Scottish Parliament Region: Glasgow

Case 200503649: Greater Glasgow and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C) raised a number of concerns about the treatment her late husband (Mr C) received at the Royal Alexandra Hospital, Paisley (Hospital 1) from 1 August 2005 to 15 October 2005. She had concerns about his clinical treatment; lack of communication between medical and surgical staff and the family and inadequate complaints handling.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C' s clinical treatment was inadequate *(not upheld)*;

(b) medical staff failed to communicate between specialities and with the family *(partially upheld)*; and

(c) there was inadequate complaints handling *(partially upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) remind staff of the importance of communication with family members;

(ii) conduct an audit to ensure that responses to complaints are within NHS Complaints Procedure Guidelines; and

(iii) conduct an investigation into the circumstances which led to a letter being issued to Mr C nearly three months after his death enquiring whether he wished to remain on the waiting list for orthopaedic surgery and offer a sincere apology to Mrs C for the distress which was caused. On this point

[1] On 1 April 2006 the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by Argyll and Clyde Health Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of Argyll and Clyde Health Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to Greater Glasgow and Clyde Health Board as its successor.

she would also draw to the Board's attention to recommendation (ii) of report 200502722 published in September 2006.

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

Main Investigation Report

Introduction

1. On 27 March 2006 the Ombudsman received a complaint from Mrs C about the treatment her late husband (Mr C) received at the Royal Alexandra Hospital, Paisley (Hospital 1) from 1 August 2005 to 15 October 2005. Mrs C complained that there was a lack of communication between hospital departments about Mr C's clinical treatment; delays in carrying out tests; and inadequate complaints handling. Mrs C complained to Greater Glasgow and Clyde NHS Board (the Board) but remained dissatisfied with their responses and subsequently complained to the Ombudsman.

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

(a) Mr C' s clinical treatment was inadequate;

(b) medical staff failed to communicate between specialties and with the family; and

(c) there was inadequate complaints handling.

Investigation

3. In writing this report I have had access to Mr C's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional medical advisers (the Adviser) regarding the clinical aspects of the complaint.

4. 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 is contained in Annex 1. A glossary of the medical terms used in this report can be found at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Clinical background

5. According to Mr C's clinical records he was a 75-year old man with a complex past medical history when he was admitted to Hospital 1 for an elective right hip replacement which took place on 2 August 2005. He had suffered from ischaemic heart and heart valve disease, type ll diabetes and high blood pressure. He had undergone decompression surgery to his neck and surgery for a compound fracture of his right humerus. After the operation he was initially treated in the orthopaedic ward and then transferred to the High Dependency Unit (HDU). Post-operatively he was found to be very anaemic

and had suffered a heart attack which was confirmed by raised cardiac enzymes. Although the matter was investigated and treatment commenced, after a week Mr C was found to have a low mood, was drowsy and rather confused. It was suspected that he may have suffered a stroke (CVA). A CT scan of the brain was reported as normal. Mr C received intravenous antibiotics for pneumonia but he also had decreasing kidney function. Blood cultures revealed he had Staphylococcus septicaemia with the possibility of endocarditis. He was transferred to Ward 8 on 28 August 2005. Mr C dislocated his right hip on 4 September 2005 and after some delay because of concern about his chest he underwent manipulation under anaesthetic on 9 September 2005 and seemed to improve. An echocardiogram showed no expected abnormality which might have indicated endocarditis. There was then an unsuccessful attempt to drain the fluid which had collected in Mr C's chest. Mr C developed pressure sores on his heels and toes and his diabetes was difficult to control but his general condition had improved. Mr C also spent time in an orthopaedic ward and then was transferred to another hospital, (Hospital 2) for rehabilitation on 29 September 2005.

6. Mr C was on medication for a presumed urine infection although both urine and blood tests proved negative. Mr C's hip then re-dislocated and he was noted to have poor kidney function, intermittent fever, low blood pressure and a fast heart rate which indicated he was suffering from another bout of sepsis. Antibiotic medication was commenced and Mr C was transferred back to Hospital 1 where he sadly died on 15 October 2005.

(a) Mr C's clinical treatment was inadequate and (b) Medical staff failed to communicate between specialities and with the family

7. Mrs C complained to the Board on 30 November 2005 that there appeared to have been a lack of communication between medical staff from different departments and towards the family. She felt that Mr C could almost have been treated by two different organisations rather than two departments within the same hospital. She said the doctors who the family spoke to seemed defensive except for a doctor at Hospital 2 who was honest enough to tell them that rehabilitation with an unstable hip and a brace was unlikely. Mrs C noted the death certificate showed the cause of death as congestive cardiac failure, mitral stenonis and myocardial infarction which she considered did not explain what had happened to Mr C during Hospital 1 admission. She felt that even though Mr C had medical problems prior to the admission the outcome should have been successful.

8. Mrs C had kept a diary of Mr C's admission to Hospital 1 and she noted that an echocardiogram was first considered on 4 August 2005 yet it was not performed until 11 August 2005. During that period Mr C had become confused; was hallucinating; and was not responsive. She complained that medical staff failed to explain what was happening to the family. Mrs C said the ward sister told her on 14 August 2005 that if Mr C was not more conscious by the following day then doctors would arrange a CT scan. Mr C became more distressed and on 15 August 2005 a doctor agreed to speak to her for a few minutes and said that they would conduct a CT scan but it would be later in the week. The CT scan was performed on 19 August 2005. Mr C continued to hallucinate and Mrs C felt it was like a roller coaster with little improvements then setbacks but no explanations why Mr C was becoming unresponsive. Mrs C had difficulty in establishing who had overall charge of Mr C in both medical and surgical matters as the doctors whom she did see could only speak for their speciality. Mrs C noticed that Mr C would not start conversations and would not be interested in talking about his usual interests which was so unlike him and she felt nobody was listening to her.

9. Mrs C stated that on 9 September 2005 Mr C underwent a general anaesthetic to reset the hip but it was still unstable and it was felt that further surgery may be required in the future but Mr C was not fit for the procedure at that time. Mrs C was told that Mr C would be transferred from HDU to the Coronary Care Unit (CCU) but there was a slight delay as no beds were available. After a week he was transferred to an orthopaedic ward. Mrs C was worried about Mr C's hip and that staff had told her they were not sure about further surgery. Mr C was measured for a brace on 21 September 2005 and it was thought it would be ready by 23 September 2005. A nurse had mentioned he would be transferred to the second Hospital as soon as the brace was fitted. Mrs C wondered why the decision had been made to move Mr C to Hospital 2 rather than trying to get him on his feet. The brace eventually arrived on 29 September 2005. Mrs C had been told it had initially been delivered to another department. Mr C was transferred to Hospital 2 that day.

10. On 10 February 2006, the Board's Director of Service Delivery (the Director) responded to Mrs C's complaint. She explained that the complaint had been investigated by the Directorate Managers for both surgery and medicine. The Director said that Mr C had been accepted for surgery on 2 August 2005 but because of his past medical history, was graded as a high risk. From a

surgical point of view the operation went well but chest pain, tiredness and general malaise the following morning was regarded as likely to suggest further myocardial ischaemia which was investigated immediately by the physicians. The blood results suggested Mr C had sustained a heart attack. The Director continued that there was unfortunately a delay in obtaining echocardiography but this was not essential for the diagnosis of a heart attack and is used to give further information regarding the state of the heart. She commented that Mr C had received standard treatment in relation to the heart attack. Mr C's persistent confusion indicated that cerebral ischaemia (brain damage) might have occurred as a result of the heart attack and this led to a request for a CT scan. An apology was made if this was not adequately explained to Mrs C. The Director said that the physicians thought Mr C's difficult diabetic control, combined with his relative immobility meant he was predisposed to subsequent chest infection and he was transferred initially to the HDU and then to CCU in the latter part of August 2005.

11. The Director continued that she had been told that muscle weakness, plus a probable awkward position of Mr C's lower limb would have predisposed him to the dislocation of his hip prosthesis in early September. It was not possible to treat the dislocation by surgical intervention which would require general anaesthesia because of Mr C's fitness for surgery due to his recent heart attack and chest infection. Mr C made an eventual satisfactory recovery from anaesthesia after manipulation of his hip on 9 September 2005 but he did require to spend four nights in HDU before transfer back to CCU, where a further week of supervision was undertaken prior to him returning to the orthopaedic ward. The Director commented that the orthopaedic team requested that a brace be supplied and fitted to avoid further instability of Mr C's hip prosthesis. An apology was made for the delay in obtaining and fitting Mr C's brace which impacted on his transfer date to Hospital 2. The Director said that Mr C was making slow but satisfactory progress on transfer but there was a subsequent deterioration in his general condition and by the time his hip prosthesis dislocated for the second time on 14 October 2005, multi-organ failure was evident and sadly he died within 24 hours of this deterioration in his condition.

12. The Director explained that the causes of death listed on Mr C's death certificate were accurate. The Orthopaedic Consultant responsible for Mr C's surgery had said that Mr C's post-operative heart attack was managed appropriately. The main reason Mr C was in so long as a patient was for

recurrent infection which was unexplained, the most likely source being in his lung. By the time Mr C was discharged from cardiology he had made a satisfactory recovery from his heart attack. Had this not been the case he would not have been transferred back to the orthopaedic unit. The main reason for Mr C's long stay in hospital was sepsis which was extensively investigated and treated. The Director said the consultant cardiologist responsible for Mr C's cardiology treatment (the Consultant Cardiologist) had reviewed Mr C's medical records and noted that Mr C's progress along with the medical staff's concerns, management and conclusions were well documented. The Consultant Cardiologist also recalled speaking with the family on three occasions during the three weeks Mr C was under his care and felt that he had communicated adequately. He apologised if Mrs C felt that was not the case but for his part considered that he had adequate communication with Mrs C and was not aware that she might have felt otherwise.

13. The Director said that she was sorry if communication on the part of medical staff fell short of Mrs C's expectations at such an understandably distressing time for Mrs C's family and she hoped her response had helped to clarify the concerns which had been raised.

14. The Adviser reviewed Mr C's clinical records and the complaints correspondence. He said that Mrs C may have assumed that doctors had to have the echocardiograph before starting treatment for Mr C's heart. In fact Mr C was treated quite appropriately and the delay in taking the echocardiograph was not material. The Adviser also felt that Mrs C may have thought that there was a delay in taking Mr C to theatre for correcting the dislocated hip but Mr C was very ill at this time and the anaesthetist was concerned about his chest and unstable condition. The nurses noted that Mr C's family were made aware of his going to theatre on 9 September 2005 but the cancellation on 8 September 2005 did not appear to have been explained. Mrs C was also concerned about the delay in getting a brain scan after Mr C had been suspected of having had a stroke. The Adviser felt it was understandable that Mrs C should be anxious, thinking it would affect his treatment, however, it would have made very little difference as there is no specific treatment for a stroke. This was not explained to Mrs C and had it been so it could have allayed her anxiety. In summary, the Adviser felt that the delays as perceived by Mrs C were not material to her husband's outcome but they should have been explained to her and it did not appear from the clinical records that they had been.

15. The Adviser stated the actual clinical treatment of Mr C was timely and reasonable both in the orthopaedic and cardiology wards but his prior medical conditions already placed him at some risk of surgery and these were compounded by recurrent hip dislocations (a recognised complication of this operation in a debilitated individual) and severe sepsis which proved difficult to eradicate. The Adviser felt it was a tragic outcome for Mr C but this was not through any shortfall in care or treatment by hospital staff. Clear, sympathetic communication with Mrs C's family was recorded infrequently in the clinical records and, therefore, the Adviser had to assume it only took place rather infrequently, particularly at critical stages of Mr C's admission. This resulted in a perception by Mrs C of dilatory and inadequate care. Her perception of the lack of an overall 'person in charge' could also be related to lack of communication with her, rather than lack of inter-departmental collaboration.

(a) Conclusion

16. Mrs C had some concerns that her husband's treatment may have been compromised by the delayed echocardiogram and CT scan as well as poor communication between medical specialities. However, the advice which I have received, and accept, is that Mr C's clinical treatment was appropriate during the period of hospital admission. The Adviser has explained that due to his past medical history, Mr C was regarded as a high risk for surgery but that the treatment which he received was appropriate. I do not uphold this aspect of the complaint.

(b) Conclusion

17. Mrs C felt that during her husband's admission there had been a lack of communication between medical specialities and the family. When she spoke to staff she said they would only talk about their department and she was not aware if one person was in overall charge to co-ordinate Mr C's treatment. Mrs C believed that staff were not listening to her and could have given her and the family more information about Mr C's treatment and their plans. The Director has apologised if communication on the part of medical staff fell short of her expectations. The Adviser has already stated that the reviews by the specialists were appropriate, therefore, there was no evidence of communication failures between departments. However, the Adviser has noted the records contain infrequent reference to communications with the family which has led him to assume that there were failures in this regard and would explain why Mrs C perceived there were failings in care. I accept the Adviser's

view and accordingly I partially uphold this aspect of the complaint to the extent that there is no evidence of communication failures between departments but there is evidence of failures in communication with Mrs C.

(b) Recommendation

18. The Ombudsman recommends that the Board remind staff of the importance of communication with family members.

(c) Inadequate complaints handling

National guidance

19. The NHS Complaints Procedure Guidance (the Guidance) was reviewed on 1 April 2005. The Guidance states that complaints should be acknowledged within three working days of receipt. Responses to complaints should be made within 20 working days with a further extension of 20 working days as long as the complainant is advised of the delay and given the option to contact the Ombudsman if required.

20. Mrs C wrote her letter of complaint to the Board on 30 November 2005. She received an acknowledgement letter from the Board's Complaints Manager (the Complaints Manager) dated 5 December 2005. The letter referred to her husband's surname only and that she should receive a full response in line with the NHS complaints procedure which was 20 working days. Mrs C's brother wrote to the Complaints Manager on 8 December 2005 and said that the whole experience of Mr C's treatment in hospital was traumatic and upsetting for the whole family but greater upset was caused with the acknowledgement letter containing incorrect reference to Mr C's name. All the family wished was for someone to take overall responsibility for Mr C and to co-ordinate his care and the fact that the Board could not get his name correct spoke volumes and clearly demonstrated a lack of care and attention. To compound matters a Medical Records Officer sent Mr C a letter on 11 January 2006 asking whether he still wished orthopaedic surgery. Mrs C wrote a letter to the Medical Records Officer advising her that Mr C had died in Hospital 1 on 15 October 2005 and said this was another example of how communication within Hospital 1 had not improved.

21. A Complaints Assistant at the Board wrote to Mrs C on 12 December 2005 and offered a sincere and unreserved apology for the typing error regarding Mr C's name.

22. Mrs C sent a reminder letter to the Board on 13 January 2006 as she still had not received a response to her complaint. The Complaints Manager acknowledged the letter on 16 January 2006 and said the investigation was almost complete and it was hoped a response would be provided soon.

23. In her letter to Mrs C dated 10 February 2006, the Director asked that Mrs C accept her apologies for the delay in receiving the response and any additional distress caused by the administration error regarding Mr C's name. The Director was sorry that it had taken so long to provide a response and explained it did take some time to properly investigate complaints which were complex and detailed in order to be able to provide a full response. Nevertheless, the Director was dissatisfied with the delay in responding to Mrs C and she said she had taken steps to ensure that delays to complaint responses were actively being addressed. The Director was sorry not to have been able to meet Mrs C's expectations in respect of the Board's response times.

(c) Conclusion

24. The acknowledgement letter was issued within the timescale referred to in the Guidance. However, the letter contained a typing error which understandably caused added distress to Mrs C and her family at such a difficult time. I commend the Complaints Assistant for immediately issuing a letter to Mrs C in which she offered her sincere and unreserved apologies for the typing error. While I appreciate that typing errors can happen, the outcome in such cases can be distressing and give the recipient the feeling that their complaint is not being treated seriously. Great care should be taken to ensure that reference to individuals is accurate.

25. Mrs C heard nothing further from the Board and sent them a reminder letter on 13 January 2006. The letter was received on 16 January 2006 and the Complaints Manager sent a letter to Mrs C that day and updated her to the effect that the investigation was almost complete. The final response from the Board was issued on 10 February 2006 which was 50 working days after receipt. However, this period would have been affected by the Christmas and New Year Holidays. The timescale for the response slightly exceeded that in the guidance and this has been accepted by the Board and action taken before the complaint was raised with them. However, Mrs C was not provided with an update after 20 working days or informed of her right to contact the

Ombudsman if she so wished. Accordingly I partially uphold this aspect of the complaint.

26. Finally, I am conscious that Mrs C was upset at receiving a letter from the medical records office addressed to Mr C nearly three months after his death in hospital. I can understand her comments that she feels the communication process has not improved. Mrs C has told me she did not formally complain about this issue other than send a short letter back to the Medical Records Officer. This could indicate that there is a problem with the internal systems within the Board which alerts departments when a patient has died to prevent appointment letters being issued in future.

(c) Recommendations

27. The Ombudsman recommends that the Board:

(i) conduct an audit to ensure that responses to complaints are within NHS Complaints Procedure Guidelines; and

(ii) conduct an investigation into the circumstances which led to a letter being issued to Mr C nearly three months after his death enquiring whether he wished to remain on the waiting list for orthopaedic surgery and offer Mrs C a sincere apology for the distress which was caused. On this point she would also draw the Board's attention to recommendation (ii) of report 200502722 published in September 2006.

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

27 March 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	Mrs C's husband
Hospital 1	Royal Alexandra Hospital, Paisley
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	The Ombudsman's professional adviser
HDU	High Dependency Unit
CCU	Coronary Care Unit
Hospital 2	Hospital where Mr C was transferred to for rehabilitation
The Director	The Director of Service Delivery
The Consultant Cardiologist	The consultant responsible for Mr C's cardiology treatment
The Guidance	The NHS Complaints Procedure Guidance
CVA	
The Complaints Manager	A Complaints Manager at the Board

Annex 2

Glossary of terms

Anaemic	Too few red blood cells in the bloodstream
Congestive cardiac failure	Inability of the heart to pump blood efficiently, leading to fluid in the body
CT scan	Computer aided scan of internal body structures
CVA/stroke	An interruption of the blood supply to the brain
Echocardiogram	Test of the heart using sound waves
Endocarditis	Inflammation of the inner lining of the heart
Humerus	Upper arm bone between shoulder and elbow
Intravenous antibiotics	The administration through a vein of medication to treat infections
Ischaemic Heart Disease	Heart muscle damage due to chronic poor coronary blood flow
Mitral stenosis	A narrowing of the mitral (heart) valve
Myocardial Infarction	A heart attack caused by an inadequate supply of blood to the heart
Pneumonia	Infection of the lung
Sepsis	Severe widespread blood-borne tissue infection, often leading to multiple organ failure
Staphylococcus septicaemia	Bacteria which causes blood poisoning

Type ii Diabetes	A chronic health condition where the body cannot produce sufficient insulin to control blood sugar levels