Scottish Parliament Region: Central Scotland

Case 200502721: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C) raised a number of concerns that her husband (Mr C) had been inadequately cared for during a stay in Hairmyres Hospital (the Hospital); that the Hospital was not clean; that the out-of-hours Doctor failed to call an ambulance; that her husband was not taken to the nearest treatment centre; and that the subsequent handling of her complaint was inadequate.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the out-of-hours Doctor failed to call an ambulance for Mr C *(upheld*);

(b) Mr C was inappropriately taken to a hospital that was not the nearest for treatment and was not transferred there subsequently (*not upheld*);

(c) the care given to Mr C in Accident and Emergency at the Hospital was not as outlined in Lanarkshire NHS Board (the Board)'s response to Mrs C (*not upheld*);

(d) the cleanliness of the Hospital was not of a good standard (*not upheld*);

(e) Mr C was not assisted with feeding at mealtimes in the Hospital (*not upheld*);

(f) Mr C's regular medication was not administered correctly while in the Hospital (*not upheld*);

(g) the appropriate action was not taken following the diagnosis of *Staphylococcus aureus* (*partially upheld*); and

(h) the response of the Board to Mrs C's complaints was not adequate (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) introduce a policy regarding ambulance contact by out-of-hours Doctors; and

(ii) apologise to Mr and Mrs C for failing to adequately communicate the findings of a swab of Mr C's elbow.

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

Main Investigation Report

Introduction

1. On 5 January 2006 Mrs C complained to the Ombudsman that, having completed the Board's complaints process, she was still dissatisfied with the responses given to her complaints about her husband's medical treatment; his care whilst in the Hospital; the cleanliness of the Hospital; and the failure of the out-of-hours Doctor to call an ambulance. In the course of her complaint, she had obtained her husband's medical records and was alarmed to see that, upon discharge from the hospital, a microbiology report suggested he had a slight growth of MRSA.

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

(a) the out-of-hours Doctor failed to call an ambulance for Mr C;

(b) Mr C was inappropriately taken to a hospital that was not the nearest for treatment and was not transferred there subsequently;

(c) the care given to Mr C in Accident and Emergency at the Hospital was not as outlined in the Board's response to Mrs C;

(d) the cleanliness of the Hospital was not of a good standard;

(e) Mr C was not assisted with feeding at mealtimes in the Hospital;

(f) Mr C's regular medication was not administered correctly while in the Hospital;

(g) the appropriate action was not taken following the diagnosis of *Staphylococcus aureus*; and

(h) the response of the Board to Mrs C's complaints was not adequate.

Investigation

3. I have examined the relevant medical records and complaint file from the Board. I have reviewed the copies of correspondence and comments submitted to this office by Mrs C, and have sought the views of a medical adviser to the Ombudsman (the Adviser). I have set out my findings of fact and conclusion. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board have had an opportunity to comment on the draft report.

4. Mr C has rheumatoid arthritis. In early April 2005 he received treatment for an infected nodule on his elbow. In the early hours of 11 April 2005, he started having what appeared to his wife to be fits of some kind. She called NHS 24, who informed her that a doctor would attend at Mr and Mrs C's home.

5. At 03:00, a doctor (Doctor 1) arrived, examined Mr C and advised that hospital treatment would be required. Doctor 1 advised that he would call for an ambulance to take Mr C to hospital. Doctor 1 then left the house at 03:15.

(a) The out-of-hours Doctor failed to call an ambulance for Mr C

6. Over an hour later, no ambulance had arrived. Mrs C's sister made an emergency call to ask why this was. She was told that no call had been logged for an ambulance but that one would be sent.

7. Following Mrs C's complaint to the Health Board, investigations revealed that Doctor 1 intended to call and believed he had in fact ordered an ambulance but Scottish Ambulance Service records show this was not the case. The Clinical Director for the Board's Out-of Hours Service discussed the incident with Doctor 1 to ensure the situation would not recur. The Out-of Hours Service does not have any specific policy or guidelines on contacting ambulances for patients.

(a) Conclusion

8. The Board have investigated and found that Doctor 1 did not call an ambulance for Mr C, having informed Mr and Mrs C that he would. I accept that Doctor 1 believed that he did call an ambulance and note that his apologies to Mr and Mrs C have been communicated to them. I also note that the Board have addressed the issue with Doctor 1. However, this action stopped short of putting in place measures to try to ensure the situation does not recur and, therefore, I uphold the complaint.

(a) Recommendation

9. The Ombudsman recommends that the Board put a policy in place that clearly outlines the roles and responsibilities for ambulance contact for out-of hours Doctors, in order to ensure this situation does not recur.

(b) Mr C was inappropriately taken to a hospital that was not the nearest for treatment and was not transferred there subsequently

10. When the ambulance arrived the crew attempted to take Mr C to Wishaw General, that being the nearest hospital, but Wishaw General had been diverting GP referrals for some hours due to the high level of cases they were treating. Mr C was instead taken to Hairmyres Hospital.

11. Mrs C was concerned that Mr C was taken to the Hospital because Wishaw General was closer and Mr C had received treatment for rheumatoid arthritis there. She was later informed by a member of staff at Wishaw General that if Mrs C had taken Mr C directly to Wishaw General herself, and not called for an ambulance, he would have been treated there.

12. The Board have explained that the three acute hospitals in the area operate as an emergency clinical network, so that when a hospital is experiencing a high rate of GP admissions the opportunity exists to redirect patients to ensure they receive the treatment they require as quickly as possible. For this reason, when Mr C was admitted to the Hospital, Wishaw General had already been diverting referrals for some hours. Attempts were made later to transfer Mr C to Wishaw General but they continued to be unable to admit patients due to a bed shortage. The Board have confirmed that, had Mrs C taken Mr C to Wishaw General, he would have been treated there, but he was taken to the Hospital in line with the process detailed above.

(b) Conclusion

13. Mr C was taken to the Hospital in line with the emergency clinical network process with the aim of administering treatment to him as soon as possible. Subsequent attempts were made to transfer him to Wishaw General but this hospital was unable to accommodate him. Accordingly, I do not uphold the complaint.

(c) The care given to Mr C in Accident and Emergency at the Hospital was not as outlined in the Board's response to Mrs C

14. After Mrs C complained, the Board investigated and the Chief Executive wrote to her with the findings on 3 June 2005. Mrs C perceived inaccuracies in this response and requested a meeting to discuss these. This meeting was held on

29 July 2005 and resulted in further investigation and a written response to Mrs C from the Chief Executive on 7 October 2005. Mrs C remained of the opinion that the treatment and medication received by her husband was not as outlined in these responses.

15. I sought the views of the Adviser on this aspect of the complaint. He is of the opinion that:

> 'a prompt diagnosis was made and appropriate investigations and treatment were instituted without delay. My review of the records confirms that the account given by the Chief Executive was accurate.'

(c) Conclusion

16. Having compared Mr C's medical records with the statements made by the Chief Executive, I agree with the Adviser's opinion and, accordingly, I do not uphold the complaint.

(d) The cleanliness of the Hospital was not of a good standard

17. While waiting in Accident and Emergency for Mr C to be taken to a ward, Mrs C overheard two cleaning staff outside remarking on the cleanliness of the Hospital. Mrs C then took note of the condition of her husband's cubicle. She observed stains on the floor and felt 'the overall cleanliness left a lot to be desired'. Following Mr C's transfer to Ward 2, Mrs C noted that leakage from his wound was cleaned from the arm of a chair and the floor using only a regular paper towel and no disinfectant. On another occasion, ECG electrodes which had fallen from Mr C on to the floor were not picked up.

18. The Chief Executive responded to these complaints, pointing out that all areas in the Hospital are cleaned in accordance with standards set by NHS Quality Improvement Scotland and that there are regular audits by the Property and Support Services Department. In the case of Accident and Emergency, he pointed out that access in order to clean cubicles can be limited due to clinical activity. It had not been possible to trace the cleaning staff referred to by Mrs C. In the case of Ward 2, the Ward Manager said that the regular domestic staff member for the ward was on long term sick leave at the time. Their post was filled on a temporary basis but a permanent member of domestic staff had now been engaged. The Ward Manager further noted that the nurse who recorded the leakage from Mr C's

wound had left the Board's employment. The incident, however, was brought up at staff meetings and the Ward Manager had also passed on his apologies to Mr and Mrs C.

19. Mrs C remained concerned that the staff she had overheard had not been traced and that their comments had added to her concerns about her husband's care. I have established that an independent company provide housekeeping staff at the hospital and that the Board undertook extensive investigation to find out who made the comments. This included checking shift rotas and helpdesk request records. Unfortunately, these investigations proved unsuccessful. I have also read an extract from the independent company's induction training relating to expected conduct when working in a sensitive patient environment, such as Accident and Emergency.

(d) Conclusion

20. It is not possible to judge the general cleanliness of the Hospital at the time, from the information that I have seen. The Board, however, clearly investigated the complaint and took significant, if unsuccessful, steps to ascertain the identities of the relevant domestic staff. I have also seen evidence of the training that domestic staff receive in relation to expected conduct, which is appropriate. The Ward Manager of Ward 2 gave an explanation of the housekeeping situation in the ward at the time of Mr C's treatment, investigated Mrs C's concerns and passed on appropriate apologies to Mr and Mrs C. As these matters had been addressed before the complaint was brought to this office, I do not uphold the complaint.

(e) Mr C was not assisted with feeding at mealtimes in the Hospital

21. Mrs C complained that it had been necessary for her to assist her husband at mealtimes because he was unable to grip the cutlery or open the packets provided. No member of staff had assisted him and his call bell was out of reach.

22. The Chief Executive, on 3 June 2005, advised that when Mr C's nutritional status and needs were assessed it was considered that he did not have any specific requirements. Following the meeting of 29 July 2005, further investigations were undertaken and, in his response of 7 October 2005, the Chief Executive explained that clinical support workers were available to provide assistance but they had not observed Mr C requiring assistance. He further stated

that a new nutritional screening tool was now being used and this improved the assessment of nutritional needs and identification of any specific assistance that was required.

23. Following my enquiries, the Board provided a copy of this new nutritional assessment which, in conjunction with the admission assessment, would identify nutritional needs and any requirement for assistance. It takes specific account of a patient's mobility and dexterity.

24. Mr C's admission assessment and his nursing notes indicate that he was taking diet and fluids well throughout his time in the Hospital. The nutritional assessment did not indicate any difficulties with feeding and no difficulties were observed by members of staff or raised by Mr or Mrs C during his stay.

(e) Conclusion

25. An assessment was carried out and it was not concluded that Mr C required assistance with feeding. I further note that there is no record that Mr and Mrs C raised the issue while he was in the ward. In response to Mrs C's complaint that the call bell was out of reach, the initial assessment noted that Mr C was mobile with the use of walking sticks. There is no indication that he would have been unable to access his call bell if it were not within immediate touching distance. Nonetheless, the Board have assured me that staff in the Accident and Emergency Department and Ward 2 have been reminded of the need to ensure that patients have access to the nurse call system. I do not uphold the complaint.

(f) Mr C's regular medication was not administered correctly while in the Hospital

26. As Mr C takes daily prescribed medication, Mrs C was concerned that this be maintained during his stay in the Hospital. She was informed that his prescribed medication (Atenolol – to treat high blood pressure, Dihyrocodeine – an analgesic and Indomethacin – an analgesic) would be supplied from the Hospital pharmacy and that supplies brought from home should be taken back. Mrs C complained that the regular medication was not administered correctly while he was in the Hospital.

27. Following Mrs C's complaint, the locum consultant physician (who was not party to the prescriptions) reviewed Mr C's notes. His conclusion, relayed to Mrs C by the Chief Executive in his reply of 3 June 2005, was that Mr C had received Atenolol and Dihydrocodeine in line with his prescription. Though he did not receive Indomethacin until his second day in the Hospital, he had received adequate analgesia in the intervening 24 hours and was comfortable with the analgesia as prescribed. The practice of supplying medication from the pharmacy rather than the patient's own supply was a matter of Hospital policy.

28. As detailed in paragraph 14, Mrs C asked for a further review. This was undertaken; the same conclusions were reached and relayed to Mrs C in the Chief Executive's letter of 7 October 2005.

29. I sought the views of the Adviser on this aspect of the complaint. He concluded that 'My review of the records confirms that the account given by the Chief Executive was accurate'.

(f) Conclusion

30. There is no evidence to suggest that Mr C's medication was not administered appropriately and, accordingly, I do not uphold the complaint.

(g) The appropriate action was not taken following the diagnosis of *Staphylococcus aureus*

31. At the meeting held on 29 July 2005, Mrs C requested copies of Mr C's medical notes. These were supplied on 17 October 2005. Among the documents supplied was a record of a swab of Mr C's elbow taken on 12 April 2005. The report was of a light growth of *Staphylococcus aureus*, sensitive to the antibiotics flucloxacillin and erythromycin. Mrs C was concerned, due to media coverage of MRSA (methicillin resistant *Staphylococcus aureus*) and because she and others were required to dress and redress the affected area, that neither she nor Mr C had been advised of the result of the swab.

32. Although the Board had not had the opportunity to respond to this specific complaint, it was agreed that the Ombudsman would investigate directly as it was one part of a larger complaint. The Board have advised me that the report was authorised by the lab on 15 April 2005 and, therefore, was not available to the

clinical team whilst Mr C was in the hospital. The Board have accepted that consideration could have been given to writing separately to Mr C when the report was authorised.

33. I sought the views of the Adviser, who informed me that the growth was not MRSA, as it was sensitive to antibiotics. Mr C received ten doses of intravenous flucloxacillin during his stay in the Hospital and was discharged with a supply of an oral antibiotic on the advice of the rheumatologist. The Adviser thought this was the appropriate action to be taken in these circumstances. The Board have also assured me that they do, however, have an appropriate policy to address the situation should the swab have grown MRSA. This would mean the clinical team being contacted by Infection Control and the Consultant Microbiologist so that any required adjustment to Mr C's management could be made. I hope this additional information will reassure Mr and Mrs C.

(g) Conclusion

34. While it is clear that Mr and Mrs C were aware that Mr C had an infection and it is also clear that the therapy provided was appropriate to treat the infection (see paragraph 33), it should have been recognised that, from a lay person's perspective, the information about the nature of the infection could be misunderstood. Therefore, I uphold the complaint to the extent that the Board's communication with Mr and Mrs C about the infection could have explained the nature of the growth and that the antibiotics administered and supplied were adequate to treat it.

(g) Recommendation

35. The Ombudsman recommends that the Board should apologise to Mr and Mrs C for their poor communication on this issue.

(h) The response of the Board to Mrs C's complaints was not adequate

36. Mrs C complained that the Board had not adequately responded to her complaints.

37. In investigating this part of Mrs C's complaint, I have read the Board's file on the complaint and their response to it.

38. I have seen that Mrs C's complaint was acknowledged within the timescales. Responses and opinions were sought from the appropriate departments and a clear written response was given to Mrs C. This response offered a meeting with Mrs C, which she took up, and the meeting was organised in line with Mrs C's availability. Following this meeting, further investigations were carried out and a further reply was sent on 7 October 2005.

(h) Conclusion

39. Clearly, the Board did take appropriate steps to investigate Mrs C's complaint. The answers they provided did not satisfy Mrs C. Nevertheless, I consider they provided a good response to the complaint. I, therefore, do not uphold the complaint.

40. 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.

28 November 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	The complainant's husband
The Board	Lanarkshire NHS Board
Doctor 1	Out-of-hours service Doctor
The Adviser	The medical adviser to the Ombudsman
The Hospital	Hairmyres Hospital
MRSA	Methicillin resistant *Staphylococcus aureus*