Scottish Parliament Region: Glasgow

Case 200500132: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospitals; nursing and medical care of an elderly patient; complaint handling.

Overview

The complainant (Mr C) raised a number of concerns about the treatment and care his mother (Mrs A) received at the Royal Alexandra Hospital, Paisley (Hospital 1) in October 2004. Mr C also complained about delay by Argyll and Clyde NHS Board, now Greater Glasgow and Clyde NHS Board (the Board), in dealing with his complaint.[1]

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs A was left alone without adequate clothing and bedding in a cold room (*upheld*);

(b) Mrs A's family were not told about the circumstances which led to Mrs A gashing her legs until after they had enquired about them (*upheld*);

(c) Mrs A's medical records did not accompany her when she was transferred from Hospital 1 to Hospital 2 and that there was subsequent delay thereafter in forwarding the records (*upheld*); and

(d) there was a delay by the Board in dealing with Mr C's complaint (*partially upheld*).

Redress and recommendations

The Ombudsman recommends that:

(i) the Board issue Mr C and his family with a full formal apology for the failures identified in complaints (a) and (b) of this Report;

(ii) the Board should audit their care planning document in one year and share the findings with the Ombudsman's office;

(iii) when a hospital patient is being transferred internally or externally, a 'tick

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[1] Argyll and Clyde NHS Board was dissolved in April 2006 and its responsibilities were transferred to Greater Glasgow and Clyde NHS Board.

list' of what needs to go with that patient should be completed before the patient leaves the ward;

(iv) when a hospital patient is being transferred externally, staff transporting the patient should also check that all the items contained on the 'tick list' accompany the patient;

(v) the 'tick list' should then be immediately checked by the receiving ward or hospital when the patient arrives there;

(vi) the Board issue Mr C with a formal apology for the errors contained in their letter of 21 January 2005, as identified in paragraph 41 of this report; and

(vii) the apology in recommendations (i) and (vi) should be in accordance with the Ombudsman's guidance note on 'apology' (which sets out what is meant and what is required for a meaningful apology).

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

Main Investigation Report

Introduction

1. On 30 March 2005, the Ombudsman received an initial letter from Mr C concerning a complaint he had made to the Royal Alexandra Hospital (Hospital 1) about his mother (Mrs A)'s care and treatment, while a patient there in October 2004. On 15 June 2005, the Ombudsman received a detailed complaint from Mr C. At the same time, Mr C also complained about delay by Greater Glasgow and Clyde NHS Board (the Board) in dealing with his complaint.

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

(a) Mrs A was left alone without adequate clothing and bedding in a cold room;

(b) Mrs A's family were not told about the circumstances which led to Mrs A gashing her legs until after they had enquired about them;

(c) Mrs A's medical records did not accompany her when she was transferred from Hospital 1 to Hospital 2 and that there was subsequent delay thereafter in forwarding the records; and

(d) there was a delay by the Board in dealing with Mr C's complaint.

Investigation

3. The investigation of this complaint involved reading all the documentation supplied by Mr C; Mrs A's clinical records and the Board's complaint file. I was assisted in my investigation by two of the Ombudsman's nursing advisers (the Ombudsman's advisers). They advised me on the clinical issues of the complaint. When I began my investigation of Mr C's complaint, the former Argyll and Clyde NHS Board was still in existence, until its dissolution in April 2006. The Board has confirmed to me that information supplied prior to April 2006 and referred to in this report is still applicable. I have set out my findings of fact and conclusions for each part of Mr C's complaint. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

4. Mrs A's records show she was found on the floor of her home by a neighbour on 17 October 2004. Mrs A complained of back pain, leg weakness, pins and needles, spasm in her back and constipation. Following a police referral, Mrs A, who lived alone at home, was admitted to Hospital 1. At the

time of Mrs A's admission, she was 92 years of age, she appeared confused and was very hard of hearing.

(a) Mrs A was left alone without adequate clothing and bedding in a cold room; and (b) Mrs A's family were not told about the circumstances which led to Mrs A gashing her legs until after they had enquired about them

5. Mr C said that on 19 October 2004 his sister, Mrs B, travelled from Inverness to visit Mrs A. She found her mother in a single room, in a side ward, Ward D. The following day, 20 October 2004, Mrs B again visited her mother. On this visit, she found Mrs A sitting in a chair, wearing only a nightdress. According to Mrs B, her mother was very cold and distressed. On calling for assistance, Mrs B said that a member of staff told her, 'rather dismissively', that her mother was about to be transferred to a four bedded ward. In the meantime, Mrs B had to put a warm top and a blanket on her mother to keep her warm until the ward transfer took place.

6. Mrs B said she also noted traces of blood around her mother's ankles. Mr C said they later found out that Mrs A had fallen and gashed both legs between the knee and ankle. No clear explanation was provided to them by hospital staff as to how Mrs A had come about these injuries.

7. On 21 October 2004 Mrs A was transferred from Ward D to Ward E of Hospital 1. The following day, Mrs A was transferred to the Vale of Leven District General Hospital (Hospital 2) for rehabilitation with no plans for follow-up.

8. In response to complaint (a), the sister in charge of Ward D apologised that Mrs A had not received a blanket when she asked for it. She could only assume that this was because the nurse concerned was 'distracted' or was 'unavoidably delayed' as the ward could be 'very busy'. The ward sister, however, did not excuse this or consider it to be acceptable that nursing staff gave the impression that they were disinterested. She had spoken to all of her staff and made them aware of Mr C's complaint.

9. In relation to complaint (b) the ward sister explained that Mrs A made her way to the toilet unassisted. She then locked herself in the toilet and was heard shouting in panic. When nursing staff opened the door they found Mrs A had fallen. On examination by a doctor, Mrs A was found to have an abrasion to her

left shin and what appeared to be an old bruise to her right shin. No treatment was required at that time.

10. The following evening, Mrs A's daughter reported that she had noticed some blood on her mother's leg. On inspection, staff found that the abrasion sustained the previous evening had opened. Nursing staff treated this by applying wound closure strips. No further injury was noted.

11. The ward sister acknowledged that Mrs A's family should have been informed of the incident when it occurred and offered her apologies that this did not happen. She added that all patients are treated with 'dignity and respect' and was sorry that Mr C's expectations were not met on this occasion.

12. The advice I have received from the Ombudsman's advisers is that there are very limited nursing records to indicate the care that was delivered to Mrs A during the period of her admission to Hospital 1. There is no evidence in the records that Mrs A, who was a very elderly lady who for much of the time appeared confused and was in addition profoundly deaf, was properly assessed. There is no indication from the clinical records of how the nursing staff managed these aspects of her needs. Her assessment sheet was poorly completed and there is a fairly blank discharge-planning sheet. The evaluation sheets are not linked to any care plans and the risk assessment sheet is inaccurately completed.

13. There was no risk assessment of the likelihood of Mrs A falling in hospital given that she had been found on the floor at home and may have fallen. There is no record in the nursing evaluation records of the incident involving Mrs A locking herself in the bathroom, or the subsequent fall, which resulted in injury to Mrs A. There is no entry in the medical records of examination of Mrs A after the incident. Further, following her fall in Hospital 1 there was no risk assessment of Mrs A carried out to prevent a recurrence of the incident.

14. There appears to have been little or poor communication with Mrs A's family following her admission and no mention of Mrs B noting the abrasions on Mrs A's shins.

15. There is an incident form partially completed by nursing staff which records the incident in the bathroom as occurring on 20 October 2004 at 18:15 and is signed by two members of the nursing staff. An incident form should be

used to complete details of how the incident occurred and what action is necessary to prevent it happening again. However, there is no clinical assessment of Mrs A's fall and what, if any, injuries were found. The risk matrix has been ignored. There is no action identified by any staff member or a review of the incident by a senior nurse or manager.

16. As part of my investigation of Mr C's complaint, I made enquiries of the Board asking for evidence that staff have been advised or trained to accurately assess, plan and evaluate patient care.

17. The Board in their response told me that in addition to academic training, ongoing practical assessment and mentorship, they provide care planning, accountability and record-keeping study sessions. These are organised through the Board's Learning and Development Department and is for both trained and untrained staff. There are also nursing auxiliary development programmes for untrained staff.

18. All new staff follow ward based education and supervision programmes during their mentorship and continue to do so for a further period of time, if found necessary. The charge nurses and mentors are responsible for ensuring that the programmes run effectively and that any problems are identified and brought to the attention of senior managers. The ward manager will sign off the documentation and confirm that the new nurse does not require any further period of supervision. Thereafter, there are annual appraisals of nursing staff by their ward managers. In addition there is an organisational policy on clinical supervision, a copy of which has been supplied to me.

19. All documentation used in respect of patient care planning and nursing observations is regularly reviewed and improvement changes are made where necessary. The Board has told me they are committed to improving this aspect of practice and in February 2007 supplied me with a copy of their revised patient care planning documents for both long term and short stay patients.

20. The Board have also completed a redesign of their patient observation document, known as the MEWS (Modified Early Warning System) chart. This sets out the criteria and tools which staff should apply when observing a patient. Implementation of the MEWS chart in Hospital 1 started in March 2006. The chart has since been amended to suit the needs of all wards and departments. The Board have supplied me with copies of both documents.

21. In relation to reporting of incidents involving patients, the Board have told me that when the current incident reporting system was implemented, training was provided to all staff in policy and form completion. The training is provided on an ongoing basis and forms part of induction for all staff.

22. There is also a risk register kept for each department, which highlights common issues, such as slips, trips and falls. Documentation guides staff on what requires to be taken into consideration if a risk is identified. All wards have their own copies of this and all staff have access to their local ward register. The nurse manager will normally discuss any recurring themes identified at her monthly sisters' meetings and information is also circulated to other staff via monthly ward meetings.

23. When an incident form is completed by a member of staff this document is communicated to the ward sister or nurse manager who will assess what further action is required or is necessary to be put in place at local level to prevent a recurrence. Should a specific incident require to be investigated, then a full investigation is carried out and recommendations put forward for changes to policy or practice if that is what is required. There is a regular audit of incident forms and the findings are discussed at the hospital wide Risk & Safety Committee Meetings.

(a) and (b) Conclusion

24. Given the history of Mrs A's care in Ward D, as described above and the comments of the sister in charge of Ward D, I have no reason to doubt the condition Mrs B found her mother in when she visited on 20 October 2004, in particular, that her mother was cold and did not have adequate clothing or bedding to keep her warm.

25. Therefore, taking into account the clinical advice I have received and the failures identified above, in particular with regard to the lack of assessment, care planning, and record-keeping in relation to Mrs A's care and the poor communication with her family, I uphold these two parts of the complaint.

26. I am critical of the failings in the treatment and care of Mrs A, which I have identified in this part of the report. However, I have noted the action taken by Hospital 1 for the assessment, planning and evaluation of patient care (see paragraphs 17 to 23). As this is subject to regular review, I consider the Board

should audit their care planning documentation in one year and share the findings with the Ombudsman's office. I also consider the Board should apologise to Mr C for the failings identified in this part of the report.

(a) and (b) Recommendations

27. The specific recommendations that the Ombudsman is making, resulting from the investigation of this part of the complaint, are:

(i) the Board issue Mr C and his family with a full written apology for the failures identified in complaints (a) and (b) of this report. The apology should be in accordance with the Ombudsman's guidance note on 'apology' (which sets out what is meant and what is required for a meaningful apology).

(ii) the Board should audit their care planning documentation in one year and share the findings with the Ombudsman's office.

(c) Mrs A's medical records did not accompany her when she was transferred from Hospital 1 to Hospital 2 and that there was subsequent delay thereafter in forwarding her medical records

28. Mr C complained that his mother's medical records had not been transferred with her when she was transferred from Hospital 1 to Hospital 2. Further, that despite numerous telephone calls from Hospital 2 to Hospital 1, Mrs A's medical records still had not been transferred a week after her transfer.

29. In response, the Board informed me that on 22 October 2004 Mrs A's medical records and x-rays were given to the porter who was taking her, by wheelchair, to the ambulance transferring her to Hospital 2. Later the same day, Hospital 2 telephoned Hospital 1 to say that Mrs A's medical records had not arrived with her. Subsequently, it was discovered that the porter had forgotten to give the records and x-rays to the ambulance driver transferring Mrs A to Hospital 2. The porter had left them in the back of the wheelchair. Hospital 2 was advised of this. Arrangements were then made to deliver Mrs A's records and x-rays to Hospital 1's x-ray department so that the transport manager could have them uplifted that afternoon to transport to Hospital 2. This was not done.

30. At this time, both the ward sister and ward clerkess in Ward E of Hospital 1 were on annual leave and were unaware of the problem with Mrs A's medical records, until Mr C's complaint was received. It was then discovered Mrs A's medical records had been filed in her x-ray envelope in the x-ray department.

The Board has told me that appropriate action has since been taken to review practices and have apologised to Mr C for this 'unacceptable shortfall'.

31. As part of my investigation of Mr C's complaint, I made enquiries of the Board to ascertain if Hospital 1 had a transfer protocol in relation to medical records and what paperwork was used to ensure information is safely transferred from one area to another, both internally and externally.

32. In response, the Board advised me that there is no written policy in place. However, medical records are tracked on their electronic 'Medical Record Tracking System'. An answer machine is available 24 hours a day to enable ward staff to leave messages if medical records are transferred out of normal business hours. The electronic system is then updated by medical records staff the following morning.

33. When patients are transferred from Hospital 1 either internally or externally, it is normal practice that a patient's case records should accompany them at the time of transfer along with any x-rays.

34. The advice I have received from the Ombudsman's advisers is that a tick list of what needs to go with a patient who is being transferred internally or externally should be completed before the patient leaves the ward. Where a patient is being transported externally, such as to another hospital, staff transporting the patient should also check that all the items contained on the list accompany the patient. This list should then be checked by the receiving hospital when the patient arrives. Hospital 2 should have immediately asked the porter or ambulance staff for Mrs A's records when she arrived there. It is also of concern that no-one asked questions about Mrs A's records when they were found in the wheelchair.

(c) Conclusion

35. I have noted the Board's explanation as to why the delay in transferring Mrs A's records from one hospital to another occurred. The Board have apologised sincerely for this failing in their letter to Mr C dated 21 January 2005.

36. However, despite the Board's explanation and the apology already given by the Board to Mr C, I uphold this part of the complaint. I consider that, based on the advice I have received from the Ombudsman's advisers, when a patient is being transferred either internally or externally procedures, a 'tick list'

system, should be put in place in order to try and prevent such an incident recurring.

(c) Recommendations

37. In summary, I uphold complaint (c) for the reasons set out above. However, the general recommendations that the Ombudsman is making, resulting from the investigation of this part of the complaint, are:

(i) when a hospital patient is being transferred either internally or externally, a 'tick list' of what needs to go with that patient should be completed before the patient leaves the ward;

(ii) when a hospital patient is being transferred externally, staff transporting the patient should also check that all the items contained on the 'tick list' accompany the patient; and

(iii) the 'tick list' should then be immediately checked by the receiving ward or hospital when the patient arrives there.

(d) There was a delay by the Board in dealing with Mr C's complaint

38. On 29 October 2004 Mr C complained to the Board about the nursing and medical care received by his mother, Mrs A, while she was a patient in Hospital 1. He stated that he was 'very concerned' about the treatment she had received while in the care of the hospital. Mr C said that he did not receive a substantive response to his complaint until January 2005.

39. In response, the Board told me that Mr C's letter of complaint was received by Hospital 1's complaints department on 2 November 2004 and acknowledged and actioned on 3 November 2004. The appropriate hospital departments were asked to respond by 16 November 2004 so as to meet the Board's target date of 30 November 2004 for responding to the complaint.

40. Responses from the ward sisters on wards D and E were received on 17 November and 1 December 2004. Holding letters to update Mr C, in line with procedure, were sent to him on 7 December 2004 and again on 11 January 2005. A further delay in drafting the response and having it signed off was due to the festive holiday period.

41. On 21 January 2005 the Board's Acting Divisional Manager wrote to Mr C. He accepted there was a 'significant delay' in responding to Mr C's complaint causing him anxiety, for which he apologised. The letter also contained an apology relating to the incident with the transfer of Mrs A's records, with

assurances that appropriate action had been taken. However, the letter also contained two errors. Firstly, the incident of the fall was recorded as occurring on 19 October 2004 and not 20 October 2004 as stated on the incident form, and secondly the wrong surname was attributed to Mrs A. Mr C was upset by the errors in the letter.

42. The Board has informed me that since Mr C's complaint was handled a new policy has been put in place for complaints management which will assist the Complaints Managers and Directorate Managers to improve the way in which they respond to and manage the investigation of a complaint. A copy of this policy has been supplied to me by the Board.

(d) Conclusion

43. I appreciate that Mr C was anxious for a response to his complaint. Responses from the two wards concerned were received by Hospital 1's complaints department at the beginning of December 2004, as indicated by the date stamps on the statements on the Board's complaints file.

44. Therefore, the Board was in receipt of the necessary information to enable them to respond to Mr C's complaint in early December 2004. The Board's response was not issued until 21 January 2005. The Board's Acting Divisional Manager has accepted that a response could have been issued to Mr C sooner and has apologised to Mr C for the 'significant delay' in responding to his complaint and the anxiety caused.

45. I have taken account of the fact that the Board has already apologised to Mr C for the delay in dealing with his complaint and that a new Board policy is in place for managing complaints. However, I consider that the errors contained in the Board's letter of 21 January 2005 to Mr C, as identified in this report, caused him distress. In view of these errors, I uphold Mr C's complaint in part and consider the Board should apologise to him for this.

(d) Recommendation

46. In summary, I partially uphold complaint (d) for the reasons set out above. The specific recommendation that the Ombudsman is making, resulting from the investigation of this part of the complaint, is the Board should issue Mr C with a formal apology for the errors contained in their letter of 21 January 2005, as identified in this report. The apology should be in accordance with the

Ombudsman's guidance note on 'apology' (which sets out what is meant and what is required for a meaningful apology).

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

22 August 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs A	The mother of the complainant, Mr C and the subject of the complaint
Mrs B	The daughter of Mrs A
Hospital 1	Royal Alexandra Hospital
Hospital 2	The Vale of Leven District General Hospital
Ward D	The first ward Mrs A was admitted to at the Royal Alexandra Hospital
Ward E	The second ward Mrs A was admitted to at the Royal Alexandra Hospital

Annex 2

List of documents and policies considered

MEWS (Modified Early Warning Scoring System) Chart, as amended.
Patient Observation Document

The Board's Clinical Supervision Policy

The Board's Healthcare Governance Strategy

The Board's patient care plans for long term and short stay, as amended

The Board's Complaints Management policy and operating guidelines