Scottish Parliament Region: North East Scotland

Case 201204933: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; General Medical; clinical treatment; diagnosis; communication; staff attitude; patient dignity

Overview

The complainant (Mrs C) complained on behalf of her mother (Mrs A) to Grampian NHS Board (the Board) about the care and treatment her father (Mr A) received while a patient in Aberdeen Royal Infirmary (the Hospital) from 5 August to 23 September 2012. Mr A had been admitted to the Hospital's Acute Stroke Unit after suffering a stroke at home. Mr A died in the Hospital on 23 September 2012.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr A's medical care in the Hospital from 5 August to 23 September 2012 fell below a reasonable standard (*upheld*); and

(b) Mr A's nursing care in the Hospital from 5 August to 23 September 2012 fell below a reasonable standard (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:		*Completion date*
(i)	draw this report to the attention of all senior medical staff involved in Mr A's care;	26 February 2014
(ii)	take steps to put in place an action plan to address the failings identified in this report;	26 March 2014
(iii)	ensure that staff document relevant discussions they have with a patient's family or their carer;	26 February 2014
(iv)	act upon the comments of Adviser 1 in relation to the introduction of a policy on the certification of a patient's death;	26 March 2014
(v)	draw to the attention of relevant staff, the importance of providing evidenced based	26 February 2014

	complaints responses;	
(vi)	share with relevant nursing staff the comments of Adviser 2 with regard to maintaining a patient's dignity;	26 February 2014
(vii)	draw to the attention of relevant staff, Adviser 2's concerns about the Board's rationale for removing Mr A's pyjama bottoms; and	26 February 2014
(viii)	apologise to Mrs A and her family for the failings identified in complaints (a) and (b).	26 February 2014

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

Main Investigation Report

Introduction

1. Mr A was admitted to Aberdeen Royal Infirmary (the Hospital) Acute Stroke Unit, Ward 39, (the Ward) in the early hours of 5 August 2012 after suffering a stroke at home and in the Ward on 23 September 2012. Mr A's daughter (Mrs C) complained on behalf of her mother (Mrs A) to Grampian NHS Board (the Board) about failures in relation to Mr A's clinical and nursing care, and in their communications with the family. In particular, when Mr A's condition deteriorated and on the day he died. Furthermore, on a number of occasions, nursing staff failed to take account of Mr A's dignity by leaving him in a state of undress. Mrs C said that the family were also distressed by errors in relation to the completion of Mr A's death certificate.

2. Following Mr A's death, Mrs C complained to the Board about Mr A's care and treatment.

3. The complaints from Mrs A which I have investigated are that:

(a) Mr A's medical care in the Hospital from 5 August to 23 September 2012 fell below a reasonable standard; and

(b) Mr A's nursing care in the Hospital from 5 August to 23 September 2012 fell below a reasonable standard.

Investigation

4. My complaints reviewer looked in detail at all the available correspondence within the complaint file. In addition, Mr A's medical records were reviewed. My complaints reviewer also sought independent advice from two of the Ombudsman's advisers, a hospital consultant (Adviser 1) and a nursing adviser (Adviser 2).

5. 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) Mr A's medical care in the Hospital from 5 August to 23 September 2012 fell below a reasonable standard

6. Mrs C said that the family spoke with a junior doctor (Doctor 1), about Mr A's condition on 7 August 2012, two days after Mr A was admitted to the Ward. They wanted to know whether Mr A's stroke could have been caused by

him stopping his Warfarin medication, which he had been previously prescribed. However, Doctor 1 apparently told them she had not read Mr A's medical notes and did not know about his medication, in particular, that he had been on Warfarin. Mrs C also said that staff failed to keep the family advised about Mr A's condition especially when his condition deteriorated. On one occasion, on 22 August 2012, they arrived at Mr A's bedside for the evening visit to find him lapsing in and out of consciousness, wearing an oxygen mask and unable to speak. However, no member of the medical or nursing staff had spoken to them in advance about this change in Mr A's condition. Mrs C and the family had found this very distressing.

7. Mrs C said that when Mrs A visited Mr A on the afternoon of 19 September 2012, Doctor 1 advised Mrs A, in the presence of Mr A at his bedside, that she should look to have Mr A placed in a nursing home. This conversation had distressed both Mr and Mrs A and so Doctor 1 had to escort Mrs A to a private room to continue the discussion about this.

8. On 21 September 2012, Mrs C said that when she visited Mr A in the afternoon, Doctor 1 advised her that, Mr A's condition that morning had not been good, and she had intended to contact the family. However, Doctor 1 had not done so as there had been an improvement in Mr A's condition. Mrs C said that the family were told that Mr A was retaining a lot of fluid and he was going to have an x-ray. In addition, Mr A would be reviewed again by medical staff the following Monday (24 September 2012). However, on the morning of 23 September 2013, Mrs C said that Mrs A received a telephone call from a member of the Ward nursing staff advising her that Mr A had died. The family did not understand how Mr A's condition had deteriorated so rapidly given that he had earlier appeared to be 'fine'.

9. After Mr A died, Mrs C said that the family were left distressed due to the Hospital issuing an incorrect death certificate and it was only when the new death certificate was issued, that Mr A's family learned that he had pneumonia in the three days before he died. However, they had not been advised of this the previous Friday (21 September 2012) when Doctor 1 had discussed Mr A's condition with Mrs C.

The Board's response

10. In response to Mrs A's complaint, the Board said that Doctor 1 had appeared to have had the majority of contact with Mr A's family. The Board

explained that Mr A's admitting consultant (Doctor 2), was also his named consultant. Doctor 2 had regular updates on Mr A's progress at the weekly ward meetings but day-to-day care of the Acute Stroke Unit patients deferred to the on-call consultant.

11. The Board explained that Mr A's Warfarin medication had been stopped by his cardiologist in May 2012 because his heart failure had resolved. Mr A had been receiving aspirin prior to his admission to the Hospital with a stroke on 5 August 2012. Mr A was given clot busting medication, thrombolysis, on 6 August 2012 but unfortunately this did not reverse the stroke. However, it was not standard for a patient, such as Mr A, who had experienced a large stroke to be started on Warfarin for at least two weeks after the stroke. Mr A was diagnosed with a clot in his lungs on 18 August 2012 and was, therefore, started on a Warfarin equivalent drug, Dalteparin. There had been no reason, prior to Mr A's stroke, to support restarting him on Warfarin.

12. The Board said that Doctor 1 had been new to the Ward at the time of Mr A's admission and had just begun to be acquainted with how the Ward was run. She was, therefore, not fully aware of Mr A's full medical history when she spoke with Mrs A and her family on 7 August 2012.

13. The Board further advised that Mr A's stroke symptoms had appeared to worsen on 22 August 2012 and he was seen and assessed by medical staff. They apologised that the family had not been informed of the deterioration in Mr A's condition prior to them entering the Ward on the evening of 22 August 2012. This had been due to the nursing staff being engaged in the nursing staff handover as the family arrived for the evening visit. The Board accepted that Mr A's family should have been informed as soon as possible and apologised that they had not been prepared for the deterioration in his condition prior to seeing him.

14. The Board commented that Doctor 1 had understood from her discussions with Mrs A that she was happy to discuss issues relating to Mr A's care and treatment at his bedside. When Doctor 1 had raised the issue of a possible nursing home placement with Mrs A and seeing her distress at this, she had immediately taken her to a private room to continue the discussion. Mr A had become upset at seeing Mrs A upset. The Board were sorry that this discussion had caused such distress to Mr and Mrs A.

15. Doctor 1 recalled having a long discussion with one of Mr A's daughters on 21 September 2012. Doctor 1 said that she had explained that Mr A's condition was very poor, that he was being treated for pneumonia, and at that stage his prognosis was limited and he might not survive the weekend. There had then been some improvement with his chest infection and heart failure. The Board further commented that, as Mrs A was understandably distressed at the time, Mrs A's daughter told Doctor 1 that she would tell her mother about Mr A's condition. The Board said that, regarding the issue of pneumonia and heart failure, based on a chest x-ray, a patient with fluid on the lungs often had infection as well. They advised that the difference between these two was difficult to distinguish on a chest x-ray. Mr A had died very suddenly on 23 September 2012 and there had been no indication that his death had been imminent.

16. Doctor 1 apologised for the errors in Mr A's death certificate and for the distress this had caused to Mr A's family. The first death certificate had been completed by a newly qualified doctor (Doctor 3) who had lacked experience and had been unfamiliar with the process. Doctor 3 had not sought advice about its completion and unfortunately this resulted in inaccuracies on the death certificate.

Advice Obtained

Communication with Mr A's family

17. Adviser 1 noted from Mr A's medical notes there were several records of discussions between Doctor 1 and the family in August and September 2012. There was evidence that the family had clearly expressed their concerns about Mr A's condition.

18. The last documented conversation between Doctor 1 and the family in Mr A's medical notes appeared to have been on 20 September 2012. The entry stated that it had been explained to Mrs A all that could be done medically for Mr A at present and that Mrs A had agreed to a nursing home referral to be started. Depending on Mr A's condition, Mrs A may have been keen for him to go home with carers and adaptations if circumstances allowed this. Mrs A also discussed that she would like Mr A to go to Inverurie Hospital while awaiting nursing home placement. Adviser 1 could find no evidence documented of any communication with Mr A's family in the medical notes after this.

19. However, Adviser 1 noted that the Board, in their response to the complaint, had stated that Doctor 1 recalled having a long discussion with Mr A's daughter on 21 September 2012 during which she had explained Mr A's poor condition, that his prognosis was limited and he might not survive the weekend. Also that Mr A's daughter had told Doctor 1 that she would discuss all these issues with Mrs A. While Adviser 1 noted there were entries from Doctor 1 and Doctor 2 in Mr A's medical notes for this day, the entry from Doctor 1 only stated 'situation not looking good inform family'. Adviser 1 could find no specific reference to a conversation between Doctor 1 and Mr A's daughter in the notes to directly support the Board's claim. Adviser 1 did not doubt that Doctor 1 did speak to Mr A's daughter on 21 September 2012 as it was supported by an entry in the nursing notes which stated 'medical staff spoken to family about treatment plan'. However, for Adviser 1 the issue was that this discussion had not been documented.

20. Adviser 1 told my complaints reviewer that it was good medical practice to document all conversations with relatives, particularly in a situation as complex and as serious as this. The lack of documentation would not be in keeping with generally recognised standards of medical practice. Adviser 1 referred my complaints reviewer to the Medical and Dental Defence Union of Scotland's (MDDUS) 'Essential guide to medical and dental records' which states that a good medical or dental record should be comprehensive and accessible. It should comprise history, examination, investigations, decisions taken, treatment, progress notes and summaries describing the continuity of the patient's care and key discussions with the patient. Records should be legible, dated and signed. Good note taking was essential.

21. Adviser 1 said that it was clear to the medical staff at this time that Mr A was very unwell, that further treatment options were limited, and despite the treatment initiated he was deteriorating. Adviser 1 told my complaints reviewer that at this point he would have expected Mr A's family to be aware that he was deteriorating, despite medical treatment. Adviser 1 also would have expected staff to try to help Mr A's family during this time, by allowing them more time at visiting, visiting outside of normal visiting hours, and the provision of a side room to help them do this. Adviser 1 found no evidence that this was done. Adviser 1 said that he was unable to determine if the gravity of the situation was sufficiently explained to Mr A's daughter, or if Mr A's daughter failed to convey that adequately to Mrs A.

22. Adviser 1 considered the evidence of conversations between Mr A's family and Doctor 1 seemed to be of a reasonable quality and well documented. In contrast, Adviser 1 could find little communication from the consultants caring for Mr A. Adviser 1 noted that Mr A had several different consultants during his admission. Whilst Adviser 1 did not have a copy of the consultant rota, it appeared that they operated a rotational policy of covering the Ward. Adviser 1 told me that this made it much more difficult for Mr A's family to communicate with consultants directly rather than junior medical staff. As a result communication fell to the junior medical staff, such as Doctor 1. Given the complexity of Mr A's admission with a severe stroke, blood clots in his lungs, heart failure, and pneumonia, Adviser 1 was of the opinion that it would have been appropriate for the consultant(s) caring for Mr A to have discussed these issues and his prognosis with his family.

23. Adviser 1 also referred my complaints reviewer to guidance from the Scottish Intercollegiate Guidelines Network (SIGN) guideline 'SIGN 108. Management of patients with stroke or TIA: assessment, investigation, immediate management and secondary prevention. A national clinical guideline December 2008'. This highlights that two of the five most important issues identified by patients and carers looking for information are medical information and consequences of stroke. The guideline recommends that 'information should be tailored to the phase of the patient's journey' and 'information should be repeated and reoffered at appropriate intervals' and 'information giving should be documented to allow consistency'.

24. Adviser 1 also referred to a further SIGN guideline 'SIGN 118: Management of patients with stroke: Rehabilitation, prevention and management of complications and discharge planning. A national clinical guideline. June 2010'. This states that 'information should be made available to patients and carers routinely and offered using active information strategies, which include a mixture of education and counselling techniques' and 'information should be tailored to the commission needs of individual patients and carers, followed up to check understanding and ensure clarity and repeated as appropriate'.

25. Adviser 1 told my complaints reviewer that, in his opinion, there was not a systematic approach to the provision of information for the family of Mr A. Requests for information were usually prompted by them rather than being volunteered by the staff. The Ward doctors responded reasonably well to these

requests but the length and severity of Mr A's illness gave opportunities for other professionals such as specialist nurses or consultants to also be involved. Adviser 1 could not find significant evidence of this within Mr A's medical notes. It was, therefore, not surprising to Adviser 1 that, on the weekend of his death, Mr A's family were not fully aware of his diagnosis or prognosis. Overall, Adviser 1 found the lack of the systematic and regular provision of information by senior medical staff fell below an acceptable standard and was unreasonable.

Clinical Treatment

26. Adviser 1 noted that Mr A had complex treatment after his initial stroke which was complicated not only by a chest infection but also by fluid retention, clots in his lungs, and deranged liver function tests in his blood results. He also had some swallowing problems which were assessed by the speech and language therapists. Adviser 1 explained that a chest infection was one of the commonest complications occurring after stroke particularly in patients who cannot swallow normally.

27. On 4 September 2012 Mr A was noted to have worsening of his breathing and on examination had abnormal findings on the right side of his chest. He was reviewed by the respiratory team later that day who also performed an ultrasound scan of his chest which suggested fluid or pneumonia at the base of his lung. They concluded that he had a new hospital-acquired pneumonia as well as the fluid retention related to his heart and kidney problems. He was again started on intravenous antibiotics with the appropriate monitoring of his blood tests.

28. On 19 September 2012 Mr A was noted to be 'chesty'. The following day 20 September 2012, he was noted to have low blood oxygen levels and, on examination, he had abnormal findings with crackles at the base of his right lung. Mr A's blood tests also showed raised inflammatory markers consistent with infection and he was treated with different antibiotics.

29. On 21 September 2012 it was documented that Mr A was drowsy and had abnormal findings in his chest and low oxygen levels. Later that day, although the time was not recorded, he was noted to have low blood pressure, a faster breathing rate and low blood oxygen levels were noted by medical staff. His breathing pattern was described as 'Cheyne-Stokes'. Adviser 1 explained that this is a pattern of respiration where breathing becomes erratic, with alternating

fast and slow rates of breathing, and was usually an ominous sign and generally regarded as a sign of a significantly worsening condition. It was recorded in Mr A's medical notes that the 'situation not looking good, inform family'. A consultant review at 12:20 on 21 September 2012 concluded that Mr A was 'struggling with peripheral oedema due to heart failure, probable right basal pneumonia (whiteout in right lung on chest x-ray) and dehydration. He is obviously not for resuscitation and our options are limited'. Mr A's antibiotic therapy was then changed with an increase in the dose. He also had low levels of oxygen and high levels of carbon dioxide consistent with respiratory failure caused by pneumonia and fluid retention. Adviser 1 said that medical staff were thus aware that Mr A was suffering from pneumonia. Although medical staff gave Mr A three separate courses of antibiotics for infection there was no specific evidence that Mr A's family were made aware of this.

30. Adviser 1 said it was clear to the medical staff at this time that Mr A was very unwell, that further treatment options were limited, and that he was deteriorating. However, Adviser 1 could find no further entries in Mr A's medical records after 23 September 2012, in particular no discussion of an end of life care process being adopted for Mr A. The medical and nursing care seemed to carry on as before without either more care and intervention to improve Mr A's care or a deliberate and active change to a more palliative approach. It seemed to Adviser 1 that the care of Mr A was halfway between active care and palliative care with none of these being done well. Adviser 1 said that, if Mr A was being actively treated by the medical staff, then he should have had a further review on the day before his death rather than nothing being done. Alternatively, if the medical staff had decided that further medical treatment was likely to be futile, a more active palliative care approach should have been pursued and this would have led to a clearer discussion with the family. Adviser 1 considered, therefore, that the last 48 hours of Mr A's care was below a reasonable standard.

31. Furthermore, while Adviser 1 was of the view that Doctor 1 seemed good at caring for Mr A, there were, however, times in the medical notes when the senior staff such as consultants and senior trainee doctors seemed to change on a daily basis. There also seemed to be some uncertainty who the consultant in overall charge of Mr A's care was. Adviser 1 was critical of the lack of consistent supervision of Doctor 1 and consistent consultant care for Mr A which was a running theme in Mr A's medical notes.

Completion of Mr A's death Certificate and the Board's response to the complaint

32. The Board stated in their letter that 'despite Mr A's difficulty there was some initial improvement treating his chest infection and heart failure'. Adviser 1 could find no evidence of this in the medical notes and there were no medical entries to suggest that Mr A's condition had improved. In contrast, Adviser 1's interpretation of the medical notes was that the medical staff were fully aware that Mr A was likely to continue to deteriorate and that his death was probable. In the absence of medical notes recorded for 22 and 23 September 2012, Adviser 1 had, therefore, reviewed Mr A's nursing notes. This showed that Mr A's blood pressure remained low and that he required the use of high levels of oxygen therapy to support his breathing. The nursing observations for this weekend also showed persistently low oxygen levels despite treatment with oxygen. None of the observations taken improved significantly and Mr A's blood pressure was becoming worse (lower rather than higher) during this time. In Adviser 1's opinion, the Board's assertion that there was an initial improvement in Mr A was incorrect and certainly not significant enough to justify that there was no specific need to inform the family of how unwell he was. Overall, Adviser 1 considered the Board's complaint response fell below appropriate standards and was unreasonable.

33. The Board provided my complaints reviewer with copies of Mr A's medical certificates stating the cause of death. The Board accepted that there were errors made by Doctor 1 and Doctor 3 when completing the death certificate on two occasion. Adviser 1 explained that issues relating to death certification are complex and should not be undertaken by junior staff without adequate supervision. This was obviously an important legal document that should not be signed by inexperienced doctors at the weekend. Given that the registration of death cannot take place until a normal working day, some hospitals take the approach that death certificates should only be completed by the team usually caring for the patient and not by the 'out-of-hours' team. Both of the doctors who made these errors were in training, and these errors could have been discussed with them at the time, and included in their training portfolio as part of their education as a 'case based discussion'. The Adviser said that, although the Board's response stated that they had 'learned from this episode', it was not clear if this was done formally. As had been shown here, errors in a patient's death certificate added undue stress and anxiety for relatives during what was already a difficult time.

34. The Board has not provided my office with any specific policies or guidance regarding the certification of death. Adviser 1 considered that the Board should review this area by exploring the possibility of introducing a policy that certification should only be completed by the clinical team usually caring for the patient during normal 'office' working hours, and not by doctors who were unfamiliar with the patient during periods of on-call work.

35. Adviser 1 also noted there were factual inaccuracies in the Board's response, where Mr A was described as having diabetes when this was not a confirmed diagnosis, although the Board had subsequently apologised for this in a subsequent letter. Adviser 1 also considered the Board's response demonstrated a lack of reflection of their care for Mr A. For example, the issue of death certification was identified as an individual error of the doctors but there was no discussion of whether this might be a wider issue for the Board which they could investigate further. The Board also referred to the 'long discussion' between Doctor 1 and Mr A's daughter on 21 September 2012. However, the Board had not acknowledged that there was no documentation of this conversation in Mr A's medical records.

(a) Conclusion

36. I have carefully considered all the information relevant to this complaint and taken account of the advice that I have received from Adviser 1 including the guidance from MDDUS and SIGN.

37. From my review of the evidence, and the advice given to me, it was clear that Mr A was very unwell; his condition was complex; further treatment options were limited; and he was deteriorating, despite treatment. Given the complexity of Mr A's health, the advice I have received is that senior medical staff (at consultant level) should have spoken to the family so that they were clearly made aware of Mr A's treatment and his poor prognosis, particularly when his condition deteriorated in the days leading up to his death. However, there was a failure to do so. Furthermore, during the course of Mr A's stay in the Ward, it appeared that his family had to make contact with medical staff to find out about his condition and treatment rather than it being initiated, as it should have been, by the medical staff treating him. Accordingly, I accept the advice I have received about the lack of systematic and regular provision of information by senior medical staff, which fell below an acceptable standard.

38. While I accept that the care which Doctor 1 provided for Mr A appears to have been good, Adviser 1 was both critical of the lack of consistent supervision of Doctor 1, and consistent consultant care for Mr A. I have also taken account of the advice received from Adviser 1 that, although Mr A's condition was deteriorating, and further treatment options were limited, the care he received was halfway between active care and palliative care. In addition, I have noted there was a lack of entries by medical staff about Mr A's condition and treatment in the 48 hours before his death. Therefore, I accept the advice of Adviser 1 that the last 48 hours of Mr A's care was below a reasonable standard.

39. It concerns me that Mr A's family were not fully aware of his diagnosis or prognosis and so were unprepared for his death. In addition, further distress was caused to the family when errors were made in the completion of Mr A's death certificate.

40. I have also taken into account that the Board's response to the complaint fell below appropriate standards and was unreasonable. In view of these failings, I uphold the complaint.

(a) Recommendations

41.	I recommend that the Board:	*Completion date*
(i)	draw this report to the attention of all senior medical staff involved in Mr A's care;	26 February 2014
(ii)	implement an action plan to address the failings identified in this report;	26 March 2014
(iii)	ensure that staff document relevant discussions they have with a patient's family or their carer;	26 February 2014
(iv)	consider implementing a policy on the certification of a patient's death; and	26 March 2014
(v)	ensure that complaint responses contain accurate information that can be clearly evidenced.	26 February 2014

(b) Mr A's nursing care in the Hospital from 5 August to 23 September 2012 fell below a reasonable standard

42. Mr A's family complained that, on numerous occasions, nursing staff left Mr A in a state of undress, his pyjama bottoms were regularly missing and he was uncovered during visiting times. Despite his family repeatedly raising this matter with nursing staff, the situation continued. Mr A's family considered it was humiliating and undignified for Mr A to be treated in this way.

43. On another occasion, one of Mr A's daughters found Mr A without his oxygen mask as the strap had broken and she was advised by the nursing attending to Mr A that she was in the process of replacing it but had got called away.

44. On the day that Mr A died, Mrs A was not contacted by the Ward until ten minutes after he passed away at which time she was telephoned at home by a member of the nursing staff. This had caused Mrs A great distress.

The Board's response

45. The Board outlined that it was more suitable for staff to change Mr A when he was not wearing pyjama bottoms because he had continence issues, and had been retaining fluid causing them not to fit. The Board accepted that Mr A's family had supplied larger sized pyjamas and apologised that staff had not dressed Mr A in these when his family and friends were visiting. The Board said that it was normal practice for staff to check this so that a patient was not left in an undignified way. They were sorry that this had not happened with Mr A.

46. The Board said that Mr A had frequently removed his oxygen mask and that it was very difficult for nursing staff to ensure that he kept it on. However, they said that the mask was routinely replaced and apologised if there was a delay in providing Mr A with a mask.

47. The Board confirmed that a nurse had telephoned the family at 08:40 which was ten minutes after Mr A's death. The Board explained that they could not call Mrs A's any sooner until Mr A's death could be confirmed by a doctor.

Advice obtained

48. Adviser 2 was highly critical of the Board's statement that 'it was deemed more suitable for staff to change him, if he was not wearing pyjamas bottoms'. While Adviser 2 considered this may have been an unfortunate choice of words, she stressed that care should be for the benefit of patients and not to suit staff. Although there may be occasions, for example, when a theatre gown may be used to cover patients (particularly when patients have numerous tubes or have areas which are swollen and may cause discomfort) the dignity of patients should be of paramount concern at all times. However, the Board had not said this and Adviser 2 considered their comment to be unacceptable without further

explanation. Adviser 2 highlighted that the Nursing and Midwifery Council Code of Conduct states 'make the care of people your first concern, treating them as individuals and respecting their dignity'.

49. With regard to the incident concerning Mr A not wearing an oxygen mask, Adviser 2 explained that it can be very difficult to ensure patients keep the oxygen mask on, and other than having one to one nursing care, nursing staff made good attempts to replace the mask and try alternative masks.

50. Adviser 2 noted that, on the night prior to Mr A's death, the entry in Mr A's medical notes did not indicate that his condition was critical. It stated 'All care given'. This suggested to Adviser 2 that Mr A would require nursing assistance for personal care requiring at least two hourly nursing care. The Scottish Early Warning Scoring (SEWS) Chart had an entry at a time Adviser 2 cannot decipher on 22 September 2012 and the Waterlow chart (for positioning and preventing pressure ulcers) had been completed at 01:25 on 23 September 2012. These entries suggested to Adviser 2 that there was an appropriate level of intervention during the night. At 08:00 on 23 September 2012, the day Mr A died, there was a record that a tube feed was given, which suggested that the nursing staff attended to Mr A at that time.

51. On the morning of Mr A's death, Adviser 2 noted that the statement from the Ward manager suggested that there was no indication of Mr A's death being imminent. In addition, the staff nurse on duty was adamant that she had not told Mrs A that she had 'not had time to call'. Adviser 2 considered there had clearly been miscommunication between the nursing staff and Mr A's family.

52. In summary, while Adviser 2 was of the view that the nursing care in the hours prior to Mr A's death was reasonable, the way in which Mr A's death was communicated to Mrs A was poor and clearly led to the distress of Mr A's family.

(b) Conclusion

53. I have considered the evidence relating to this complaint carefully and taken account of the advice received from Adviser 2.

54. The respect for the dignity of a patient should be of paramount concern at all times. I do not consider the Board's reasons for removing Mr A's pyjama bottoms were justified and I have taken account of the criticisms of Adviser 2 in relation to the Board's response which she considered to be unacceptable.

55. Whilst the nursing care Mr A received in the hours prior to his death appears reasonable, I accept that Mrs A would have been very distressed to receive the news about Mr A's death in a telephone call, particularly given she was not expecting such news. However, I am unable to reach a conclusion about the manner in which the Ward nurse spoke to Mrs A when she notified her about Mr A's death.

56. In view of the failings identified above, I uphold the complaint.

(b) Recommendations

57.	I recommend that the Board:	*Completion date*
(i)	share with relevant nursing staff the comments of Adviser 2 with regard to maintaining a patient's dignity; and	26 February 2014
(ii)	draw to the attention of relevant staff, Adviser 2's concerns about the Board's rationale for removing Mr A's pyjama bottoms.	26 February 2014

General Recommendation

58.	I recommend that the Board:	*Completion date*
(i)	apologise to Mrs C and her family for the failings identified in complaints (a) and (b).	26 February 2014

59. The Board have accepted the recommendations and will act on them accordinlgy. The Ombudsmand asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr A	Mrs C's father and the subject of the complaint
the Hospital	Aberdeen Royal Infirmary
the Ward	Ward 39, Acute Stroke Unit, Aberdeen Royal Infirmary
Mrs C	the complainant and daughter of Mr A
Mrs A	the wife of Mr A and the mother of Mrs C
the Board	Grampian NHS Board
Adviser 1	a clinical adviser to the Ombudsman
MDDUS	Medical and Dental Defence Union of Scotland's
SIGN	Scottish Intercollegiate Guidelines Network
Adviser 2	a nursing adviser to the Ombudsman
Doctor 1	the junior doctor who treated Mr A
Doctor 2	Mr A's admitting consultant and also his named consultant
Doctor 3	the junior doctor who originally completed Mr A's death certificate

Annex 2

Glossary of terms

Cheyne-Stokes	cycles of respiration that are increasingly deeper then shallower with possible periods where breathing temporarily stops
Dalteparin	a blood thinner used to prevent or treat blood clots
Peripheral oedema	fluid retention usually in the lower limbs
SEWS Chart	patient observation chart
Thrombolysis	clot busting medication
Warfarin	a type of medicine to stop clots forming in the blood
Waterlow chart	a tool to assess risk of a patient developing a pressure ulcer

Annex 3

List of legislation and policies considered

Medical and Dental Defence Union of Scotland's (MDDUS) Essential guide to medical and dental records

Nursing and Midwifery Council Code of Conduct

Scottish Intercollegiate Guidelines Network (SIGN). SIGN. 108: Management of patients with stroke or TIA: assessment, investigation, immediate management and secondary prevention. A national clinical guideline. December 2008

Scottish Intercollegiate Guidelines Network (SIGN). SIGN 118: Management of patients with stroke: Rehabilitation, prevention and management of complications and discharge planning. A national clinical guideline. June 2010