Scottish Parliament Region: Glasgow

Case 200600419: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C) raised a number of concerns about the treatment her late mother (Mrs A) received at the Southern General Hospital, Glasgow in November and December 2005. Her concerns included that Mrs A should have been treated in a High Dependency Unit; nursing staff failed to maintain Mrs A's oral and personal hygiene; staff failed to react when Mrs A's condition deteriorated; and poor communication.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs A received inadequate clinical treatment *(not upheld)*;

(b) staff failed to provide Mrs A with basic nursing care*(not upheld)*; and

(c) staff failed to communicate adequately with Mrs A's relatives *(not upheld)*.

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 6 July 2006 the Ombudsman received a complaint from Mrs C about the treatment her late mother (Mrs A) received at the Southern General Hospital, Glasgow (the Hospital) in November and December 2005. Her concerns included that Mrs A should have been treated in a High Dependency Unit (HDU); nursing staff failed to maintain Mrs A's oral and personal hygiene; staff failed to react when Mrs A's condition deteriorated; and poor communication. Mrs C complained to Greater Glasgow and Clyde NHS Board (the Board) but remained dissatisfied with their response and subsequently complained to the Ombudsman.

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

(a) Mrs A received inadequate clinical treatment;

(b) staff failed to provide Mrs A with basic nursing care; and

(c) staff failed to communicate adequately with Mrs A's relatives.

Investigation

3. In writing this report I have had access to Mrs A's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional medical advisers (Adviser 1) and a nursing adviser (Adviser 2) 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. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Medical history

5. On 26 November 2005, Mrs A, who was 68 years of age, was found at home slumped by the telephone with right sided weakness; numbness in her face; and was unable to speak. She was taken to the Accident and Emergency Department at Monklands Hospital and transferred later that day to the Hospital. She was taken to theatre where a left parietal craniotomy (surgical opening of the skull) was performed and evacuation of intracranial haematoma (collection of blood within the skull). Mrs A was cared for post-operatively in the Intensive Care Unit (ICU) and then transferred to a neurosurgical ward (the Ward) on

29 November 2005. Mrs A was subsequently transferred back to Monklands Hospital on 2 December 2005. Mrs A sadly died on 2 January 2006.

(a) Mrs A received inadequate clinical treatment

6. Mrs C complained that the family were led to believe by staff that Mrs A would be in theatre for about an hour and a half and it turned out to be nearly four and a half hours. They wondered if anything had happened in theatre as the time was longer than anticipated. Mrs C said she visited Mrs A the day after surgery and was told by staff that Mrs A had a raised temperature and a crackle (noise when air moves through fluid-filled airway) in her chest. Mrs A was taken off ventilation and was transferred from ICU to the Ward which the family did not feel was appropriate. Mrs C was concerned that Mrs A was lying completely flat and was worried that she could develop a chest infection. Mrs C commented that Mrs A also had a tendency to suffer from frequent sinus infections and her family felt that antibiotics were required. Mrs C also felt that by being nursed in a neurological ward rather than HDU, Mrs A's chances of recovery were being compromised. Mrs C said Mrs A's chest condition then appeared to worsen but they were not reassured by staff who said they had taken a blood sample and would have to wait two days for the result.

7. Mrs C commented that Mrs A was given paracetamol on 30 November 2005 which did bring her temperature down. At afternoon visiting, staff told Mrs C that Mrs A was now being turned two hourly. The Consultant in charge of Mrs A's care arrived on the Ward and said that a Registrar would discuss Mrs A's condition with the family. The Registrar met with the family and would not discuss the result of the blood test. Mrs C said that the meeting with the Registrar deteriorated and he kept repeating that he had no comment to make. At visiting time that night, Mrs C said she noticed that Mrs A was visibly distressed; had difficulty breathing and she stated her chest was making terrible sounds. Mrs C said her family pleaded that Mrs A should be seen by a doctor. A Senior House Officer (SHO) was called and arrangements were made for a nebuliser (machine which turns liquid medication into a fine mist so that it can be breathed directly to the lungs via a face mask). An ECG (test to record the electrical activity of the heart) and two kinds of antibiotics were prescribed. Mrs C felt that Mrs A had had the chest infection since 27 November 2005 yet it had taken until the night of 1 December 2005 for doctors to take action despite the family making staff aware of their concerns.

8. The Board's Chief Operating Officer (the Chief Officer) responded that Mrs A's operation, excluding transfer and anaesthetic time, was about two hours which would be normal in such a situation. There were no particular difficulties or problems during surgery. He said it was a medical decision to transfer patients from ICU and nurses would comply with any instructions which were given. The Chief Officer said that Mrs A was not nursed flat as she always had two pillows and was nursed upright when she could tolerate it. He commented that Mrs A's position was changed on a two hourly basis and Mrs A was also seen daily by the ward physiotherapist and received suction to help keep her chest clear. The Chief Officer said that antibiotics were prescribed and administered to Mrs A following the result of a sputum specimen. This ensured that the appropriate antibiotic was administered.

9. Adviser 1 said that the clinical records indicated there was little evidence that Mrs A was suffering from a significant infection from 26 November to 28 November 2005 other than a raised temperature. Adviser 1 felt the observations, investigations and reviews by medical staff were reasonable. It was a fever on 29 November 2005, with no other features, which led the doctor to take a blood culture and prescribe paracetamol. This was successful in reducing Mrs A's fever and it was sensible to withhold antibiotics until more information was available. Adviser 1 felt the first sign of possible infection in the right lung base was on 1 December 2005 which was corroborated by x-ray changes and the presence of thrush. Medical staff consulted with the Microbiology Department and prescribed appropriate antibiotics. Adviser 1 could see no evidence that medical or nursing staff failed to appreciate what was happening to Mrs A post-operatively. Adviser 1 commented that as Mrs A was stable following surgery it was entirely reasonable to move her from ICU to a specialist neurological ward.

(a) Conclusion

10. Mrs C was concerned that Mrs A did not receive adequate clinical treatment following the operation and that she should not have been transferred to a neurological ward. The advice which I have received and accept is that the medical staff were fully aware of Mrs A's condition following the operation and took appropriate action once the test results were known. Although Mrs A was noted to have a high temperature this was treated appropriately with paracetamol in the first instance. I am also satisfied that it was appropriate to transfer Mrs A from ICU once her condition had stabilised and that she no

longer required specialist medical or nursing interventions. As a result, I do not uphold this complaint.

(a) Recommendation

11. The Ombudsman has no recommendations to make.

(b) Staff failed to provide Mrs A with basic nursing care

12. Mrs C said that on 29 November 2005 the family noticed Mrs A's mouth was dry, sore and red which indicated that oral hygiene was not being addressed. Mrs C said the family were more than pleased to work with the nurses to care for Mrs A but that suggestion appeared to fall on deaf ears. Mrs C noted a change on 1 December 2005 in that the nurses asked the family to bring in nightdresses and shampoo. She said that although these items were brought in Mrs A's hair was still not being washed.

13. The Chief Officer said that Mrs A was bed-bathed daily and her hair was also washed during her stay. In the absence of personal gowns, Mrs A was changed into a fresh hospital gown after each bed-bath. He commented that it was accepted that Mrs A's mouth was dry, which was caused by her oxygen therapy and the fact that Mrs A breathed through her mouth. Oral hygiene was completed regularly by staff but, despite this, Mrs A's mouth remained dry. The Chief Officer said that during the time Mrs A was a patient in the Ward staff felt that Mrs A received professional, appropriate and sensitive care. When Mrs A was transferred back to Monklands Hospital her chest had improved; neurologically she was brighter; her pressure areas were intact; and she had an established feeding regime.

14. Adviser 2 told me that Mrs A's records were very well written and included an assessment of Mrs A's condition on admission; risk and dependency assessments; pressure ulcer risk assessment; clear and regular recording of Mrs A's vital signs; regularly completed fluid balance charts; nursing intervention plans; nutritionalist input; good nursing/evaluation notes; clearly documented physiotherapy notes; and a full discharge/transfer summary of her condition and needs at the time of discharge. The notes also recorded on a regular basis the nursing care delivered to Mrs A including daily bed-bath, position changed 2-3 hourly and mouth care. There was a recognition that Mrs A had a dry mouth and coated tongue, that she had 'sinus' trouble and constantly breathed through her mouth. Adviser 2 felt that the planning and delivery of care was

well recorded down to the smallest detail and supported the view that the nursing care which Mrs A received was appropriate.

(b) Conclusion

15. Mrs C complained that Mrs A was not provided with basic nursing care such as personal and oral hygiene and that she was not turned frequently. This does not accord with the entries in the nursing records which Adviser 2 feels are extremely comprehensive and informative. It was acknowledged that Mrs A suffered from a dry mouth but this was caused by the oxygen therapy and the fact that Mrs A tended to breathe through her mouth. The records also substantiate the contention that Mrs A was turned on a regular basis. In view of the evidence obtained during this investigation, I have decided not to uphold this complaint.

(b) Recommendation

16. The Ombudsman has no recommendations to make.

(c) Staff failed to communicate adequately with Mrs A's relatives

17. Mrs C said that medical and nursing staff would not give her information about Mrs A's condition. The family repeatedly asked for information as a doctor had not spoken to them since immediately after the operation (see paragraph 7). Mrs C asked the ward sister what Mrs A's temperature was and was told it was normal but this was immediately contradicted by a nurse who said it was 38.7 (high). Mrs C thought this was another example of poor communication between staff.

18. The Chief Officer commented that staff work with relatives to try and address queries or concerns, however, for confidentiality reasons information relating to patients can only be released with the consent of the patient. In instances where the patient is mentally incompetent and unable to give consent, the amount of information given to relatives is at the discretion of the doctor. The Chief Officer said the ward sister had explained to Mrs C that, as she was in charge of the unit, her duties took her in and out of the ward and it was only for that reason that she had not been aware that Mrs A's temperature had changed.

19. Adviser 1 noted from the clinical records that medical staff had spoken to the family about Mrs A's condition on 26 November 2005, 29 November 2005 and 1 December 2005. He said that in such a situation, with a very ill patient

who is not mentally competent, it is reasonable, unless there is evidence to the contrary, for doctors to assume that the patient's family would wish to know what was happening.

(c) Conclusion

20. Issues such as communication between staff and relatives frequently result in complaints to the Ombudsman. I can fully understand that relatives would be concerned about the condition of the patient and that they would wish to know about the diagnosis, what clinical treatment was planned and the possible outcome of such treatment. I can also appreciate that staff have a difficult judgement to make in that they have to balance the patient's right to confidentiality as against the need to provide the relatives with information. At times staff would provide relatives with general information such as the patient is stable and that could leave them dissatisfied. In this instance, I have seen that it is recorded that medical staff spoke with Mrs C or members of her family on three occasions for what was a relatively short admission period. As such, I believe that staff communicated to Mrs A's family at an acceptable level and I do not uphold this complaint.

(c) Recommendation

21. The Ombudsman has no recommendations to make.

22 August 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mrs A	Mrs C's mother
The Hospital	Southern General Hospital, Glasgow
HDU	High Dependency Unit
The Board	Greater Glasgow and Clyde NHS Board
Adviser 1	Ombudsman's professional medical adviser
Adviser 2	Ombudsman's professional nursing adviser
ICU	Intensive Care Unit
The Ward	The Neurological ward
SHO	Senior House Officer
The Chief Officer	The Board's Chief Operating Officer