Scottish Parliament Region: Mid Scotland and Fife

Case 200602412: Forth Valley NHS Board

Summary of Investigation

Category

Health: Hospital; palliative care

Overview

The complainant, Mrs C, raised several concerns about the care and treatment provided to her mother (Mrs A) at Stirling Royal Infirmary, following her admission on 29 May 2006. Mrs A did not respond to treatment and the decision was taken to pursue palliative treatment only. Sadly, Mrs A died on 7 June 2006.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) it was proposed, inappropriately, to send Mrs A to a ward where her family could not be guaranteed to have access to her at all times (*upheld*);

(b) the bed managers initiated inappropriate conversation in Mrs A's room (*upheld*);

(c) when Mrs A moved from a High Dependency bed, intravenous medication was stopped and no adequate alternative medication was arranged (*upheld*);

(d) medical staff failed to review Mrs A's medication (*upheld*); and

(e) the response to Mrs C's complaint was inadequate and did not address her concerns (*upheld*).

Redress and recommendations

The Ombudsman recommends that Forth Valley NHS Board (the Board):

(i) apologise to Mrs C for the shortcomings identified in this report and specifically for the actions of the bed managers;

(ii) review the operation of the Palliative Care Manual in relation to the bed management of terminally ill patients;

(iii) ensure that this incident is discussed at the bed managers' annual appraisals;

(iv) remind staff of the importance of documenting concerns raised by patients and their families in the patient's clinical records;

(v) review their pain management documentation and recording;

(vi) demonstrate how they will ensure that the two documents Living and Dying Well and Palliative and End of Life Care in Scotland can be implemented and that such change in practice can be reviewed by all hospital staff on a regular basis;

(vii) conduct an audit in prescription chart recording over a six month period;

(viii) ensure that night staff recognise when there is a need to contact on call staff to review medication for patients in pain; and

(ix) ensure that information is obtained from the staff involved to allow complaints to be investigated appropriately and all issues raised in complaints are addressed.

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

Main Investigation Report

Introduction

1. Mrs A had suffered from emphysema since 1985. She had been treated for several infections at home but had not previously required admission to hospital. On 29 May 2006, however, Mrs A required to be admitted with breathing difficulties. Mrs A was treated with antibiotics, steroids, nebulised bronchodilator and aminophylline infusion in a High Dependency bed in the Coronary Care Unit (CCU). Despite this, by 31 May 2006, it became obvious that Mrs A was not responding to treatment. A Consultant Physician (Consultant Physician 1) discussed the poor outlook with Mrs A and her family. Mrs A said that she did not wish to be resuscitated. Mrs C (Mrs A's daughter) returned early from her honeymoon on 2 June 2006. Later that day it was agreed that Mrs A would only receive palliative care and arrangements were made to move her from the High Dependency bed. Mrs C complained to the Forth Valley NHS Board (the Board) about various concerns which she and other members of the family had, relating to this move and subsequent events in the hours which followed. She said that, apart from matters which were the subject of this complaint, she considered that her mother and her family were treated with respect and with a high standard of care. The Board's Chief Operating Officer responded to the complaint but Mrs C remained dissatisfied and complained to the Ombudsman.

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

(a) it was proposed, inappropriately, to send Mrs A to a ward where her family could not be guaranteed to have access to her at all times;
(b) the bed managers initiated inappropriate conversation in Mrs A's room;
(c) when Mrs A moved from a High Dependency bed, intravenous medication was stopped and no adequate alternative medication was arranged;
(d) medical staff failed to review Mrs A's medication; and
(e) the response to Mrs A's complaint was inadequate and did not address her concerns.

Investigation

3. In order to investigate this complaint I have had access to Mrs A's medical records and the correspondence relating to the complaint. I have corresponded with the complainant and her family and with the Board. I have received advice from the Ombudsman's professional advisers who are a nurse (Adviser 1) and a hospital consultant (Adviser 2). An explanation of the abbreviations used in this

report is contained in Annex 1 and a glossary of terms is in Annex 2. 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.

(a) It was proposed, inappropriately, to send Mrs A to a ward where her family could not be guaranteed to have access to her at all times

4. Mrs C said that she understood that Mrs A could not continue to occupy a High Dependency bed when the decision had been made that she would receive only palliative care. Although she could understand the reason for it, the decision to move Mrs A to another ward was difficult for her and for the family as they had built up a relationship of trust with the staff looking after Mrs A. What the family could not accept was the proposal to move Mrs A to a six bedded medical ward, where the family were not guaranteed to be able to stay with her at all times. Mrs C said that Mrs A had said she was afraid and her father and her brother had not left her side since then. Mrs C said that she considered the proposal to move Mrs A to a six bedded bay to be inappropriate. In the event Mrs A did not make this move and, instead, moved to a single room in a surgical ward (see paragraph 10).

5. In response to the complaint, the Chief Operating Officer wrote to Mrs C on 19 September 2006. She said that the management of bed allocation and availability is constantly being reviewed and they were looking at how best they could meet patient requirements with minimal discomfort to the individual and their family members.

6. In a statement dated 27 March 2008 the staff nurse who was looking after Mrs A (the Staff Nurse) said she was not surprised that the family were upset when it was suggested that Mrs A be transferred to a six bedded bay in a medical ward. The Staff Nurse said that the family fully accepted that Mrs A no longer required a critical care bed but felt that a six bedded bay was inappropriate due to her poor condition and because they were keen to have a family member with her at all times, as this appeared to help with her agitation.

7. In the Board's Palliative Care Manual at page 152 it states that, in these circumstances:

> 'best practice should be to offer a single room'.

(a) Conclusion

8. Despite what is stated in the Palliative Care Manual, there is no evidence that the offer of a single room was considered when the suggestion was made that Mrs A would be moved to a six bedded bay in a medical ward where her family would not be able to stay with her. The Chief Operating Officer did not make any further comment when this complaint was intimated and offered no explanation as to why it was suggested that best practice should not be followed in this case. In the event Mrs A did not move to the six bedded ward as she was offered a single room. Whilst it may not be possible to follow best practice in every case, for example, if there are no single rooms available, there is no evidence that the Board's Palliative Care Manual was taken into account in this case. In the circumstances, I have concluded that the proposal was inappropriate and, in the absence of an explanation of why best practice could not be followed, I have decided to uphold this complaint.

(a) Recommendations

9. The Ombudsman recommends that the Board:

(i) apologise to Mrs C; and

(ii) review the operation of the Palliative Care Manual in relation to the bed management of terminally ill patients.

(b) The bed managers initiated inappropriate conversation in Mrs A's room

10. Mrs C said that the family asked for a single room where they could have access to their dying mother and the staff nurse informed them that there was a single room available in a surgical ward (Ward 24) which they accepted. (Mrs A was moved to this room later the same day.) Shortly after this, two bed managers (Bed Manager 1 and Bed Manager 2) came into the room where Mrs C said she had just managed to get her mother off to sleep. Mrs C said that they approached aggressively and began discussing the move with her and her brother. When Mrs C told one of them the discussion was inappropriate, the other asked her if she wanted to take it outside. Mrs C said she had to ask them to leave, which they did.

11. In response to Mrs C's complaint, the Chief Operating Officer said that she was concerned both by the treatment and manner in which certain members of staff had spoken to Mrs C. She said that the way they communicated with patients and their families was an important part of the care they provide. An ongoing programme of communication training for all members of staff was

being provided, raising awareness of patient needs and focussing on concerns that family members have for loved ones. The Chief Operating Officer said that she regretted and apologised unreservedly for the shortcomings of certain members of staff.

12. Mrs C said that the apology, while appreciated, did not indicate that the bed managers concerned had reflected on their practice or acknowledged that their actions either caused distress or were inappropriate.

13. In response to the complaint, Bed Manager 1 said that on 2 June 2006 she was walking past a room in CCU when Mrs C's sister gestured her into the room. Bed Manager 1 asked Bed Manager 2 to wait outside but she had followed her in. Mrs C's sister said to Bed Manager 1 that her mother was being moved. Bed Manager 1 said that she had heard this. It was at that point that Bed Manager 1 became aware of a conversation between Mrs C and Bed Manager 2. Mrs C was saying that she thought it was terrible that her mother was being moved in her condition and Bed Manager 2 replied 'Would you like to discuss this outside?' Mrs C said that she did not wish to discuss anything and they had left. Bed Manager 2 then told the Charge Nurse that she thought the family were not happy about the move but he thought that it was alright as they were getting a side room, which was what they had requested.

14. In a subsequent statement in response to my enquiries on 16 April 2008, Bed Manager 1 said that she had been paged by Bed Manager 2, who required a side room for Mrs A to be transferred into. As Bed Manager 1 was in the ward next door she walked through to give her the information. Bed Manager 1 said that, because of the noise from the oxygen machine, she was unable to hear any of the conversation between Mrs C and Bed Manager 2 apart from the short exchange she had mentioned in her original statement. Bed Manager 1 said that, following discussions with the Charge Nurse, she accepted that something happened but she was unsure of exactly what it was.

15. Bed Manager 2 was not asked for a statement at the time of the original complaint because she had gone to work elsewhere but when she returned she provided a statement on 27 March 2008. Bed Manager 2 said that she remembered that there was an issue surrounding the transfer of Mrs A from CCU to Ward 24. They were asked to attend CCU. The family were understandably anxious and Bed Manager 1 spoke to them to discuss their concerns. Bed Manager 2 could not remember contributing to the conversation.

16. In a subsequent statement on 19 April 2008, Bed Manager 2 said that she could recall attending CCU with Bed Manager 1 but could not remember why they were together. Bed Manager 2 said that she was there to allocate a bed in Ward 24 for Mrs A. She recalled giving this information to the Charge Nurse. Understanding that the family would have concerns, they walked towards Mrs A's room. Bed Manager 1 had spoken to the family. Bed Manager 2 could not recall what was said but said that her tone was sympathetic. Bed Manager 2 said she did not contribute to the conversation. Bed Manager 2 said that it would not be her intention to say or act in a way which would enhance an obviously sensitive situation.

17. The Staff Nurse, who was in the vicinity at the time, provided a statement of her recollection of events on 28 April 2008. She said that Mrs A's family had expressed their gratitude to her after she had spent some time liaising with the bed managers, medical staff and the nursing staff of Ward 24, to organise Mrs A's transfer to a side room in Ward 24 even though it was a surgical ward. At this point the Staff Nurse said that the situation was defused. To her recollection, it was by chance that the two bed managers on duty were walking past the double side room where the Staff Nurse was with Mrs A and her family. The Staff Nurse said that she did not know why the bed managers approached and she could only surmise that they misjudged the situation. The bed managers had approached side by side and Bed Manager 1 abruptly asked; 'Is there a problem here?' The Staff Nurse said that she could not remember the content of the conversation between the family and the bed managers but she did recall that their manner was confrontational and that the family were upset and angry at being approached in this manner while sitting with their ill relative. The Staff Nurse said that she was puzzled that the bed managers had approached Mrs A and her relatives and the family were still upset when she handed over care to Ward 24. The Staff Nurse confirmed her statement as this was how she recalled events at the time.

18. In a statement on 27 April 2008, the Charge Nurse said that he remembered having a debate with the Staff Nurse about moving Mrs A out of CCU. She was reluctant to do so as she felt Mrs A was near the end of her life and the bed which the bed managers had identified was not in a side room. While he agreed with the Staff Nurse that a ward space was not ideal, he thought that it would be better to move Mrs A during the day in an organised and unhurried way, as opposed to during the night when the bed could be

required for a new emergency admission and the move would have to happen very quickly. The Staff Nurse had then agreed and had spent most of the shift preparing the patient and her family for the move. The Charge Nurse said that he did not witness what happened with the bed managers but he recalled that the Staff Nurse spoke to him about it and was upset. The Charge Nurse said that he had spoken to the bed manager concerned about getting involved in patient care related issues at ward level without speaking to the nurse in charge first. He made it clear that he was not happy about how this had been handled. The Charge Nurse commented that he was surprised that he was not asked for information at the time of the internal investigation.

19. In her letter to me on 8 April 2008, the Chief Executive (following internal reorganisation within the management structure, the then Chief Executive of Acute Services became the Chief Operating Officer and the title of Chief Executive was retained by the Board's Chief Executive) indicated that both bed managers have now attended a communication workshop. She said that the Service Manager had met with Bed Manager 1 to reflect on the view that the family had gained. At that time Bed Manager 1 was concerned about the interpretation of events but did not feel that she had been unprofessional. Given the outcome of the interview, the Service Manager had not felt that any further action was appropriate.

20. In response to my further enquiries, the Chief Executive wrote to me on 30 April 2008. She said that Bed Manager 2 recalled that she was originally paged by a member of staff from CCU although she could no longer recall who. No one had been able to recall the time when Bed Manager 2 was paged but it is assumed that it would be prior to 18:20. Bed managers receive about 300 pages on a shift, hence the difficulty in recalling specific details. The Chief Executive said that it was normal practice for bed managers to walk around the wards, to identify patients who might be fit for transfer and it may be that during the course of these walkabouts, and probably after the transfer had been resolved, the bed managers became involved with the family. She advised that, given the passage of time, she felt it was unlikely that further clarity would be obtained.

21. Mrs C's sister said that she had not gestured Bed Manager 1 into the room as she had her back to the door. She did acknowledge her after she and her colleague had entered the room. Bed Manager 1 had addressed her brother and asked him if he was satisfied now, or words to that effect, concerning her

mother's move. Mrs C did not say it was terrible her mother being moved as she understood why it was being done. When asked not to discuss the move in front of Mrs A, Bed Manager 2 was aggressive and confrontational.

22. Mrs C's brother said that the bed managers entered the room in an aggressive manner. His sister had not gestured them into the room. They were argumentative and he was shocked when one of them challenged his sister to take it outside. Mrs C asked the bed managers to leave, as their conduct was inappropriate and they were concerned it could distress their mother.

23. There is no reference to this incident in Mrs A's clinical notes. In her original complaint Mrs C said that she was confident that the circumstances would have been documented, as she had brought her concerns to the attention of staff at the time. Her sister said that she had discussed the incident with the Charge Nurse, who told her it would be documented. Mrs C's brother said that the Staff Nurse had assured the family that the events would be noted. In response to the complaint, the Staff Nurse said that she did not document the incident in the notes as she could not recall the full content of the conversation which occurred between the bed managers and the family. The Charge Nurse said that he was sure that the family were told that the incident would be documented when they made it clear that they intended to make an official complaint. He accepted that he should have ensured that this was done. Bed Manager 1 said that, in future, as a team, they intended to document any conversation with patients or family members in the family dialogue sheets in the patient's notes to ensure that there is a permanent record of events recorded at the time.

(b) Conclusion

24. It is more difficult to investigate the circumstances of a complaint where there is no written record of the events made at the time and a significant amount of time has elapsed. From the information available, however, a bed in a single room was identified and this information was passed to the family by the Staff Nurse. From the evidence, it appears that the family had already indicated that the arrangement was acceptable before the bed managers entered the room. I am, therefore, not satisfied that there was any reason for the bed managers to be there. It is also clear that the family found their attitude to have been aggressive and confrontational. The family's impression has been corroborated by the Staff Nurse who was looking after Mrs A and, indirectly, by the recollection of the Charge Nurse. In the circumstances and taking into

account all of the available evidence, I have concluded that the bed managers' behaviour was inappropriate and, therefore, I uphold this complaint.

(b) Recommendations

25. The Ombudsman recommends that the Board:

(i) apologise to Mrs C specifically for the actions of the bed managers;

(ii) ensure that this incident is discussed at the bed managers' annual appraisals; and

(iii) remind staff of the importance of documenting concerns raised by patients and their families in the patient's clinical records.

(c) When Mrs A moved from a High Dependency bed, intravenous medication was stopped and no adequate alternative medication was arranged

26. Mrs C said that when her mother was in a High Dependency bed she had been given drugs intravenously. When Mrs A awoke after the move to Ward 24, she was very distressed and was offered oral medication. Mrs C said that her mother was too distressed to take anything orally. During that first night her mother awoke every two to three hours, terrified, distressed, pulling her oxygen mask off, becoming hypoxic and fighting to get out of bed. Mrs C said that although the staff were very kind during this period, the failure to arrange appropriate medication meant that this scenario was replayed every few hours, which was very distressing for their dying mother and for the family who were left with these images. Although a syringe pump was commenced the following day, Mrs C did not understand why it could not have been done before Mrs A was moved.

27. In response to the complaint, the Chief Operating Officer wrote to Mrs C on 19 September 2006. She said that in terms of pain management it can sometimes be difficult to find a medicine to control the level and type of pain experienced. This is dependent on the individual's pain tolerance level, their sensitivity to the medicine prescribed and the part of the body involved. Mrs A had received regular pain management support and the effects were monitored and reviewed. As part of the review it was decided to commence Mrs A on a syringe pump to assist in providing effective pain management control. Staff acknowledged that the family were concerned about the pain Mrs A was experiencing and regret they had been unable to reassure them.

28. Mrs C said that the Chief Operating Officer's reply had discussed analgesia when they considered that their mother's requirement that night was for sedation. Mrs C agreed that sedation had been given as per the notes but what the notes did not highlight was that it was administered as a result of continual requests to staff when their mother was in a distressed state when the medication was becoming less effective.

29. Mrs C's sister said that their mother was very upset by the move. She did not have the correct medication transferred with her, so it was not available when it was required. The nurse had to run between floors for it. When Mrs A's medication was wearing off, the family tried to calm and restrain her and request medication but it was never available in time to stop the cycle being repeated. Mrs C's sister and brother both said that they felt that this memory would remain with them for a long time.

30. The Chief Executive in her letter to me on 3 August 2007 said that the Liverpool Care Pathway was in place on Ward 24. This is an integrated care pathway for end of life care, developed to improve the care of the dying to embrace the hospice philosophy in the acute hospital setting. The Palliative Care Manual and Resource Pack was also in use.

31. Adviser 2 said that Mrs C reasonably pointed out that the Board's response about Mrs A's medication missed the point. The point was that the intravenous route had been discontinued on CCU and the family's perception was that the administration of analgesics and sedation on Ward 24 was only in response to repeated requests from the family rather than proactive drug management. Adviser 2 said that the nursing records for the night of 2 March 2006 recorded the anxiety of the patient and the presence of the family but did not indicate that staff responded to repeated requests for medication. Adviser 2 reviewed the drug charts for Mrs A for the period 01:20 on 1 June 2006 to 10:10 on 3 June 2006. Adviser 2 said that the drug charts were not as clear as they should be. Adviser 2 said that morphine had been given at roughly two hour intervals during the early hours and morning of 2 June 2006. Mrs A had slept all afternoon on 2 June 2006 according to the notes but was quite distressed and uncomfortable in bed when on Ward 24.

32. Adviser 2 said the distress and discomfort was due to poor evaluation by nursing staff of Mrs A's pain/anxiety, which resulted in a syringe pump not being set up before Mrs A left CCU or when she arrived on Ward 24. Adviser 2 said

that the fact that three morphine injections, four of midazolam and one of lorazepam had to be given during the night should have indicated to nursing staff that a subcutaneous syringe pump would have been more appropriate. Adviser 2 said that, given the decision to give palliative treatment only was made in CCU on the morning of 2 June 2006 and a pattern of analgesia already established from the day before, there should have been no delay in implementing the care of the dying pathway and using a syringe pump to lessen the need for frequent injections, especially as there was no drip running. Adviser 2 said that the fluid charts showed that a saline drip ran from 22:30 on 1 June 2006 for, presumably, the prescribed 12 hours but no drip was running until 10:55 on 3 June 2006. It would appear, therefore, that Mrs A did not have a drip for either fluid intake or intravenous administration of medications for 24 hours. Adviser 2 said that there was no recording of the reason for not giving Mrs A intravenous fluids for 24 hours.

(c) Conclusion

33. The advice I have received is that there was poor evaluation of Mrs A's pain/anxiety by the nursing staff. Adviser 2 said that a syringe pump should have been employed before 08:45 on 3 June 2006. Taking all of the circumstances into account along with the advice I have received, I uphold this complaint.

(c) Recommendations

34. The Ombudsman recommends that the Board:

(i) review their pain management documentation and recording;

(ii) demonstrate how they will ensure that the two documents *Living and Dying Well* and *Palliative and End of Life Care in Scotland* can be implemented and that such change in practice can be reviewed by all hospital staff on a regular basis; and

(iii) conduct an audit in prescription chart recording over a six month period.

(d) Medical staff failed to review Mrs A's medication

35. Mrs C said that it would be her expectation that when the management of a distressed patient became as difficult as her mother's was that night, it would not be unreasonable to expect review by the on call medical staff. That did not occur and all contact was solely by telephone. Mrs C said that as a family they understood how busy the staff were but her mother's medication should have been reviewed.

36. In response to my enquiries, the Chief Executive wrote to me on 8 April 2008 but made no comment regarding review of Mrs A's medication between her transfer to Ward 24 and the following morning. The Chief Executive said that Mrs A was reviewed by medical staff at 08:00 on 3 June 2006 and, following this, was commenced on a continuous infusion of morphine and Haloperidol. Mrs A also required Midazolam 2.5mgs sub-cutaneous at 10:10, 11:25, 14:30 and 16:30. She also had Lorazepam 1mg at 15:00 and 17:50. At 18:00 Mrs A was reviewed again by medical staff and the infusion was changed. At 23:30 Mrs A was reviewed by medical staff and it was documented that she was comfortable and the family were happy with the arrangements. Mrs A was settled throughout the night and slept with no difficulties.

37. Adviser 2 said that it was difficult to understand why only 2.5 mg of morphine was prescribed and given on 2 June 2006, after Mrs A was moved to Ward 24. Adviser 2 said that the nurses had noted that 5mg at 12:00 had settled Mrs A for the afternoon but 2.5mg of midazolam and no morphine did not. Adviser 2 said that the nurses' evaluation of pain/anxiety over these hours was poor or, at least, poorly recorded and doctors failed to review Mrs A when there was a need to re-assess analgesia following Mrs A's transfer. Adviser 2 said that there were no explanations of the long gaps in either pain evaluation or treatment in the notes and no recording of what doses of lorazepam were given.

(d) Conclusion

38. Mrs C's complaint concerns the period prior to Mrs A's review by medical staff at 08:00 on 3 June 2006. Adviser 2 said that he did not understand why only 2.5 mg of morphine had been prescribed when 5mg had been required to settle Mrs A the afternoon before. Adviser 2 has already identified that Mrs A had to be given injections on three occasions during the period between 21:50 on 2 June 2006 and 07:30 the following morning but her medication was not reassessed until 08:00. Having considered all of the evidence and the advice I have received, I am satisfied that medical staff failed to review Mrs A's medication between her transfer to Ward 24 and 08:00 the following morning and I uphold the complaint for this period.

(d) Recommendation

39. The Ombudsman recommends that the Board ensure that night staff recognise when there is a need to contact on call staff to review medication for patients in pain.

(e) The response to Mrs C's complaint was inadequate and did not address her concerns

40. Mrs C said that she felt that the response she received to her complaints was quite superficial and dismissive. She considered that it did not address their concerns. She noted the Chief Operating Officer intended to create a bereavement officer post but she failed to see what a bereavement officer, when appointed, could have done in the situation the family had experienced.

41. In the response to the complaint, the Chief Executive said that Mrs C's letter and notes had been shared with the staff involved with Mrs A's care and they were asked to reflect on her concerns and assist her in responding appropriately.

42. The Chief Executive, in her letter of 8 April 2008, said that staff involved in Mrs A's move from CCU to Ward 24 had been asked that they reflect on their statements and recollection of events.

43. A statement was obtained from Bed Manager 1. Bed Manager 2 had left at that point and no attempt appears to have been made to contact her at the time. It was not until after her return that a statement was taken from her.

44. The Charge Nurse, in his statement of 27 April 2008, said that he was surprised that he was not asked for information at the time of the internal investigation (see paragraph 18).

45. From the documents concerned with the complaint, the Staff Nurse appears not to have been asked for a statement prior to her statement of 27 March 2008.

46. The Chief Operating Officer wrote to Mrs C on 19 September 2006 but, as identified in this report, the letter did not address Mrs C's concerns. (see paragraphs 12 and 28).

47. Adviser 2 said that neither the gaps in analgesic management nor the lack of intravenous fluid for 24 hours (see paragraph 32) were acknowledged by the Board.

(e) Conclusion

48. It appears from the complaint correspondence that some complaints were not addressed and others not understood. Although the Chief Executive said that Mrs C's complaint had been shared with the staff involved, it appears that Bed Manager 2, the Staff Nurse and the Charge Nurse were not asked for a statement at the time. Lack of information from them meant that the Chief Operating Officer could not send a substantive response to Mrs C's complaints. Other issues were not addressed. Having considered the matter carefully, I have concluded that the response to Mrs C's complaints failed to address her concerns adequately and I uphold this complaint.

(e) Recommendation

49. The Ombudsman recommends that the Board ensure that information is obtained from the staff involved to allow complaints to be investigated appropriately and that all issues raised in complaints are addressed.

50. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs A	Mrs C’s mother
CCU	Coronary Care Unit
Consultant Physician 1	The Consultant Physician who treated Mrs A
Mrs C	The complainant
The Board	Forth Valley NHS Board
Adviser 1	The Ombudsman’s professional adviser, who is a nurse
Adviser 2	The Ombudsman’s professional adviser, who is a hospital consultant
The Staff Nurse	The Staff Nurse who looked after Mrs A in CCU
Bed Manager 1 and Bed Manager 2	The Bed Managers who attended CCU

Annex 2

Glossary of terms

Aminophylline infusion	A type of medicine used to open the airways and aid breathing in lung conditions
Antibiotics	Medicines used to treat infections caused by bacteria
Emphysema	A chronic and progressive lung condition, characterised by patchy damage and over-extension of lung tissue, making it less elastic and less efficient at gaseous exchange and rendering the patient breathless and liable to recurrent infections
Haloperidol	A drug to reduce restlessness
Hypoxic	Shortage of oxygen in the body
Lorazepam	A drug used to alleviate anxiety states
Midazolam	A sedative used to treat restlessness
Morphine	An opoid used for severe pain
Nebulised bronchodilator	A method of assisting breathing
Steroids	Substances used as anti-inflammatory drugs
The Palliative Care Manual	The Palliative Care Manual and Resource Pack used by the Forth Valley Local Managed Clinical Network in Palliative Care

Annex 3

List of legislation and policies considered

The Palliative Care Manual and Resource Pack Forth Valley Local Managed Clinical Network in Palliative Care

Palliative and End of Life Care in Scotland Scottish Partnership for palliative care May 2007

Living and Dying Well NHS Scotland October 2008