Scottish Parliament Region: Glasgow

Case 200702752: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; oncology; clinical treatment

Overview

The complainant (Mrs C) raised a number of concerns that her husband (Mr C) had not received reasonable care and treatment whilst under the care of Greater Glasgow and Clyde NHS Board (the Board) in early 2007. She was particularly concerned about the arrangements made for her husband to undergo a surgical procedure at another hospital and the administration of medicines to her husband. She also raised concerns about the action the Board took following her complaints about discussions between medical staff and Mr C's family.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board's requirement that Mr C attend Gartnavel Hospital at 09:00 on 11 January 2007 for a procedure that did not begin until 11:35 was unreasonable (*no finding*);

(b) the Board's administration of steroids to Mr C during his admission in January 2007 was not reasonable (*upheld*); and

(c) the Board did not take adequate action in response to Mrs C's complaints about discussions with Mr C's family on 12 January 2007 about his resuscitation (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mr C's family that the dosage of steroids was not increased following either the suspicion of sepsis or the incident of septic shock;

(ii) take steps to ensure that medical staff are aware of the need to increase the dose of steroids following suspicion of sepsis or incidents of septic shock; and

(iii) ensure that induction materials for medical staff clearly cover the specific requirements of the Board's resuscitation policy. This would serve to draw

inductees' attention to the policy, and, specifically, its application in terms of provision of information to, and discussion with, patients, relatives and carers and provide evidence of this to the Ombudsman.

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

Main Investigation Report

Introduction

1. On 28 March 2008 the Ombudsman received a complaint from Mrs C, the wife of a man (Mr C) who had passed away in January 2007. Mrs C complained that Mr C had not received reasonable care and treatment whilst under the care of Greater Glasgow and Clyde NHS Board (the Board) in early 2007. She was particularly concerned about the arrangements made for her husband to undergo a surgical procedure at another hospital and the administration of medicines to her husband. She also raised concerns about the action the Board took following her complaints about discussions between medical staff and Mr C's family.

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

(a) the Board's requirement that Mr C attend Gartnavel Hospital (Hospital 2) at 09:00 on 11 January 2007 for a procedure that did not begin until 11:35 was unreasonable;

(b) the Board's administration of steroids to Mr C during his admission in January 2007 was not reasonable; and

(c) the Board did not take adequate action in response to Mrs C's complaints about discussions with Mr C's family on 12 January 2007 about his resuscitation.

Investigation

3. The investigation of these complaints involved obtaining and examining the relevant medical and nursing records and the complaints file from the Board. This included internal correspondence of the Board during the investigation of Mr C's complaints. I also had several discussions with Mrs C by telephone. I sought the views of clinical advisers to the Ombudsman, including two Medical Advisers and a Nursing Adviser, and had several discussions with these advisers. I have set out my findings of fact and conclusion. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. The terms used to describe other people referred to in the report are noted in Annex 1 and a glossary of the medical terms used is noted in Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

4. On 8 January 2007 Mr C was admitted to The Beatson Oncology Centre at the Western Infirmary in Glasgow (Hospital 1) for a second cycle of chemotherapy due to cancer. Sadly, Mr C passed away on 12 January 2007.

(a) The Board's requirement that Mr C attend Hospital 2 at 09:00 on 11 January 2007 for a procedure that did not begin until 11:35 was unreasonable

5. Mr C was scheduled to undergo a stent procedure at Hospital 2 on 11 January 2007. The appointment was scheduled for 09:00. The Board made enquiries of the Scottish Ambulance Service (the Service) about the availability of an ambulance to take Mr C from Hospital 1 to Hospital 2. The Service told them that no ambulance was available at a time that would guarantee Mr C's arrival at Hospital 2 by 09:00. Given this, the Board arranged for Mr C to be transported by taxi with a nurse escort.

6. Mrs C complained to the Board that the taxi had not arrived on time and that this meant that Mr C had to remain in a sitting position, which caused him pain. The Board told Mrs C that Mr C had been fully ambulant and that a bed had been made available so that he could lie on his side until the taxi arrived. Mrs C was unhappy with this response because she felt it ignored the fact that the taxi had been late, because her understanding was that Mr C had to plead to be allowed to lie down and because, for some months, Mr C had not been able to lie comfortably on his side. The Board explained to Mrs C that the exact time that transport for patients arrived was not usually documented in medical or nursing records and the staff concerned could not recall when the taxi arrived.

7. I asked the Board how it had been ascertained that the Service would not be able to transport Mr C to Hospital 2 by 09:00. They told me that telephone contact had been made by ward staff who had been advised the Service would not be able to guarantee Mr C's arrival by 09:00. The Board told me that this situation is not unusual and that, in such circumstances, alternative arrangements are made. Mr C's medical records indicate only that alternative arrangements had been made. Nothing is noted in the medical records about any delay to the transfer.

8. Mrs C complained that these arrangements were unreasonable given Mr C's condition. I sought the advice of the nursing adviser to the Ombudsman (the Nursing Adviser) and a medical adviser to the Ombudsman (Medical

Adviser 1) on this complaint. The Nursing Adviser and Medical Adviser 1 told me that, though it would have been preferable for Mr C to be transported by ambulance, the decision to transport Mr C by taxi was reasonable with regard to Mr C's clinical condition at the time. The Nursing Adviser and Medical Adviser 1 were concerned, however, that Mr C was required to attend at Hospital 2 at 09:00 when, according to the medical notes, the stent procedure was not begun until 11:35.

9. I asked the Board why Mr C was required to attend at Hospital 2 at 09:00. They told me that the junior doctor who made the arrangements had been told by the interventional radiologist that Mr C's stent procedure could be carried out if he could be at Hospital 2 at 09:00. The Board told me that, in order to respond to my enquiry, they had tried to ascertain why, in the event, the procedure had not begun until 11:35. However, they had not been able to confirm why this had happened. The Board suggested that it may have been due to unforeseen circumstances, such as other emergencies or other operational or clinical pressures. I asked the Board whether the delay in Mr C's taxi arriving, that Mrs C had mentioned, had been the cause of a delay to Mr C's stent procedure. The Board said that they could not comment on the possibility that this was the cause of the delay as there could have been other pressures in the department that morning that they now had no record of.

10. I asked the Board whether any consideration had been given to having Mr C attend later than 09:00. They told me that no consideration was given to this because the staff at Hospital 1 were not made aware that the stent procedure may have been, or had been, delayed.

(a) Conclusion

11. In my investigation I sought to uncover any clear evidence why the stent procedure scheduled for 09:00 was not begun until 11:35. I have seen no evidence that gives a clear indication of the reason why the procedure was not begun until 11:35. Given that it is not clear why the procedure was not begun until 11:35, I cannot reach a conclusion as to whether or not the requirement that Mr C attend at 09:00 was reasonable. I have, therefore, made no finding on this complaint.

(b) The Board's administration of steroids to Mr C during his admission in January 2007 was not reasonable

12. Mrs C complained about various aspects of the administration of prescribed antibiotics and steroids to her husband in the final days of his life. I sought the opinion of the Nursing Adviser and Medical Adviser 1 on this complaint. The Nursing Adviser told me that, in relation to the antibiotics Mr C had been prescribed, the Board's actions had been reasonable. However, Medical Adviser 1 raised concerns about the administration of steroids to Mr C on 12 January 2007. Medical Adviser 1 was concerned that the level of steroids administered to Mr C had not increased following an incident of septic shock on 12 January 2007.

13. I asked the Board to comment on Medical Adviser 1's opinion. They told me that it would generally be the case that ongoing steroids may be increased in dosage if there was a significant infection, provided there were no contraindications in a given clinical situation to so doing on the basis that the clinical situation and signs were such that the medical team felt this was appropriate.

14. In their correspondence with Mrs C, the Board stated that Mr C had first been administered steroids at 17:30 on 9 January 2007, and also that Mr C had first been administered steroids between 16:00 and 18:00 on 8 January 2007. Mrs C said that her husband had been anxious, and she and the family had been alarmed to learn, during evening visiting hours on 9 January 2007 that he had not yet received any steroids. The Board clarified that steroids were recommenced to Mr C on 9 January 2007 as annotated in the nursing notes and signed as being administered on the drug prescription sheet. The Board apologised for any variation to that statement. I sought precise clarification from the Board, and they told me that their view was that the first recording of steroids being recommenced to Mr C in the nursing notes is timed at 15:00 on 9 January 2007 but that the steroid had been actually been administered between 12:00 and 14:00 on 9 January 2007.

15. I sought the advice of another medical adviser to the Ombudsman (Medical Adviser 2). He agreed with Medical Adviser 1 that Mr C should have been put on a higher dosage following the incident of septic shock, but gave his opinion that a higher dosage should have been commenced when sepsis was suspected on 9 January 2007. However, Medical Adviser 2 also commented

that, had Mr C been administered steroids as he should have, it is likely that the ultimate outcome for Mr C would have been the same.

(b) Conclusion

16. Both Medical Adviser 1 and Medical Adviser 2 agree that the dosage of steroid should have been increased due to the incident of septic shock, and Medical Adviser 2 gave his opinion that the dosage should have been increased when the sepsis was suspected on 9 January 2007. I accept the advice of Medical Advisers 1 and 2 and, therefore, uphold the complaint.

(b) Recommendations

17. The Ombudsman recommends that the Board:

(i) apologise to Mr C's family that the dosage of steroids was not increased following either the suspicion of sepsis or the incident of septic shock; and

(ii) take steps to ensure that medical staff are aware of the need to increase the dose of steroids following suspicion of sepsis or incidents of septic shock.

18. In commenting on a draft of this report, the Board told me that the Associate Medical Director for Regional Services had provided a comment agreeing with the adviser's evaluation of a requirement to increase steroids in the incidence of septic shock. They also said that this specific issue and the terms of the recommendation will be discussed with the lead cancer clinician and clinical teams.

(c) The Board did not take adequate action in response to Mrs C's complaints about discussions with Mr C's family on 12 January 2007 about his resuscitation

19. Mr C's family became aware, during a discussion shortly after his death, of a note made by a Senior House Officer (the SHO) of a discussion held on 12 January 2007 with Mr C's family. It was suggested to Mr C's family that the note recorded that the question of resuscitation of Mr C in the event of a cardiorespiratory arrest had been raised during that discussion.

20. Mrs C complained to the Board that the question of resuscitation had not been discussed on 12 January 2007. In their response to Mrs C's complaint the Board explained that the SHO had recorded a discussion with a Specialist Registrar, when the question of resuscitation had been raised, and a separate discussion in which the SHO explained to Mr C's family how ill he was and that

he may not survive. The Board offered their unreserved apologies that the issue of resuscitation was not explicitly discussed.

21. After Mrs C had received the Board's response she also received Mr C's medical records. Mrs C wrote to the Board again, complaining that there had been no discussion whatsoever of resuscitation with Mr C's family. In their response to Mrs C, the Board again offered their apologies that the issue of resuscitation was not discussed in full.

22. Mrs C again wrote to the Board regarding this issue. She said that she found it difficult to understand how the Board could state that resuscitation was discussed at all and asked where in the SHO's note it was stated that she had explained to Mr C's family that resuscitation would not be attempted. In their response to Mrs C, the Board explained that the SHO's note recorded that she had a discussion with Mr C's family regarding his condition and treatment. Once again, the Board offered their sincere apologies if resuscitation was not part of that discussion.

23. Mrs C complained to the Ombudsman that the Board had not appropriately responded to her complaints. I examined the SHO's note and the correspondence between Mrs C and the Board. I decided the Board had appropriately apologised that resuscitation had not been part of the discussion between the SHO and Mr C's family. However, I was concerned that the SHO's long and detailed account of her discussion with Mr C's family did not explicitly mention any discussion of the question of resuscitation. The SHO had discussed this specific issue with a Specialist Registrar and I would have expected the decision not to resuscitate to have been explained to Mr C's family during the later discussion with them.

24. I asked the Board about their investigation of Mrs C's complaints. They told me that by the time the investigation was undertaken the SHO no longer worked for the Board and that a review of the case notes was undertaken to investigate Mrs C's complaints. The findings of these investigations had then been communicated to Mrs C.

25. I asked the Board what actions they had taken, beyond their correspondence with Mrs C, as a result of the findings of their investigations of Mrs C's complaints. The Board told me that a review of resuscitation policy had been carried out, and it had been decided that the specific requirements of the

policy, with regard to its application and the documentation of decisions and communications with relatives, patients and other staff, would be emphasised during the induction training of medical staff. The importance of documenting the arrangements for resuscitation in nursing notes had also been emphasised to nursing staff by the lead nurse for the service. I asked the Board to provide evidence that these actions had been undertaken. In relation to the specific requirements of the policy being emphasised during the induction training of medical staff the Board provided a copy of the checklist of areas covered in the induction training of medical staff and a schedule for induction training that included a session on palliative care at which, the Board told me, the resuscitation policy was discussed, although resuscitation was not specified on the checklist. The Board also told me that their clinical handbook was being reviewed and an updated version would include guidance on resuscitation. In regard to the importance of documenting the arrangements for the resuscitation in nursing notes being emphasised to nursing staff, the Board assured me that this had been undertaken at a Charge Nurse meeting at which no formal notes were taken. The Board told me that they were confident that the importance of communication regarding the application of the resuscitation policy had been adequately highlighted to medical staff because this issue had not been raised through their clinical incident reporting or complaints systems.

(c) Conclusion

26. As noted in paragraph 22, I consider that the Board appropriately apologised to Mrs C that the issue of resuscitation was not discussed in full with Mr C's family. It is reassuring that the Board reviewed their resuscitation policy as a result of the findings of their investigations of Mrs C's complaints and that no further issues about the application of the resuscitation policy had been raised to the Board. My view, therefore, is that the Board have taken adequate action in response to Mrs C's complaints and, given this, I do not uphold the complaint.

27. I am, however, concerned that, while the evidence that the Board provided to me demonstrates that communication with patients and relatives and palliative care is part of the induction training of medical staff, this evidence does not indicate what specific training medical staff receive about what to communicate to patients or relatives about the resuscitation policy and the need for documentation of that. I have, therefore, made a general recommendation to address this.

(c) General recommendation

28. The Ombudsman recommends that the Board ensure that induction materials for medical staff clearly cover the specific requirements of the Board's resuscitation policy. This would serve to draw inductees' attention to the policy, and, specifically, its application in terms of provision of information to, and discussion with, patients, relatives and carers and provide evidence of this to the Ombudsman.

29. 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 C	The complainant, Mr C's wife
Mr C	Mrs C's husband
The Board	Greater Glasgow and Clyde NHS Board
Hospital 1	The Western Infirmary, Glasgow
Hospital 2	Gartnavel General Hospital
The Service	The Scottish Ambulance Service
The Nursing Adviser	An adviser to the Ombudsman with specialist knowledge of nursing
Medical Adviser 1	An adviser to the Ombudsman with specialist medical knowledge
Medical Adviser 2	An adviser to the Ombudsman with specialist medical knowledge, particularly in relation to general hospital medicine
The SHO	A Senior House Officer at the Western Infirmary

Annex 2

Glossary of terms

Cardiorespiratory arrest	The abrupt cessation of normal circulation of the blood due to failure of the heart to contract effectively during the process of drawing blood out of the heart chambers
Septic shock	A medical condition caused by decreased tissue perfusion and oxygen delivery as a result of infection
Stent	A man-made tube inserted into a natural passage to prevent, or counteract, a disease-induced, localized flow constriction