Scottish Parliament Region: Glasgow

Case 200600378: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mr C) raised a number of concerns about aspects of the care and treatment of his mother (Mrs A) by NHS Greater Glasgow and Clyde (the Board) from May 2005 until her death in October 2005.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) records were not knowingly available to staff or of sufficient quality *(upheld)*;
(b) action taken to prevent falls was inadequate (*not upheld*);
(c) there was a lack of planned therapy for Mrs A (*upheld*); and
(d) there were delays in providing adequate pain relief (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) reflect on the lessons that emerge from the record-keeping issues in this case, consider whether the documentation should be changed or if the issue is rather about staff induction/training and advise her of the outcome of this consideration;
(ii) complete the work on a Bed Alarm Policy and submit a copy to SPSO when this is issued;
(iii) arrange for staff to reflect on the importance of good communication and involvement of patients and relatives in decisions about care and treatment and advise her of the steps taken to achieve this; and
(iv) consider how to address the needs of longer term patients for mental stimulation to enhance their quality of life and advise her of the outcome of this consideration.

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

Main Investigation Report

Introduction

1. On 8 May 2006 the Ombudsman received a complaint from the complainant (Mr C) about several aspects of the care and treatment provide to his late mother (Mrs A) by Greater Glasgow and Clyde NHS (the Board) between May 2005 and her death in October 2005. Mr C had first raised the matter with his mother's consultant (the Consultant) in June 2005 and later made a formal complaint (with additional concerns) to the Board in August 2005. Mr C received a final written response (the Response) on 29 September 2005 but remained unhappy and brought his complaint to his office.

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

(a) records were not knowingly available to staff or of sufficient quality;
(b) action taken to prevent falls was inadequate;
(c) there was a lack of planned therapy for Mrs A; and
(d) there were delays in providing adequate pain relief.

3. I considered another aspect of Mr C's complaint relating to discussions about a transfer to another NHS facility closer to Mrs A's home but decided not to investigate this matter as there was insufficient evidence to reach a useful conclusion.

Investigation

4. Investigation of this complaint involved reviewing Mrs A's clinical records and the NHS complaint file alongside the documents supplied by Mr C. I have also solicited the views of Mr C and further comments from the Board – in particular relating to complaint (d) which had not previously been responded to by the Board. I have sought the views of a medical and a nursing adviser to the Ombudsman (the Medical and Nursing Advisers).

5. 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.

(a) Records were not knowingly available to staff or of sufficient quality

6. Mr C complained to the Consultant in June 2005 that he had been informed that Mrs A had been put on a course of antidepressants but when he

had asked for specific information about this staff were not able to tell him about this. In his subsequent formal complaint the Board were also unable to tell him when the drug had been discontinued, why this decision had been taken and whether the drug had been of any effect. Mr C also raised a concern about potential errors in the recordings of Mrs A's weight. In responding to the overall complaints the Board indicated that when Mrs A had transferred from the Mansionhouse Unit (Hospital 1) to the Victoria Infirmary (Hospital 2) her records were not available to the staff at Hospital 2. Mr C was also generally unhappy that the records at Mrs A's bedside did not reflect the most recent assessments of her needs (see complaint (b)).

Antidepressant Medication

7. In response to Mr C's complaint the Board apologised that staff had not given him the information about which drug was prescribed. The Medical Adviser commented that while the prescription of the antidepressant medication was reasonable in Mrs A's circumstances it would have been appropriate to inform the relatives of the drug prescribed and the plan for its use. The records do indicate when the drug was discontinued but there is no reference in the clinical records of ay ongoing review of her mood or the decision to discontinue it.

Weight Recordings

8. Mr C noted that his mother's weight was recorded as 44.9kgs on 24 July 2005 and 50.2kgs on 31 July 2005, an increase which he considered to be unlikely at a point where the family's perception was that their mother was becoming more frail and not eating well. In its subsequent response the Board initially stated that this was an accurate record. During the course of my investigation I asked the Board to comment on some further weight gain/loss discrepancies in the records and the Board advised me that it was now felt that there were errors in the recordings and that there had not been a significant weight gain as indicated in the record. The Nursing Adviser commented that while errors do sometimes occur the concern here is that such an apparently large increase in weight (or loss in weight) was not picked up by staff and acted upon. This would either have corrected the error at that time or prompted further appropriate action if such a significant change had in fact occurred.

Availability of Records

9. In the Response the Board noted that Mrs A's nursing notes were not included in the medical case notes when she transferred from Hospital 1 to

Hospital 2 on 5 July 2005. During the course of my investigation I asked the Board to comment on this and they have advised me that in fact the records were in fact available but that the nurse who admitted Mrs A did not recognise this as the format used for the records is different in the two wards. One is a unified record while the other contains separate nursing and medical records. The Nursing Adviser commented that the different formats are acceptable but that the lack of awareness can cause difficulties as illustrated in Mrs A's case when staff believed the notes to be missing.

(a) Conclusion

10. The impression gained by Mr C in the course of this complaint is that the records were sloppy and sporadic which both reflected and exacerbated a lack of understanding from staff about Mrs A's care needs and care plan. The Nursing Adviser has noted that while it is acceptable to have different record formats in operation it is not acceptable for this not to be understood by staff and for very obvious errors in record-keeping not to prompt further action to confirm and/or correct them. The Board have accepted that there were some errors and misunderstandings. I conclude that there are aspects of the records which were not of a reasonable quality and there were problems of apparent lack of availability of information caused by a lack of awareness by staff of different record formats and accordingly I uphold this aspect of the complaint.

(a) Recommendation

11. In light of this conclusion the Ombudsman recommends that the Board should reflect on the lessons that emerge from the record-keeping issues in this case, consider whether the documentation should be changed or if the issue is rather about staff induction/training and advise her of the outcome of this consideration.

(b) Action taken to prevent falls was inadequate

12. Mr C complained that Mrs A suffered a number of falls while in hospital, including one which caused her a broken hip. He complained to the Board that a number of falls were not recorded and the family had no evidence of any risk assessment and preventative measures being taken for several weeks after the falls started.

13. The Board response noted that Mrs A's falls were properly recorded in line with the policy and that her risk was assessed with action being taken to use

hip-protectors and bed rails and following a later assessment a bed and chair alarm were introduced.

14. The Nursing Adviser reviewed the records for evidence of risk assessments undertaken with respect to falls. The Nursing Adviser told me that a risk assessment was made on 8 June 2005 which indicated Mrs A was at risk. Hip-protectors were requested on that date and these were apparently worn thereafter. Hip-protectors are designed to protect the hips should a fall occur but do not in themselves prevent falls. Mrs A was also advised to use the nurse call bell system when she wished to mobilise. A further assessment was done on 5 July 2005 following her transfer. The risk factors had increased giving a score of 21. The decision was taken on 18 July 2005 to request bed/chair alarms and this preventive action commenced on 19 July 2005.

15. The Board have provided me with details of their Falls Management Policy (amended since the events of this case) but advised me that they do not yet have a policy on bed alarms although one is currently planned.

16. In response to the Board's comments Mr C told me that Mrs A's family were not aware of hip-protectors being in place and the bed-side records did not reflect assessments and actions supposedly taken to promote her safety. Mr C concluded that the records reflect policy rather than practice.

17. The Nursing Adviser has told me that the policy on falls management she reviewed is reasonable but she has concerns about the time delay in further action being taken by staff following Mrs A's second assessment when her risks had increased. Unfortunately the Nursing Adviser cannot comment on the apparent discrepancy between policy and practice although she noted that it would have been preferable to discuss the provision of hip-protectors with the family who would then have been aware of the situation and able to check with staff if they were concerned that the hip-protectors were not in place.

(b) Conclusion

18. The clinical advice I have received is that the Falls Management Policy was reasonable and appears to have been followed but that it is not possible to clarify the difference in views between Mr C and the nursing records. Had the family been involved in discussions about assessments this difference in views might have been addressed at the time to everyone's advantage. In these circumstances I do not have sufficient evidence to uphold this aspect of the

complaint. I do not uphold the complaint but do consider that there would be merit in further action by the Board.

(b) Recommendation

19. In light of this conclusion the Ombudsman recommends the Board:

(i) complete the work on a Bed Alarm Policy and submit a copy to SPSO when this is issued; and

(ii) arrange for staff to reflect on the importance of good communication and involvement of patients and relatives in decisions about care and treatment and advise her of the steps taken to achieve this.

(c) There was a lack of planned therapy for Mrs A

20. Mr C raised a concern that Mrs A did not receive any stimulation and diversion while in Hospital 2 and that this contributed to her general decline. Mr C told me that the family made suggestions about this and did their best to provide Mrs A with help but he felt the care as planned made no attempts to enhance her quality of life rather than simply her physical well being.

21. The Board have advised me that they have no policy on provision of mental therapy.

22. The Nursing Adviser expressed concern at the apparent lack of any planned therapy for Mrs A, who was in hospital for several months. The Nursing Adviser noted that such therapy could largely have involved her family who were clearly willing and able to offer assistance in this area had they been asked to assist. The Nursing Adviser has reviewed the situation for me within other hospitals and health board areas and noted that there is a woeful lack of planning in this important area throughout the NHS in Scotland. The Nursing Adviser concluded that this was an issue about the quality of life experience offered particularly to longer term patients.

(c) Conclusion

23. I am stuck by the apparent lack of mental therapy offered to patients in Mrs A's situation and acknowledge the very real importance of ensuring patients are given mental stimulation to improve their quality of life in hospital. While recognising that the Board are not alone in not having a policy on this matter I consider that mental therapy is an important part of clinical care and treatment and I uphold this aspect of this complaint.

(c) Recommendation

24. The Ombudsman recommends that the Board consider how to address the needs of longer term patients for mental stimulation to enhance their quality of life and advise her of the outcome of this consideration.

(d) There were delays in providing adequate pain relief

25. Mr C has suggested that Mrs A's IV morphine was often delayed because it required two nurses for its administration and there were not sufficient nurses in Hospital 2 to provide this service with nurses being required to come from Hospital 1 for this purpose.

26. The Board advised me that they have checked this situation and do not agree with Mr C's views. At my request the Board reviewed Mrs A's nursing notes and medication records and could find no indication that there was an undue delay in administration of morphine. Following a further request the Board also reviewed the staff rotas and confirmed that there were always two trained nurses available in each ward during the day. However, there were two occasions overnight where only one trained member of staff was available (due to short term staff sickness) although this absence would have been covered by the night sister who would have based herself in the affected ward on these occasions.

27. In response to the Boards initial comments Mr C told me that there was certainly one occasion overnight when they had to wait for a nurse to attend from Hospital 1 and at other times they had to wait during the ward round dispensing of drugs until a second trained nurse was available.

28. The Nursing Adviser commented that while delays were regrettable they were always possible but that she considered it was unlikely that there would not be two qualified members of staff on duty in the whole unit although this might involve asking a nurse to attend from another ward.

(d) Conclusion

29. The clinical advice I have received is that the policy on administration of morphine was reasonable and appears to have been followed but that it is not possible to clarify the difference in views between Mr C and the nursing records. In these circumstances I do not have evidence to uphold this aspect of the complaint. I do not uphold this aspect of the complaint.

19 September 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs A	Mr C's mother, the aggrieved
The Board	Greater Glasgow and Clyde NHS Board
The Consultant	The Consultant initially responsible for Mrs A's care
The Response	The response letter sent by the Board on 29 September 2005
The Medical Adviser	The medical adviser to the Ombudsman
The Nursing Adviser	The nursing adviser to the Ombudsman
Hospital 1	The Victoria Infirmary, Glasgow
Hospital 2	The Mansionhouse Unit, Glasgow