Scottish Parliament Region: Glasgow

Case 201100402: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category

Health: Hospital; care of the elderly; general medical; nursing

Overview

The complainant (Mrs C) raised a number of concerns regarding the nursing care provided to her late mother (Mrs A) during an admission to the Royal Alexandra Hospital in Paisley (the Hospital) from 12 October 2010 until her death on 16 October 2010.

Specific complaint and conclusion

The complaint which has been investigated is that there were several unacceptable shortcomings in care during Mrs A's admission to the Hospital in October 2010 *(upheld).*

Redress and recommendations

The Ombudsman recommends that Greater Glasgow and Clyde NHS Board (the Board):	*Completion date*
(i) provide him with an update regarding their implementation of the introduction of the Liverpool Care Pathway;	20 June 2012
(ii) consider the Adviser's comments on the several failings in Mrs A's end of life nursing care and draw up and implement an action plan to address these failings;	18 July 2012
(iii) conduct a significant events review of this case; and	20 June 2012
(iv) apologise to Mrs C for the failures identified in this report.	6 June 2012

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

Main Investigation Report

Introduction

1. On 4 May 2011, the Ombudsman received a complaint from Mrs C about the nursing care her late mother (Mrs A) received from the Royal Alexandra Hospital in Paisley (the Hospital) from 12 October 2010 to 16 October 2010.

2. On 12 October 2010 Mrs A presented to the Accident and Emergency department of the Hospital at about 15:30 with severe back pain and was admitted. She was known to have an aortic aneurysm for some years, however, this had not been suitable for surgical intervention. Mrs C stated she arrived at the Hospital shortly after Mrs A's admission and one of the doctors told her he thought the aortic aneurysm was leaking and there was nothing he could do. Thereafter Mrs C followed the advice of a nurse, that it would be advisable for her to contact other family members about this serious situation.

3. In due course, Mrs A was moved into a ward then a single room then back to the ward. During this period Mrs C and several family members visited Mrs A in turns as they were under the impression Mrs A was getting better.

4. However, Mrs C received a telephone call from the Hospital on 16 October 2010 at 08:50 and was told Mrs A was really ill and for her to inform the family. Mrs C stated she resides only ten minutes from the Hospital, however, by the time she arrived, Mrs A, who was 86 years old, had died.

5. Mrs C stated that Mrs A had a large and loving family and the fact she died alone, with no-one with her, will haunt them forever. Mrs C stated that she is not questioning the cause of Mrs A's death, but it was the way Mrs C and her family were treated before and after Mrs A died that was unacceptable. Mrs C and her family felt they were not allowed to be with Mrs A when she died.

6. The complaint from Mrs C which I have investigated is that there were several unacceptable shortcomings in care during Mrs A's admission to the Hospital in October 2010.

Investigation

7. As part of my investigation, my complaints reviewer obtained copies of Mrs A's clinical records (the Records) and the complaints correspondence from Greater Glasgow and Clyde NHS Board (the Board). Advice was sought from

one of my independent nursing advisers (the Adviser). My complaints reviewer also met and discussed this compliant with the Adviser.

8. 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.

Complaint: There were several unacceptable shortcomings in care during Mrs A's admission to the Hospital in October 2010

9. In her letter of complaint to the Board dated 21 December 2010, Mrs C stated that when she arrived at the Hospital on 12 October 2010 shortly after Mrs A was admitted, a doctor told her there was nothing he could do as he thought the aneuryism was leaking. Mrs C stated that about an hour later another doctor and nurse told her the same thing and the nurse advised her to contact the rest of the family.

10. Mrs C stated that eventually Mrs A was moved into the ward and thereafter put into a single room. Mrs C said that the family were told they could stay with Mrs A as she would probably not last the night. Mrs C stated that on 13 October 2010 Mrs A was still with them. Mrs C asked the doctors if they were sure about the diagnosis that the aneurysm was leaking and they confirmed this.

11. On 14 October 2010 Mrs C was told Mrs A was being moved into a normal ward. Mrs C said she took this as a good sign. Mrs C stated they were also told it would only be normal visiting. Mrs C said she was present when Mrs A was moved into the ward and she returned to visit her again that evening. However, when she arrived she found that Mrs A had been moved back into a single room again.

12. Mrs C discovered this move was due to nursing staff having discovered that Mrs A had contracted Methicillin-resistant Staphlococcus Aureus (MRSA) some years previously. Mrs C stated that there was a 48 hour delay in getting the medical records to the ward, which meant Mrs A's previous MRSA was not known earlier. Mrs C requested to discuss Mrs A's situation with a doctor.

13. Mrs C said that during her conversation with the doctor, he told her that without an ultrasound scan medical staff could not be sure the aneurysm was

actually leaking and a scan was arranged for the next day. Mrs C said she was told the ultrasound scan had not been done as Mrs A had been too ill.

14. Mrs C stated that at this time the family were under the impression that Mrs A was getting better and she was only in the single room due to her medical history of MRSA. The visiting was evenings only and the family decided to take these visits in turns.

15. Mrs C said Mrs A had the ultrasound scan the next day. Mrs C stated she phoned the Hospital several times to find out the results, however, she was told they did not have them.

16. Mrs C said she received a phone call from the Hospital at 08:50 on 16 October 2010 and was told that Mrs A was really ill and to advise her family.

17. Mrs C stated she resides only ten minutes from the Hospital, however, when she arrived Mrs A was already dead. Mrs C stated that her mother had a large loving family and her dying alone, with no-one with her, had caused them all great distress.

18. Mrs C said that the doctor on the ward on the morning of 16 October 2010 was rude and insensitive and she was told to pick up the death certificate later that day. Mrs C said she telephoned the Hospital during the afternoon; however, the death certificate had not been signed. Mrs C was subsequently told that the doctor would not sign the death certificate as Mrs A's notes were being sent to the Procurator Fiscal and there may be a post mortem. No post mortem was carried out and Mrs C said she subsequently received the death certificate several days after Mrs A's death.

19. In his response to Mrs C dated 9 February 2011, the Director of Surgery and Anaesthetics (the Director) stated that Mrs C's complaint had been investigated by the Clinical Service Manager for General Surgery in Clyde in conjunction with a consultant surgeon (the Consultant Surgeon).

20. The Director stated that Mrs A had presented at the Hospital on 12 October 2010 with hypotension (low blood pressure) tachycardia (rapid pulse) and abdominal pain. Mrs A was known to have a large thoraco-abdominal aortic aneurysm and she had been identified as unsuitable for elective surgery for this condition several years previously. The Director stated

that an ultrasound scan had confirmed the presence of a 6.5 centimetres aortic aneurysm and that Mrs A was not considered suitable for emergency surgery. She was admitted to a ward for end of life care, as a diagnosis of rupture of the aneurysm had been made by the duty Surgical Registrar (the Registrar).

21. The Director stated that the most likely diagnosis of the aneurysm and its inevitable outcome was explained to Mrs C and family members in Accident and Emergency by the Registrar, who also broke the news that Mrs A was likely to die soon.

22. The Director stated that on the morning of 13 October 2010 Mrs A's general clinical condition was found to have improved. The Director stated that the Consultant Surgeon spoke to Mrs A and three members of her family during the ward round that morning. The Consultant Surgeon stated she told the family that while it was possible the aneurism may stabilise for a period before finally rupturing, Mrs A was still at significant risk of dying. The Consultant Surgeon also stated that, given Mrs A's improvement, other possible, (however, much less likely) causes of her symptoms, would be investigated.

23. The Director stated that, on the morning ward round of 14 October 2010, it was noted that Mrs A's renal (kidney) and liver functions were markedly impaired and an abdominal ultrasound was requested that day.

24. The Director stated that on 14 October 2010, in conjunction with Mrs A's wishes, she was moved from her room to the ward, to be more visible and to have company of other patients. The Director also outlined the reasons why Mrs A was moved back to the room and why there was a delay in getting the results of the MRSA screening and he apologised for this. The Director stated that on that same evening, Mrs C met with the Registrar. The Director stated that the Registrar had a lengthy discussion with Mrs C to explain the events up to that point and also why a Computed Tomography (CT) scan had not already been carried out (see paragraphs 10 to 13).

25. The Director stated that on 15 October 2010, an ultrasound scan confirmed the aneurysm had stretched and was 7.9 centimetres in diameter. He said a report on the results of the ultrasound scan was written in Mrs A's case notes that afternoon, however, it would not have been available for medical staff until that evening. He said that results are not given over the

telephone, due to patient confidentiality and apologised to Mrs C for the difficulties she experienced at that time (see paragraph 15).

26. The Director stated it was documented that Mrs A was regularly monitored by nursing and medical staff. He said that while Mrs A's condition had improved, on 16 October 2010 it deteriorated and nursing staff felt it necessary to contact Mrs C, however, sadly, the family had not arrived when Mrs A died. The Director stated that a member of nursing staff was sitting with Mrs A at this time and although Mrs C not present, Mrs A was not alone (see paragraphs 16 and 17).

27. The Director expressed regret that Mrs C found the doctor on the ward that morning rude and insensitive and also noted her concern over the delay of the issuing of the death certificate. He said that, due to the Consultant Surgeon's awareness of the family's concerns, it was considered appropriate to discuss matters with the Procurator Fiscal before issuing the death certificate. The Director said he understood the Registrar telephoned Mrs C on 18 October 2010 about this and also contacted the Procurator Fiscal that same day. He stated that the death certificate was written and ready for collection on 20 October 2010. The Director apologised to Mrs C for the added upset this situation had caused.

28. The Director said that although Mrs A's condition had improved, family members were advised of the seriousness of the situation on multiple occasions during her stay in the Hospital. He apologised that Mrs C was not with Mrs A at the time she died, however, he stated that nursing staff had tried to contact the family on Mrs A's deterioration. He stated it was not the case that Mrs C was not allowed to be there with Mrs A and expressed regret if Mrs C had been given this impression.

29. In Mrs C's response to the Board dated 16 February 2011 she disputed several statements made in the Director's letter, dated 9 February 2010, and raised further questions.

30. In the response dated 8 April 2011 from the General Manager for General Surgery (the General Manager), she addressed and offered clarification on the further concerns Mrs C had raised. For example, the General Manager stated that medical records were dispatched to the ward as soon as possible following their request. She expressed regret that the pertinent information which had

been available, in terms of past medical information, had not included Mrs A's MRSA status. She offered her sincere apologies to Mrs C that it took so long for Mrs A's case notes to reach the ward.

31. On 2 May 2011 Mrs C responded to the Board and stated that she still did not understand why Mrs A had died on her own with not one of her ten children with her. Mrs C also outlined the issues she remained concerned about and stated that some of the replies she had received from the Board were contradictory.

32. The Adviser noted that within the Records there was no note about visiting times or any record of discussion(s) between family and nursing staff which related to visiting/visiting guidelines. The only reference to the aspect of visiting was contained in the second letter to Mrs C from the Board dated 8 April 2011 (see paragraph 30) as follows:

> 'I understand [the Sister] requested that although [Mrs A] has been moved back to a single room, it would be preferable if normal visiting time would be maintained. On reflection, [the Sister] can see why this remark caused you concern and appeared uncaring under the circumstances.'

33. The Adviser added that she was unable to find within the Records where this statement originated, as the Sister did not mention the issue of visiting in her statement.

34. The Adviser stated that the Board had a policy on visiting which should contain guidance about flexible visiting arrangements for patients at the end of their lives. However, the Adviser also stated that the ward staff had also to balance the extent that open visiting may have had on the infection control policies.

35. The Adviser stated that, according to the Nursing and Midwifery Council, 'you must work with others to protect and promote the health and wellbeing of those in your care, their families and carers and the wider community'. The Adviser stated that on balance it appeared that nursing staff did not take the needs of Mrs C's family into account by allowing them access to Mrs A at the end of her life and, as such, she was critical of this.

36. According to the Adviser, two of the key reasons for patients being cared for in a single room are for isolation of infection and to provide privacy at the

end of life. She stated that, in this case, Mrs A was given a single room as her condition was very poor and she was not expected to survive. According to the Adviser, a single room will accommodate open visiting and allow relatives privacy at a very difficult time.

37. The Adviser stated that there did appear to be a contradiction in the records about why Mrs A was moved from the single room (see paragraphs 10, 11 and 24). The nursing note on the 13 October 2010 stated:

> 'complaining that you [Mrs A] can never get a nurse when you need one. I asked if she buzzed, she stated 'no', I asked if she wanted anything she said 'no'.'

38. The Adviser stated there was no record of Mrs A requesting to be moved and in the Adviser's view there also appeared to be a lack of insight into how ill Mrs A was. That said, the Adviser stated that nursing staff have to make decisions about patient movement which take into account clinical and other priorities, therefore, the move from the single room to the ward may have been reasonable at the time. The Adviser noted that following the MRSA positive result, Mrs A was moved back into a single room, in line with infection control policies.

39. The Adviser acknowledged that the movement may have been inconvenient for the family, however, the steps taken were reasonable. The move back to the single room was timely following the MRSA diagnosis.

40. The Adviser considered that the delay in retrieving Mrs A's medical notes resulted in Mrs A being moved, however, she stated that other aspects of Mrs A's treatment were unaffected by this delay. The Adviser said that although this was not ideal, a delay in finding the medical notes by a few hours was not unreasonable.

41. The Adviser noted that the Registrar had documented his conversation on 13 October 2010 with Mrs C that Mrs A 'will pass away' and that she was not to be resuscitated. There was a subsequent note written retrospectively, on 18 October 2010, about a conversation held on 14 October 2010 with Mrs C. In her statement, the Consultant Surgeon stated that she spoke to two members of the family on the morning of 13 October 2010; however, the Adviser stated that there was no record of this conversation. The Adviser noted that within the Board's response dated 9 February 2011 they stated the Consultant Surgeon

spoke to three members of the family (see paragraph 22). The Adviser said it was expected that the Consultant Surgeon should have recorded this conversation in the notes and this would have ensured that junior staff could have accessed this record and made certain that a consistent message was given to Mrs A and her family.

42. However, the Adviser stated that there was no record of any communication between nursing staff and the family. There was no communication sheet or any record of communication in the care plan. The Adviser said that the lack of ongoing communication, support and feedback was unacceptable and would have contributed to the distress Mrs C and the rest of the family faced when Mrs A died.

43. The Adviser stated that the nursing staff failed in their communication and, therefore, preparation for the end of life care of Mrs A. She said that the nursing notes provided little or no statements which suggested that end of life care was being provided. The medical records were clearer as the medical staff had documented their discussions with the family on 13 October and 14 October 2010 and following the death of Mrs A.

44. The Adviser observed that the nursing notes on admission stated 'not for resus – plan analgesia, TLC [tender loving care]'. She stated that while there is evidence that analgesia was given, she has not seen evidence that Mrs A was being afforded end of life care. The Adviser stated that Mrs A's symptoms of agitation, pain, decreased renal function and shouting out, all suggested she was approaching the end of her life. However, she had seen no record of nursing staff speaking with the family and providing them with updates. The Adviser also stated that the care plan was sparse at best and contained no information which would enable an individual plan of care to be given. She noted that the care plan was a tick box list, with many sections blank and she said, 'indeed there is no section for pain or death or dying'.

45. The Adviser noted that although the Board have mentioned introducing the Liverpool Care Pathway (a part of Living and Dying Well), the fundamentals of care and compassion were not evident in this case. She stated that staff should not require a policy document to treat people as individuals (see paragraph 43).

46. In summary, the Adviser stated that the nursing documentation including assessment, care planning and care given was poor. She said there was little

evidence that Mrs A was provided with the care expected of someone at the end of her life and her family were, therefore, unprepared and distressed when she died.

Conclusion

47. Mrs C complained that the management of Mrs A's end of life care in the Hospital was inadequate. Mrs C stated that Mrs A was moved back and forth from a single room to a ward and Mrs C and her family's visiting hours were restricted. This resulted in Mrs A dying alone. Mrs C states Mrs A was denied the right to have her family with her at the end of her life.

48. The Adviser states there were several failures made by nursing staff responsible for Mrs A's end of life care. These include poor communication between nursing staff and Mrs A's family, inadequate documentation about nursing issues, for example, no communication sheet or communication record within Mrs A's care plan. The Adviser has additionally stated that there is no record of a conversation between the Consultant Surgeon and Mrs A's family members which was stated to have taken place on 13 October 2010.

49. From the evidence I have seen I consider that the poor communication with Mrs C and her family, inadequate record-keeping (such as in the care plan) and specifically the lack of documentation of discussions between Mrs C, her family, nursing staff and the Consultant Surgeon (where conflicting information has been documented over who participated in this discussion) (see paragraph 41), are individual service failures and combine as significant service failures in this case.

50. I have also taken account of the Adviser's view that (i) the nursing staff failed in their communication and, therefore, the preparation of end of life care of Mrs A and (ii) there was nothing to suggest in the nursing notes that end of life care was being provided, despite the Adviser noting from the Records that Mrs A demonstrated symptoms which suggested she was approaching the end of her life (see paragraph 43).

51. Taking all these factors into account, I consider that from the evidence I have seen Mrs A did not receive the end of life care that Mrs C and her family rightly expected that the Hospital nursing staff should have provided. For all the reasons I uphold this complaint.

Recommendations

52. I recommend that the Board:	*Completion date*
(i) provide me with an update regarding their implementation of the introduction of the Liverpool Care Pathway;	20 June 2012
(ii) consider the Adviser's comments on the several failings in Mrs A's end of life nursing care and draw up and implement an action plan to address these failings;	18 July 2012
(iii) conduct a significant events review of this case; and	20 June 2012
(iv) apologise to Mrs C for the failures identified in this report.	6 June 2012

53. 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
Mrs A	The late mother of Mrs C
The Hospital	The Royal Alexandra Hospital, Paisley
The Board	Greater Glasgow and Clyde NHS Board Acute Services
The Records	Mrs A's medical records
The Adviser	The Ombudsman's nursing adviser
MRSA	Methicillin-resistant Staphlococcus Aureus
The Director	The Director of Surgery and Anaesthetics, who responded to Mrs C's complaint
The Registrar	The Surgical Registrar on duty at the A&E department when Mrs A was admitted to the Hospital
The Consultant Surgeon	The Consultant who saw Mrs A on the ward
The General Manager	The General Manager for General Surgery, who responded to Mrs C's complaint
The Sister	The nursing sister of the ward in which Mrs A was a patient

Annex 2

Glossary of terms

Analgesia	Pain relief
Aortic aneurysm	Swelling of the aorta (vein / artery)
Computed tomography (CT) Scan	Scan which uses special x-ray equipment
Hypotension	Low blood pressure
Liverpool Care Pathway (LCP)	An integral care pathway which a patient can expect in the final days and hours of life
Renal	Kidney
Tachycardia	Rapid pulse
Thoracaobdominal aortic aneurysm	A weakened and bulging area in the upper part of the aorta
Ultrasound scan	Diagnostic imaging technique of internal body structures

Annex 3

List of legislation and policies considered

Nursing and Midwifery Council: The code – standards of conduct, performance and ethics for nurses and midwives

Scottish Government Living and Dying Well