Scottish Parliament Region: North East Scotland

Case 200802345: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; medical, nursing and palliative care

Overview

The complainant (Miss C), supporting her mother (Mrs A), raised a number of significant concerns about the care and treatment her father (Mr A) received at Ninewells Hospital, Dundee in the days leading up to his death, from cancer, in June 2008. Miss C was particularly concerned that Tayside NHS Board (the Board) had delivered sub-standard care to her father in a number of important respects such as assistance with feeding, hygiene, cleanliness, management of symptoms and pain as well as failing to accord him dignity and respect. Miss C also complained that hospital staff failed to communicate adequately with Mr A's family about his palliative care or to properly manage Mr A's transfer to a hospice. Miss C was also unhappy with the handling of her complaint.

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) failed to treat Mr A with all appropriate medical, nursing and personal care and dignity (*upheld*);
(b) failed to communicate adequately with Mr A or his family (*upheld*); and
(c) failed to deal with Mrs A's complaint in a timely or appropriate manner (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mrs A and Miss C for the failings identified in this report;
(ii) review their administrative policy for the documentation of the administration of controlled drugs; documentation of patient symptom control; and support to foundation level doctors in the management of terminal patients;
(iii) review their policy for the insertion of chest drains to include the reporting of chest x-rays following drain insertion and the management and investigation of pain following drain insertion; and

(iv) review their approach to the documentation of complications of procedures such as chest drains including; i) decisions relating to best management of the complications; and ii) information given to the injured party or their relatives.

The Ombudsman also asks that the Board keep him appraised of progress towards achieving the goals of the Action Plan.

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

Main Investigation Report

Introduction

1. On 5 January 2009 the Ombudsman received a complaint from the complainant (Miss C) on behalf of her mother (Mrs A). Miss C complained about a number of aspects of the care of her father (Mr A) during a hospital admission to Ninewells Hospital, Dundee (the Hospital) from 30 May 2008 up to and including his transfer to a hospice (the Hospice) on 10 June 2008; very shortly before his death in the Hospice on 11 June 2008. Miss C was particularly concerned about the care Mr A received in a side-room of Ward 3 (the Ward). Mrs A had raised a complaint with Tayside NHS Board (the Board) on 26 July 2008 and had a meeting with Board staff on 2 September 2008. Mrs A finally received an interim response on 4 December 2008 but was dissatisfied and a meeting was held with the Director of Nursing, Delivery Unit (the Director of Nursing) on 5 December 2008. Mrs A received a written response from the Director of Nursing on 20 December 2008 which contained an apology for 'our shameful failure to care for [Mr A] in the way you and he had the right to expect'. Mrs A and Miss C were not satisfied with the limited explanations offered by the Board in that response for the problems originally identified. They also had concerns about new issues which arose from the Board's response. Mrs A and Miss C remained concerned that all the problems they had experienced during Mr A's admission were not being addressed by the Board and Miss C complained to the Ombudsman's office.

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

(a) failed to treat Mr A with all appropriate medical, nursing and personal care and dignity;
(b) failed to communicate adequately with Mr A or his family; and
(c) failed to deal with Mrs A's complaint in a timely or appropriate manner.

Investigation

3. Investigation of this complaint has involved obtaining and reviewing Mr A's clinical records for the relevant time. I have also obtained and reviewed the records for the Hospice. I have received clinical advice from a nursing adviser (the Nursing Adviser), a medical adviser (the Medical Adviser) and a specialist respiratory adviser (the Respiratory Adviser) to the Ombudsman. I have met with Miss C, Mrs A and representatives of the Board. I have spoken by

telephone with the senior nurse at the Hospice (the Hospice Nurse). I have also made a number of written enquiries of the Board.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Miss C, Mrs A and the Board were given an opportunity to comment on a draft of this report.

Background

5. Mr A was admitted to the Hospital on 30 May 2008 by his GP for investigation of two recent onset symptoms; rectal bleeding and pleural effusion (fluid in the lungs). A chest drain was inserted on 30 May 2008 and a CT scan, blood transfusion and chest x-ray were requested. A chest x-ray was carried out on 31 May 2008 and a CT scan on 2 June 2008. The results of the CT scan were reported on 3 June 2008 and showed Mr A to have widespread cancer in the pancreas, liver and lungs. The prognosis was very poor and the consultant respiratory physician responsible for Mr A (the Consultant) broke the devastating news to Mr A, advising him that he was likely to live only a few weeks more. Mr A asked that the Consultant break the news to his family. Mr A was transferred to a side-ward the same day and as he was complaining of right shoulder pain he was prescribed low dose morphine as required. The Consultant spoke with Mrs A and Miss C on 3 June 2008 and advised them that Mr A was too ill to be cared for at home.

6. Mr A was seen by the palliative care team on 4 June 2008 who noted that Mr A was in no pain but was unlikely to manage at home. On 5 June 2008 nursing records noted he was in pain overnight. Mr A was reviewed on 6 June 2008 by the Consultant who noted that pain management was better and removed the chest drain.

7. Mr A was transferred to the Hospice on the morning of 10 June 2008 by specialist ambulance. The transfer documentation relating to pain relief medication was incomplete and there was an initial concern about providing pain relief medication to Mr A. Mr A died shortly after midnight on 11 June 2009.

8. Mrs A complained on 26 July 2008 and a meeting was arranged at the request of the Board for Mrs A and Miss C to discuss their concerns with the senior charge nurse (the Senior Charge Nurse) responsible for the Ward and a member of hospital management staff on 2 September 2008. A written

response in the form of a meeting note was provided on 4 December 2008. This meeting and response did not resolve Mrs A's concerns and in fact added to them. A further meeting was held on 5 December 2008 with the Director of Nursing who ordered a further investigation and a further written response was provided on 20 December 2008. Mrs A and Miss C were not satisfied with this response as they felt it did not explain why the problems admitted to had been allowed to occur.

9. Miss C complained to the Ombudsman's office about the lack of dignity and respect afforded to her father and the unnecessary pain suffered by him. She was also concerned that she and Mrs A had been unsupported throughout this stressful period. Miss C also sought an independent review of Mr A's care and treatment and the quality of information contained in Mr A's notes, as she had significant concerns about his care and treatment as a result of the information they had been given by the Board about the admitted failures in Mr A's care. In particular Miss C sought detailed explanations for why a number of the admitted failures had occurred. Miss C noted that there had been an announcement on 18 December 2008 in the local press of an initiative to make hospital wards more efficient and she was concerned that this so closely coincided with her mother finally getting a written response from the Board.

(a) The Board failed to treat Mr A with all appropriate medical, nursing and personal care and dignity

10. Miss C raised a significant concern about the incomplete transfer documentation sent with Mr A to the Hospice and the delay this caused in obtaining adequate pain relief for him. She was also particularly concerned at the apparent lack of medical awareness of his swallowing problem, which seemed to go largely untreated during his admission although it was a known problem causing him severe difficulties with eating and drinking, which itself caused Mr A added distress.

11. Miss C told me that the Board had admitted that the nursing care provided to Mr A was unacceptable on a number of occasions but that she had not had an explanation as to why this was the case. Mrs A had complained that although her husband had a known swallowing problem, staff on the Ward seemed unaware of this and consequently her husband was not being offered appropriate meals or assisted to eat as required. Mrs A noted that staff would leave his food at his bedside and leave him to feed himself and simply remove

the uneaten food later. Mr A was not able to open containers etc and nurses did not offer him basic assistance such as opening yoghurt pots. When Miss C had expressed concern about this lack of assistance and his swallowing problems, staff expressed surprise that he had swallowing difficulties and arranged a visit from the SALT (Speech and Language Therapy) team who gave Mr A a drink supplement from 6 June 2008. Miss C also noted that it was the family who had drawn attention to Mr A's sore mouth, which was identified as thrush and which then required treatment.

12. Mrs A was generally concerned that Mr A had to wait excessively long to get assistance once he was transferred to the side-ward as staff were rarely in and around his room. Mrs A was also concerned that the side-room was not cleaned as well as the main ward and had issues with dirty hospital laundry, which was possibly not even his laundry, being left lying in the room for several days. Mrs A has also complained that the practice of stacking unused urine bottles on the bed-table was both unhygienic and unacceptable, particularly when the bed-table was used as a meal table and was not cleaned before use. This did not happen on the main ward.

13. Miss C was also concerned about the poor personal care Mr A had received and the lack of dignity and respect shown to him by staff throughout his admission. Miss C described to me how she had spent several hours on the afternoon of 8 June 2008 trying to satisfy Mr A’s thirst and hunger by giving him, at his request, tiny sips of water, fruit juice, milk and jelly as Mr A was desperate for something. Miss C also told me that both she and her mother had been very distressed to arrive for a visit on 9 June 2008 to find her father in an unclean and unhygienic state. The family drew this to the attention of medical and nursing staff but nothing was done to thoroughly wash Mr A and clean his room until the family had contacted the palliative care nurse (the Palliative Care Nurse) later that afternoon to ask for her assistance. Miss C was also distressed that Mr A was left in a semi-naked state with visitors present when a hospital gown would have allowed his nursing needs to have been attended to while maintaining his dignity. In general Mrs A and Miss C felt that Mr A was simply regarded by staff as an old and dying man who did not matter.

14. Miss C accepted that the Board had apologised for a number of the problems but remained unhappy that they would not provide any explanation as to why the problems had occurred.

15. In addition to her original concerns about the lack of information on the transfer sheet about pain medication Miss C also raised a concern about the dosage of Mr A's pain medication on occasions and whether the lack of food and drink over the time of his admission might have hastened his death. Miss C told me that when she had asked staff about putting her father on a drip since he found swallowing so difficult she was told that they could not force feed him - which was not what she had meant. Miss C remained concerned that Mr A might have had a more comfortable last few days if he had been on a drip. Miss C also raised a concern that Mr A's cancer was not detected until it was so advanced and sought an independent medical review of this question.

The Board Responses

16. In the Board's response the Director of Nursing indicated that there had been several significant failings in the care provided to Mr A and that these were not acceptable and would not be tolerated. The Director of Nursing made a number of apologies. In my meeting with Board representatives, the Director of Nursing stated at the outset that there were aspects of the care Mr A had received that were not acceptable and should not have happened. The Director of Nursing did not, however, feel there was more information that could be given with regard to why the failings had happened beyond those already given to Mrs A and Miss C. The explanations offered included the day-to-day supervision and oversight of ward staff, staff awareness of issues such as end-of-life care and the Ward staff distribution especially in relation to the day-to-day nursing allocation to the side-rooms. The Director of Nursing emphasised that steps had already been taken to increase the staffing levels on the ward; a new senior charge nurse had been appointed and a new post created Senior Nurse/ Clinical Team Manager (the Clinical Manager). Part of the role of the Clinical Manager is to provide support to the Senior Charge Nurses in their leadership and management of the ward team. The Clinical Manager also attended the meeting and subsequently provided this office with an updated action plan (the Action Plan) to address the issues which had been identified as a result of Mrs A's complaint. A copy of the Action Plan is attached at Annex 4. The Clinical Manager also accompanied me and the Nursing Adviser on a visit to the Ward to review the changed arrangements and in particular the nursing cover now provided for the side-wards.

The Nursing Adviser

17. The Nursing Adviser reviewed Mrs A and Miss C's complaints, the clinical records for Mr A and the Boards responses. She also attended a meeting with

the Director of Nursing on 30 March 2009 at the Hospital to discuss the progress being made towards achieving the changes identified by the Board in their review of the issues raised by Mrs A and Miss C. The Nursing Adviser also reviewed the Action Plan provided to me on 20 April 2009 by the Board. The Nursing Adviser told me that the Action Plan had a good level of detail with specific, measurable, realistic and timely actions with appropriate accountability for taking these actions forward. She considered that the Action Plan showed good evidence that lessons have been learned and changes have been made or were planned to prevent reoccurrence and should address all the nursing problems identified by the complainants.

18. The Nursing Adviser told me that the pilot announced in the local press on 18 December 2008 was a pilot study being conducted by NHS Scotland following the 'Releasing Time to Care: The Productive Ward' programme. The Hospital was participating in the pilot study which was running between July and December 2008 (the ward participating was not one Mrs A was complaining about). The Nursing Adviser considered the timing of the announcement to be coincidental as the pilot had been planned before the events of this complaint. The report of the pilot study was published in February 2009 and made a number of recommendations including the roll out of the programme to all acute wards. The Director of Nursing advised me in March 2009 that the Board have indicated their intention to participate in the national work on this programme.

The Medical Adviser

19. The Medical Adviser reviewed Mrs A and Miss C's complaints and the medical records. The Medical Adviser commented that the admitting team documented that Mr A complained of swallowing difficulty. The medical team managing Mr A believed his oesophageal problem was unrelated to the immediate cause of his admission (rectal bleeding and increased breathlessness) and it was the diagnosis of these immediate problems that was their focus. The Consultant may not have been aware of the detail of the oesophageal problem when he met the family to discuss the diagnosis of cancer and its implications. The Medical Adviser noted this was regrettable, but did not impact on Mr A's overall medical care. The Medical Adviser considered that once the finding of spreading cancer was made on 2 June 2008, all care offered would be only symptomatic and it would be inappropriate to submit the patient to invasive investigations or treatments regarding the swallowing problem, or to start clinically assisted nutrition (tube feeding).

20. The Medical Adviser reviewed Mr A's actual nutritional intake and considered whether a drip would have been appropriate. He noted that:

> 'fluid charts were only available 31 May 2008 and 1 June 2008 and that there is no comment in the records regarding signs of dehydration. The blood biochemistry result available for 3 June 2008 does not suggest Mr A was dehydrated. A Stage D soft and moist diet was recommended on 5 June 2008. A nursing entry on 6 June 2008 suggests 'fluid intake good, not keen on diet'. In the context of his overall condition and the fact that he had been told that he had malignant disease and the fact that he had apparently been eating poorly before admission, limited oral intake would not be unexpected and in my view increased oral intake of food would <u>not</u> have altered the outcome or improved any symptom. There is no evidence that a drip to provide IV fluid would have improved symptoms and outcome. Clearly however, given the fact that the family were concerned about intake, it would have been better had the medical team registered that and documented their views more clearly.'

21. The Medical Adviser reviewed the pain relief medication as recorded for Mr A. He noted that Mr A was started on regular paracetamol on the 31 May 2008. Mr A was prescribed oramorph 5 mg 'as required' on 1 June 2007 but this was never given and the dose was changed to 2.5 mg 'as required' on 3 June 2008. It is not clear why the 5 mg dose was never given, and why the dose was reduced to 2.5 mg when the effect of 5 mg had apparently never been assessed. The Medical Adviser noted that it is reasonable to use 'as required' analgesia, providing one can be sure that the patient can communicate their needs and that staff can respond timeously, but it does not appear that this strategy worked for Mr A. Mr A was prescribed regular oramorph on 4 June 2008 and received one regular dose as above at 18:00 on that day. The prescribed 22:00 dose was not given, but he received an 'as required' dose at 23:35. On 5 June 2008 three of his four regular prescribed oramorph doses (08:00, 12:00, 18:00) were not given and there is no indication in the drug sheet to explain why. The Medical Adviser expressed a concern at this as it relates to the prescription of a controlled drug and Mr A was documented as being in pain on that day in the medical notes. He received one 'as required' dose of oramorph at 08:35. It is possible that this caused drowsiness and the regular doses were then withheld but if this was the case this should have been recorded on the drug sheets. On 6 June 2008 Mr A received three of his four regular doses, the other not given because 'patient refused'. On 7 June 2008 Mr A is noted as refusing all four of his regular doses,

but had taken two 'as required' doses in the early hours of that morning. The nursing notes suggest he was 'sleepy' – if this was the case the Medical Adviser considered that this should not be recorded as 'refused'. On 7 June 2008 the 'as required' dose frequency is changed to one hourly, usually implying that the doctor felt that the need for analgesia was increasing, rather than that side effects were becoming limiting. However, on 8 June 2008 Mr A received none of his prescribed doses – three being again indicated as refused and one blank. There is no documentation of Mr A's pain status that day. On 9 June 2008 and 10 June 2008 there is no indication as to what happened to the regular doses. Mr A did receive one 'as required' dose at 22:20 on 9 June 2008 and in the early hours of 10 June. The Medical Adviser expressed concern that the regularly prescribed doses are not accounted for in the records. He noted that the nursing transfer record suggested Mr A was 'refusing analgesia' but the overall documentation of the use of morphine was inadequate. The Medical Adviser noted that Mr A's confusion noted by Miss C could have related to the pain relief medication or could have been a delirium relating to the cancer itself – it is not possible to say categorically which but Mr A's distress suggests that his symptom control, for whatever reason, was not what it should have been.

22. The Medical Adviser commented that the palliative care offered to Mr A and his family was poor, as evidenced, by the poor documentation of pain, documentation of possible limiting side effects, documentation of prescription and use of morphine, apparent supervision of the prescription and use of morphine, and overall consideration for the need for pain control for Mr A was chaotic. Neither the medical or nursing record nor the drug sheets adequately explain what was happening and – on the basis of this evidence - it seems likely that the family's perception that there was limited attention to symptom control was correct.

23. The Medical Adviser reviewed the diagnosis of cancer and considered whether this could have been made sooner or treatment started earlier. The Medical Adviser told me that the difficulty with swallowing was extremely unlikely to be related to the final diagnosis of pancreatic malignancy. It is much more likely to have related to other pre-existing problems (hiatus hernia and reflux of acid into the gullet for which dilatation of the gullet had previously been undertaken). The difficulty with swallowing had been investigated some time before the final admission and it was noted that the patient was frail then and that invasive investigation or treatment such as further gullet stretching (for the narrowing causing the swallowing difficulty) would be risky. A conservative

approach was, therefore, selected and this was not unreasonable. A chest x-ray was initially taken on 22 April 2008 in the community but did not show any obvious signs of the cancer which could have been picked up then. The Medical Adviser concluded that the cancer was found promptly (three to four days) after admission to the Hospital, and he did not consider that could have been quicker or that had it been found earlier that treatment would have made any difference to outcome as no curative option was available.

24. The Medical Adviser noted in conclusion that the sense of an overall lack of care and compassion gained by the family, the mishandled transfer to the Hospice and the patient's continuing pain and distress and possible side effects of his analgesia were all indicative of poor care and treatment by staff.

The Hospice Nurse

25. The Hospice Nurse told me that she was contacted by the Palliative Care Nurse on 9 June 2008 and asked if they would be able to accept Mr A as a matter of urgency as his family were not happy with the Ward. The Hospice was able to do so and the transfer was arranged. The Hospice Nurse told me that Mr A's condition on arrival (shortly after 12 noon) was far worse than she had expected from her telephone call with the Palliative Care Nurse but she noted that pancreatic cancer can cause sudden deterioration. The Hospice Nurse told me that Mr A had arrived with a very dry mouth and she had prescribed treatment for that immediately. She did not consider that this was a new problem but must have persisted for a few days. The Hospice staff had called the Ward for more information and had contacted Mr A's GP to advise of Mr A's admission shortly after his arrival. At the time it was the practice that the GP would attend later the same day to clerk the patient. The expectation though was that the patient would be in a stable condition on transfer so the GP would not have expected to attend with a degree of urgency. The Hospice Nurse advised me that as a nurse practitioner she was able to prescribe medication to help Mr A when he became agitated and following a telephone call to the GP surgery at 15:00, the GP was requested to attend as Mr A was in pain. Again the Hospice Nurse prescribed morphine sulphate for Mr A at that point which was administered immediately. The GP surgery was called again at 16:00 as Mr A was still distressed, despite the medication, and asked to attend as a matter of urgency. The GP and the Hospice Nurse agreed over the telephone that a syringe driver be set up immediately for Mr A to provide the necessary medications and this was in operation when the GP arrived at 16:50.

Mr A was then commenced on the Liverpool Care Pathway for the Dying Patient (a best practice protocol for end-of-life patient care) by the GP.

26. The Hospice Nurse also told me that following on from this complaint a new transfer sheet check list is used for patients coming from the Board's hospitals and this has been very successful in preventing the problems that occurred in Mr A's case.

(a) Conclusion

27. One of the concerns Miss C expressed to me was that her father could not have been alone in suffering as he did on the Ward since standards were so poor and that the number of admitted failings made her additionally concerned that there may be yet more failings they were not aware of. I appreciate too the desire to find specific reasons for the failures but accept the views expressed by the Director of Nursing that no single occurrence, person or practice is responsible but rather there was a series of interconnected failings which all contributed to the total problem. The evidence I have reviewed has not found any significant further nursing failings but at the Board's own admission there was a serious failure to provide appropriate nursing care and treatment to Mr A and consequently he was not treated with the dignity he and his family were entitled to expect. This evidence I have considered corroborates the views of Mrs A and Miss C about Mr A's care and the potential for the failings to affect other patients, consequently, I uphold this complaint.

28. In the view of the Nursing Adviser, the Action Plan provided by the Board should address the issues identified. I will ask for updates of the progress towards achieving the actions set out in the Action Plan but have no further recommendation to make beyond this on the issues of nursing care. The Medical Adviser identified areas of concern about pain relief prescribing and monitoring and the Ombudsman does have recommendations to make in that regard. The Director of Nursing has made a number of apologies already to Miss C and Mrs A but in view of the serious nature of the failings described in this report, I would consider it appropriate for a written apology to be given to Mrs A and Miss C from the Chief Executive of the Board.

(a) Recommendations

29. The Ombudsman recommends that the Board:

(i) apologise to Mrs A and Miss C for the failings identified in this report; and

(ii) review their administrative policy for the documentation of the administration of controlled drugs; documentation of patient symptom control; and support to foundation level doctors in the management of terminal patients.

(b) The Board failed to communicate adequately with Mr A or his family

30. Miss C was concerned that the Palliative Care Nurse did not discuss options for future care with Mr and Mrs A. In particular she noted that the option of Mr A returning home rather than going into a hospice seemed to be dismissed and they were told they couldn't manage although he had been ill for some time and had managed well so far. At the request of Mrs A and Miss C, the Palliative Care Nurse arranged a visit to one hospice on 6 June 2008 but Mrs A was concerned that it was some distance from her home which would make visiting very difficult. They were also advised that there was a shortage of hospice beds with a waiting list in operation. On 9 June 2008, the Palliative Care Nurse did not come to visit Mrs A on the Ward as she had expected and Miss C had to go and find her. The Palliative Care Nurse told Mrs A that Mr A would be transferred to the Hospice the following day. While both Mrs A and Miss C were very satisfied with the nursing care Mr A received in the short time he was in the Hospice, they both felt that they had been given no options and would have preferred Mr A to be transferred home to be cared for there (as was his wish). Miss C told me that following their visit on 6 June 2008 there were no further discussions with the Palliative Care Nurse about where Mr A might be transferred to and they were simply told on 9 June 2008 that he was to be moved on 10 June 2008. Miss C and Mrs A both told me that they felt that the Hospital staff wanted to move Mr A out as quickly as possible and in the end it was rushed, causing Mr A to be transferred when he was not in a fit state to do so and without all the appropriate documentation.

The Hospice Nurse

31. I have summarised the evidence from the Hospice Nurse in paragraph 25 and I note here her comments about the reasons given for the transfer request and Mr A's poor condition on transfer.

The Respiratory Adviser

32. The Respiratory Adviser commented at the request of the Medical Adviser, who was concerned about aspects of the chest drain insertion and in particular the impact this had had on the pain experienced by Mr A. The Respiratory Adviser noted that the CT scan on 2 June 2008 showed that the tip of the chest

drain was misplaced as it had passed through the diaphragm. He noted though that it was none the less effective in draining the fluid and there was no indication of damage to the abdominal organs. The Respiratory Adviser considered that the decision to insert the drain was a reasonable one and the procedure used to do this was good practice. He noted that there was no record made of the nature of the fluid drained or whether the drain was 'swinging' (this term reflects pressure changes in the chest with breathing and is evidence of proper placement). The Respiratory Adviser told me that the National Patient Safety Agency (NPSA) for England and Wales issued a report a few days before this event in which it recommended that chest drain insertion procedures should be carried out by medical staff with the 'relevant competencies' and he was concerned that this may not be true of the junior doctor who performed the procedure in this case, although he was not critical that this happened on this occasion as the NPSA report had only recently been issued and there would have be no opportunity to consider it. However, the Respiratory Adviser noted that there is no note in the medical record of the chest x-ray findings although these would not have detected the misplaced drain. He was concerned that while the CT scan indicated a difficulty with the drain there was apparently no discussion with Mr A or his family about this. The Respiratory Adviser acknowledged that Mr A was already receiving devastating news that day and it may have been better to explain this mishap at a later time, particularly as there were no complications arising from this, but that it should have been communicated to the family later.

33. The Respiratory Adviser concluded that the records do clearly show that it was the chest drain that caused Mr A's initial pain but that this is not uncommon with any chest drain. He supported the comments of the Medical Adviser on the poor pain management thereafter (see complaint heading (a)). He was critical of the lack of recording of the immediate outcome of the insertion process and of any discussions about the misplaced drain once this was discovered but felt that the management of the drain, although not ideal, was not below that which would reasonably be expected.

34. In response to further enquiries from the Ombudsman's office the Board advised me of a number of changes that have been made to the Board's practice in relation to chest drains since the events of this case as a result of a publication in November 2008 from the British Thoracic Society: 'Guidance for the implementation of local trust policies for the safe insertion of chest drains for pleural effusion in adults'. The Board told me that many of the

recommendations of that report are already in place and they are actively pursuing the outstanding recommendations. The Board also noted that in view of Mr A's very recent prognosis it may well have been thought inappropriate to discuss the problem of the chest drain insertion with him or his family as it had caused no complications. The Respiratory Adviser welcomed these developments but noted that while it might be thought best not to discuss an uneventful problem with a patient in these circumstances such a decision should be recorded as otherwise there is nothing to indicate that appropriate thought was given to informing the patient.

(b) Conclusion

35. Communication is always an important aspect of patient care and especially vital at a time when a patient and a family are coping with devastating, unexpected news and find themselves in an unplanned situation which they are unprepared for. At such times clinical staff need to provide information and advice but also to listen and respond to the needs of the patient and family. It is also important to recognise the difference between palliative care, which may last for some time, and end-of-life care which is more immediate in nature. In Mr A's case the nursing staff on the Ward did not appear to recognise that Mr A and his family were in need of more intensive support and I cannot dismiss the possibility that Mrs A and Miss C are justified in their concern that Mr A was transferred to the Hospice at a time when he was not medically stable because of the concerns being raised by his family. While the medical records are not sufficiently detailed for me to reach that conclusion I do conclude that there was insufficient communication with the palliative care team and Mr A's family and insufficient discussion of his options for end-of-life care. I note that this is one of the issues identified in the Action Plan and there is an ongoing work programme for the Ward staff to raise awareness of palliative and end-of-life care issues.

36. The Respiratory Adviser concluded that while the chest drain insertion itself was reasonable there were issues about communication with the patient/his family about the problem that occurred with the insertion. Again I conclude there was a failure to communicate with the patient or properly record a decision not to communicate and overall I uphold this complaint.

(b) Recommendations

37. The Ombudsman recommends that the Board:

(i) review their policy for the insertion of chest drains to include the reporting of chest x-rays following drain insertion and the management and investigation of pain following drain insertion; and

(ii) review their approach to the documentation of complications of procedures such as chest drains including; i) decisions relating to best management of the complications; and ii) information given to the injured party or their relatives.

(c) The Board failed to deal with Mrs A's complaint in a timely or appropriate manner

38. Mrs A complained on 26 July 2008. The letter was acknowledged on 8 August 2008. Mrs A was advised she would receive a response from the Chief Operating Officer within four weeks. In fact it was decided by the Board that a meeting would be offered in the first instance and a meeting was arranged for 2 September 2008 to discuss Mrs A's concerns with staff, including the Senior Charge Nurse. At the meeting Mrs A was promised a written response and an update on several issues raised at the meeting. Miss C complained several times about the protracted delays in receiving the written response and received a number of apologies for the delays. In the event Mrs A received a written summary of the meeting on 2 November 2008 with a further update from the Senior Charge Nurse but not a written response to all the points she had raised and no indication that one was intended.

39. Mrs A was not satisfied with the lack of a formal response and the time taken to produce a summary of the meeting and wrote again on 8 November 2008 to the complaints team and the Director of Nursing with detailed comments on the notes provided and raising her concerns about the handling of her complaint. A meeting was held with the Director of Nursing on 5 December 2008 and a final written response was provided on 17 December 2008 which contained a number of apologies for failings identified and an action plan for improvements to be made on the Ward. The response also gave some information about a root cause analysis review (the Review) conducted by the Clinical Manager and complaints staff into the problems caused by the handling of this complaint. The Review identified a number of issues where changes already implemented would have prevented some of the problems identified and other areas for ongoing improvement. All changes are being reviewed by the Head of Safety, Governance and Risk for the Board on a monthly basis.

(c) Conclusion

40. Miss C was not happy with the number and length of delays and with the lack of a written response as promised but was anxious that these issues should not detract from the Ombudsman's office's consideration of her very serious concerns about her father's care. Complaint handling errors do contribute to a significant number of the complaints received by the Ombudsman's office and a positive experience in making a complaint can do much to restore the confidence the complainant may have lost thorough their experience with the service so far. The Board conducted the Review which was good practice. The Review indicates that there had been several problems in the handling of Mrs A's complaint and that there had been substantial changes to the complaints handling process over the time of Mrs A's complaint. I, therefore, uphold this aspect of the complaint but recognise the work undertaken by the Board in the latter stages of this complaint to address the problems experienced by Mrs A and Miss C in making their complaint.

(c) Recommendations

41. The Board have already taken significant steps in conducting the Review and implementing a number of changes to the way complaints are handled and are reviewing the changes made on an ongoing basis. The Board have also made written apologies to Mrs A and Miss C for the problems caused by the complaint handling. For these reasons the Ombudsman has no further recommendations to make.

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

Annex 1

Explanation of abbreviations used

Miss C	The complainant
Mrs A	The aggrieved's wife
Mr A	The aggrieved
The Hospital	Ninewells Hospital, Dundee
The Hospice	The hospice (run by a charity) where Mr A was transferred
The Ward	The ward in the Hospital where Mr A was for the majority of his admission
The Board	Tayside NHS Board
The Director of Nursing	The Director of Nursing for the Board
The Nursing Adviser	A nursing adviser to the Ombudsman
The Medical Adviser	A medical adviser to the Ombudsman
The Respiratory Adviser	A respiratory medicine adviser to the Ombudsman
The Hospice Nurse	The senior charge nurse at the Hospice when Mr A was admitted
The Consultant	The consultant responsible for Mr A during his admission to the Hospital
The Senior Charge Nurse	The senior charge nurse responsible for the Ward during Mr A's admission

SALT	Speech and Language Therapy
The Palliative Care Nurse	The palliative care team nurse who arranged Mr A's transfer to the Hospice
The Clinical Manager	The clinical team manager responsible for the Ward – appointed after the events of this complaint
The Action Plan	The action plan drawn up by the Board to address the care and nursing failures identified during their investigation of this complaint
NPSA	National Patient Safety Agency
The Review	The root cause analysis review conducted by the Board into the complaint handling problems

Annex 2

Glossary of terms

Pleural Effusion	Fluid collecting in the lungs
Chest Drain	A drain inserted into the chest cavity to drain fluid accumulated there
CT Scan	A technique in which multiple x-rays of the body are taken from different angles in a very short period of time to build a three dimensional image
Oesophageal	The gullet
Oramorph	A form of morphine

Annex 3

List of legislation and policies considered

National Patient Safety Agency – Report of Chest Drains – Issued 22 May 2008

Releasing Time to Care: The Productive Ward. NHS Scotland Report February 2009

http://www.lanpdc.scot.nhs.uk/reports/documents/Releasing%20Time%20to%20Care.pdf

The Liverpool Care Pathway for the Dying Patient: an evidence based framework for the delivery of appropriate care for dying patients and their relatives in a variety of care settings