Scottish Parliament Region: Glasgow

Case 200503089: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Clinical treatment

Overview

The complainant raised a number of concerns about the care and treatment that her mother received in Vale of Leven hospital (Hospital 1) prior to her death.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) medical and nursing staff were not able to tell Mrs C what was wrong with her mother and did not seem to recognise that her condition was deteriorating rapidly *(partially upheld*);

(b) it was inappropriate to prescribe five antibiotics (*not upheld*);

(c) it was inappropriate to use a catheter when her mother had a urine infection (*not upheld*); and

(d) it was inappropriate to perform a CT scan because her mother was too ill, and that no account was taken of the fact that her mother was claustrophobic culminating in her having a panic attack *(not upheld).*

Redress and recommendations

The Ombudsman recommends that the Board emphasise to staff the importance of communicating with relatives and of keeping an appropriate note of what was said.

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

Main Investigation Report

Introduction

1. On 10 February 2006, the Ombudsman received a complaint from Mrs C about the care and treatment that her mother (Mrs A) received in Vale of Leven hospital (Hospital 1) before her death on 13 June 2005.

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

(a) medical and nursing staff were not able to tell Mrs C what was wrong with her mother and did not seem to recognise that her condition was deteriorating rapidly;

(b) it was inappropriate to prescribe five antibiotics;

(c) it was inappropriate to use a catheter when her mother had a urine infection; and

(d) it was inappropriate to perform a CT scan because her mother was too ill, and that no account was taken of the fact that her mother was claustrophobic culminating in her having a panic attack.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Mrs C and Greater Glasgow and Clyde NHS Board (the Board). I have had sight of the appropriate medical records and the Board's complaint file. I have also received advice from the Ombudsman's medical adviser (the Adviser). On 25 September 2006 a written enquiry was made of the Board and their responses were dated 30 September and 20 November 2006.

4. Although I have not included in this report every detail investigated, 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) Medical and nursing staff were not able to tell Mrs C what was wrong with her mother and did not seem to recognise that her condition was deteriorating rapidly

5. Mrs C said that on 16 May 2005 her mother, who was 74, was admitted to hospital. She said Mrs A had a chest complaint and was suffering from extreme lethargy and dizzy turns. She complained that although after admission Mrs A's condition appeared to decline rapidly, staff did not recognise this and were

unable to say what was wrong. She said that Mrs A became very swollen but she was told there was nothing to worry about.

6. Mrs A's medical notes indicated that in the 1950s she had suffered from tuberculosis and that this left her with a predisposition to infection. Over the years Mrs A's GP had frequently treated her for chest infections and she was receiving treatment for chronic atrial fibrillation (irregular heart beat) and heart failure (breathlessness and swollen legs). She was prescribed warfarin (to prevent blood clotting due to heart irregularity leading to a possible stroke). On 16 May 2005 Mrs A was admitted from home to Hospital 1 with recent symptoms of confusion and dizziness, coughing greenish phlegm, poor mobility and frequent falls. In addition, her regular blood tests showed over-warfarinisation (while a target level on an international scoring scale of 2.5 to 3.5 was aimed for, the reading for Mrs A was 9.6).

7. On admission, Mrs A was examined and found to have a slightly raised temperature and a chest x-ray taken showed more marked shadowing in both her lungs than had been present at an earlier x-ray, 11 days before. The records showed that a diagnosis of 'severe bilateral pneumonia' was made and Mrs A was given oxygen and two antibiotics (intra-venous augmentin and oral clarithromycin). Although warfarin had already been stopped by the GP, a warfarin antidote (vitamin K) was given.

8. By 19 May 2005, the notes indicated that Mrs A's condition had deteriorated and that within a 24 hour period her white cell count had risen from 27,700 to 49,800. Accordingly, the antibiotic augmentin was changed to cefotaxime. On 25 May 2005, her antibiotics were changed again. Mrs A's condition continued to worsen and by now she had a fungal lung infection. Then, on 28 May 2005, it was noted again that there had been an inadequate response to the antibiotics prescribed and that she had begun to develop heart failure. The records noted that Mrs A's daughter was contacted, although what was said was not recorded.

9. Early in the morning of 29 May 2005 the Senior House Officer was called to see Mrs A because she was very breathless and had more swollen limbs. Her blood tests showed some renal impairment and a suggestion of liver congestion resulting from heart failure. It was noted that Mrs A's daughter was contacted and after a naso–gastric tube was inserted for feeding, Mrs A's family was told of her poor prognosis. The notes showed that because of respiratory

and renal failure, and because Mrs A had a fungal lung infection and her circulation was worsening, Mrs A was transferred to the Hospital 1's intensive care unit (ICU) on 29 May 2005. The next day, Mrs A was transferred to the ICU at another hospital. Unfortunately, her condition never improved and she died on 13 June 2005. In commenting on the draft of this report Mrs C said her reading of it was the first full indication of all the problems affecting her mother. She maintained that during her mother's stay in hospital no one had taken the time to discuss Mrs A's declining condition with her.

(a) Conclusion

10. Mrs C complained that staff were unable to tell her what was wrong with her mother and did not seem to re-act to the fact that she was deteriorating badly. Paragraphs 5 to 9 above show that Mrs A's medical records noted her changing condition and the symptoms from which she was suffering. Similarly, the changes in her treatment and the drugs that were prescribed to her were recorded. I have asked the Adviser specifically about this and he is satisfied that the medical notes are of a satisfactory standard. He said that the nursing notes on the whole were of a high standard and that doctors made appropriate attempts to make diagnoses with the most appropriate investigations. He said they instituted reasonable treatments. It was his opinion that staff knew and recorded Mrs A's condition. In so far as this aspect of this complaint is concerned, I have to be guided by the Adviser. He is satisfied that staff were aware of Mrs A's condition.

11. However, Mrs C also said that staff were unable to tell her what was wrong with her mother and given my conclusion above (paragraph 10) this appeared to indicate communication issues. The medical records indicated that Mrs A's daughter was contacted on 28 May 2005 and her daughter and her family were contacted on 29 May 2005 (paragraphs 8 and 9). However, the notes do not record what was said.

12. In their response to me of 20 November 2006, the Board advised that another of Mrs A's daughters (not Mrs C) was a staff nurse at Hospital 1 and the consultant involved in Mrs A's care maintained that, from the outset, he kept this daughter informed of her mother's progress twice a week. (Although the notes did not record this.) Internal correspondence from the consultant, dated 4 October 2005 and on the Board's complaint file, said that he explained to Mrs A's other daughter that her mother's condition was serious because of the extent of lung damage from her previous tuberculosis, and the complicating

pneumonia. The consultant expected this daughter to tell the rest of the family, but, on Mrs A's death, he learned that this had not been the case. He made the point, however, that Mrs C had never asked to see him to discuss her mother's condition so, he had been unaware that she was concerned. In her comments on the draft of this report, Mrs C maintained that she had arranged an appointment with a doctor, who gave her very little information, while I do not doubt Mrs C's recollection, I have been unable to trace any record of this.

13. It is my view that the consultant should have noted that he had spoken regularly to Mrs A's daughters (whichever one) and he did not do so. Also, the content of the telephone calls of 28 and 29 May 2005 (paragraphs 8 and 9) went unrecorded. Therefore, I must record this as a procedural failure and partially uphold this aspect of the complaint. However, I also note that Mrs C never requested to speak with the consultant (although she said she spoke to someone) as she could have and in the circumstances, I think it was reasonable for the consultant to believe that the daughter he spoke to would have passed on the information. He had no reason to presume otherwise. I make no criticism of the fact that the consultant did not seek out Mrs C to speak to her.

(a) Recommendation

14. The Ombudsman recommends that the Board emphasise to staff the importance of communicating with relatives and of keeping an appropriate note of what was said.

(b) It was inappropriate to prescribe five antibiotics

15. While she was in hospital, Mrs A was prescribed five antibiotics (augmentin, clarithromycin, cefotaxime, ceftazidine, and tazocin) and two antifungal agents (nystatin, for oral thrush and itraconazole, for the fungal chest infection). Mrs C believes that this should not have been allowed.

16. In their response to me dated 20 November 2006, with regard to this specific complaint, the Board gave detailed information about the antibiotics prescribed to Mrs A and the reasons why these were changed (to reflect her changing and deteriorating medical condition). It was the consultant's view that he could see no problem with the change in antibiotics as staff were acting in the best interest of the patient.

(b) Conclusion

17. I have sought advice about this and the Adviser was satisfied that the Board gave very reasonable explanations for the changes in the antibiotics given to Mrs A. It was his view that the antibiotic therapy offered was appropriate to each stage of Mrs A's clinical progress. In clinical matters, I am guided by the Adviser and, therefore, I do not uphold this aspect of the complaint.

(c) It was inappropriate to use a catheter when her mother had a urine infection

18. Mrs C said that her mother's body was swollen badly and although the staff thought she had a urine infection, a catheter was inserted. The complainant said that she voiced her concerns only to be told there was nothing to worry about.

19. With regard to this aspect of the complaint, the Board said that because of Mrs A's deteriorating condition it was necessary to monitor her urine output, particularly as her renal function was deteriorating further. Nevertheless, Mrs C remained unhappy with this explanation and I hope she will be reassured by the Adviser's opinion that the insertion of a catheter was appropriate in that Mrs A's circulation, heart and kidney function needed to be closely monitored and her urine output had to be accurately measured. He took the view that this would have been the case whether Mrs A had a urine infection or not. As it turned out, Mrs A did not have a urine infection.

(c) Conclusion

20. I do not uphold this aspect of the complaint but, would point out to the Board that, on occasion, it is perhaps necessary for staff to give the fullest possible advice and information. Given Mrs A's declining condition and her poor prognosis, Mrs C would already have been worried and she would have been concerned to avoid any situation that would have exacerbated Mrs A's already poor condition. An explanation of the need for a catheter may have gone some way to alleviate her fears.

(d) It was inappropriate to perform a CT scan because her mother was too ill, and that no account was taken of the fact that her mother was claustrophobic culminating in her having a panic attack

21. Mrs C said that latterly Mrs A was sent for a CT scan and that this was the 'worse case scenario', because she had suffered a panic attack when sent for

one on a previous occasion. At that time, the doctor concerned decided against the scan, being concerned for Mrs A's health.

22. In a letter dated 12 January 2006, addressed to Mrs C, amongst other things, the Board said that Mrs A was given an emergency CT scan as medical staff were querying the possibility of Mrs A having Aspergillosis, a fungal infection of the lungs. The medical records noted that this was carried out on 27 May 2005. The Board's response to my enquiry of 20 November 2006 gave further detail in that it said that the consultant felt that the CT scan would give more clarification of Mrs A's condition and exclude other possible diagnoses as she had not been responding to antibiotic treatment up to that point. Furthermore, they said Mrs A was being considered for ventilation and a CT scan of the chest was an important investigation. The consultant indicated that he was not aware that Mrs A suffered from claustrophobia and he had not been told this by any family member. He confirmed that it would have been usual practice for the x-ray department to give sedation to an anxious patient.

(d) Conclusion

23. The Adviser confirmed that a CT scan was the best way to determine whether Mrs A was suffering from a fungal growth in her chest and he accepted the explanation offered by the Board. However, I note that Mrs C was concerned that her mother's condition may have been so poor that she could not have made it known to staff that she was claustrophobic. Mrs C thought that her mother could have been very distressed as a consequence and she believed that she may have been shocked and suffered a panic attack.

24. It does not seem that Mrs A suffered an adverse reaction to the scan as the records do not mention there having been a problem. While Mrs C has suspicions, they cannot be confirmed. However, in the light of her concerns, the Adviser commented that in reviewing Mrs A's case notes, her condition had deteriorated because of her failing heart, poor lung function and sepsis and not because of any panic she may have experienced. He confirmed that it would have been normal practice to give anxious patients a mild sedative before receiving a CT scan but that the notes did not show any evidence that this was required in Mrs A's case.

25. Taking the foregoing into account (paragraphs 21 to 24) I do not uphold Mrs C's contention that in the circumstances, it was inappropriate to give her mother a CT scan. However, on a general point, I consider that it would have

been helpful to Mrs C if the letter of 12 January 2006 (paragraph 22) which was sent to her had gone into the same detail as was available in the medical notes and as was given to me in the Board's formal reply of 20 November 2006. The availability of more detailed information at an earlier stage in Mrs C's complaint may have negated the need for a complaint to the Ombudsman.

26. Finally, while I have not upheld complaints (b) to (d), the Ombudsman's recommendation with regard to communication may also be relevant.

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

27 March 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mrs A	Mrs C's mother
The Board	Greater Glasgow and Clyde NHS Board
CT scan	Computerised tomography scan
The Adviser	The Ombudsman's medical adviser
Hospital 1	Vale of Leven Hospital
ICU	Intensive Care Unit