Scottish Parliament Region: Glasgow

Case 200500103: Argyll and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Hospitals; Clinical treatment

Overview

On 12 April 2005 the Ombudsman received a complaint from Mr C and his sister (Ms C) that Argyll and Clyde NHS Board (the Board) failed to provide their father (Mr A) with adequate clinical care and treatment at the Accident and Emergency Department (A&E) at the Inverclyde Royal Hospital (the Hospital) during his admission following a fall on 29 April 2004. It should be noted that on 1 April 2006, Greater Glasgow and Clyde NHS Board took over responsibility for the Hospital.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board failed to provide adequate clinical care and treatment to Mr A within the A&E Department (*not upheld*);

(b) the Board failed to provide adequate nursing care to Mr A within the A&E Department (*upheld*);

(c) the nursing notes were not adequate *(upheld)*; and

(d) the Board failed to handle Mr and Ms C's complaints adequately *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

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[1] Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to the former Board or Greater Glasgow and Clyde Health Board as its successor. However, the recommendations within this report are directed towards Greater Glasgow and Clyde Health Board.

(i) perform a full audit of A&E nursing records in the next three months and provide the Ombudsman's office with the results of this audit;

(ii) take further action to ensure that the failings in the nursing documentation and communication my investigation identified are addressed, and that the Board provide the Ombudsman's office with details of who will take responsibility for this, and what action will be taken;

(iii) provide evidence of educational programmes and systems of competency-based measurement for A&E nursing staff in relation to triage performance, record-keeping, nursing assessment, care planning and discharge planning;

(iv) review their complaints handling; and

(v) write to Mr and Ms C to apologise for the Board's failure to address their concerns satisfactorily.

The Board have accepted my recommendations and are already acting on them.

Main Investigation Report

Introduction

1. Mr A, an 86-year old gentleman, attended Accident and Emergency (A&E) on 29 April 2004, following a fall at home during which he sustained abrasions to his head. He had a long history of emphysema and his breathlessness had increased over recent months. After examination in A&E, Mr A was discharged home in the company of his son and daughter, with a referral to the respiratory out-patient clinic in view of his worsening breathing problems. Mr A was attended by his General Practitioner that afternoon, but died at home the following day.

2. The complaints from Mr and Ms C which I have investigated are that:

(a) the Board failed to provide adequate clinical care and treatment to Mr A within the A&E Department; and

(b) the Board failed to provide adequate nursing care to Mr A within the A&E Department;

(c) the nursing notes were not adequate; and

(d) the Board failed to handle Mr and Ms C's complaints adequately.

Background

3. Mr and Ms C complained to the Board on 16 May 2004 about the care and treatment provided to their father; they requested a meeting with someone in authority to discuss their concerns. One of the Board's complaints officers (Officer 1) wrote to them on 19 May 2004 to arrange such a meeting. Officer 1 also requested that they set out the points they felt required investigation and discussion at the meeting in order that appropriate personnel would attend.

4. Ms C responded by letter on 26 May 2004, setting out the following points that they wanted the meeting to address:

- 'The doctor who 'attended' to my father, by his own admission, was not a respiratory doctor, so why didn't he call for someone who was experienced in that field?
- How was this doctor unable to diagnose a serious chest and lung infection (which was diagnosed less than two hours later by his GP) and thus treated accordingly?
- Why did a superficial graze to my father's head, which was the result of him collapsing at home, command priority over his more serious condition?

- If the graze on my father's head was considered important enough to treat, why wasn't he detained for observation being that he was 86 years old?
- When it was obvious that they could not get rid of him quickly enough, why was there no medication offered, why did no single member of staff assist us to get him dressed, get him on a wheelchair and even see us to the car? Had they done so, they would have seen the very distressed condition he was in, and in our opinion, would have wheeled him straight back in….he was that bad.'

5. On 31 May 2004, Officer 1 wrote a memo addressed to a consultant in Emergency Medicine (Consultant 1), the Clinical Nurse Manager of the A&E Department (Nurse 1), and the Directorate Nurse Manager, which asked them to supply dates that they would be able to attend a meeting with Mr and Ms C. Officer 1 attached a copy of Ms C's letter of 26 May 2004 to the memo, and explained that it detailed the points the family would like to raise at the meeting.

6. The meeting took place on 8 June 2004, and on 11 June 2004 Officer 1 wrote to Mr and Ms C and set out a summary of what had been discussed at the meeting:

> 'I refer to our meeting on Tuesday, 8 June 2004. Present were yourselves, Consultant 1, Nurse 1 and myself.
>
> I did introductions and informed those present that we would commence the meeting by addressing the points that had been detailed in your letter of 26 May 2004.
>
> The series of events that occurred on Thursday 29 April when the late [Mr A] was brought to Accident and Emergency were given in detail. [Ms C] expressed deep concern regarding [Doctor 1]'s concentration on the graze on her late father's head rather than on his breathlessness. [Mr C] indicated that he had spoken to [Doctor 1] outside the cubicle in an effort to stress his concern regarding his father's condition.
>
> [Ms C] was also very concerned regarding the lack of nursing assistance offered to them after [Doctor 1] had decided that [Mr A] should be discharged home. A nurse had left a wheelchair at the door of the cubicle then left. There was no offer of assistance to dress [Mr A] or to ensure that he was able to make his way to [Ms C's] car.

[Consultant 1] informed you that he was unable to explain to you why [Doctor 1] did not admit [Mr A]. However, he did inform you that [Doctor 1] is an experienced doctor and good at his job. [Consultant 1] advised you that he was very sorry that you had experienced such a great deal of anxiety and stress and agreed that you had suffered an awful ordeal. It was acknowledged that this stress and anxiety occurred due to the fact that as caring relatives, you felt that your father had not received the appropriate treatment from the Accident and Emergency Department.

[Nurse 1] was also concerned about the lack of nursing assistance and expressed her regret. She agreed that at the very least, assistance should have been given to dress [Mr A], and even just as a matter of courtesy, a member of staff should have accompanied you to the car.

In conclusion, it was agreed that [Consultant 1] would discuss the matter in detail with [Doctor 1], informing him of the anxiety and stress that resulted, in an effort to ensure that such a situation did not recur.

[Nurse 1] agreed to speak to all nursing staff within the department, advising them of the need to assist relatives with patient's dressing etc and also that it is only common courtesy to ensure that patients and relatives leave the premises safely. Customer Care Training will be arranged if necessary.

I advised you that if you were still dissatisfied with the outcome of this meeting, I could arrange for Conciliation or you could request an Independent Review.

Please accept our profound apologies for the anxiety and stress you have experienced. We will make every effort to ensure that this does not happen again.'

7. Mr and Ms C remained dissatisfied with the outcome of the meeting and requested an Independent Review on 13 September 2004.

8. The Independent Complaints Convener wrote to Mr And Ms C on 28 February 2005 and advised them that he had decided that it would be appropriate to convene an Independent Review Panel. Subsequently, however, the Board determined that the Convener had not consulted with the Lay Chair

appropriately, and, therefore, had not followed the correct procedure. As it would have been necessary to reappoint a Lay Chair and Convener, and since Independent Review Panels were due to be abolished on 1 April 2005, the Board decided it would be more appropriate for Mr and Ms C's complaints to be referred to the Ombudsman's office. Mr and Ms C agreed, and on 4 April 2005 authorised the Ombudsman to investigate their complaints.

Investigation

9. The investigation of this complaint involved reading all the documentation supplied by Mr and Ms C, Mr A's relevant medical records and the Board's complaint files. I obtained advice and guidance from a clinical adviser (the Clinical Adviser), with expertise in the practice and procedures of emergency medicine, as well as an A&E nursing adviser (the A&E Nursing Adviser), who had extensive experience and expertise in A&E nursing. I set out my findings of fact and my conclusions for each of the heads of Mr A's complaint. Where appropriate, the Ombudsman's recommendations are set out at the end of the sections dealing with individual heads of complaint. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr and Ms C, and the Board have had the opportunity to comment on a draft of this report. A glossary of medical terms used appears at Annex 2.

Mr A's medical history prior to attending A&E

10. Mr A's medical records showed that Mr A was under the care of cardiologists for heart failure. He was known to have aeortic stenosis, a condition in which there is obstructed blood flow out of the heart due to a narrowing of the main vessel. This puts strain on the heart and causes it to fail. In addition, he suffered from intermittent irregular heartbeats, which also hampered the efficiency of his heart. At a review in September 2003, it was found that Mr A's main complaint was shortness of breath, and that this was gradually getting worse. The cardiologist suspected, after examining Mr A's chest, that his worsening symptoms might be due to lung disease rather than his heart condition, and so sent him for additional tests. These were performed in September 2003, and it was found that he had a very reduced flow rate in his airways, which is indicative of obstructive lung disease. This was in addition to his cardiac problems. The cardiologist wrote to Mr A's GP on 20 October 2003 asking her to refer Mr A to the respiratory team. The GP's notes record that this letter was marked as seen and filed, but there was no indication that any referral was made.

Evidence obtained from Mr A's medical records relating to his attendance at A&E

11. Mr A was taken by ambulance to the A&E Department on 29 April 2004 following a fall in his bedroom at home. The time of his arrival is recorded as being 15:39. Doctor 1 saw him at 16:00. After he had taken Mr A's history and performed a number of tests, including an electrocardiogram, Doctor 1 diagnosed that Mr A was suffering from a minor head injury and arranged for an anti-tetanus booster and head injury advice to be given to Mr A. Mr A's temperature was recorded as being 36.9 degrees centigrade. Doctor 1 arranged for Mr A to be referred to a respiratory clinic, he further advised the family that they may want to speak to their GP to ask if the GP considered it appropriate to give Mr A a temporary nebuliser or oxygen. Mr A was then discharged at 16:45 into the care of Mr and Ms C.

Evidence obtained from GP's records

12. The GP's entry in Mr A's medical notes of her home visit on 29 April 2004 recorded that Mr A said that his shortness of breath worsened over the previous four weeks such that he could hardly walk and he was also confused at times. The notes record that he had fallen twice, once the previous night, when he became pale, short of breath, his eyes were rolling and he became confused for three to four minutes. This settled, but again that day he fell over and was found on the floor. An ambulance was called.

13. The GP noted that Mr A had had no chest pain but did have green phlegm. His temperature was a little raised (37.3 degrees centigrade) and when she listened to his chest there were signs on the left side which were indicative of infection. Her treatment was recorded as follows:

> 'Impression – chest infection. Amoxycillin.
> (Offered admission as family initially upset that patient was discharged. Patient himself not keen for hospital admission, therefore, treat at present and review if problems)'

14. The final entry in the notes obtained from the GP practice was dated 30 April 2004, and recorded that Mr A had collapsed as the GP arrived at 16:45. The cause of death was recorded as 'Acute myocardial infarction; aortic stenosis; paroxysmal AF; COAD; chest infection'. (An explanation of these terms is provided at Annex 2.)

(a) The Board failed to provide adequate clinical care and treatment to Mr A within the A&E Department

15. The Clinical Adviser examined the clinical notes written by Doctor 1. She advised that they are comprehensive and that the examination notes are good and directed at excluding underlying acute medical conditions or serious head injury. They are signed and timed at 16:00, which was within 30 minutes of Mr A's arrival at A&E. The Clinical Adviser observed that although the recorded history was that of a 'trip out of bed', the notes provided evidence that Doctor 1 considered other possible underlying causes for the fall such as black out, cardiac causes, and a stroke.

16. The Clinical Adviser considered that the clinical notes, in conjunction with the statement made by Doctor 1, provided evidence that Doctor 1 took further details from Mr and Ms C in respect to Mr A's recent history of gradual decrease in exercise tolerance and increased breathlessness. She considered Doctor 1 also clearly went to some lengths to find out what care Mr A was receiving for his chest condition, obtained Mr A's medical notes; and rang the respiratory clinic to find out whether the specialist referral to the respiratory clinic, which had been recommended to Mr A's GP on 20 October 2003, had been implemented. When Doctor 1 discovered that no such referral had been made, Doctor 1 wrote a personal letter to the respiratory clinic to request an urgent appointment. The Clinical Adviser commented that strictly speaking, this should have been the GP's responsibility. Doctor 1 also stressed the need for the GP to ensure that this was arranged. She also commented that Doctor 1's notes were of a good standard, and his statement provided further reassurance that Doctor 1 made his decisions only after careful consideration.

17. In light of the documented findings, Doctor 1 concluded that Mr A's chest complaint was a long-standing issue, and that it did not warrant acute admission. It is evident that Doctor 1 considered Mr A's respiratory condition as an incidental, though worrying, finding and he took steps to ensure that appropriate care for the chronic condition was put in place. The role of an A&E clinician is to diagnose and treat sudden illness or injury. The reason for Mr A's attendance at A&E, in the first instance, was due to his fall and his head injury and not the deterioration in his chest condition. It was for these reasons, the clinical adviser explained, that his head injury was treated in the A&E Department, and not his breathlessness.

18. The Clinical Adviser's opinion, based on the clinical findings, was that Doctor 1's diagnosis of a minor head injury was reasonable, as was his decision not to admit Mr A to hospital on the basis of his chest condition, given that there appeared to have been no acute episode. The clinical adviser found that Doctor 1's decision to refer Mr A to a respiratory clinic, and to advise his family to consult the GP regarding the possible use of additional chest medication rather than summon a respiratory specialist, was appropriate.

19. The GP's entry to Mr A's medical notes recorded that during her consultation with Mr A he had no chest pain, but he did have green phlegm. It is also recorded that at that time his temperature was slightly raised and there were signs on the left side of his chest, which were indicative of infection. The Clinical Adviser found that there was nothing in the records to suggest that the GP considered this infection to be 'very serious' and although she did offer to refer Mr A to hospital, she has noted that the GP did so because the family were unhappy about his being discharged, but she was content to treat the suspected infection at home. The Clinical Adviser commented that the chest infection that the GP diagnosed was something that patients with Mr A's history would be prone to, and that courses of antibiotics were a feature of his past medical history, therefore, the diagnosis represented nothing unusual. The GP decided to treat Mr A at home, which she was unlikely to have done if she considered that Mr A had a condition that required urgent hospitalisation, and this supports the conclusion that Mr A's discharge from A&E was not unreasonable.

20. The Clinical Adviser stated that the signs that would have suggested a chest infection, such as a productive cough with green sputum or a raised temperature, were both absent at the time Mr A attended A&E.

21. The Clinical Adviser noted that the GP who attended Mr A on 30 April 2004 listed a number of causes for his death, and considered that the order in which they were written signified that the cause of Mr A's death was considered to be a sudden heart problem and his longstanding conditions and the chest complaints, including the chest infection, were of secondary importance.

(a) Conclusion

22. I have considered all the records in detail, and accept the advice of the Clinical Adviser in its entirety. As a result, I do not find any evidence that the

medical care and treatment provided to Mr A in the A&E Department was unreasonable. I, therefore, do not uphold this aspect of the complaint.

(b) The Board failed to provide adequate nursing care to Mr A within the A&E Department

23. I did not consider that I would obtain any additional evidence in respect of the care provided to Mr A by interviewing the relevant staff, because almost a year had elapsed between the events complained about, and the complaint being lodged with the Ombudsman's office. My investigation into the adequacy of the nursing care provided to Mr A was, therefore, heavily reliant on the evidence provided by the nursing documentation (see complaint (c) below).

24. The A&E Nursing Adviser reviewed the specific complaints that Mr and Ms C had put to the Board. In her opinion, the nursing staff should most certainly have offered assistance to Mr A's family to dress him and to support him to the car if necessary. She did not consider that the Board's response at the meeting with Mr and Ms C on 8 June 2004 to be adequate, as she considered this should have taken place not only 'as a matter of courtesy', but it would have provided an opportunity for the nursing staff to observe him standing and walking, to review his breathing and to provide additional reassurance and discharge advice.

25. The A&E Nursing Adviser further commented that there was no evidence that Mr A received a credible assessment of his mobility, his ability to cope at home, his previous falls history and risk factor that could contribute to future falls. Concern associated with any of these factors could have influenced the decision to discharge.

(b) Conclusion

26. I accept the A&E Nursing Adviser's opinion, find that the nursing care provided to Mr A was inadequate, and, therefore, uphold this aspect of the complaint.

(c) The nursing notes were not adequate

27. The A&E records consisted of a computerised front sheet containing patient demographical details, nursing (Triage) notes, medical notes and discharge information. After the A&E Nursing Adviser reviewed all the notes, she advised me that she was not satisfied that there was an acceptable level of nursing documentation to provide evidence that reasonable triage assessment

and subsequent nursing care was provided to Mr A. In her opinion, the Nursing and Midwifery Council's Guidelines (see Annex 3) for records and record-keeping had not been followed in Mr A's case.

28. I wrote to the Board on 5 September 2005 advising them of the A&E Nursing Adviser's concerns and asking for their comments. I also set out some of the examples of some of the omissions in the nursing documentation that the A&E Nursing Adviser had brought to my attention, which included the following:

- the record had not been timed or dated;
- there was no further objective or subjective history recorded, other than 'Tripped out of bed today. Abrasions to the head';
- the sections headed 'Nurse intervention at Triage', 'Mobility', 'Condition' and 'Other comments' had been left blank; and
- there were no details of Mr A's physical appearance at triage or subsequent nursing assessment; of the events surrounding the fall; his ability to cope at home, who he lived with; his social situation; normal mobility, or a full description of the injury to his head.

29. The nursing discharge section had not been completed fully: it merely stated 'Home [with] son and daughter. HI [head injury] advice given'. The spaces relating to out-patient referral, transport arrangements and communications with relatives were not completed.

30. The Board responded in a letter dated 2 November 2005. They stated:

'Following a review of the nursing documentation, we would agree that the notes are not of a standard that is acceptable and do not comply with the Nursing and Midwifery Council's Guidelines.'

[…]

The nurse who carried out the triage assessment on [Mr A] was a 'G' grade Senior Sister with eleven years experience of A&E nursing. Please be assured that the assessments would have been thorough, although we would apologise for the lack of detail to record this.

[…]

'[Mr A's] mobility was not assessed as he arrived by ambulance and was returning home under the care and supervision of his family. His presenting complaint was of a possible trip with superficial abrasion to his head. A mild head injury was the initial diagnosis made by the attending doctor and is documented within the casualty card. [Mr A] was known to suffer from emphysema and obviously had a stressful day with a full,

ambulance journey and attendance at A&E. An effective assessment of mobility did not take place and a superficial abrasion was noted. The attending doctor confirmed this and requested tetanus prophylaxis with head injury advice. The attending doctor did not seek to admit [Mr A] and it was decided that it was safe to discharge him home under the care of his son and daughter. As the abrasion to the head was superficial, ongoing advice was not considered necessary, which would explain why there was nothing documented.'

[…]

'During a meeting with [Mr A's] son and daughter on 8 June 2004, which was attended by [Nurse 1] and [Consultant 1], the issue of lack of nursing assistance was raised. [Nurse 1] acknowledged that there may have been a lack of nursing assistance and apologised for this. She agreed that she would make staff aware of the issues raised by the family and has since reminded her staff of the importance of attending to patients' basic needs and communicating with patients and relatives.'

[…]

'In summary, an experienced triage nurse assessed [Mr A], on admission, which was within the agreed parameters, based on the Manchester Triage System. We are unable to confirm whether [Mr A's] basic nursing care needs were not met, due to the standard of documentation.

While the issues raised by the family have already been discussed with staff, [Nurse 1] will again remind them of the importance of good communication and the need for adequate documentation, which complies with the Nursing and Midwifery Council's standards.'

31. The Ombudsman's nursing adviser stated that she was concerned by the Board's response, which she considered to be inappropriate and inadequate.

32. The Board agreed that the nursing records did not meet NMC standards, however, they sought to defend the triage nurse in that she assessed Mr A within a very short time frame and that we should 'please be assured that the assessment would have been thorough'. I do not find this to be acceptable, as there is no evidence to support the Board's assertion that the assessments would have been thorough. The A&E Nursing Adviser commented that, from her many years experience of A&E triage, she was aware that assessments were often made quickly, and this would be appropriate in many circumstances and would reflect the rapidly changing emergency environment and urgent

patient need. However, there was no excuse for not recording the assessment. Where a brief, initial triage was carried out by a triage nurse, this should have always been followed up by a secondary in-depth assessment by a suitably trained nurse in A&E, in whichever area the patient is subsequently nursed. This did not happen in this case, and what is more, the Board failed to acknowledge this.

33. In the A&E Nursing Adviser's opinion, even if Doctor 1 had seen Mr A immediately upon his arrival, this should have been recorded by the triage nurse. It would not excuse the lack of effective nursing assessment, particularly in light of a fall at home by an elderly person. The assessment could have been carried out after Doctor 1 had seen Mr A, as part of a quality discharge assessment.

34. The A&E Nursing Adviser was concerned by the Board's explanation that Mr A's mobility was not assessed because he arrived by ambulance, and returned home with his family. In her opinion, the patient's mode of arrival should have been irrelevant, and the fact that he went home with his family did not negate the need for effective assessment of the mobility of a vulnerable older person, who had attended A&E as the result of a fall. Furthermore, the A&E Nursing Adviser was most concerned that the Board stated that it was deemed safe to discharge Mr A home without supporting evidence of his ability to move safely, she considered it should not have been the responsibility of his family to make this judgement, and as a result being placed in a position where they may not have been able to cope. The A&E Nursing Adviser asserted that proper discharge planning should always be carried out and documented, particularly for elderly patients.

(c) Conclusion

35. The A&E Nursing Adviser concluded that the nursing issues in this case related to poor A&E triage notes, almost non-existent nursing notes, and poor discharge planning. Accordingly, I uphold the complaint.

36. I was dissatisfied with the Board's response to the concerns that I had raised with them, they focussed on Mr A's attendance with a 'minor' injury, and failed to acknowledge their lack of detailed objective nurse assessment and care planning for a vulnerable elderly patient. I do not consider the Board's response had addressed the lack of nursing care to an adequate degree, and it

was clear they had not developed an action plan to address the lack of triage or subsequent assessment, nursing documentation or discharge planning.

37. I am concerned that part of the Board's response to my enquiries failed to recognise the real failings that existed. I have not derived any reassurance from the Board's response that they will 'remind' staff of the importance of good communication, attending to patients' basic needs, and the need for adequate documentation that complies with the Nursing and Midwifery Council's standard. I do not find this to be sufficient.

(c) Recommendation

38. The Ombudsman recommends that the Board perform a full audit of A&E nursing records in the next three months. She also recommends that the Board take further action to ensure that the failings in the nursing documentation and communication are addressed, and that the Board provide details of who will take responsibility for this and what action will be taken. The Ombudsman further recommends that the Board provide evidence of educational programmes and systems of competency-based measurement for A&E nursing staff in relation to triage performance, record-keeping, nurse assessment, care planning and discharge planning.

d) Failure of the Board's complaint handling

39. From examining the minutes of the meeting that took place on 8 June 2004, in handling the complaint I am aware Nurse 1 expressed her regret about the lack of nursing assistance provided to Mr A, but offered no further explanation for this omission. Consultant 1, the consultant in emergency medicine, was not able to provide an explanation as to why Doctor 1 did not admit Mr A, or provide any further information about Mr A's clinical care in the A&E Department.

40. In my opinion, Officer 1 failed to carry out an adequate investigation and Consultant 1 and Nurse 1 failed to make any necessary inquiries prior to the meeting arranged with Mr and Ms C that would have ensured they would be in a position to respond fully to the concerns Mr and Ms C had raised.

41. I would have expected the Board to have interviewed all the relevant medical and nursing staff who had responsibility for the care of Mr A on 29 April 2004, or required them to have made written statements in direct response to Ms C's written concerns. I would have also expected the Board to

have identified and reviewed the relevant practices and procedures that were in place at the time, in order to establish whether they had been followed correctly, and whether they were competent. This would have enabled the Board to have offered a detailed response to Mr and Ms C's concerns at the first available opportunity, and would also have given the Board the potential to identify and address any failings in the system.

42. I find fault with the Board's handling of Mr And Ms C's complaint, both in that they failed to investigate or respond to their concerns adequately. I am also concerned about the Board's belief that it would be sufficient to 'remind' staff of the importance of good communication and documentation in light of the evident failings, rather than to take more robust action.

43. Mr and Ms C were naturally distressed at the death of their father, and their letter suggests that this was exacerbated by their belief that his death could have been prevented if he had received appropriate treatment from the A&E Department. The Board had the opportunity to relieve these anxieties at a very early stage of their bereavement, but failed to do so due to inadequacies in their complaint handling.

(d) Recommendation

44. The Ombudsman recommends that the Board review their complaints handling procedures with an emphasis on identifying, acknowledging and resolving any faults in their practices and procedures, and offering a detailed response to any complaints made in future. The Ombudsman also recommends that the Board write to Mr and Ms C to apologise for failing to address their concerns satisfactorily.

45. The Board have accepted my recommendations and are already acting on them.

27 March 2007

Annex 1

Explanation of abbreviations used

Mr and Ms C	The complainants
Mr A	The complainant's father
The Board	Argyll and Clyde NHS Board
A&E	Accident and Emergency Department
The Hospital	Inverclyde Royal Hospital
Officer 1	One of Argyll and Clyde NHS Board's complaints officers
Doctor 1	A Senior House Officer, the attending doctor in the Accident and Emergency Department of Inverclyde Royal Hospital
Consultant 1	Consultant in Emergency Medicine at the Inverclyde Royal Hospital
Nurse 1	Clinical Nurse Manager of the A&E Department
NMC	The Nursing and Midwifery Council