Scottish Parliament Region: Glasgow

Case TS0106_03: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Clinical Care

Overview

The complainant (Ms C) raised a complaint that the South Glasgow University Hospital NHS Trust (the Trust) [now Greater Glasgow and Clyde NHS Board] had failed to provide her with an appropriate level of care during her stay in the Southern General Hospital (the Hospital) in Glasgow.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Ms C was not supported to the bathroom and had to lie on a bed pad and urinate and defecate in bed (*upheld*);

(b) The above resulted in a deterioration in her skin condition (*not upheld*); and

(c) the Convenor failed to take appropriate professional advice on the nursing and clinical aspects of Ms C's complaint (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Ms C for failing to take sufficient account of her needs when considering her care provision; and

(ii) ensure that it now has appropriate training in place to ensure staff are aware of the potential issues which may arise when treating patients who have communication difficulties.

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

Main Investigation Report

Introduction

1. On 18 March 2002 Ms C complained about her treatment whilst in the care of the Southern General Hospital, Glasgow (the hospital). Her complaints were considered and a reply was issued by the South Glasgow University Hospital NHS Trust (the Trust) on 28 May 2002. At this time, the NHS complaints procedure in Scotland allowed for the complainant, if they remained dissatisfied with the Trust's response, to request an Independent Review of their complaint. Ms C requested such a review on 7 June 2002.

2. On 4 September 2002 the Convenor responded to Ms C's complaints, he detailed his view of the Board's response and added that he had decided that it would not be appropriate to convene an Independent Review Panel (IRP). Ms C contacted the Ombudsman's predecessor office by letter on 8 October 2002 advising that she remained dissatisfied with the Convenor's response to point two of her complaint, where she complained of being recorded on her nursing records as being double incontinent.

3. Ms C's complaint was originally submitted to the office of the former Office of the Health Service Commissioner for Scotland on 8 October 2002. That office had made some enquiries about the case but had not reached a conclusion on it when this office was established and took over the Health Service Commissioner for Scotland's functions. This office, therefore, took over responsibility for consideration of Ms C's complaint. I very much regret that for a variety of reasons the process of considering this complaint has taken much longer than it should have done. For that, I apologise to both Ms C and the Board.

Background

4. Ms C has cerebral palsy causing considerable disability, resulting in her needing help with activities of daily living as well as having difficulties in communication.

5. Ms C was admitted to hospital on 14 January 2002 with a history of wheezing and shortness of breath. She remained in hospital until being discharged on 8 February 2002.

6. The records of Ms C's time in the hospital's care are clear and well presented. A Nursing Assessment was prepared when Ms C was first admitted. Included in this document was an assessment of activities of daily living. This detailed that Ms C would ask for the toilet when it was required. Additionally a Nursing Care Plan was produced to ensure that Ms C's special requirements were considered during her stay. One of the actions mentioned in the plan was the following:

> '4. Offer patient toilet facilities as requested – patient is normally hoisted from bed to chair and toilet.'

7. The nursing records provide extensive details of how Ms C was cared for in respect of her continence during her stay. They detail that from an early stage, nursing staff considered that Ms C was incontinent of urine. This is mentioned often in the records along with details of the care provided to address this issue. Following the prescribing of antibiotics, the records indicate that Ms C suffered from diarrhoea which led to faecal incontinence.

8. Ms C complained to the Board on 18 March 2002 about aspects of her care whilst in hospital. In particular, she felt that she did not receive satisfactory assistance to carry out normal daily functions such as visiting the toilet. This she believes led to her developing skin problems.

Investigation

9. I have reviewed the correspondence provided by the complainant. I have obtained the complaints file and clinical records from the Board and have requested clinical advice from the Ombudsman's independent clinical advisers (the advisers).

10. In the course of my investigation I have sought to consider the allegations made by Ms C in light of the problems associated with her cerebral palsy and potential communication problems which may have arisen between her and nursing staff at the hospital.

11. I have set out, for each of the two main headings of Ms C's complaint, my findings of fact, and conclusions. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. The Board and Ms C have had the opportunity to comment on the draft of this report.

(a) Ms C was not supported to the bathroom and had to lie on a bed pad and urinate and defecate in bed

12. Ms C lives in supported accommodation and has cerebral palsy. She has a number of carers who assist her with her daily needs. The central point of dispute in respect of the complaint is that nursing staff assumed that Ms C was incontinent when she claims she was not. The key question is whether nursing staff focused sufficiently on overcoming communication difficulties with Ms C. I have sought advice from the advisers on the level of care provided.

13. It is accepted by Ms C and her carers that she was incontinent at some stages of her care and that this continued until after she was discharged. However, Ms C believes that the hospital discriminated against her by considering her doubly incontinent when she was not.

14. The records of Ms C's time in the hospital's care are clear and well presented. From shortly after admission until discharge Ms C was recorded in the nursing notes to be incontinent of urine and often of faeces. A great deal of attention has been given in the notes to the care provided in response to this incontinence including bed baths, cleaning routines and skin care.

15. There are, however, no details given in respect of any discussions with Ms C or her carers in respect of her toiletry requirements. She was given an initial assessment of her toiletry requirements for activities of daily living when first admitted. In the 'Elimination' section it is recorded that Ms C 'asks for the toilet'. Additionally in the 'Mobilisation' section it is detailed that Ms C is 'chair bound, needs hoist to transfer'. The entry at Elimination does not state a history of incontinence prior to admission.

16. Ms C was admitted at 19:15 on 14 January 2002 and is recorded as not passing urine at least from then till 19:30 on 15 January 2002 when she was incontinent. The nursing records state that 'seems much better after this' suggesting that she had a degree of urinary retention that had resolved itself. Ms C had a previous history of urinary retention. Thereafter Ms C is recorded as being incontinent with a few entries saying 'dry' which I interpret as not having passed urine during that period. The last record of incontinence is 7 February 2002. It goes on to state that she was continent of urine during the night into 8 February but nothing is said to indicate how this was achieved. Ms C was discharged on 8 February 2002. Our Adviser has checked the Fluid

Balance Charts and all reflect that she was incontinent throughout her stay in hospital.

17. Ms C was being hoisted up to sit in her own chair from 16 January. Given this, it would have been possible to hoist her onto a commode at regular intervals in an attempt to retrain her back to continence. There is nothing in the notes to suggest that this happened, neither is there evidence of staff establishing at any time if Ms C required to visit the toilet.

18. Ms C received good care in respect of keeping her clean, dry and attending to her skin but evidence is lacking that an attempt was made to improve her incontinence by regular toileting.

(a) Conclusion

19. Ms C was very ill when admitted to hospital. There is no doubt that for some of her stay at least, she was incontinent. Her illness, her stay in a strange place, her medication and the disruption to her routine could all have contributed to problems with continence. From my review of the notes, and the views of the advisers, I consider that nursing staff dealt appropriately with periods where Ms C was incontinent. However, Ms C and her carers say she was continent at times when she was treated as incontinent. Because of the communication difficulties, and the lack of detail about continuing review of this issue in the notes, there is no way of being certain of the extent to which nursing staff made assumptions about Ms C. Nevertheless, I can make a judgment based on the balance of probabilities.

20. There is no evidence in the nursing records of any follow-up to the initial care plan in respect of Ms C's activities of daily living. There does not appear to be special emphasis placed on establishing what Ms C's changing needs were at any particular time or evidence of action taken to help improve her continence.

21. Because of the above, I believe that, on the balance of probabilities, nursing staff did not give sufficient attention to Ms C's needs around issues of continence. I, therefore, uphold the complaint.

(a) Recommendation

22. The Ombudsman recommends that the Board apologise to Ms C for failing to take sufficient account of her needs when considering her care provision.

Additionally, the Board should ensure that it now has appropriate training in place to ensure staff are aware of the potential issues which may arise when treating patients who have communication difficulties.

(b) The above resulted in a deterioration in her skin condition

23. It is not possible to establish exactly when Ms C was continent or incontinent. As a result of this I cannot say to what extent the subsequent skin tenderness can be directly attributed to this.

(b) Conclusion

24. Because based on the information available it is not possible to directly attribute the skin tenderness to actions by the Board, I cannot uphold this aspect of the complaint.

(b) Recommendation

25. The Ombudsman makes no recommendations in this regard.

(c) The Convenor failed to take appropriate professional advice on the nursing and clinical aspects of Ms C's complaint

26. On 7 June 2002 Ms C requested that an Independent Review of her complaint be carried out. The NHS complaints procedure at the time detailed that when a request for such a review is received, by the Board or Trust, the request must be considered by a Convenor appointed to examine complaints. Prior to deciding whether to convene an IRP, the Convenor should consult with the Lay Chairman and, if required, obtain clinical advice.

27. The Convenor in this case did not seek clinical advice prior to making his decision not to convene an IRP.

(c) Conclusion

28. The complaint was about the needs of Ms C who has a considerable level of disability. While this may not be an entirely clinical issue, a clinical view should have been sought. I uphold the complaint.

(c) Recommendation

29. Given the length of time since this complaint was investigated, and as the Independent Review process no longer exists, the Ombudsman makes no recommendations on this point.

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

18 July 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Trust	South Glasgow University Hospital NHS Trust (now NHS Greater Glasgow and Clyde)
The hospital	Southern General Hospital, Glasgow
The advisers	Independent clinical advisers to the Ombudsman
IRP	Independent Review Panel

Annex 2

Glossary of terms

Double Incontinence	Incontinent of Urine and Faeces