Scottish Parliament Region: Lothian

Case 200702661: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant, Mrs C, raised a number of concerns about the care and treatment which her late mother, Mrs A, received at the Royal Infirmary of Edinburgh (the Hospital) in August 2007. Mrs C complained that there were delays in carrying out a CT scan and for Mrs A to be seen by a dietician. She also complained that there were communication problems with the staff.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was a delay in carrying out a CT scan following Mrs A's admission to the Hospital (*upheld*);

(b) it was inappropriate for staff to assume Mrs A was suffering from bowel cancer and this compromised her treatment plan (*not upheld*);

(c) there was a delay in Mrs A being seen by a dietician and to ensure she received an adequate level of nutrition (*upheld*); and

(d) the level of communication with Mrs A's family was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that Lothian NHS Board (the Board):

(i) give consideration to whether communication links between clinical and radiology staff require review in view of the findings in this report;

(ii) conduct a review of the current procedures for requesting a CT scan at the weekend, to ensure that patient care is not compromised, should the status of the request be downgraded;

(iii) conduct an audit of the clinical and nursing records in the ward, to ensure that they are completed in accordance with the guidance issued by the regulatory bodies such as the General Medical Council and the Nursing and Midwifery Council;

(iv) reflect on Adviser 1's comments about the lack of urgency in the clinical investigation and consider whether the degree of patient orientation or clinical leadership at ward level is appropriate;

(v) review their policies for nutritional assessments and dietetic referrals and consider whether nursing staff would benefit from the implementation of a robust education programme related to meeting the nutritional needs of older people in hospital, with clear links to Food, Fluid and Nutritional Care Standards (NHS Quality Improvement, Scotland NHS Scotland September 2003);

(vi) should provide evidence of clinical benchmarking of 'Communication', which is clearly linked to Standard 8 Clinical standards for older people in acute care (Clinical Standards Board for Scotland October 2002), to ensure that this aspect of practice is audited and there is demonstrable evidence of improvement in this aspect of care delivery; and

(vii) issue Mrs C an apology for the failings which have been identified in this report.

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

Main Investigation Report

Introduction

1. On 23 January 2008 the Ombudsman received a complaint from Mrs C about the care and treatment which her late mother, Mrs A, received at the Royal Infirmary of Edinburgh (the Hospital) in August 2007. Mrs C complained that there were delays in carrying out a scan and for Mrs A to be seen by a dietician and that there were communication problems with the staff. Mrs C complained to Lothian NHS Board (the Board) but remained dissatisfied with their response and subsequently complained to the Ombudsman.

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

(a) there was a delay in carrying out a CT scan following Mrs A's admission to the hospital;

(b) it was inappropriate for staff to assume Mrs A was suffering from bowel cancer and this compromised her treatment plan;

(c) there was a delay in Mrs A being seen by a dietician and to ensure she received an adequate level of nutrition; and

(d) the level of communication with Mrs A's family was inadequate.

Investigation

3. In writing this report I have had access to Mrs A's clinical records and the complaints correspondence from the Board. I obtained clinical advice from one of the Ombudsman's professional medical advisers (Adviser 1), who is a consultant gastroenterologist, and a nursing adviser (Adviser 2) regarding the medical and nursing 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. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of the medical terms used in this report can be found at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Clinical background

5. According to Mrs A's clinical records she was admitted to the Hospital on 10 August 2007 (aged 74 years old) with a one week history of increased abdominal pain, anorexia and weight loss. On 11 August 2007 a request was made for an urgent non-contrast CT scan because of Mrs A's poor renal function. The request for the CT scan was discussed between Mrs A's

consultant (Consultant 1) and the radiology department on 13 August 2007 but there was a delay in the decision to proceed with the scan because of Mrs A's poor renal function. On 15 August 2007 the radiologists tried to contact the surgical team for advice regarding the most appropriate investigative option but the surgical team were unavailable as they were in the Emergency Department. Therefore, a message was left requesting that a surgeon contact the radiologist. Mrs A was referred to a dietician on 15 August 2007 regarding weight loss and poor appetite.

6. On 17 August 2007 it was noted that the original plan was to proceed with a contrast enema to exclude obstruction of the bowel. However, following review of the request and the previous plain abdominal films by the consultant radiologist (Consultant 2), a decision was made for a non-contrast CT scan as there appeared to be no obvious sign of obstruction. Consultant 2 reported his interpretation of the films to the surgical registrar, who was in the radiology department at that time – an obstruction was excluded but an obvious diagnosis was not provided. However, as Mrs A had abdominal distension on 20 August 2007, the plan to proceed with a barium enema was changed. Mrs A was reviewed by a dietician on 22 August 2007 and the suggestion was made to consider naso-gastric tube and enteral feeding. A flexible sigmoidoscopy was performed on 22 August 2007 but no abnormality was detected. Mrs A's condition deteriorated on 23 August 2007 and it was provisionally thought that she had developed a pulmonary embolism and she was transferred to the intensive care unit. Mrs A was ventilated and a CT scan with contrast was undertaken. This suggested an intra-abdominal abscess with perforation and possible ischaemia of the bowel. Mrs A's condition deteriorated and, sadly, she died later that morning.

(a) There was a delay in carrying out a CT scan following Mrs A's admission to the hospital; and (b) it was inappropriate for staff to assume Mrs A was suffering from bowel cancer and this compromised her treatment plan

7. Mrs C complained to the Board on 27 September 2007 about the level of care and treatment which Mrs A had received in the Hospital. Mrs A was admitted on 10 August 2007, which was a Friday, and she was given pain relief in Accident and Emergency before being transferred to a ward. There, the family were told a scan/bowel examination would be performed the following day. Mrs A was nil by mouth pending the examination but it was not carried out, as they were later told that only emergency examinations were carried out at

the weekend. Mrs A was examined on 17 August 2007. This examination consisted of a non-contrast CT scan and was not the type of examination originally told to the family. On return to the ward after the examination, Mrs C said her mother was drowsy; it took her until 18 August 2007 to recover; and in that time it did not appear that she had received any treatment. The family were told that a dietician had been called for Mrs A on 13 August 2008 but that nobody had arrived. Mrs C's family were annoyed that nobody had taken responsibility for Mrs A's treatment and an appointment was made for them to see a clinician on 20 August 2007. At the meeting they were told Mrs A was quite ill but there was a waiting list for the investigations to take place. Mrs C was told a doctor thought that Mrs A was suffering from cancer and was frail but there was little staff could do. Mrs C said that was not true as Mrs A was not frail on admission and that a lack of care and nourishment was the cause of her poor condition. Mrs C said the family were told on 22 August 2007 that an examination had caused Mrs A some discomfort and there appeared to be a blockage in her bowel and that staff did not want to probe further at that time. Mrs C said the family were contacted by the Hospital at 03:00 on 23 August 2007 to say that Mrs A had deteriorated and by 09:00 she had passed away. Mrs C said Mrs A never regained consciousness due to the heavy sedation she received in intensive care to alleviate her pain. Mrs C also thought that the post mortem revealed that Mrs A's bowel had burst due to the prodding connected with the examination the previous day. Mrs C believed that, had Mrs A received proper and prompt treatment on admission to the Hospital, she would still be alive.

8. The Board's Acting Director of Operations (the Director) responded to Mrs C on 18 December 2007. She explained that the initial assessment suggested the possibility that Mrs A had cancer in the large bowel and it was also documented that she had poor kidney function. The clinical team requested an urgent non-contrast CT scan on 11 August 2007 to help with the diagnosis. As the request was made on a Saturday, it was not considered to be urgent and the request was not reviewed until the Monday morning and discussed between Consultant 1 and the radiology department. In view of the staff's concern for Mrs A's poor kidney function, there were ongoing discussions between the surgical and radiology teams as to which investigations to perform. The radiologists were concerned, given the possibility of bowel cancer, whether a non-contrast scan or direct visualisation of the bowel was the way to proceed. Staff had agreed to proceed with a contrast enema on Friday 17 August 2007 to exclude obstruction of the bowel, as this was the forefront of the surgical team's

concern. When Consultant 2 reviewed this request and Mrs A's previous plain abdominal films, it appeared there were no obvious signs of obstruction and, therefore, Mrs A was put forward for a non-contrast CT scan instead. Although the radiology department was busy, Consultant 2 added Mrs A to the day's list and reported the films urgently and directly to the surgical registrar, who was present in the Department. The main message from the film, interpreted in sub-optimal conditions, excluded obstruction but did not provide an obvious diagnosis.

9. The Director continued that Mrs A remained stable over the weekend, when Consultant 3 was providing cover, and he handed over to Consultant 4 on Monday 20 August 2007. It was understood Consultant 4 spoke to the family and discussed what staff did and did not know and tried to explain the problems they had in obtaining an accurate diagnosis. It was planned to proceed with a barium enema but, due to Mrs A's abdominal distension, this was altered to a flexible sigmoidoscopy which was carried out on 22 August 2007 and showed no abnormality. Mrs A's condition deteriorated suddenly in the early hours of 23 August 2007 and it was felt she had suffered a pulmonary embolus and she was transferred to intensive care; placed on a ventilator and a CT scan with contrast was arranged to check her lungs and abdomen. The Director explained that it is common practice to fully sedate patients who are on ventilators, so that the machine takes over the work of the lungs and offers the body the best chance of recovery. The Director understood the scan results suggested Mrs A had suffered an intra-abdominal abscess with perforation and possible ischaemia of the bowel. Mrs A continued to deteriorate and, sadly, died shortly afterwards.

10. The Director said that an opportunity was taken to discuss the management of Mrs A by the consultant surgeons and radiologists who were involved. There was a clear delay in arranging the initial CT scan, which was partly because Mrs A had poor renal function and therefore a non-contrast CT scan was originally requested. Between 13 and 17 August 2007 the surgeons and radiologists discussed how best to proceed, in the light of carrying out a CT scan in sub-optimal conditions without contrast. As a result, Consultant 1 arranged for a gastroscopy to be carried out but this did not provide a diagnosis and a further discussion took place as to whether imaging of the large bowel by direct visualisation would be more appropriate than a non-contrast scan. Following this procedure, Mrs A required an antidote to the

sedation. The Director advised this was in part reflective of the degree of renal impairment Mrs A had, as sedation is normally excreted by the kidneys.

11. The Director apologised that Mrs C was disappointed with the lack of communication between the staff and the family. Staff are encouraged to keep relatives informed of a patient's care and progress as much as possible. The Director gave explanations concerning the business of the ward; nature of surgery; staff rotation; and shift changes, which could affect communication but said that the charge nurses are available to talk to relatives at any time. The Director said that on this occasion medical and nursing staff may have been hampered by the lack of a definitive decision on which scan to proceed with and when it was to be carried out. The Director continued that the notes indicated that Mrs A was referred to a dietician on 15 August 2007 and was reviewed by them on 21 August 2007. In addition, a food chart had been completed by nursing staff from 17 August 2007 and an apology was made if this was not explained to the family.

12. The Director concluded that there was undoubtedly a delay in organising a CT scan and this was an issue which was being taken up with the radiology department, in order to try and improve the communication and organisation of emergency tests, particularly in difficult situations such as in Mrs A's case, where underlying conditions such as renal failure alter the optimal tests which might be organised. The Director added that if the CT scan had been carried out sooner because it was non-contrast and the abscess was not detected by the radiologist reporting the films, it was unlikely that further action would have been taken at that time, particularly as Mrs A's observations were stable right up until her collapse on 23 August 2007, therefore, the outcome may not have been different.

13. Adviser 1 noted that when Mrs A was admitted to the Hospital she was under the care of Consultant 1, who went on leave on 17 August 2007. On 18 August 2007, Mrs A's care was taken over by Consultant 3. On the evening of 20 August 2007 Mrs A came under the care of Consultant 4, who appeared to be the senior surgical cover for that night. When Mrs A suddenly deteriorated on 23 August 2007 she was initially seen by the specialist registrar of the on-call team before being transferred to the intensive care unit. Adviser 1 noted that a provisional diagnosis of 'underlying malignancy? Lower GI' was made, which meant suspected cancer of the colon. However, Adviser 1 said the presenting symptoms on which the provisional diagnosis was based were not specific and

were equally consistent with a diagnosis of diverticular disease. Mrs A had given a history on admission of having previously had a colonoscopy, apparently for diverticulitis.

14. Adviser 1 said there was no clearly documented management plan for the first week of Mrs A's admission and no factual record of the discussions concerning the various investigations under consideration. Adviser 1 believed that the clinical investigation of Mrs A's condition lacked an appropriate degree of urgency. Despite her cachexic appearance (a term used to describe a patient with severe and unintentional weight loss), insufficient attention was given to nutritional support. Adviser 1 told me that, in view of the apparent autopsy findings, it seemed likely that Mrs A was suffering on admission from an abscess caused by diverticulitis and that this abscess ruptured into the peritoneal cavity, probably causing her sudden deterioration on 23 August 2007 and her sad death from peritonitis. Promptly diagnosed and appropriately treated, diverticular abscess is usually survivable but not always so, particularly when patients are elderly and of poor nutrition. Adviser 1 commented that there was poor communication between the admitting clinical team and the radiology department. The initial request for urgent CT scan was made at a weekend and, therefore, was treated as routine by the radiology department. Adviser 1 explained that, generally speaking, CT scans would only be available at weekends for an emergency. For an urgent (but non-emergency) scan he would have expected that a suitably senior member of the clinical team would contact the appropriate radiologist to request and discuss an urgent scan if, for example, an abdominal abscess was suspected. This did not occur. Adviser 1 felt it was equally surprising that the request should be automatically downgraded to routine, apparently without contact or discussion with the team concerned.

15. Adviser 1 reviewed Mrs A's first abdominal CT scan which was performed on 17 August 2007 without the use of intravenous contrast. This scan showed free fluid in the pelvis and no free gas. This is an abnormal but non-diagnostic finding, which suggested a possible inflammation or neoplastic process in the area. Contrast would have improved the definition on the scan but can exacerbate poor kidney function. Given the importance of early diagnosis of abdominal abscess and the fact that Mrs A's kidney function impairment was not particularly severe, it was arguable that the use of contrast was justifiable. However, Adviser 1 said this was a clinical judgment and could only be made by a clinician present at the time, who would assess the patient's degree of

hydration, etc. Of significance, however, was the delay which resulted from the poor communication between the clinical and radiological teams and the apparent lack of leadership from a senior clinician. The second CT scan after Mrs A's collapse was interpreted as showing evidence of severe intestinal ischaemia. Although this was a reasonable interpretation, it was not correct as it was sub-optimal, in that it was again performed without the use of contrast. While this demonstrated an admirable degree of caution, Adviser 1 noted that Mrs A's kidney function had by then significantly improved. Despite the influence of impaired kidney function on Mrs A's management, Adviser 1 was unable to locate any record of a plan for the diagnosis or treatment of the condition.

16. Adviser 1 felt the provisional diagnosis of carcinoma of the colon was reasonable and investigation by CT scan was appropriate. However, he felt the team appeared to have lost sight of Mrs A's previous history of diverticular disease and its possible role in her illness. Adviser 1 said the delay in the CT scan may have been due to a system which was not appropriately patient-centred or perhaps a lack of leadership in liaison with the radiology department. Adviser 1 told me that if, after appropriate discussion, senior radiology advice was against CT then a clear alternative management plan should have been formulated, recorded and promptly acted upon.

17. Adviser 1 told me that it appeared there was no discussion initiated before the first Monday after Mrs A's admission which was surprising, given that the request for a CT scan was marked as urgent. However, Adviser 1 felt that it was entirely appropriate for discussions to take place between senior members of staff in the clinical and radiological teams. It was, however, surprising that the discussion between the radiologist and consultant surgeon on 13 August 2007 did not result in an agreed CT scan or an alternative management plan.

18. Adviser 1 gave his opinion on whether, if an earlier CT scan had been performed, it would it have affected the final outcome. He said that no investigative technique is guaranteed to give perfect results every time and the two CT scans taken were interpreted in sub-optimal conditions. Adviser 1 took this to mean that the interpretation was limited by the absence of contrast enhancement. The scans appeared to give misleading results. It was arguable that the correction/improvement of the renal impairment to allow the use of contrast enhancement would improve the probability of an accurate diagnosis of an abscess. An accurate diagnosis of abscess at an earlier stage by CT scan

or other imaging techniques would undoubtedly have influenced the management of Mrs A's condition. A diverticular abscess would have been treated energetically with antibiotics with or without surgical drainage/resection. Adviser 1 said whether this would have affected the final outcome was speculative but, if treated before rupture and the onset of peritonitis, the condition is undoubtedly survivable though this could not be guaranteed.

19. Adviser 2 said that a comprehensive assessment is the cornerstone to establishing the needs of any patient admitted to hospital and in reviewing this case she identified no evidence of person centred assessment or care planning. She noted there were no core or individualised care plans. Several pages of the multi-disciplinary clinical records did not have any identification indicating the name, date of birth, or hospital record number of the patient. Adviser 2 said this was a serious omission and it had to be acknowledged that shortcomings in record-keeping were significant in terms of the contribution by all members of the multi-disciplinary team.

(a) Conclusion

20. Mrs C believes there was a delay in Mrs A receiving a CT scan following her admission to hospital. The advice which I have received and accept is that there were various factors which affected the time taken to arrange the scan. Firstly, there was discussion between the clinicians and radiology staff about whether the scan should be contrast or not, as account had to be taken of Mrs A's poor renal function. Therefore, it was appropriate for the clinicians and radiologists to take care when reaching their decision as, without the use of contrast the result would be sub-optimal, whereas with contrast it could exacerbate Mrs A's kidney problems. Another factor was that the admission spanned a weekend, when only emergency CT scans would be performed. Although the request for Mrs A's scan was marked urgent, it took until the Monday for discussions to start and, even then, it was surprising that this did not result in an agreed timely CT scan or an alternative management plan. I am also concerned that it appears there was a lack of a clear management plan and, while it was appropriate for clinicians and radiology staff to discuss matters, there is no documentary evidence about what was discussed. In the circumstances, I uphold the complaint.

(a) Recommendations

21. The Ombudsman recommends that the Board:

(i) give consideration to whether communication links between clinical and radiology staff require review in view of the findings in this report;
(ii) conduct a review of the current procedures for requesting a CT scan at the weekend, to ensure that patient care is not compromised, should the status of the request be downgraded;
(iii) conduct an audit of the clinical and nursing records in the ward, to ensure that they are completed in accordance with the guidance issued by the regulatory bodies such as the General Medical Council and the Nursing and Midwifery Council;

(b) Conclusion

22. Mrs C felt that Mrs A's treatment was compromised by staff assuming that she had bowel cancer. However, as has been explained by Adviser 1, the provisional diagnosis of carcinoma of the colon was reasonable and the investigation by CT scan was appropriate. I have also noted Adviser 1's comments that the clinical investigation of Mrs A's condition lacked an appropriate degree of urgency and that the clinicians appeared to have lost sight of her previous history of diverticular disease and whether this may have had a bearing on her current illness. However, in general, I believe the provisional diagnosis of carcinoma of the colon was reasonable and I do not uphold this complaint.

(b) Recommendation

23. Although this aspect of the complaint is not upheld, the Ombudsman recommends that the Board reflect on Adviser 1's comments about the lack of urgency in the clinical investigation and consider whether the degree of patient orientation or clinical leadership at ward level is appropriate.

(c) There was a delay in Mrs A being seen by a dietician and to ensure she received an adequate level of nutrition

24. Adviser 2 noted that on admission to hospital it was commented in the records that Mrs A looked cachexic. She said that, while it is important to record the underlying cause of the weight loss, it is also necessary to ensure prompt referral to a dietician and she could find no recommendation to that affect. Adviser 2 also noted it was recorded that, prior to admission, Mrs A had a 'fairly healthy appetite when well, nausea++, no special diet; and recent weight loss'. The admission assessment was not fully completed and a nutritional assessment had not been undertaken. It was clear to Adviser 2 that if the initial assessment had been more thorough then a more robust and

person-centred plan of care could have been developed, which should have included a timelier referral for dietician review. Adviser 2 noted the dietician referral was not made until Wednesday 15 August 2007. Adviser 2 acknowledged that, as Mrs A had been admitted at the weekend, that would have delayed the referral but she could see no reason why this was not made on Monday 13 August 2007. Adviser 2 felt the delay was unsatisfactory.

25. Adviser 2 continued that Mrs A's food chart was not commenced until 17 August 2007. It was clear that Mrs A's intake of diet was extremely poor and Adviser 2 was concerned that action was not taken to enhance Mrs A's dietary intake by the use of nutritional supplements. There was no evidence from the records that multi-disciplinary discussion took place regarding Mrs A's nutritional status and nutritional supplements had not been prescribed. Mrs A was reviewed by a dietician on 21 August 2007. Adviser 2 felt there was an unreasonable delay from time of referral to time of review. She felt there was no evidence to demonstrate that nurses attempted to escalate their concerns regarding Mrs A's poor nutritional intake or to expedite dietetic review.

26. Adviser 2 also noted that the dietician calculated Mrs A's Body Mass Index as being 17.2 kg/m (among elderly people, a BMI below 22 is an indicator of the risk of malnutrition). The dietician made recommendations regarding the nutritional requirements to increase Mrs A's weight. The dietician further reviewed Mrs A on 22 August 2007 and suggested that a naso-gastric tube and enteral feeding would need to be considered. This recommendation and the concerns expressed by nursing staff regarding Mrs A's poor dietary intake was noted by a junior doctor later that day. Following review the doctor's plan was 'Encourage patient to eat and drink. Note dietician r/v (review). Start IV fluids to rehydrate'. There is no evidence that the junior doctor discussed the management plan with senior medical colleagues, which would have been important in view of the recommendations made by the dietician. Mrs A was next reviewed the following day, when she was seen by a senior registrar due to her acute deterioration.

27. Adviser 2 told me that an initial screening assessment was not undertaken; there was a delay in referral to the dieticians and a further delay before Mrs A was reviewed by them. Mrs A's poor nutritional intake was documented by nursing staff but a proactive approach was not undertaken. For example, other methods of meeting her nutritional needs were not explored. Adviser 2 considered there was a failure by the Board to acknowledge the steps

which should have been taken in order to provide a reasonable and acceptable standard of care.

28. Adviser 1 felt that, in view of Mrs A's weight loss, cachexia, poor appetite and the possibility of a need for surgical treatment, he would have expected that an active programme of nutritional support would have been implemented from the time of admission. In view of Mrs A's nausea, this would best be provided by slow feeding with balanced liquid feed through a fine bore nasogastric feeding tube inserted into the stomach through the nose (enteral feeding). Such feeding needs to be started slowly and could be commenced (in the absence of a dietician) from the day of admission until the support of dieticians became available. Adviser 1 said most hospitals of a suitable size and with heavy emergency workload are likely to have a dietician on call to advise in such situations. In the event, dietetic advice was not provided until 21 August 2007 and there is nothing in the records to explain why this unreasonable delay occurred.

29. In response to an enquiry, the Board provided me with details of a Malnutrition Universal Screening Tool (MUST) which is used to identify adults who are at risk of malnutrition and includes guidance which can be used to develop an appropriate care plan. They also provided details of their protocol for referrals to the Dietetic Service. Adviser 1 and Adviser 2 both reviewed the MUST and thought it would have little application in Mrs A's case, as she was deemed to be cachexic on admission and would have scored as 'high risk' and should have resulted in a timelier referral for dietician review. In addition, they felt that Mrs A would have satisfied the protocol criteria for a dietetic referral after one day for a patient assessed as requiring enteral nutrition or within two days if she had been assessed as requiring dietary supplementation.

(c) Conclusion

30. Mrs A was admitted to the Hospital on 10 August 2007 with a cachexic appearance and a reported history of weight loss. The dietician referral was made on 15 August 2007 and a food chart was commenced on 17 August 2007. A dietician reviewed Mrs A on 21 August 2007 which was, by then, over ten days since her admission. Such a length of time for a dietetic review was unreasonable, as nursing and medical staff would have been aware of Mrs A's poor nutritional status and thought should have been given to providing nutritional supplements or considering alternative methods of feeding. I am also concerned that staff did not consider the use of the MUST or application of the

protocol for dietetic referral, as these would have highlighted a timelier referral for dietetic review. There was also no evidence that staff had brought their concerns to the attention of senior clinicians. In the circumstances, I believe that there was an undue delay by staff in addressing Mrs A's nutritional status and being seen by a dietician and, therefore, I uphold this complaint.

(c) Recommendation

31. The Ombudsman recommends that that the Board review their policies for nutritional assessments and dietetic referrals and consider whether nursing staff would benefit from the implementation of a robust education programme related to meeting the nutritional needs of older people in hospital, with clear links to Food, Fluid and Nutritional Care Standards (NHS Quality Improvement, Scotland NHS Scotland September 2003).

(d) The level of communication with Mrs A's family was inadequate

32. In relation to communication issues, Adviser 2 said that it must be acknowledged that on at least two occasions when the family did raise concerns, this occurred when the night staff were on duty. Adviser 2 noted, however, that at 16:50 on 14 August 2007 nursing staff received a call from Mrs A's daughter expressing her concern that Mrs A had been waiting since her admission on 10 August 2007 for a CT scan. A nurse explained that unless the scan had been an emergency the scan would not have been available and not ordered until Monday and it takes a few days to be scanned. Adviser 2 felt that if this was Board policy then there was no reason that Mrs A or her family should not have been given this information at the time of the admission. This would have ensured that they were well informed at the time of admission. It was also recorded on 16 August 2007 at 23:40 that the relatives were complaining that Mrs A was not receiving good/adequate care. The staff nurse documented her communication with the family and her request for a member of medical staff to speak to the family. The Senior House Officer refused to speak to the relatives because he did not know enough about Mrs A. (This would suggest that he was a member of the duty 'on call' team and not a member of Mrs A's regular medical team.) It appeared that the staff nurse informed the family of Mrs A's situation and reassured them that Mrs A would be cared for to the 'best of our ability'.

33. Adviser 2 suggested that there should be a clear pathway with regard to escalation of concerns about any aspect of care, including a system for ensuring that family members can speak to a senior member of medical or

nursing staff as necessary. This would be usual practice in any acute setting where a Senior Registrar should be available at night as part of the night cover team in any given clinical speciality. Adviser 2 said that another option would be to offer the family a meeting with a specific clinician within the patient's regular team at a time that would be suitable to the clinician and the family. It was noted a member of the surgical team did speak with Mrs A's family on 17 August 2007. Adviser 2 saw that it was recorded on 19 August 2007 at 00:20 that the family were anxious about Mrs A's care in regard to fluid management and a lack of accurate record-keeping. The record entry mentioned 'the relatives have been spoken to by the [ward] sister'. Adviser 2 could find no contemporaneous record of this discussion. Adviser 2 told me it is important to recognise that there are clear standards for record-keeping in nursing (Nursing and Midwifery Council 2002, updated 2005) and the importance of documenting facts cannot be over-emphasised. Nurses and other professionals must keep an accurate record of any communication they have had with the patient, family and carers as essential facts/information could be forgotten in the passage of time. Good recordkeeping also offers clarification to other team members regarding levels and type of information shared.

(d) Conclusion

34. Mrs C had concerns about the information which staff gave to the family about Mrs A's condition. In this case it was not entirely clear what was causing Mrs A's problems and this would have affected the amount of information which could be communicated. However, although there was reference in the records that the family wished to discuss Mrs A's treatment there was no indication of what was discussed. It can sometimes be difficult due to shifts, weekends etc, to identify a member of staff with sufficient knowledge about the patient's condition to provide explanations. However, if that was the case then an appointment should be made for them to see an appropriate person as soon as possible. Families are anxious about the patient and if explanations are not provided in a timely fashion then this adds to their concerns. Where discussions are held between staff and patients, a record should be made of the discussion so that staff who follow up are aware of what already has been explained. In view of the advice which I have received, I uphold this complaint.

(d) Recommendations

35. The Ombudsman recommends that the Board:

(i) should provide evidence of clinical benchmarking of 'Communication', which is clearly linked to Standard 8 Clinical standards for older people in acute care (Clinical Standards Board for Scotland October 2002), to ensure that this aspect of practice is audited and there is demonstrable evidence of improvement in this aspect of care delivery; and

(ii) issue Mrs C an apology for the failings which have been identified in this report.

36. 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	Mrs C's mother
The Hospital	Royal Infirmary of Edinburgh
The Board	Lothian NHS Board
Adviser 1	The Ombudsman's professional medical adviser
Adviser 2	The Ombudsman's professional nursing adviser
Consultant 1	Mrs A's consultant surgeon
Consultant 2	Consultant radiologist
MUST	Malnutrition Universal Screening Tools
Consultant 3	Covering consultant
Consultant 4	Covering consultant
The Director	The Board's Acting Director of Operations

Annex 2

Glossary of terms

Abdominal distension	Enlargement of the abdomen, which may be caused by an accumulation of fluids and gas
Barium enema	Procedure where a liquid is inserted in the rectum which, when x-rayed, outlines the interior of the colon and rectum
Contrast	A special dye which shows up on x-ray; however, it has to be used with caution in patients with poor kidney function, as the dye is excreted by the kidneys
Contrast enema	As for barium enema
CT scan	Computed Tomography Scan: computer generated image of body structures derived from multiple x-rays
Diverticulitis	Inflammation of balloon-like out-pouches (diverticula) in the wall of the colon
Enteral feeding	Infusion of liquid feed directly into the intestine through a tube, usually introduced through the nose
Ischaemia	Inadequate blood supply, due to blockage of the blood vessels
Naso-gastric tube	Plastic tube fed through the nostril into the stomach to allow feeding
Neoplastic	Abnormal or uncontrolled cell growth

Pulmonary embolism	Blood clot in the lungs
Sigmoidoscopy	Inspection of the lower colon, using a thin lighted tube