Scottish Parliament Region: Glasgow

Case 201102830: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category

Health: Hospital; Accident and Emergency

Overview

The complainant (Ms C) complained about the lack of communication with her family after her mother (Mrs A) was admitted to the Emergency Department in the Victoria Infirmary in Glasgow (the Hospital). Mrs A was 84 years old and had a history of dementia. The family were not told that Mrs A's condition in the Hospital had deteriorated. Mrs A subsequently died and Ms C considers that the family lost the opportunity of being with Mrs A at the end of her life.

Specific complaint and conclusion

The complaint which has been investigated is that the Board's lack of communication with the family just before Mrs A's death was unreasonable (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) issue a written apology to Ms C for the failure to inform her of the deterioration in her mother's condition; and	12 December 2012
(ii) provide him with an action plan and / or steps in place to ensure communication with relatives and carers is addressed within the Emergency Department.	21 January 2013

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

Main Investigation Report

Introduction

1. The complainant (Ms C) complained about the lack of communication with her family after her mother (Mrs A) was admitted to the Emergency Department in the Victoria Infirmary in Glasgow (the Hospital). Mrs A was 84 years old and had a history of dementia. The family were not told that Mrs A's condition in the Hospital had deteriorated. Mrs A subsequently died and Ms C considers that the family lost the opportunity of being with Mrs A at the end of her life.

2. The complaint from Ms C which I have investigated is that the Board's lack of communication with the family just before Mrs A's death was unreasonable.

Investigation

3. Investigation of the complaint involved reviewing the information received from Ms C and the Board's medical records for Mrs A. My complaints reviewer also obtained advice from a professional nursing adviser (the Adviser).

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 terms used in this report can be found at Annex 2. A list of the legislation and policies considered is at Annex 3. Ms C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The Board's lack of communication with the family just before Mrs A's death was unreasonable

5. Mrs A was admitted to the Emergency Department in the Hospital at 19:46 on 10 January 2010 after being found lying on the floor at her home. Her family, including Ms C, were asked to wait in the waiting room. An electrocardiogram (ECG) was performed and this showed evidence of ischaemic changes.

6. Arrangements were made to transfer Mrs A to a medical ward. However, at 23:10 a Staff Nurse (the Staff Nurse) recorded that her left hand and leg were cyanosed and she had a marked left-side weakness. The note in the nursing documentation states that she had not previously been like this at 23:00 and the family were yet to become aware of this, as further assessment was required. Mrs A was subsequently reviewed by a surgeon and a computerised

tomography (CT) scan was organised. However, Mrs A had a cardiac arrest in the CT scanning room before this was carried out. She was pronounced dead at 01:20 on 11 January 2010.

7. Ms C complained to the Board on 31 January 2010. She said that the Staff Nurse and Mrs A had passed her in the waiting area, when they were on their way to the scan. She said she asked the Staff Nurse to come back and tell her about the scan, but she never saw her again.

8. The Board responded to Ms C on 3 March 2010. They told her that the initial plan for Mrs A did not indicate that a CT scan was needed. It was only when Mrs A's symptoms changed that it was decided the CT scan was needed. Mrs A left the Emergency Department at 00:40 to go to the CT scanning room. The Board said that a doctor (the Doctor) advised Ms C to contact her brother after 01:00, as he was aware that Mrs A's condition had deteriorated suddenly and staff were attempting to resuscitate her. They said that they would like to apologise for the confusion and distress the communications had caused. Ms C has disputed that the Doctor told her to contact her family at 01:00.

9. Ms C wrote to the Board again on 15 March 2010. She asked why the family had not been told of the change in Mrs A's conditions after the review at 23:20. She said that they could have been with her instead of sitting in the waiting area.

10. The Staff Nurse completed a statement in response to Ms C's complaints. She said that she had pulled back Mrs A's blanket at 23:10, as she was to be transferred to a medical ward. She noticed that Mrs A's left hand looked discoloured/dark blue. She said that the family were with Mrs A at the time and she asked them to go back to the waiting area. She said that she did not want to alarm them and that further investigation was required.

11. The Staff Nurse said that she was conscious of the fact that she had asked the family to sit in the waiting area and they did not know about the deterioration in Mrs A's condition. She said that she considered it appropriate that doctors should speak to the family once a thorough reassessment had been carried out so that maximum information could be given to them. She stated that doctors informed the family of Mrs A's deterioration before she was taken to the CT scanner. The Staff Nurse said that Mrs A was pronounced dead in the CT scanner. She said that they contacted the bed manager and it

was decided to take her to the nearest ward. She said that she had been told that the Doctor and a surgeon informed the family of Mrs A's death. There is no statement from the Doctor in the Board's records and he is no longer employed by them.

12. The Board responded to Ms C on 29 April 2010. They said that the Staff Nurse had noted the change in Mrs A's condition and had informed medical staff. She also documented that the family were yet to become aware of this, as further assessment was required. The Board said that at this point, the priority was to ensure that the appropriate action was taken for Mrs A. They said that it would not have been appropriate to have had the family in with Mrs A while she was being assessed. They stated that the Staff Nurse documented that the family were not aware of this to ensure that staff knew that the family still needed to be communicated with.

13. In their response to our enquiries about the complaint, the Board said that Mrs A's family had been with her in the Emergency Department following her admission there. They stated that the Staff Nurse then noted a sudden change in Mrs A's condition whilst organising for her to be transferred to a medical ward and notified the Doctor. The Doctor reviewed Mrs A at 23:20. He considered that the clinical findings might have indicated a complication of an aneurysm of her aorta. Mrs A was referred to a surgeon. The surgeon arrived at 23:40 and after reviewing her, organised a CT scan for confirmation of the clinical position.

14. The Board told us that both a radiographer and radiologist had to co-ordinate, prepare and attend for the CT scan. They said that this was done in a timely fashion and within the one-hour timescale. The Board told us that the Doctor spoke to Mrs A's family after 00:40. They said that he advised the family on Mrs A's current condition and that she was to have a CT scan. The Board told us that Mrs A had a cardiac arrest at the CT scanner and after resuscitation attempts was pronounced dead at 01:20.

15. The Board said that, after Mrs A died, it was considered more appropriate to take her to a side room for the family to see her in private. They said that the family were taken there as soon as possible after Mrs A's transfer there had been organised. They stated that it would appear that the family were communicated with regarding Mrs A's condition throughout her time in the Emergency Department and as soon as possible after her deterioration in the CT scanning room. They said that the time lapse between communications

would appear to be consistent with the time taken for clinical assessments, confirmation of a working diagnosis and enacting the immediate treatment plan for Mrs A's clearly critical condition. They commented that Mrs A's clinical condition would have been the priority at the time.

Advice obtained

16. I asked the Adviser if it was reasonable for the Staff Nurse to record in the notes at 23:10 that the family were yet to become aware of the deterioration in Mrs A's condition, as further assessment was required. The Adviser said that this was good practice and a member of staff should have acted on this note.

17. I also asked the Adviser if staff at the Hospital had communicated reasonably with Mrs A's family regarding the deterioration in her condition considering they were in a room nearby. In her response, the Adviser commented that staff within the Emergency Department had a responsibility to keep relatives fully informed of a patient's condition and of any changes that occurred. The General Medical Council (GMC)'s Good Medical Practice states: 'You must be considerate to relatives, carers, partners and others close to the patient, and be sensitive and responsive in providing information and support, including after a patient has died.'

18. The Adviser said that evidence of any communication with Mrs A's family was minimal. She commented that there were various places in the notes where staff could have noted information given and there was no record anywhere in the notes of that being done. She stated that whilst she could understand that staff would have been occupied with the clinical care and treatment along with making arrangements to take Mrs A for the CT scan, this did not justify the lack of communication and indeed compassion in providing the family with a few moments with their mother. She commented that even in the most critically ill patient, time must be afforded to relatives to see them.

19. The Adviser also said that it would appear that there was a breakdown in communication between staff within the Emergency Department. She said that the Staff Nurse had indicated in her notes that the family had not been spoken to, but no one acted on this. The most senior doctor is responsible for ensuring that relatives are fully informed of the patient's condition, particularly when the situation is critical. The Adviser stated that she would have expected that a member of staff, usually a senior doctor or delegated to a senior nurse, should have given Mrs A's family an update; explained that the CT scan was needed to

confirm the diagnosis; and also prepared them for the strong possibility that Mrs A was dying. She said that they should also have offered to accompany the family to Mrs A's bed. There is no evidence in the contemporaneous records that this happened.

20. The Adviser said that the absence of a senior member of the Emergency Department team talking to Mrs A's family prior to her going for the CT scan was a significant failing in communication and compassion. She said that she agreed with Ms C that the family were not afforded the opportunity to say goodbye to Mrs A and that this has probably impacted on the distress of their bereavement.

21. I asked the Adviser for her comments on whether the Board's actions in taking Mrs A to a ward after her death were reasonable. In her response, the Adviser said that the rationale behind this decision was reasonable. She said that it could have been distressing to transport Mrs A back through the corridors or to the Emergency Department where the family were waiting when relatives were unaware that she had died.

Time of death

22. Ms C also complained that the family were given conflicting information about Mrs A's time of death. She said that the mortuary had advised that the card they received said that the time of death was 00:25. Another nurse told them that the time of death was 00:40. In the Board's letter to Ms C dated 3 March 2010, they said that Mrs A was pronounced dead at 01:20. They stated that this was clearly documented in the notes and concurred with the information received from the staff who looked after her. They apologised to Ms C for the error that must have occurred when the time was entered as 00:25. They also said that Mrs A left the Emergency Department at 00:40 and the nurse had incorrectly given this as the time of death. In their response to us, the Board said that these were human errors and staff had been spoken to about the consequences of providing inaccurate information on the time of death.

23. The post mortem report shows that Mrs A died at 01:20. Based on the evidence I have seen, I am satisfied that this was the time at which Mrs A died. I have also seen that the Board have apologised to Ms C for the failings in relation to this. They have also spoken to staff about this.

Conclusion

24. Ms C has complained about the lack of communication with the family around the time of Mrs A's death. She said that they were not informed that their mother's condition had changed. Ms C has also stated that she feels robbed of not being with her mother in her final hours, when she and her family were sitting so nearby. She also said that the family should have been consulted.

25. I have received advice that the Staff Nurse's action in recording in the notes that the family were yet to become aware of the deterioration in Mrs A's condition, as further assessment was required, was good practice. Although I recognise that staff could not have predicted Mrs A's death before she underwent the CT scan, there is no evidence in the contemporaneous records that staff subsequently acted on the Staff Nurse's note and informed Mrs A's family of the deterioration in her condition. The family were in the waiting room and should have been spoken to prior to Mrs A going for the CT scan. They should have been given a few moments to see Mrs A. There is no evidence that this happened.

26. I uphold Ms C's complaint.

Recommendations

27.	I recommend that the Board:	*Completion date*
(i)	issue a written apology to Ms C for the failure to inform her of the deterioration in her mother's condition; and	12 December 2012
(ii)	provide me with an action plan and / or steps in place to ensure communication with relatives and carers is addressed within the Emergency Department.	21 January 2013

28. 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

Ms C	The complainant
Mrs A	The aggrieved, Ms C's mother
The Hospital	The Victoria Infirmary in Glasgow
The Adviser	The Ombudsman's Nursing Adviser
The Staff Nurse	The Staff Nurse who reviewed Mrs A
The Doctor	The Doctor who reviewed Mrs A

Annex 2

Glossary of terms

Aneurysm	A bulge in a blood vessel that is caused by a weakness in the blood vessel wall
Aorta	The main vessel in the arterial network, which conveys oxygen-rich blood from the heart to all parts of the body except the lungs
Computerised tomography (CT) scan	The use of x-rays and a computer to create detailed images of the inside of a body
Cyanosed	The appearance of a blue or purple coloration of the skin or mucous membranes due to the tissues near the skin surface being low on oxygen
Electrocardiogram (ECG)	A test that records the electrical activity of the heart
Ischaemic	Insufficient blood supply for the need of a part of the body

Annex 3

List of legislation and policies considered

The General Medical Council (GMC)'s Good Medical Practice