further TIAs she suffered that day could have been as a consequence of this.

14. It has been established that Mrs A did not suffer from bleeding in her brain (see paragraph 9). If she had, the Board told me that aspirin would not have been appropriate but, in Mrs A's case, prompt administration of aspirin was likely to reduce the chance of further stroke rather than increase it. The Adviser agreed and said that Mrs A's history of atrial fibrillation and previous anticoagulation, with recurrence of TIA over two months after cessation of

anticoagulants, was strongly in support of TIA and not a bleed and, therefore, the prescription given to Mrs A (see paragraph 7) was entirely appropriate. The Board also confirmed that their actions were in line with NHS Quality Improvement Scotland standards that aspirin treatment was initiated within 48 hours of admission for all stroke patients. The Adviser confirmed that National Guidelines said that patients likely to have a diagnosis of TIA should be prescribed 'an alternative antiplatelet regime immediately (i.e. aspirin or other)'. The Board went on to tell me that the scan Mrs A had on 12 May 2007 did not show any bleeding on her brain, despite what Miss C thought, and that although they tried to reassure her about this, she would not accept their explanation.

(b) Conclusion

15. Despite Miss C's opinion, Mrs A was treated in accordance with relevant guidelines (see paragraph 14) and she did not suffer any bleeding in the brain. It was, therefore, appropriate to prescribe aspirin. In these circumstances, I do not uphold the complaint.

(c) There was a delay in the Board informing the family that Mrs A had contracted MRSA

16. Miss C said that it was only on 26 June 2007, when Mrs A's family asked the ward sister for an update on her condition, that they learned that Mrs A had contracted MRSA. While she said that the ward sister apologised for not telling them, she was concerned that if the family had not made such an enquiry, they may not have been kept properly updated.

17. The Board's response to me on this aspect of the complaint was that a specimen had been taken from Mrs A's PEG site (Percutaneous endoscopic gastrostomy site, the site of an intravenous feeding tube) on 18 June 2007 and the result had come back positive the next day. Mrs A was then moved to another part of the ward where an adjacent bed could be left empty and further testing was undertaken. This was also positive and full treatment was started. The Board maintained that the family should have been told of the positive result on 19 June 2007 and given relevant information. However, they said that there was no information within the notes to confirm that this happened.

(c) Conclusion

18. The Board said that Mrs A's family should have been told on 19 June 2007 that Mrs A had contracted MRSA but Miss C specifically recalled that it was not

until 26 June 2007 that the family learned this. Mrs A's medical notes are silent on the matter and, on balance, I am, therefore, disposed to believe Miss C. In all the circumstances, I uphold this part of the complaint.

(c) Recommendation

19. The Ombudsman recommends that the Board formally apologise to Miss C for the delay in advising that Mrs A had contracted MRSA. Also, that they emphasise to staff the importance of good communication in keeping family members advised of a patient's changing condition and of recording such conversations in the appropriate clinical notes.

20. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that she be notified when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Miss C	The complainant
Mrs A	The complainant's late mother
The Hospital	Stobhill Hospital
A and E	Accident and Emergency
MRSA	Methicillin-resistant Staphylococcus aureus
TIA	Transient Ischaemic Attack
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	The independent medical adviser
PEG site	Percutaneous endoscopic gastrostomy site