Scottish Parliament Region: Glasgow

Case 200500511: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; General Medical

Overview

The complainant (Ms C) raised a number of concerns regarding the treatment and care her late father (Mr A) received at the Victoria Infirmary, Glasgow.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) inadequate supervision led to Mr A suffering a fall *(not upheld);*

(b) inappropriate action was taken following an infection outbreak *(not upheld);* and

(c) there was inadequate analgesia *(not upheld).*

Redress and recommendation

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 28 September 2005 the Ombudsman received a complaint from Ms C about the treatment and care provided to her late father, Mr A, at the Victoria Infirmary, Glasgow (the Hospital) from 3 May 2005 to 5 June 2005.

2. Ms C complained to Greater Glasgow and Clyde NHS Board (the Board) about the treatment and care her father had received and was dissatisfied with their response. Ms C then complained to the Ombudsman.

3. The complaints from Ms C which I have investigated are that:

(a) inadequate supervision led to Mr A suffering a fall;

(b) inappropriate action was taken following infection outbreak; and

(c) there was inadequate analgesia.

Investigation

4. In writing this report I have had access to documents supplied by Ms C; the Board's complaints correspondence and copies of Mr A's clinical records. I have obtained clinical advice from the Ombudsman's Professional Medical Adviser (Adviser 1) and Nursing Adviser (Adviser 2). 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 can be found at Annex 1. A glossary of terms used in this report is at Annex 2. Ms C and the Board were given an opportunity to comment on a draft of this report.

Medical background

5. Mr A was a 90 year old man with a history of heart disease who was admitted to the Hospital via the Accident & Emergency Department on 3 May 2005 with acute breathlessness and a productive cough that was occasionally bloodstained. On admission he was diagnosed with left ventricular failure and a possible chest infection. He was prescribed antibiotics and oxygen therapy and within a few days his symptoms had settled. On 5 May 2005 the plan was to transfer Mr A to another Unit for rehabilitation with the aim of a discharge home the following week. However, Mr A's son objected to the move as he believed Mr A would receive better medical and nursing care if he remained within the main hospital building.

Mr A was then transferred to Ward 12A. Mr A began to suffer from angina, breathlessness and abdominal pains with vomiting and diarrhoea. He had a fall on 20 May 2005 in which he bumped his forehead and became drowsy. As a result, a brain CT scan was ordered to exclude haemorrhage. This showed only old strokes. Mr A then underwent an abdominal CT scan which showed gallstones which probably accounted for abnormal liver function test results. Mr A's diarrhoea settled but he continued to have intermittent abdominal pain. A further surgical review was requested but Mr A was not considered suitable for gallstone surgery. Mr A continued to have abdominal pain which required regular pain relief. On 1 June 2005 Mr A's condition suddenly worsened with the onset of heart failure and a chest infection. Despite further treatment, Mr A deteriorated and sadly died on 5 June 2005.

(a) Inadequate supervision led to Mr A suffering a fall

6. Ms C complained to the Board that Mr A fell in the early hours of 20 May 2005 while going to the bathroom unaided and sustained a head injury. She did not think it was appropriate for an elderly person, who was severely weakened from not eating and drinking for several days, with a chest infection, angina and breathlessness, to be allowed to go to the bathroom unsupervised. The fall caused extensive bruising on the top of Mr A's head, down his face and a black eye. Ms C wanted explanations as to why the cot sides were not put up to prevent Mr A climbing out of bed; the circumstances which led to the fall; and the subsequent action which medical and nursing staff had taken. Ms C said Mr A had told her that he had cried out all night but no one came and she wondered how long he had been lying on the floor. She also wanted to know why the family had not been advised of Mr A's fall as she was only told when she telephoned the ward later that morning at 07:45.

7. The Board Chief Executive responded that Mr A's fall occurred at 00:30 on 20 May 2005. Staff had found Mr A on the cubicle floor after he had used the emergency buzzer. Mr A was alert and used the buzzer system as he fell whilst on the toilet. He had not been unconscious and had not been lying on the floor for any length of time. Within five minutes Mr A had been moved into the main ward and was reviewed by a doctor who was on the ward at the time. On examination Mr A was found to have some swelling above his right eye and a pressure bandage was applied. Mr A complained of abdominal pain at 06:30 and a doctor

was called again and analgesia was given to relieve the discomfort. Mr A was reviewed by medical staff four times that day including seeking a cardiology opinion and consultant review. Due to Mr A's severe bruising and slight drowsiness that day an urgent brain scan was carried out within an hour of the request. The CT scan did not show any evidence of trauma as a result of the fall.

8. The Chief Executive said that staff had reviewed Mr A and as he was stable it was felt there was no urgent requirement to contact the family in the early hours and, therefore, cause additional distress or undue worry. The ward sister decided to contact a family member when she came on duty later that morning but in the meantime Ms C had already telephoned the ward. A Falls Risk Assessment had been carried out and the indication was that Mr A was independently mobile and independent with his personal hygiene, therefore, it was not appropriate for cot sides to be in place. Although Mr A did not require supervision to attend the toilet, staff would still have waited outside it to afford him some privacy and the fall would still have occurred. An ECG which was carried out on 20 May 2005 showed that Mr A had a rapid irregular pulse. Later that day it was noted to be beating regularly. It was possible that Mr A had an intermittent irregularity of the heart. However, it was not possible to confirm whether or not that contributed to his fall. Blood tests taken on 19 May 2005 did not show that Mr A was suffering from dehydration.

9. Adviser 1 said that from the recorded evidence, Mr A actually fell in the toilet probably due to faintness or actual blackout as he was feeling ill with a virus. Mr A may have had a heart irregularity and his blood pressure may have dropped. Mr A pulled the emergency buzzer and was assessed and treated promptly. The drowsiness noted later could not be ignored although it could have been the effect of the virus and the doctor was absolutely justified in requesting a brain CT scan, which was carried out within one hour of the request. Adviser 1 could not fault the management of Mr A's fall including the decision not to telephone Ms C in the middle of the night but wait until the following morning. Adviser 1 concurred with the view that Mr A's fall had nothing to do with his subsequent deterioration or his death.

10. Adviser 1 explained that Clexane and Digoxin were prescribed by the consultant at the ward round on 20 May 2005 in response to Mr A's fast irregular

heart rate following his fall. This is routine treatment for this condition but Digoxin was only given for one dose as Mr A reverted to regular (sinus) rhythm later that day and on the advice of the cardiology department. Clexane was continued until 3 June 2005 in case Mr A went back to an irregular rhythm when it was discontinued because Mr A developed a chest infection.

11. Adviser 1 said that Mr A's final deterioration started out as a recurrence of his heart failure (signs in the chest, swollen ankles and increasing breathlessness). This was appropriately treated but he then developed signs of a chest infection as well and he was commenced on antibiotics. As is often the case in frail elderly people with co-morbidities, a chest infection, particularly when accompanied by lung congestion and prostration from heart failure, may be unresponsive to antibiotics and overwhelm the patient. Mr A had got over his diarrhoea but his gallstones and hernia, which were presumably causing much of the intermittent abdominal pain, had debilitated him to such an extent that he could not fight the supervening chest infection.

12. Adviser 1 said that none of the illnesses which befell Mr A were the result of poor care or inadequate treatment. The cause of his pain was difficult to sort out and the records demonstrate that staff regularly reviewed his condition and pain. There were clearly times when Mr A complained of pain to his family but this was not substantiated when staff asked him.

13. Adviser 2 said that nursing staff did a Falls Risk Assessment on Mr A and judged that he was at low risk. The nursing notes indicate that prior to the fall he was moving about independently, therefore, there was no cause for concern. Mr A was mobilising to the toilet when he fell in the cubicle and given that he had been mobilising independently to that point, Adviser 2 felt that there was no reason for staff to believe his level of risk had changed. Adviser 2 also thought that staff had responded immediately after the fall and took appropriate action by having Mr A assessed and treated. Adviser 2 could find no suggestion that Mr A required cot sides before his fall and this is borne out by the risk assessment. Adviser 2 also felt that in the circumstances it was reasonable for staff not to inform the family during the night.

(a) Conclusion

14. The advice which I have received and accept is that as Mr A was independently mobile there was no need for staff to supervise him attending the toilet. The Advisers have provided explanations for the probable cause of Mr A's fall. I have taken the view that staff could not have predicted that Mr A was going to suffer a fall and accordingly I do not uphold this complaint. Both advisers have confirmed that medical and nursing staff took appropriate action following Mr A's fall.

(b) Inappropriate action was taken following an infection outbreak

15. In her complaint to the Board Ms C said that there had been an outbreak of gastroenteritis on the ward and her father had contracted it. She wanted to know what preventative measures were in place to protect vulnerable patients and, although her father was quite ill with the debilitating effects of sickness and diarrhoea, why was he was not moved out of the side room.

16. The Chief Executive responded that there had been an outbreak of Norovirus in the ward during May 2005. The ward was closed to new admissions from 18 May 2005 to 26 May 2005. Routine precautions were taken which included restriction of staff movement between wards; cleaning was increased to twice daily; strict use of personal protective clothing and hand hygiene were reinforced; non-urgent investigations to other departments were postponed and discharges to other care home settings were cancelled. The actions which had been taken had been approved by the Public Health Department and the national agency, Health Protection Scotland.

17. The Chief Executive said that prior to Mr A's fall it was noted that he had vomited twice that day but this settled with anti-emetics. This was the first instance that Mr A had complained of loose stools and it was recorded that evening that he felt better and had no further diarrhoea and no breathlessness. Mr A's abdominal pain had been relieved by analgesia. Mr A was able to mobilise independently to the toilet and was deemed suitable for a side room at this time. If the ward sister or any of the staff had felt there was a risk to Mr A being in the side room then he would have been moved.

18. Adviser 1 said that Norovirus is a common problem in hospital wards and although measures such as the frequent use of hand cleansing gel for staff and visitors may reduce the incidence of infective diarrhoea, it is unlikely to eliminate it for good. The Hospital appeared to have carried out proper cross-infection protocol procedures and it was unfortunate that Mr A became infected. Mr A was appropriately treated with antibiotics and fluid supplements.

19. Adviser 2 said that she considered staff had taken correct action and that the Chief Executive's explanation was appropriate in regard to the outbreak of gastroenteritis. She was also satisfied that Mr A had received appropriate antibiotics and fluid replacement therapy during the period he had vomiting and diarrhoea.

(b) Conclusion

20. Taking into account the advice which I have received, I am satisfied that staff took appropriate action, based on recognised procedures, to prevent the spread of the Norovirus from the ward. Insofar as Mr A is concerned I am satisfied that he received appropriate treatment including antibiotics and fluid replacement therapy. Accordingly I do not uphold this complaint.

(c) There was inadequate analgesia

21. Ms C also complained that the treatment administered to Mr A on 4 June 2005 was inappropriate. It caused him untold discomfort and pain and he had difficulty breathing. Ms C also felt that staff took too long to arrange pain relief for Mr A and the family frequently found him crying out. Ms C said two days before his death Mr A had told her that he could not take much more of the pain.

22. The Chief Executive said that at times Mr A's notes indicate that he did have abdominal pain which was intermittent and pre-dated his fall. However, the pain got worse during his hospital stay. There is no reference in the notes to Mr A being distressed or in pain on 4 June 2005. His blood oxygen levels were good and he was receiving Oramorph for breathlessness and discomfort in breathing. It is documented in the notes that Mr A was given pain relief from 17 May 2005. Changes were made increasing the strength of pain relief on 18 May 2005, 23 May 2005, 27 May 2005 and 3 June 2005. Mr A's pain relief was controlled by analgesia and he was commenced on a pain chart which was used two hourly. All

analgesia administered is fully recorded and this was documented in Mr A's notes. He was also prescribed Morphine for his abdominal pain which was later withdrawn because it caused him drowsiness. Mr A also suffered from intermittent confusion which may have been distressing for his family to accept. There was an occasion when Mr A's son approached the ward sister to advise her that Mr A was in terrible pain but when she spoke to Mr A he denied being in pain.

23. Adviser 2 said that there is sufficient documentary evidence to show that Mr A was receiving adequate pain control and this was monitored and assessed frequently. Mr A was suffering abdominal pain and investigations were ongoing to attempt to establish the cause. Adviser 2 had no concerns that staff were not vigilant in their assessment and treatment of Mr A's pain.

(c) Conclusion

24. There is no doubt that Mr A complained of abdominal pain. The advice which I have received indicated that staff prescribed appropriate analgesia which was monitored and assessed on a frequent basis. I also note that Mr A suffered from intermittent confusion and, although he had told his family he was in pain, he denied this to nursing staff. I recognise that Ms C was concerned that Mr A was not receiving adequate analgesia and staff took too long to administer analgesia. I am persuaded that the clinical records indicate that staff prescribed appropriate analgesia and kept the matter under review. Accordingly I do not uphold this complaint.

25. I appreciate that Ms C may not be content with the outcome of this investigation. However, I hope she will be reassured that Mr A's treatment and care have been independently investigated with the support of two medical advisers who consider that he received appropriate treatment.

28 November 2006

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mr A	The complainant's father
The Board	Greater Glasgow and Clyde NHS Board
The Hospital	The Victoria Infirmary, Glasgow
The Chief Executive	The Board's Chief Executive
Adviser 1	Ombudsman's medical adviser
Adviser 2	Ombudsman's nursing adviser

Annex 2

Glossary of terms

Clexane	A drug to thin the blood
CT Scan	Computed Tomography – Computerised X-Ray of internal body images
Digoxin	A drug to combat heartbeat irregularities
ECG	Electrocardiogram – test to measure heart activity
Norovirus	Virus which can cause nausea, sickness and diarrhoea in humans
Oramorph	A drug containing Morphine
Ventricular failure	Heart failure