SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Glasgow

Case 201303786: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category

Health: Hospital; clinical treatment; diagnosis

Overview

The complainant (Mr C) raised concerns that his late mother (Mrs A) had not received adequate fluids and nutrition during her admission at Vale of Leven Hospital. Mr C also complained that, following her diagnosis with oesophageal cancer, Mrs A did not receive palliative treatment for nearly three weeks until he raised his concerns with the consultant in charge of Mrs A's care.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) staff at Vale of Leven Hospital failed to ensure that Mrs A received an adequate level of fluids and nutrition despite her swallowing difficulties (*upheld*); and

(b) staff at Vale of Leven Hospital and Paisley Royal Alexandra Hospital failed to ensure that Mrs A received appropriate and timely clinical treatment in view of the symptoms which she presented with (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) review the processes for ensuring that fluid intake and balance is appropriately monitored and recorded on the Vale of Leven Hospital acute medical ward;	11 February 2014
(ii) issue a written apology to Mr C, clearly acknowledging the gravity of Mrs A's experience and the specific failings which led to the delay in her treatment; and	17 December 2014
(iii) take steps to ensure that the failings his investigation identified have been fully addressed	14 January 2014

in the revised pathway for onward speciality referral for upper gastrointestinal within Clyde, and explain what awareness raising has been undertaken in relation to this.

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

Main Investigation Report

Introduction

1. On 10 March 2014, my office received a complaint from a member of the public (Mr C) against Greater Glasgow and Clyde NHS Board (the Board). He complained that the Board failed to ensure his mother (Mrs A) received adequate fluid and nutrition when she was a patient at Vale of Leven Hospital, and that, following her diagnosis with oesophageal cancer, Mrs A did not receive any palliative treatment for nearly three weeks until he raised the issue with the consultant in charge of Mrs A's care.

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

(a) staff at Vale of Leven Hospital failed to ensure that Mrs A received an adequate level of fluids and nutrition despite her swallowing difficulties; and

(b) staff at Vale of Leven Hospital and Paisley Royal Alexandra Hospital failed to ensure that Mrs A received appropriate and timely clinical treatment in view of the symptoms which she presented with.

Investigation

3. My complaints reviewer considered the documentation provided by Mr C and by the Board. My complaints reviewer also sought professional advice from a consultant general surgeon with experience in oesophageal cancer (the Surgical Adviser) and an experienced nurse (the Nursing Adviser).

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) Staff at Vale of Leven Hospital failed to ensure that Mrs A received an adequate level of fluids and nutrition despite her swallowing difficulties

5. Mrs A was admitted to Vale of Leven Hospital with difficulty in swallowing and keeping any foods or liquids down, including her oral medications. She was diagnosed with oesophageal cancer five days later. Mrs A remained on the ward at Vale of Leven Hospital for nearly three weeks, before being transferred to Royal Alexandra Hospital.

6. Mr C complained to my office that, during this time, Mrs A was unable eat or drink, aside from a very brief remission on one occasion, but staff continued

to provide her with food despite her swallowing difficulties. Mr C was concerned that, to his knowledge, no attempt was made to feed Mrs A intravenously. Mr C was also concerned that Mrs A was unable to take her normal medication which mitigated against recurrent urinary tract infections and a chronic heart condition.

7. Mr C said that Mrs A entered hospital mobile, self-caring and independent, but due to her physical and mental deterioration she was reduced to a state of near-total dependence on nursing staff. Mr C described the stress of witnessing Mrs A's deterioration as 'unbearable' and said he felt the health service seemed to view elderly people as problems, rather than people.

8. In response to Mr C's complaint, the Board met with Mr C twice (once with medical and nursing staff, and again with surgical staff present). In the first meeting, nursing staff noted that Mrs A had not been able to take food orally from the time of her admission, and had been a 'high risk' due to her swallowing issue. They explained that nursing staff had done what they could whilst waiting for a surgical decision on Mrs A's palliative treatment, including arranging for a dietician to review Mrs A.

9. The Board told my complaints reviewer that, following Mr C's complaint, they had reminded nursing staff of the need to comply with the Right Patient, Right Meal, Right Time policy, and had undertaken awareness raising with staff about the Nutritional Care in Acute Services Manual.

10. The Nursing Adviser reviewed Mrs A's nursing records, and said that the these show that appropriate assessments and referrals were made in relation to Mrs A's swallowing difficulty on her admission. As Mrs A was at high risk of malnutrition, a care plan was commenced to manage this and she was reviewed regularly by the dietician, who prescribed supplements. The Nursing Adviser considered that the nursing notes show staff were aware of Mrs A's difficulty swallowing and appropriately encouraged fluids and soft diet. However, Mrs A appears to have been unable to tolerate much at all, and most of the fluid she attempted had to be spat out again. The Nursing Adviser explained that this is common in patients with late onset cancer of the oesophagus. The difficulty swallowing is a distressing symptom and it is difficult to strike a balance between encouraging patients to drink even small amounts, to achieve some hydration, against the context of keeping the patient comfortable towards the end of life. The Nursing Adviser acknowledged that this condition is very distressing for relatives.

11. The Nursing Adviser said that food and fluid balance charts were in place initially to monitor Mrs A's intake. However, there are no fluid balance charts for a ten day period in the middle of Mrs A's admission. This means there is no evidence about Mrs A's fluid intake for this period, and the Nursing Adviser was critical of this oversight. It does not appear that Mrs A had intravenous fluids during this period, and while the nursing notes show that she was being encouraged with her fluid intake, this should have been charted and monitored so that, if required, intravenous fluids could be started.

12. The Nursing Adviser said that Mrs A received intravenous fluids on a number of occasions during her admission (most days, aside from the ten day period mentioned above). The Nursing Adviser explained that intravenous fluids may not be well tolerated for long periods in patients in Mrs A's condition, and noted that continually re-siting the intravenous drip can be uncomfortable and painful for patients. The Nursing Adviser considered that the decision not to continually re-site the drip would have involved balancing Mrs A's fluid needs against the need to keep her comfortable.

13. In relation to Mrs A's on-going medication, the Nursing Adviser explained that the medication record shows that oral tablets were crushed or given to Mrs A subcutaneously or in liquid form. The Nursing Adviser considered that staff, therefore, made reasonable efforts to ensure that Mrs A continued to receive her medication.

(a) Conclusion

14. I am satisfied that nursing staff took appropriate steps to assess and refer Mrs A's difficulty swallowing, as well as encouraging her with fluid and diet intake. I am also satisfied that staff took reasonable steps to ensure that Mrs A continued to receive her medication, while waiting for her palliative treatment plan.

15. However, I note the advice from the Nursing Adviser that the Board failed to monitor and record Mrs A's fluid intake for a ten day period, and I am critical of this failing. As the Nursing Adviser has indicated, Mrs A's fluids should reasonably have been charted, particularly as she was not receiving intravenous fluids during this period. Therefore, I uphold the complaint.

16. Mr C has described his distress at Mrs A's deterioration while in the Vale of Leven Hospital, and his concern that she was not receiving enough fluid or nutrition. When he wrote to my office, Mr C said that he wanted an apology that explicitly acknowledged the gravity of what happened to Mrs A. I have recommended that the Board make this apology (see recommendations in relation to the second complaint below), and also that the Board review the monitoring of fluid balance for patients on the acute medical ward at Vale of Leven Hospital.

(a) Recommendation

17. I recommend that the Board:	*Completion date*
(i) review the processes for ensuring that fluid intake and balance is appropriately monitored and recorded on the Vale of Leven Hospital acute medical ward.	11 February 2014

(b) Staff at Vale of Leven Hospital and Paisley Royal Alexandra Hospital failed to ensure that Mrs A received appropriate and timely clinical treatment in view of the symptoms which she presented with

18. Shortly after Mrs A's diagnosis of oesophageal cancer, hospital staff told Mr C that her condition was terminal, but that palliative care would be considered, which was likely to be a stent (a tube placed in the oesophagus to keep a blocked area open so the patient can swallow soft food and liquids). However, no action followed for nearly three weeks, aside from a staging scan to determine the extent of the cancer. Mr C then became concerned about the delay and Mrs A's deteriorating condition. He raised his concerns with the consultant on the ward, who contacted a consultant surgeon at the Royal Alexandra Hospital and arranged for Mrs A to be transferred to Royal Alexandra Hospital that day, for consideration of whether to insert a stent.

19. Shortly after her transfer, Mrs A underwent an urgent endoscopy with dilation (an operation to attempt to stretch or expand the oesophagus), but this was unsuccessful. She then underwent a further unsuccessful attempt to insert a stent ten days later, which was abandoned at the sedative stage as she had a bad reaction. In a third attempt, six days later, a stent was successfully fitted without a sedative being administered. Sadly, Mrs A developed an infection which led to pneumonia, and she passed away three days after the stent was inserted.

20. Mr C complained to my office about the delay in transferring Mrs A. He said that nothing was done to progress Mrs A's palliative care after her diagnosis, until he decided to raise his concerns with the consultant.

21. In response to his complaint, staff from the Board met with Mr C on two occasions. In these meetings, staff expressed their condolences for his loss and apologised for the experience which he and Mrs A had. Staff also acknowledged that Mrs A should have been transferred to the surgical ward sooner, and explained that the delay in transferring Mrs A occurred because the Upper-Gastrointestinal Multi-Disciplinary Team (MDT) meeting that was due to consider Mrs A's case had been cancelled in each of the two weeks following her admission.

22. In the first meeting, medical staff told Mr C that the MDT had not been made aware of his complaint, but agreed to ask them to look at their practice in regard to this matter following the meeting. In the second meeting (including surgical staff), the surgical consultant in charge of Mrs A's care expressed his personal condolences for Mr C's loss, and acknowledged that there should have been better communication between the surgical and medical teams when it became a matter that Mrs A could not swallow. However, the surgical consultant said that the message that Mrs A's swallowing had become so bad that she had not been able to swallow at all had not been communicated to him.

23. While he acknowledged that the Board had apologised, Mr C felt that the medical staff and surgical staff each blamed one another for the delay. He said he wanted to know where the responsibility properly lay, as well as a letter of apology which fully acknowledged the gravity of what happened to Mrs A.

24. In response to my complaints reviewer's enquiries, the Board again acknowledged that Mrs A did not receive appropriate and timely treatment, and said that in their first meeting with Mr C a greater focus should have been given to apologising more clearly for the failings in Mrs A's care. The Board explained that a number of improvement actions were taken forward after learning of Mrs A's experiences, specifically:

- discussion of Mrs A's case at the Royal Alexandra Hospital / Vale of Leven Hospital morbidity and mortality review meeting in January 2014 to share the learning from Mrs A's experience;
- reinforcement and refinement of the pathway for onward speciality referral for upper gastrointestinal patients within Clyde;

- implementation of a daily 'safety pause' within the acute medical ward at Vale of Leven Hospital, to enable all team members to meet to discuss each patient and determine what each discipline needs to do to progress treatment or arrange discharge or transfer; and
- a weekly MDT meeting for all patients in the acute medical ward at Vale of Leven Hospital who have been in hospital for longer than a week, to ensure all relevant referrals have been made.

25. My complaints reviewer asked the Surgical Adviser to comment on the cancellation of the two consecutive MDT meetings, which the Board said resulted in the delay in Mrs A's transfer and treatment. The Surgical Adviser noted that it is regarded as good policy not to proceed with a treatment plan until it has been approved by an MDT, but said that in circumstances where consecutive MDT meetings were cancelled, alternative arrangements should exist. The Surgical Adviser explained that the usual alternative to an MDT meeting was an ad hoc discussion between the referring clinician and the chair of the MDT, together with any other appropriate clinicians identified by these two. The Surgical Adviser noted that this is what eventually happened in Mrs A's case, when the medical consultant at Vale of Leven contacted the surgical consultant at the Royal Alexandra Hospital to discuss Mrs A's palliation treatment plan. The Surgical Adviser commented that the medical notes show the surgical team was contacted two days before Mrs A's transfer, but as it was reported that Mrs A was able to swallow some fluids at that time, she was not accepted for immediate transfer.

26. My complaints reviewer also asked the Surgical Adviser whether there had been unreasonable delay in arranging the stent for Mrs A, after her transfer to Royal Alexandra Hospital. The Surgical Adviser did not consider that there was any unreasonable delay at this stage. The Surgical Adviser explained that the first attempt at stent placement was cancelled as Mrs A's potassium was very low and she had electrolyte imbalance, due to her poor oral intake and intravenous fluids. The second attempt failed as the surgeon was not able to get past the tumour and Mrs A regurgitated. The Surgical Adviser explained that this is a known hazard, and it was appropriate for the surgeon to stop and try on a different day.

27. The Surgical Adviser noted that it was unlikely that the delay in placing the stent would have affected the outcome for Mrs A, as stents are often very poor at palliation. The Surgical Adviser explained that stents do not allow proper

swallowing, as it is not just the blockage to the gullet that prevents swallowing but also the fact that the muscles in the gullet do not work to propel food and drink. Stents can also cause pain, and even perforation, and are, therefore, usually considered a 'least worst option' rather than good palliation. In Mrs A's case, the Surgical Adviser explained that it appears from the notes that the stent did not improve her swallowing and that, therefore, earlier stent placement was unlikely to have improved the outcome for her.

28. Finally, my complaints reviewer asked the Surgical Adviser to comment on the measures put in place by the Board in response to Mr C's complaint. The Surgical Adviser considered that these measures were reasonable and proportionate, in particular the reinforcement and refinement of the pathway for onward specialist referrals.

(b) Conclusion

29. The Board has acknowledged that they did not ensure Mrs A received appropriate and timely treatment. In view of this acknowledgement, and the Surgical Adviser's advice that alternative arrangements to the MDT should have been in place, I have concluded that the actions of Vale of Leven Hospital and Royal Alexandra Hospital staff in this respect were unreasonable. Therefore, I uphold the complaint.

30. When Mr C wrote to my office, he said he wanted to know where the responsibility properly lay for Mrs A's treatment, as he felt that the surgical and medical staff blamed each other for the delay. In view of the advice from the Surgical Adviser, I have concluded that the delay in treatment for Mrs A resulted from a failure in communication between the two hospitals. This was caused by a combination of the cancellation of two consecutive MDT meetings by Royal Alexandra Hospital surgical staff and the failure of the medical consultants in charge of Mrs A's care at Vale of Leven Hospital to make a direct referral, through an ad hoc discussion, for nearly three weeks after diagnosis. While the Surgical Adviser has indicated that Vale of Leven Staff did contact the surgical team the day before Mr C raised his concerns, it appears that the message that Mrs A had been unable to eat or drink for several weeks was not clearly passed on.

31. I am critical of the communication failings between Vale of Leven Hospital and Royal Alexandra Hospital which led to the delay in Mrs A's treatment, and I

am also critical of the Board for failing to clearly acknowledge to Mr C where responsibility lay for this issue.

32. However, I acknowledge that the Board has taken a number of steps to address the failings identified in Mrs A's care and treatment, to ensure that a treatment plan is in place for patients in Mrs A's position in future. I have made recommendations to ensure that these steps fully address the factors which led to the delay. I have also recommended that the Board issue a written apology to Mr C which acknowledges the gravity of Mrs A's experience and clearly identifies the failings which led to the delay in her treatment.

(b) Recommendations

33. I recommend that the Board:

		Completion date
(i)	issue a written apology to Mr C, clearly acknowledging the gravity of Mrs A's experience and the specific failings which led to the delay in her treatment; and	17 December 2014
(ii)	take steps to ensure that the failings my investigation identified have been fully addressed in the revised pathway for onward speciality referral for upper gastrointestinal within Clyde, and explain what awareness raising has been undertaken in relation to this.	14 January 2014

34. 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

Mr C	the complainant
the Board	Greater Glasgow and Clyde NHS Board
Mrs A	the complainant's mother
the Surgical Adviser	a consultant general surgeon who provided advice on the complaint
the Nursing Adviser	an experienced nurse who provided advice on the complaint
MDT	multi-disciplinary team

Annex 2

Glossary of terms

endoscopy with dilation	an operation to attempt to stretch or expand the oesophagus
stent	a tube placed in the oesophagus to keep a blocked area open so the patient can swallow soft food and liquids