Scottish Parliament Region: North East Scotland

Case 200502722: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; Record keeping

Overview

The complainant was unhappy at the length of time it took a hospital to inform her late husband's GP of his death. She was further aggrieved that the hospital sent, some months later, an appointment card for her late husband.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the hospital did not, within a reasonable time, inform Mr C's general practice of his death (*not upheld)*; and

(b) an appointment card was sent by a department within the Hospital for Mr C in December 2005 (*not upheld)*.

Redress and recommendations

The complaints have not been upheld as the Board had already taken appropriate action before Mrs C approached this office. However, the Ombudsman recommends that the Board:

(i) monitor the policy they have introduced to notify general practices of the death of patients to ensure effectiveness; and

(ii) until all systems are interfaced with the Community Health Index for Scotland, remind staff of the need to access this system before sending out appointment cards and to reinforce the training given at regular intervals.

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

Main Investigation Report

Introduction

1. On 26 July 2005 Mrs C's husband (Mr C) died in Ninewells Hospital (the Hospital) in the NHS Tayside Board region. Six weeks later, the hospital informed Mr C's general practitioner of his death. Unfortunately, Mrs C had visited the practice prior to this and had to tell them of Mr C's death herself and to ask the Hospital to inform the practice formally. Mrs C complained to the Hospital and received an apology and assurances that this would not happen again. Mrs C was further upset when, some months later, the same Hospital sent an appointment card for Mr C. Mrs C again accepted the Board's apology but was concerned that this might recur with other patients and complained to the Ombudsman.

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

(a) the Hospital did not, within a reasonable time, inform Mr C's general practice of his death; and

(b) an appointment card was sent by a department within the Hospital for Mr C in December 2005.

Investigation

3. The investigation of this complaint involved questioning the Board about their practice and procedures and obtaining all the relevant documentation and complaint files. I also sought advice from a clinical adviser to the Ombudsman. My findings of fact and conclusion are set out below. 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) The hospital did not, within a reasonable time, inform Mr C's general practice of his death

4. After Mr C's death on 26 July 2005, Mrs C complained to the Board on 7 September 2005 that the Hospital had not informed Mr C's general practice of his death. She said that she had visited the general practice three weeks after her husband's death and had been distressed that she had to inform them of this. On 1 September 2005, she again visited the practice and was told they had still not received formal notification from the Hospital. Notice was sent to the practice on

15 September 2005, although the letter of notice indicated that it had been dictated on 3 August 2005.

5. In the Board's reply to Mrs C, dated 28 September 2005, they apologised for the lack of communication and said that a senior member of staff had spoken to the medical staff concerned to prevent a recurrence.

6. In response to my questions, the Board said that the standard practice of the unit where Mr C had died required the clinician to complete a form indicating they had informed the general practice and this was then put on the medical record. However, they had discovered that use of this form had been patchy and, therefore, was to be replaced by a new policy which had been approved by the Medical Director. The date of introduction throughout the Board was 1 May 2006. Under the new policy, the clinician would be required to write on the death certificate stub what action they had taken to contact the relevant practice.

7. With reference to the specific ward where Mr C died, particular measures to prevent this recurring had been put in place and the ward clerkess now contacted the practice by telephone. This procedure was then extended across the clinical group in November 2005.

8. The Board said that the specific delay that had occurred between the dictation date and sending date of the letter occurred as a result of severe staffing difficulties. Delays of six weeks were being experienced at that time. However, this situation had since been addressed and the estimated time between discharge of a patient and communication to the relevant general practice was now two to three weeks.

9. The Board also confirmed that, generally, where it was felt information should reach the general practice more quickly, a notation would be made on the letter of discharge given to the patient. The patient would be told to deliver this to the general practice and if the matter was of particular urgency or importance, the relevant member of staff would telephone the practice direct.

(a) Conclusion

10. There was an unacceptable delay in the time taken to inform Mr C's general

practice of his death. The Board accepted this and, before Mrs C submitted her complaint to the Ombudsman, apologised to her. They also put in place in the Hospital arrangements to prevent a recurrence. These arrangements are now being superseded by a new Board-wide policy. In the absence of further maladministration, I do not uphold this complaint.

(a) Recommendation

11. Although the complaint is not upheld, it is recommended that the Board should monitor the policy they have introduced to notify general practices of the death of patients to ensure its effectiveness.

(b) An appointment card was sent by a department within the hospital for Mr C in December 2005

12. On 5 December 2005, Mrs C received an appointment card for her late husband Mr C and on 2 January 2006 she wrote to the Board to complain about the distress this had caused. On 5 January 2006 she wrote to the Ombudsman. The Board replied on 23 January 2006 and said that, although the staff had checked Mr C's details before sending out the card, up-to-date information was not on the computer system. The Board and department involved apologised for the distress and indicated that lessons would be learned. In a letter to the Ombudsman of 13 March 2006, Mrs C said that although she accepted the apology she was concerned that this should not happen again. She felt she had had no assurance that the systems would be improved to prevent this and, therefore, submitted her complaint.

13. In response to my questions, the Board said that the computer system in the department concerned was a stand-alone system and not connected to the Community Health Index for Scotland (CHI). Whereas the CHI receives notification of an individual's death from both general practices and the Registrar General, this was not recorded in their system and they required staff to check the CHI. Following Mrs C's complaint and their internal investigation into this, a memo from the Board's Medical Director on 8 February 2006 had been sent to all departments involved in making appointments affirming that staff should access the CHI before sending out appointment cards. This had not always been the case and staff had not been trained in this system. The Board said this had now been rectified and

furthermore, the majority of their systems were now interfaced to the CHI and they were working to ensure that all stand-alone systems were so interfaced.

(b) Conclusion

14. The appointment card was clearly sent in error and to an extent this resulted from a lack of training. The Board have apologised again and, after completing their internal investigations, sought to prevent this from recurring by retraining. They are also seeking a more robust solution by linking all systems to the CHI. As the Board made efforts to prevent a recurrence prior to the involvement of the Ombudsman in this matter, I do not uphold this complaint.

(b) Recommendation

15. Although this complaint is not upheld, it is recommended that, until all systems are interfaced with CHI, the Board should remind staff of the need to access this system and reinforce their training in the system at regular intervals.

16. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board to notify her when the recommendations have been implemented.

26 September 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	Mrs C's husband
The Hospital	Ninewells Hospital
The Board	Tayside NHS Board
CHI	Community Health Index for Scotland