Scottish Parliament Region: Glasgow

Case 200503077: Greater Glasgow and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Ms C) raised concerns about the number of times her mother (Mrs A) had been moved while a patient at the Vale of Leven Hospital (the Hospital). Some of Mrs A's personal belongings had been mislaid and Ms C wondered whether staff had taken into account that the moves would affect Mrs A's psychological and physical care.

Specific complaint and conclusion

The complaint which has been investigated is that staff failed to take into account the detrimental effect the multiple moves had on Mrs A and failed to take steps to ensure that all her personal belongings were moved with her *(not upheld)*.

Redress and recommendation

The Ombudsman has no recommendations to make.

[1] On 1 April 2006 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 Argyll and Clyde Health Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of Argyll and Clyde Health 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 Greater Glasgow and Clyde Health Board as its successor.

Main Investigation Report

Introduction

1. On 9 February 2006 the Ombudsman received a complaint from Ms C about the treatment Mrs A received when being moved between and within wards at Vale of Leven Hospital (the Hospital) in October 2005. Ms C complained that staff did not take into account the effect that the moves had on Mrs A's health and that some of her personal belongings had been mislaid. Ms C complained to Greater Glasgow and Clyde NHS Board (the Board) but was dissatisfied with their response and subsequently complained to the Ombudsman.

2. The complaint from Ms C which I have investigated is that staff failed to take into account the detrimental effect the multiple moves had on Mrs A and failed to take steps to ensure that all her personal belongings were moved with her.

Investigation

3. In writing this report I have had access to Mrs A's nursing records and the complaints correspondence from the Board. I obtained nursing advice from the Ombudsman's professional nursing adviser (the Adviser).

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in the report can be found at Annex 1. Ms C and the Board were given an opportunity to comment on a draft of this report.

Complaint: Staff failed to take into account the detrimental effect the multiple moves had on Mrs A and failed to take steps to ensure that all her personal belongings were moved with her

5. Ms C wrote a letter to the Board on 1 November 2005. She complained that Mrs A had been a patient in the Hospital for 15 days and had been moved five times. Ms C said that patients in the ward were confused, frustrated, frightened and psychologically fragile and that staff treated them with no respect. While she was sure the Board could give reasons why patients were being moved she wondered why their belongings did not follow them. During Mrs A's admission, her dentures and slippers had been mislaid but subsequently had been found. Ms C was annoyed that all Mrs A's cards were lost in transit as well as expensive flowers.

6. The Board's Director of Service Integration (The Director) wrote to Ms C on 9 December 2005. He explained that Mrs A was transferred from Accident and Emergency to Ward 6 for an initial assessment. She was then transferred to Ward F for rehabilitation following her strokes [interruption of blood supply to the brain which can cause paralysis]. Mrs A suffered an extension to her stroke and was placed in a side room to allow some privacy. Mrs A began to recover and was placed back in the main ward which vacated the side room for a patient who required to be nursed in isolation. This move had to be carried out at short notice because the patient who required the single room was en route to the Hospital. Staff were occupied in the movement of beds and possessions and had not completed the allocation and tidying up of patient belongings when Ms C arrived and took steps to locate Mrs A's belongings.

7. The Director continued that nursing staff do try to explain to all patients why and where they are being moved prior to the transfer. The Director was sorry that some of Mrs A's items were mislaid and that such things can happen in the confusion but generally matters are resolved before too long. The Director said that Mrs A had a large number of flowers and it was not possible to have them at the bedside due to the limited amount of space. When this happens flowers can be moved to another surface such as the dining table or a window ledge and staff encourage relatives to take excess flowers home with them.

8. Ms C responded to the Director on 20 December 2005. She still had not received an explanation as to what happened to her flowers. She said that there was something terribly wrong with the care and attention given to patients on Ward F. She said the patients' surroundings are absolutely vital to the psychological development of each patient. It was imperative that such things as flowers from close friends and family follow, especially when the move is traumatic and upsetting for all.

9. The Board subsequently sent a compensation form to Ms C to claim for the lost flowers. Ms C complained to the Ombudsman that she was not satisfied with the Board's responses.

10. The Adviser reviewed Mrs A's nursing records and said that it is never ideal when patients have to move from clinical area to clinical area or within a ward. She noted the Board have acknowledged this is sometimes inevitable

because of the changing clinical priorities that face the staff. The Adviser said from a practical point of view it is almost impossible to take note of individual patient's flowers in a busy clinical environment where clinical matters must take priority. The Adviser believed the Board had handled Ms C's complaint appropriately.

Conclusion

11. Ms C had concerns that the amount of moves Mrs A had to endure during the hospital admission would have affected her psychological and physical care as well as the loss of personal items. The Board have clearly explained the reasons for the moves and that staff try to explain to patients why they are being moved. The advice which I have received, and accept, from the Adviser is that the Board have dealt with Ms C's complaint appropriately and that the moves were inevitable due to the changing clinical priorities.

12. Ms C has not provided evidence that staff failed to take into account the needs of patients and there is nothing in the nursing records which would substantiate this aspect of the complaint. I can fully accept that multiple movements between and within wards can cause a patient distress, however, providing the moves are for appropriate reasons and explanations are given to the patient, then I would not criticise the action taken by staff. Further, I can understand that to ensure a patient's personal belongings, such as flowers, transfer with them can be difficult when more than one patient is involved. On the other hand I can also appreciate Ms C's concern for her mother's welfare. However, taking all the evidence into account I have decided not to uphold this complaint.

27 March 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mrs A	Ms C's mother
The Hospital	Vale of Leven Hospital
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	The Ombudsman's professional nursing adviser
The Director	The Board's Director of Service Integration