Scottish Parliament Region: Glasgow

Case 201003696: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category

Health: Hospital; Care of the elderly

Overview

The complainant (Miss C) raised a number of concerns that in August 2010, the Board failed to properly identify her late father (Mr A)'s health complications, provide adequate post-operative nursing care and failed to communicate with her about his care.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) medical staff failed to properly identify health complications leading to Mr A's death (*upheld*);

(b) Mr A did not receive adequate nursing care post-operatively on 18 and 19 August 2010 (*upheld*); and

(c) nursing staff failed to communicate adequately with Miss C regarding Mr A's care (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) provide evidence of the measures in place to address the failures identified within this report in the MEWS system;	14 March 2012
(ii) confirm to the Ombudsman that they will raise this report with the junior doctor in their annual appraisal;	15 February 2012
(iii) bring this report to the attention of the relevant staff; and	14 March 2012
(iv) apologise to Miss C for the failures identified.	15 February 2012

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

Main Investigation Report

Introduction

1. Miss C complained about the care and treatment provided to her late father (Mr A) by Glasgow Royal Infirmary (the Hospital) from his admission on 15 August 2010 until his death on 20 August 2010. Mr A was admitted to hospital to have a large bladder tumour removed and following his operation on 16 August 2010, his condition deteriorated and he died on 20 August 2010. Miss C complained that health care professionals had failed to act on the symptoms indicating Mr A's rapid deterioration before his transfer to the intensive care unit. She also complained about the nursing care Mr A received and of problems in communication with the nursing staff. Miss C said that as a result of the Board's failures, she remained very distressed at her father's death and believed that it may have been prevented had the Board acted properly.

2. Miss C complained to the Board on 30 August 2010. The Board responded to Miss C's letter of complaint on 6 October 2010. Miss C raised further issues and met the Board on 2 November 2010. Miss C remained dissatisfied with the Board's responses and complained to my office on 4 January 2011.

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

(a) medical staff failed to properly identify health complications leading to Mr A's death;

(b) Mr A did not receive adequate nursing care post-operatively on 18 and 19 August 2010; and

(c) nursing staff failed to communicate adequately with Miss C regarding Mr A's care.

Investigation

4. During the course of the investigation to this complaint, my complaints reviewer obtained and examined Mr A's clinical records and complaint correspondence from the Board. She obtained advice from two of the Ombudsman's professional advisers: a consultant physician specialising in care of the elderly (Adviser 1) and a nursing adviser with extensive experience including surgical nursing (Adviser 2).

5. 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.

Clinical background

6. Mr A was admitted to hospital on 15 August 2010 to have a large malignant tumour removed from his bladder. Mr A's anaesthetic record described him as having chronic obstructive pulmonary disease. His pre-operative electrocardiogram was abnormal. These abnormalities can occur in patients with pulmonary hypertension (high blood pressure within the vessels supplying the lungs) which is most commonly caused by lung disease in this age group. On 16 August 2010, the operation to remove the tumour was performed. Following the operation, the medical records showed that the developing physiological changes observed included hypotension, low body temperature and confusion. On 20 August 2010, Mr A was transferred to the intensive care unit and he died later that day. Proposed cause of death was recorded by the Hospital as severe pulmonary hypertension and hospital-acquired pneumonia.

(a) Medical staff failed to properly identify health complications leading to Mr A's death

7. Miss C said that the Board had failed to detect the health complications leading to Mr A's death including pneumonia within a reasonable time and that earlier detection may have prevented his death.

Board's response

8. In their response to Miss C's complaint, the Board said a CT scan showed a malignant tumour on Mr A's bladder which required an operation. He had a number of serious pre-existing medical conditions including chronic obstructive pulmonary disease, peripheral vascular disease, cerebrovascular disease and an ulcer. An electrocardiogram was carried out before surgery and showed no changes from an earlier one. His heart size was slightly larger because it was affected by his chronic respiratory and cardiovascular problems but this did not preclude him from having surgery. The Board said that Mr A's medical conditions had been managed on the appropriate medication and he had acceptable levels of fitness needed for an operation.

9. The Board went on to say that following Mr A's surgery on 16 August 2010, there was nothing in the first 48 hours in his medical records to

indicate that he had experienced anything untoward; he was routinely reviewed every four hours and recordings were taken of his blood pressure, pulse, temperature and oxygen saturations. He had respiratory signs in keeping with his chronic obstructive pulmonary disease. Nursing staff confirmed that there were no particular clinical issues other than the prolonged haematuria (blood in the urine) and removal of the catheter on 18 August 2010. On the morning of 19 August 2010, Mr A collapsed. His blood pressure and oxygen saturation were low and he was returned to bed and his blood pressure began to improve. He was appropriately monitored throughout the day. He appeared confused on the evening of 19 August 2010. There was no clinical indicators at that time that Mr A had a chest infection. On the morning of 20 August 2010, Mr A's condition deteriorated rapidly and he was transferred to the intensive care unit. The Board said that Mr A's deterioration happened in the last 24 hours of his life and there were no major signs that this would happen before then. His death on 20 August 2010 was caused by his pre-existing chronic lung and heart conditions. The Board apologised to Miss C that aspects of her father's care had caused her distress.

Advice received

10. Adviser 1 said it was highly likely that Mr A had chronic obstructive pulmonary disease and emphysema with pulmonary hypertension. Adviser 1 also believed that Mr A was physically frail and that his general physical condition could have arisen from his chronic lung disease or the malignant tumour or both. Despite this, it was Adviser 1's view that surgery was wholly appropriate because of the significant bladder tumour that required treatment. The was no evidence that the operation, anaesthetic or pre-operative care contributed to Mr A's deteriorating condition, but his post-operative management was of concern.

11. Adviser 1 said that the response by clinical staff to Mr A's observations documented in a modified early warning score (MEWS) was below a standard that could reasonably be expected. Early warning systems such as MEWS are standard across NHS in Scotland and should be familiar to all staff. By measuring simple observations, they provide early warning of changes in the normal function of the body that might suggest the development of the significant illness before the patient's condition becomes critical. There was a clear 'calling criteria' in MEWS indicating how staff should respond to specific values or changes in values of the scores calculated from basic observations. A higher score was more concerning than a lower score. Adviser 1 was critical

of the overall clinical response to Mr A's changing observations from 17 August 2010 and highlighted two areas of concern in particular.

12. On 17 August 2010 at 11:15, Mr A had a MEWS score of 6. His blood pressure had fallen and his body temperature was under 36 degrees. The suggested actions in the calling criteria were to contact the senior nurse and critical care outreach team and increase frequency of patient observation. Instead, staff increased the oxygen concentration and waited two hours before rechecking the oxygen saturations, but no other observations were taken and no MEWS score calculated. It was not clear from either the nursing or medical notes whether the nursing and medical staff communicated about the abnormal observations. Adviser said that the basic response to the MEWS score of 6 and the fall in blood pressure both in terms of action and documentation was below a standard that could reasonably be expected. The changing observations at 22:55 also indicated that Mr A had developed hypotension, but there did not appear to be any exploration of the possible reasons or even action to monitor blood pressure more frequently. Instead, the response was to defer any further observations for eight hours.

13. The second area of concern related to Mr A's episode of collapse on the morning of 19 August 2010. A diagnosis of 'vasovagal episode' (a reflex response of the body to a variety of possible stimuli) was recorded at 11:30 by a junior doctor. Adviser 1 said that the episode was unlikely to have been innocuous given the abnormal observation changes for the preceding 48 hours. Mr A could have been, amongst other things, septic (blood cultures could have been taken), bleeding internally, having a pulmonary embolism, myocardial infarction etc. There was no diagnostic consideration at this point, which Adviser 1 said was below a level that could reasonably be expected. If these observations had been discussed with a more experienced clinician, then a more detailed assessment would have been undertaken. Furthermore, the oxygen saturations level at 11:35 should have led to an increased frequency of observations and the senior nurse being contacted, but no contact was made and observations were not recorded until five hours later.

14. My complaints reviewer asked Adviser 1 if a reasonable standard of care would have changed the outcome for Mr A. Adviser 1 said the underlying cause of Mr A's deterioration and ultimate death was speculative. His view was that the developing physiological changes observed would support the view by the intensive care unit that Mr A was septic, possibly due to hospital-acquired

pneumonia, although other causes could not be absolutely excluded. Moreover, given Mr A's apparently limited pre-morbid condition, it could not be said with certainty that had more intensive action been taken earlier than 20 August 2010, the final outcome would have been any different.

(a) Conclusion

15. Miss C complained about the standard of medical care Mr A received following his operation. The advice I have accepted is that the medical care in relation to the MEWS scoring systems and assessment of the episode of collapse were below a standard that could reasonably be expected. These failures meant that Mr A's deterioration was not acted upon and his care was neither optimal nor timely, and suggested a systematic problem that needs to be addressed. However, it was impossible to say if the outcome would have been different had Mr A received a better standard of care. I uphold the complaint.

(a) Recommendations

16. I recommend that the Board:	*Completion date*
(i) provide evidence of the measures in place to address the failures identified within this report in the MEWS system; and	14 March 2012
(ii) confirm to the Ombudsman that they will raise this report with the junior doctor in their annual appraisal.	15 February 2012

(b) Mr A did not receive adequate nursing care post-operatively on 18 and 19 August 2010

17. Miss C complained that on 18 and 19 August 2010, nursing staff failed to act on symptoms such as Mr A's confusion suggesting that his condition was deteriorating.

Board's response

18. The Board said that following the first 48 hours after his surgery, Mr A was routinely reviewed and there was nothing in his medical records to indicate any deterioration until the last 24 hours of his life. Nursing staff confirmed that there were no particular clinical issues other than the prolonged haematuria and removal of the catheter on 18 August 2010.

Advice received

19. My complaints reviewer asked Adviser 2 to consider whether the nursing care Mr A received following his operation was reasonable. Adviser 2 said that MEWS was a component of care that reflected the overall post-operative care and when used properly, gives early detection of patients who are deteriorating. There were specific areas of nursing care provided to Mr A that were reasonable including nursing assessment, care planning, treatment of personal hygiene, pain management and wound care. However, there were failures in relation to adhering to the MEWS system. Nursing staff failed to act upon MEWS scores and the further actions and calling criteria were not met. On 19 August 2010, there was a record that Mr A was very confused, but this was not fully investigated. Delirium was often a sign of reduced oxygen levels to the brain and must be taken seriously. Any underlying cause should be investigated and acted upon as it was often a sign of infection. Nursing staff also failed to complete the MEWS charts accurately. Adviser 2 concluded that there were failings in the nursing care in that the principles underlying the use of MEWS were not followed and the deterioration in Mr A was not acted upon until he was transferred to the intensive care unit. The nursing role was crucial to early assessment and intervention of patients who were deteriorating, so the failings in this case were significant and needed to be addressed.

(b) Conclusion

20. Miss C complained about the standard of nursing care Mr A received following his operation. The advice I have accepted is that the post-operative nursing care Mr A received in relation to the early warning system in place was not reasonable. I uphold the complaint. The recommendations I made in paragraph 16 are relevant here also.

(c) Nursing staff failed to communicate adequately with Miss C regarding Mr A's care

21. Miss C complained about failures in communication with nursing staff in that nursing staff failed to address the concerns the family had raised about Mr A's condition and keep them informed.

Board's response

22. The Board said that staff did not recall Mr A or his family raising any specific issues. However, they were aware that this was contrary to Miss C's statement that she and her brother had discussed Mr A's care with nursing staff on 18 August 2010.

Advice received

23. Adviser 2 said there was no record of any communication with Miss C until 20 August 2010 when Mr A deteriorated markedly and was transferred to the intensive care unit. It was clear from the Board's response that although nurses and doctors recorded Mr A's acute confusion on 19 and 20 August 2010, no member of staff had spoken to the family about it. Adviser 2 said it was unacceptable not to keep families informed of any deterioration in the patient's condition and that this should be carried out proactively. The nurse in charge during visiting should be accessible to relatives and ensure that they discuss any concerns with them. Adviser 2 went on to say that it was very distressing to see a relative confused and an explanation should have been given to Mr A's family. Nursing staff also failed to involve Mr A's family in any decision-making about his care and treatment.

(c) Conclusion

24. Miss C complained about the failures in communication about Mr A's care by nursing staff. The advice I have accepted is that the communication fell below a reasonable standard. Effective communication with patients and their family or carers is integral to providing a reasonable standard of care and treatment. I uphold the complaint and I recommend that the Board bring this report to the attention of the relevant staff to ensure effective communication with patients and their families or carers.

(c) Recommendation

25. I recommend that the Board:	*Completion date*
(i) bring this report to the attention of the relevant staff.	14 March 2012

General recommendation

26. I recommend that the Board:	*Completion date*
(i) apologise to Miss C for the failures identified	15 February 2012

27. 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
Mr A	The complainant's late father
The Hospital	Glasgow Royal Infirmary
Adviser 1	A consultant physician specialising in care of the elderly
Adviser 2	A nursing adviser with extensive experience including surgical nursing
MEWS	Modified early warning score
CT scan	Computerised tomography scan

Annex 2

Glossary of terms

Cerebrovascular disease	a group of brain dysfunctions related to disease of the blood vessels supplying the brain
Chronic obstructive pulmonary disease	a condition where the airways in the lungs become narrowed and limits the flow of air to and from the lungs
Haematuria	blood in the urine
Hypotension	abnormally low blood pressure
Pneumonia	inflammatory condition of the lung
Pulmonary hypertension	high blood pressure within the vessels supplying the lungs