Scottish Parliament Region: Central Scotland

Case 200503208: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; Nursing care

Overview

The complainant (Miss C) raised a number of concerns about the nursing care which her grandmother (Mrs A) received in Wishaw General Hospital (the Hospital), the nursing staff's management of her grandmother's diabetes, the communication between nursing staff and the Hospital Emergency Care Team (HECT), the communication between nursing staff and the family, the fact that information was missing from her grandmother's medical records and the fact that the wrong cause of death was recorded on her grandmother's death certificate.

The Board carried out an investigation into Mrs A's care and devised an action plan to remedy most of their failings, for which I commend them. I have, however, upheld all of Miss C's complaints principally because the Board did not apologise to Mrs A's family for any of their failings. An appropriate apology is an important part of remedying a failing and I am disappointed that the Board did not apologise despite recognising that aspects of Mrs A's care had been inadequate.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) nursing staff's communication with Miss C and her family about Mrs A's health was inadequate *(upheld to the extent that no apology was given);*

(b) erroneous information was given to Miss C and her family about the cause of Mrs A's death and, additionally, that the wrong cause of death was recorded on Mrs A's death certificate *(upheld);*

(c) nursing care and conduct were inadequate *(upheld to the extent that no apology was given)*;

(d) nursing staff failed to adequately manage Mrs A's diabetes *(upheld to the extent that no apology was given)*;

(e) nursing staff's communication with the HECT did not convey the urgency of Mrs A's situation *(upheld)*; and

(f) information was missing from medical records *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) issue an apology to Mrs A's family for staff's failure to adequately explain Mrs A's medical condition to them;

(ii) apologise to Mrs A's family for the distress and inconvenience caused by the fact that they recorded the wrong cause of death on Mrs A's death certificate;

(iii) take steps to ensure that the correct cause of death is recorded on a patient's death certificate;

(iv) issue an apology to Mrs A's family for the poor standard of nursing care received by Mrs A in the Hospital;

(v) apologise to Mrs A's family for their failure to adequately manage Mrs A's diabetes;

(vi) apologise to Mrs A's family for nursing staff's failure to convey the urgency of Mrs A's condition to HECT;

(vii) issue an apology to Mrs A's family for their failure to record all of the necessary information in Mrs A's medical records;

(viii) remind relevant staff of the importance of recording important patient data accurately; and

(ix) consider how best to improve communication between healthcare professionals, especially via the telephone.

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

Main Investigation Report

Introduction

1. On 20 February 2006 the Ombudsman received a complaint from a woman, referred to in this report as Miss C, about the nursing care received by her grandmother (Mrs A) whilst a patient in Wishaw General Hospital (the Hospital). Mrs A's daughter (Mrs B) first complained to Lanarkshire NHS Board (the Board) on 16 August 2005 She received a reply on 16 September 2005. A meeting was arranged with the General Manager of the Hospital (the General Manager) on 25 October 2005. Further correspondence took place between the Board and Mrs B in which the General Manager informed Mrs B that an action plan had been put into place to remedy the failures identified. Miss C contacted the Ombudsman as she was not satisfied with the response Mrs B had received to her complaint.

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

(a) nursing staff's communication with Miss C and her family about Mrs A's health was inadequate;

(b) erroneous information was given to Miss C and her family about the cause of Mrs A's death and, additionally, that the wrong cause of death was recorded on Mrs A's death certificate;

(c) nursing care and conduct were inadequate;

(d) nursing staff failed to adequately manage Mrs A's diabetes;

(e) nursing staff's communication with the Hospital Emergency Care Team (HECT) did not convey the urgency of Mrs A's situation; and

(f) information was missing from Mrs A's medical records.

Investigation

3. This investigation is based upon correspondence between Mrs B and the Board, the Board's complaint file on this matter which includes minutes of the meeting held, statements from staff involved and details of the investigation carried out into the complaint. I have also obtained advice from a clinical adviser. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Miss C and the Board were given an opportunity to comment on a draft of this report.

(a) Nursing staff's communication with Miss C and her family about Mrs A's health was inadequate

4. Mrs A was admitted to the Hospital in July 2005 because 'her heart kept racing and she felt poorly'. Miss C and her family visited regularly. Miss C has told me that whenever she or other family members asked the nurses about what was wrong with Mrs A, they were always told that she was fine. Mrs A died in August 2005. Miss C has told me that Mrs A's condition was not explained to her family before she died. However, following her death, they found out that Mrs A had been suffering from pneumonia and bi-ventricular cardiac failure.

5. There is some evidence in Mrs A's medical records that nurses and doctors spoke to the family on a few occasions but this appears to have related to Mrs A's day-to-day care rather than her diagnosis. There is no evidence that the family were informed about Mrs A's pneumonia and cardiac failure. Miss C stated that she and her family had never been told this and had been told that the cause for Mrs A's heart racing was unknown and could be down to a number of things.

6. During the meeting on 25 October 2005, the General Manager said that any failure in communication 'was unacceptable and that staff should have given the family their full attention'. She also said 'that the quality of service could have been improved, in particular, communication with nursing staff' and that 'it is part of medical and nursing responsibility to update relatives'.

7. One of the points of action which arose from the investigation into this complaint was that all staff on the ward were informed that relatives are to be approached at visiting times and updated regarding their relatives' care. The Acting Ward Manager (the Ward Manager) was responsible for implementing this. The Board have informed me that they have taken steps to ensure that nursing documentation is routinely audited and have sent me a copy of a communication sheet which is used to assess the adequacy of nursing staff's communication with patients and their families.

(a) Conclusion

8. The Board have accepted that the standard of communication between nursing staff and Mrs A and her family was generally poor. It is obvious that the family were concerned about Mrs A. I believe that the family were not told exactly what was wrong with Mrs A despite asking. A member of staff, either a

doctor or a nurse, should have been proactive in ensuring that the family fully understood all of Mrs A's health problems. The family were informed in a letter on 12 December 2005 from the General Manager that the issues had been fully investigated and that the issue of good communication had been addressed with the ward staff.

9. I commend the Board for reminding nursing staff that relatives should be updated regarding their relatives' care. As indicated previously, apology is an important part of remedy. The Board did not apologise to Mrs A's family for the failure in communication. I, therefore, uphold this complaint to the extent that no apology was given.

(a) Recommendation

10. The Ombudsman recommends that the Board should issue an apology to Mrs A's family for staff's failure to adequately explain Mrs A's medical condition to them. Although there is no evidence that similar problems are occurring elsewhere in the Hospital, the Ombudsman suggests that Board should consider what steps it can take to ensure that standards of communication in other wards in the Hospital are up to standard.

(b) Erroneous information was given to Miss C and her family about the cause of Mrs A's death and, additionally, the wrong cause of death was recorded on Mrs A's death certificate

11. Mrs A's death certificate stated that her cause of death was a stroke. This was a mistake and the family had to return to the hospital to have this changed.

12. During the meeting, the Associate Medical Director stated that hypoglycaemia can give signs of a stroke but that a scan had shown no evidence of this. He went on to say that this should never have been written on the death certificate but he was unable to respond to why this had been done.

(b) Conclusion

13. The Associate Medical Director has accepted that the wrong cause of death was recorded on the death certificate. A provisional cause of death should have been given and then adjusted when further evidence as to the cause of death became available. The Board has not apologised to Mrs A's family for this error. I, therefore, uphold this complaint.

(b) Recommendation

14. The Board has not addressed this point in their action plan. The Ombudsman recommends that the Board take steps to ensure that this does not recur. She also recommends that they apologise to Mrs A's family for the distress and inconvenience caused by this error.

(c) Nursing care and conduct were inadequate

15. Miss C raised several concerns about the nursing care received by Mrs A. She stated that staff failed to attend when Mrs A buzzed for attention, that she was not always given the attention that she required, that certain members of staff were rude and that Mrs A's nightwear was not changed when it was dirty. When asked to comment on a draft of this report, Miss C also stated that staff were not on hand when needed and were not approachable and that she found this unacceptable.

16. The Board's action plan includes several action points relating to nursing care. In a letter on 12 December 2005, the family were informed that the Ward Manager had formally met with the ward staff to discuss care management, to try and ensure that these types of incidents do not arise again. They were also told that the Ward Manager had put in place a system to monitor the staff and correct any deficiency in care timeously.

17. The Board was unable to conclude on Miss C's complaint about incidents of staff rudeness. I have similarly been unable to conclude on this aspect of the complaint as I have not been able to obtain any independent evidence. Nonetheless, the General Manager apologised in her letter of 16 September 2005 to Mrs B for any inappropriate comments made by staff and the Ombudsman commends the Board for this. Although I have been unable to conclude on the incidents of staff rudeness, the Ombudsman's nursing adviser has stated that the Nursing and Midwifery Council Code for Professional Conduct states that 'you are personally accountable for ensuring that you promote the interests and dignity of patients and clients'. This aspect of the Code cannot be met if patients are treated by a nurse in a way that makes them feel vulnerable by the attitude or behaviour towards them. Opportunity should be taken at training sessions to reinforce this responsibility.

(c) Conclusion

18. The fact that the Board has several action points on this matter indicates that they accept that aspects of the complaint about nursing care have

foundation. Although I commend the Board for devising an action plan for the ward, I do not think this goes far enough to resolve this matter because the Board have not apologised to Mrs A's family. I, therefore, uphold this complaint to the extent that no apology was given.

(c) Recommendation

19. The Ombudsman recommends that the Board should apologise to Mrs A's family for the poor standard of nursing care received by Mrs A in the Hospital. Although there is no evidence that similar problems are occurring elsewhere in the Hospital, the Ombudsman suggests that the Board should consider what steps it can take to ensure that similar issues with nursing care are not arising in other wards within the Hospital.

(d) Nursing staff failed to adequately manage Mrs A's diabetes

20. Mrs A had non-insulin dependent diabetes. Miss C complained that nursing staff did not ensure that Mrs A ate regularly so as to ensure that her blood sugar levels did not drop. She also complained that when Mrs A became hypoglycaemic on 14 August 2005, she should have been given a complex carbohydrate as well as Dextrose. Because this was not done, Mrs A became hypoglycaemic again two hours later.

21. In her reply to Mrs B on 16 September 2005, the General Manager accepted that Mrs A should have been given a complex carbohydrate or been commenced on a Dextrose infusion to prevent recurrence of hypoglycaemia.

22. The Consultant Physician (Consultant 1) who was in charge of Mrs A's ward was asked to perform a review of the management of Mrs A's diabetes.

23. Consultant 1 states that it was fairly predictable that Mrs A would develop hypoglycaemia as she had Human Mixtard treatment at 17:00. Her initial two hypoglycaemic episodes were treated with intravenous Dextrose and one with Lucozade. There is no documentation that Mrs A was given any complex carbohydrate in order to prevent further hypoglycaemia and this would have been the appropriate action. The subsequent commencement of 5% and then 10% Dextrose intravenous infusion in the High Dependency Unit (HDU) was the appropriate care and was found to be effective. Consultant 1 is unable to conclude on whether Mrs A's treatment with Lucozade was the appropriate action due to a lack of documentation in Mrs A's notes. Consultant 1 states that if Mrs A was in a fit state to be treated orally for hypoglycaemia, he has no

doubts that more complex carbohydrates should also have been given.

24. Consultant 1 states that it would be unusual for Mrs A's neurological deficit at 11:15 to be related to hypoglycaemia at a level of 3.9mmols and that it could be linked to one of Mrs A's other health problems. He also states that he is of the opinion that Mrs A's hypoglycaemia was treated ineffectively because refined bolus Dextrose was the sole treatment and no complex carbohydrate being given.

25. The Board have advised me that, as a result of this complaint, they have produced a set of protocols for the management of hypoglycaemic patients. Junior Doctors are made aware of these protocols as part of their induction programme. These protocols have been reviewed by a Clinical Adviser who stated that these protocols are acceptable and should prevent the recurrence of the problems which arose in this complaint. The Board did not apologise for their failure to adequately manage Mrs A's diabetes.

(d) Conclusion

26. Consultant 1 stated that Mrs A's hypoglycaemia was treated ineffectively. As a result of this complaint, the Board have produced a set of protocols for the management of hypoglycaemic patients, however, they have not apologised to Mrs A's family. For this reason, I do not think this action goes far enough to remedy this failure. I, therefore, uphold this part of the complaint to the extent that no apology was given.

(d) Recommendation

27. The Ombudsman recommends that the Board apologise to Miss C for their failure to adequately manage Mrs A's diabetes.

(e) Nursing staff's communication with the HECT did not convey the urgency of Mrs A's situation

28. The HECT Nurse's account of events is that, at approximately 21:45 on 14 August 2005, a Nurse (Nurse 1) called HECT to say that Mrs A's blood sugar level had dropped. HECT advised that Mrs A should be given a sugary drink and that Nurse 1 should check blood sugar levels again after this and call HECT again if Mrs A didn't improve or if Nurse 1 had any further concerns about the patient.

29. At approximately 22:30 Nurse 1 called again as Mrs A had become less

responsive, had developed a facial droop and her blood sugar level had fallen again. At this stage HECT stated that they would be there as soon as possible. They were, however, engaged with a patient in another ward and attended Mrs A as soon as they were finished. A cardiac arrest call was put out before HECT attended. HECT then assisted in transferring Mrs A to the HDU.

30. Miss C informed me that Mrs A stopped breathing before the first call was made to HECT. She stated that her Cousin had to shake Mrs A in order to make her start breathing again. She has also told me that Mrs A stopped breathing on another two occasions before respiratory arrest was diagnosed. She told me that it was only at this stage that a Doctor attended. The first three instances of respiratory arrest which Miss C related to me were not recorded in Mrs A's medical records. The failure to record information in Mrs A's medical records is addressed under heading (f), below.

31. Mrs A's notes were reviewed by a Clinical Adviser. She stated that Mrs A did progress following each intervention to improve her hypoglycaemia. It would, however, appear that each episode was treated as an individual occurrence rather than part of a bigger picture. If the incidents had been evaluated in light of Mrs A's condition throughout the evening then this would perhaps have injected a greater sense of urgency into the conversations between Nurse 1 and HECT. Miss C told me that she believed Nurse 1 was unable to fully explain Mrs A's situation as she had not been present when many of the problems occurred and cited this as a further example of the fact that nursing staff were not available when needed.

32. In their reply to Mrs B's complaint, the Board stated that the delays in the medical review of Mrs A were totally unacceptable. They explained that the HECT team prioritises patients based on the information which they receive and that it would appear that the information relayed about Mrs A might not have conveyed the degree of urgency required.

(e) Conclusion

33. The Board have acknowledged that nursing staff's communication with HECT did not convey the urgency of Mrs A's situation. They have not, however, apologised for this failure and have not included any points in their action plan which would remedy this. I, therefore, uphold this part of the complaint.

(e) Recommendation

34. The Ombudsman recommends that the Board apologise to Miss C and her family for nursing staff's failure to convey the urgency of Mrs A's condition to HECT. Additionally, the Board should consider how best to improve communication on clinical matters between health professionals, especially via telephone.

(f) Information was missing from Mrs A's medical records

35. Miss C has informed me that Mrs A had stopped breathing before the first call was made to HECT. Miss C stated that her Cousin had to shake Mrs A in order to make her start breathing again. She has also told me that Mrs A stopped breathing on another two occasions before respiratory arrest was diagnosed. This information is not recorded in Mrs A's medical records. Miss C has told me that the information was not recorded because there were no nursing staff available when this incident occurred.

36. The statements from the nurses involved do not refer to any unrecorded instances when Mrs A stopped breathing. They do, however, state that the ward was very busy that evening due to a number of patients requiring attention.

37. Consultant 1's analysis of Mrs A's care makes several references to inadequate documentation of Mrs A's conscious level the first time the HECT team were called.

(f) Conclusion

38. There is no further evidence to confirm or deny that Mrs A stopped breathing on three occasions, so I cannot conclude on whether or not this information was not recorded. However, Consultant 1 has stated that there is no documentation present in either Mrs A's medical or nursing notes of her conscious level at 21:45 when HECT were first called. I, therefore, uphold this complaint.

(f) Recommendations

39. The Ombudsman recommends that the Board apologise to Miss C for their failure to record all of the necessary information in Mrs A's medical records. Furthermore, relevant staff should be reminded of the importance of recording appropriate patient data accurately.

27 March 2007

Annex 1

Explanation of abbreviations used

Miss C	The complainant
Mrs A	Miss C's grandmother
The General Manager	The General Manager of the Hospital
Mrs B	Mrs A's daughter
The Board	Lanarkshire NHS Board
HECT	Hospital Emergency Care Team
Consultant 1	The Consultant physician in charge of Mrs A's ward
HDU	High Dependency Unit
Nurse 1	A nurse in Mrs A's ward
The Hospital	Wishaw General Hospital

Annex 2

Glossary of terms

Bolus	A single dose of drug usually injected into a blood vessel over a short period of time
Cardiac Arrest (failure)	When the heart stops beating
Complex Carbohydrates	Include starches and fibres and provide more nutrients than simple carbohydrates (sugars)
Dextrose	A commonly used name for glucose (sugar) solutions given intravenously
Human Mixtard	At type of insulin. Insulin is the main hormone responsible for the control of sugar in the blood
Hypoglycaemia	Blood sugar levels less than the lower value of normal. The normal range is 3.9 – 6.1 mmol/L
Lucozade	An energy drink which contains a quick acting carbohydrate which may be used to treat hypoglycaemia
Respiratory Arrest	Cessation of Breathing