Scottish Parliament Region: Lothian

Case 200603703: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C) was concerned that her mother (Mrs A) received inadequate care and treatment after being admitted to Royal Victoria Hospital (the Hospital) between 17 July 2006 and 20 October 2006. She also raised concerns about the cleanliness of the Hospital.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Lothian NHS Board (the Board) failed to appropriately monitor and audit the cleanliness of the Hospital (*partially upheld to the extent that there were failures in cleaning and monitoring*);

(b) nursing staff failed to take action when they were advised of concerns by Mrs A's family and were often unavailable, in several instances because they were at management meetings (*no finding*);

(c) a nurse acted inappropriately by trying to remove Mrs A's ring without a local anaesthetic (*upheld*); and

(d) as a result of the poor care Mrs A received, her health and general condition deteriorated during her stay at the Hospital (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) bring the findings of this report to the attention of all staff involved in cleaning, supervising and monitoring cleaning, to remind them of the importance of cleaning all required areas, recording cleaning appropriately and carefully checking cleaning and monitoring documentation so that the omissions highlighted in this report are not repeated in future;

(ii) ensure that the induction of new staff includes appropriate and adequate training on the completion of cleaning records;

(iii) apologise to Mrs A and her family for attempting to remove her ring without local anaesthetic and for the distress this caused; and

(iv) put measures in place to ensure that, where the condition of a finger is clearly such that removal of a ring will be painful, removal should be carried out with the use of a local anaesthetic.

The Board have accepted the Ombudsman's recommendations and will act on the accordingly.

Main Investigation Report

Introduction

1. On 27 February 2007, the Ombudsman received a complaint from a woman, referred to in this report as Mrs C, about the care and treatment of her 91 year-old mother, referred to in this report as Mrs A, during an admission to Royal Victoria Hospital (the Hospital) between 17 July 2006 and 20 October 2006. She also raised concerns about the cleanliness of the Hospital.

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

(a) Lothian NHS Board (the Board) failed to appropriately monitor and audit the cleanliness of the Hospital;

(b) nursing staff failed to take action when they were advised of concerns by Mrs A's family and were often unavailable, in several instances because they were at management meetings;

(c) a nurse acted inappropriately by trying to remove Mrs A's ring without a local anaesthetic; and

(d) as a result of the poor care Mrs A received, her health and general condition deteriorated during her stay at the Hospital.

Investigation

3. The investigation of this complaint involved obtaining and reading the complaint correspondence between Mrs C and the Board and obtaining copies of Mrs A's clinical records. I also made two written enquiries of the Board and sought the advice of one of the Ombudsman's clinical advisers (the Adviser), who advised me on the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to appropriately monitor and audit the cleanliness of the Hospital

5. In her complaint to the Board, Mrs C said that, on numerous occasions, she had to clean Mrs A's bed frame with antiseptic wipes because it was visibly dirty. She believed this dirt posed a threat of infection to Mrs A. Mrs C said the general standard of cleanliness observed by her and her family was poor. She said there was: dirty stain marks on the floor; dirt and debris gathered in the

corners of stairs, floors, ward furniture and equipment; a foul smell on several occasions; and a lack of regular cleaning of the visitor toilets.

6. In responding to the complaint, the Board said there was a ward cleaning rota in place and that both ad hoc and formal monitoring of compliance with this rota took place. They said formal monitoring was carried out on three occasions during the time Mrs A was at the Hospital. The Board said a further audit was carried out by an independent body. They confirmed that these audits had recorded that the ward showed a good standard of cleanliness.

7. With regard to Mrs A's bed frame being dirty, the Board apologised and said they had reminded their staff to be alert to that kind of issue. With regard to debris and dirt on the ward, the Board said the audits they had carried out showed no mention of debris and dirt. They said, however, that the ward did have a number of paint flakes imbedded in the floor which might give the impression that there was debris.

8. Referring to the visitor toilets, the Board said they were regularly cleaned. They said, however, that it could be very difficult to keep them clean at all times due to the number of visitors using them. They said that cleaning staff invariably found paper on the floor and debris not placed in buckets. The Board said they had asked for the situation to be monitored more closely and for cleaning to be increased when required.

9. The Board said ward staff tried to eliminate odours as far as possible, but this was difficult in a hospital environment and in particular where there were large groups of elderly people. The Board said they could not always ventilate these areas, because older people could get cold very quickly, but said that air fresheners were used regularly.

10. In response to my investigation the Board provided me with:

- copies of hygiene and cleaning protocols (the Protocols) that were in place at the Hospital during Mrs A's admission;
- cleaning records (the Cleaning Records) for the ward that Mrs A was admitted to (the Ward), covering the period of her admission;
- a selection of 'Healthcare Acquired Infection: What to Look For' audits (the Infection Audits) that had been carried out on the Ward (the Board explained that this process involved an internal auditor and a Clinical Nurse Manager or Head of Department attending the Ward and carrying

out an observation exercise of the clinical area and asking questions of staff and patients relating to the prevention of hospital acquired infections);

- the results of an 'Observation of Environment and Fundamental Care' audit (the Environment Audit) carried out by a member of the Board's staff who had no involvement in the clinical area under observation and an individual independent of NHS Lothian; and
- cleaning services monitoring documentation (the Monitoring Documentation).

11. The Protocols provided details of cleaning work that had to be carried out on a daily and weekly basis. The Protocols for cleaning on weekday mornings stated:

> '**Area includes:**
> Dayroom including toilet areas
> 4x6 Bed Bays including toilet/shower areas
> 6x1 Bed Side Rooms including toilet areas
> Treatment/Sluice/Utility Rooms – Bathrooms - Shower Room – Nursing Office – Linen Room – Quiet Room – Corridor – Kitchen – Pantry – DSR …
>
> **07:00am-10:00am**
> *Water Jugs & Tumblers:*
> Collect all water jugs and tumblers
> Wash in dishwasher. Refill jugs and redistribute.
>
> *Dayroom:*
> Daily – Basic Clean Offices/Rooms:- Daily – Remove Waste
>
> *Treatment/Sluice/Utility Rooms/Dayroom Toilets:*
> Daily – Basic clean Weekly – Thorough clean …
>
> **10.15am – 01:30pm**
> *4x6 Bed Bays – 6x1 Bed Rooms – All Toilet/Showers/Bathrooms*
> Daily: - Basic clean Weekly:- Thorough clean …
>
> **02:00pm – 03.00pm**
> Continue cleaning duties.'

The Protocols for week-day afternoon cleaning (between 16:30 and 20:00) and for weekend cleaning followed a similar pattern, although involved different tasks. It is not necessary to set these out in detail here.

12. The Protocols included definitions explaining what 'thorough clean' and 'basic clean' meant for each area of the Ward. For example, the Protocols provided the following definition for 'side rooms' and 'six bed bays':

> 'Thorough Clean:
> High dust – Walls and ceilings including vents and window frames behind curtains. Damp dust – All window sills and frames. Radiators including fronts and vents. Bed lights, curtain rails and lockers including wheels. All beds: top, bottom, wheels, bumpers and cot sides. All chairs – include seat, back, cushion, wheels (if power-assisted chair include cable). (Always unplug and store cable before moving or cleaning power-assisted chair.) All bed tables – include top, bottom, wheels, underneath tops and all edges. All furniture, fixtures and fittings. All doors including frames, handles and vents. Move all beds and furniture and clean floor and skirtings: damp wide skirtings. Vacuum floor – deck scrub corners and edges – scrub, damp mop and buff floor. Clean glasswork. Re-hang curtains as required. Record area thorough cleaned.
>
> Basic clean:
> Damp dust – window sills, curtain rails and bed lights, locker tops, edges and bottoms. Check other furniture and chairs and rake appropriate action. Vacuum and/or damp mop floor (include underneath and behind beds, under chairs and behind lockers.'

The Protocols contained similar definitions for each area of the Ward. As above, it is not necessary to set each one out in detail here.

13. The Cleaning Records provided by the Board consisted of a sheet listing areas required to be cleaned and next to each area left a space for a date and signature to be inserted to show the area had been cleaned. The Cleaning Records show that the Ward was 'thorough cleaned' on a weekly basis during Mrs A's admission.

14. However, there are a number of omissions in the Cleaning Records. For instance, the Cleaning Records sheet stated that on Saturdays the dayroom and corridor should be damp dusted and that on Sundays the dayroom should

be vacuumed and the corridor damp mopped. On only one occasion during the period of Mrs A's admission, was a date and signature placed next to these tasks. Similarly, there were a number of occasions when areas do not appear to have been cleaned, for example: in the week commencing 24 July 2006, the two dayroom toilets and the shower were not recorded as being cleaned; in the week commencing 7 August 2006 the corridor, bay 4, room 1, room 3, room 5 and the dayroom toilets were not recorded as having been cleaned; and in the week commencing 25 September 2006 the corridor and none of the rooms were recorded as being cleaned.

15. I asked the Board to explain these omissions. They attributed the gaps in the Cleaning Records to staff not adhering to the proper procedures due to insufficient training in completing the forms. The Board said this did not mean that the areas in question were not cleaned and they said there was no reason why cleaning would not have been carried out. They said that Domestic Supervisors were responsible for ensuring that the Cleaning Records were correctly completed and that, unfortunately, no follow-up action was taken in relation to the gaps identified here.

16. The Board submitted Infection Audits dated 15 May 2006, 2 September 2006 and 18 April 2007. These were in the form of sheets asking various questions including: 'Toilets: are there enough and are they clean? Do you consider the state of cleanliness in ward to be acceptable?' Next to the questions a space was left for comments and scores were awarded from one to four, with four being very good and one unsatisfactory. In all three audits, only one question was answered as 'unsatisfactory'.

17. The Board submitted an Environment Audit dated 29 March 2006. The Audit summary stated: 'In conclusion this was a clean, pleasant, well-kept ward area'. Of the 32 separate matters which were audited, four were described as being 'poor'. These related to chairs being in disrepair and there not being enough shower facilities. The cleanliness of the toilets was also one of the things found to be poor, with this comment recorded:

> 'No hand-rub in three toilets – holder available but no hand-rub. No bin-bag in one bin. Faecal matter in one toilet.'

18. The Board submitted Monitoring Documentation for the period March to November 2006. This consisted of sheets, filled out on a monthly basis, which listed each item or area to be cleaned on the ward and assessed whether those

areas passed or failed in terms of cleanliness. Where they were noted as failing, comments were recorded and a space was left next to this to record when a problem had been rectified. Some of the comments supported statements that Mrs C had made in her complaint. For example, the monitoring sheet for 30 July 2007 found that the floor in two rooms 'failed' due to corners and edges not being clean. However, on each occasion where a 'fail' was recorded the monitoring sheet showed that action was taken to rectify the problem. Each monitoring sheet was also given an overall score: for the period March 2006 to November 2006, the average score was 93.4 percent.

19. In addition, the Board said that self-monitoring was periodically validated using peer reviews. They said that a peer review, which included a member of the public, was carried out on 21 September 2006. This showed a score of 94 percent overall and did not identify any major cleanliness issues.

(a) Conclusion

20. The Board have been able to demonstrate a range of procedures and tools for monitoring and auditing the cleanliness of the Hospital. In my view, these procedures form an appropriate and robust system and I am satisfied that they should be sufficient to ensure that the Hospital is clean. I do not find fault with, and have no criticism to make of, the Board's procedures. I do, however, have some concerns about the way in which these procedures were implemented in certain instances.

21. Indeed, there were some omissions in the Cleaning Records which, in my view, show a failure by the Hospital to ensure that appropriate cleaning occurred at all times and a failure to follow their procedures by ensuring that monitoring took place. While I note the Board's argument that the absence of records does not mean that cleaning did not take place, I must take the absence of records as being indicative of a failure in the instances highlighted at paragraph 14 above.

22. Overall, the evidence I have seen does not fully corroborate Mrs C's perception of the cleanliness of the Hospital as the various audit and monitoring documentation indicate generally good standards of cleanliness. However, the omissions in the Cleaning Records, and evidence from one of the Environment Audits and some of the Monitoring Documentation did provide some support for Mrs C's complaint. For example, paragraph 17 above shows that, on one

occasion, toilets were found not to be clean during an audit, which echoes one of Mrs C's concerns.

23. There is, therefore, evidence which provides some corroboration for the specific failures Mrs C highlighted in her complaint (see paragraph 5 above). There is also evidence that records were not properly filled out and checked, which I also take to be evidence of a failure to carry cleaning out in the specific instances I have highlighted.

24. In conclusion, I do not criticise the procedures the Board have in place for cleaning, monitoring and auditing the Hospital. I find that those are sound. However, I am critical of the way those procedures were, on occasions, implemented and the fact that there is evidence of several failures in cleaning, monitoring and record-keeping. In all the circumstances, therefore, I partially uphold the complaint to the extent that there were failures in cleaning and monitoring. I do not uphold the part of the complaint that relates to alleged failures in auditing as I have seen no evidence of failures in that regard.

(a) Recommendations

25. The Ombudsman recommends that the Board:

(i) bring the findings of this report to the attention of all staff involved in cleaning, supervising and monitoring cleaning, to remind them of the importance of cleaning all required areas, recording cleaning appropriately and carefully checking cleaning and monitoring documentation so that the omissions highlighted in this report are not repeated in future;

(ii) ensure that the induction of new staff includes appropriate and adequate training on the completion of cleaning records.

(b) Nursing staff failed to take action when they were advised of concerns by Mrs A's family and were often unavailable, in several instances because they were at management meetings

26. In response to Mrs C's complaint to them, the Board made the point that, had she raised some of her concerns at the time they occurred, they may have been able to be resolved on the spot. For example, the Board referred to Mrs C's concern that there had been no alcohol rub available at the entrance to the Ward and said immediate steps could have been taken to rectify this.

27. Mrs C said she had reported her concerns to staff on a number of occasions throughout Mrs A's stay. She said, however, that despite Mrs A's

proximity to the nurses' station, staff were often unavailable, possibly because they were attending other patients but in several instances because they were at management meetings.

28. In response to my investigation, the Board said there were only two management meetings a month, from 13:30 to 15:30, and that only the Charge Nurse or the Nurse in charge would be required to attend from the Ward. They also provided me with an action plan that had been drawn up as a result of Mrs C's complaint. One of the points referred to communication and two of the actions proposed were that nurses should introduce themselves to family members to see if they could be of assistance and also that a booklet which outlines how carers can speak to anyone from the multi-disciplinary team should be placed behind each bed space and at the Ward's entrance.

29. The clinical records show evidence that Mrs A's son discussed her discharge arrangements with staff on several occasions. However, they show no other evidence of contact between Mrs A's family and nursing staff and do not record the family raising concerns.

(b) Conclusion

30. The number of management meetings taking place and the number of staff required to attend these were very low and it is, therefore, unlikely that staff would have been unavailable because of these. The Board have, however, used Mrs C's complaint as an opportunity to put measures in place to ensure that relatives have the opportunity to voice concerns when nurses introduce themselves and also that they can obtain information via the booklet to help them contact other members of staff. I commend the Board for taking action to make their staff more accessible to patients' relatives.

31. In determining whether Mrs C and her family raised issues with staff at the time and in determining how available staff were, I do not feel able to reach a conclusion. That is because the only substantive evidence available to me is contained within the clinical records and these make no mention of concerns being raised, nor can they shed any light on whether staff were available when Mrs C or her family wished to speak with them. It is, of course, possible that concerns were raised and simply not recorded, but such a conclusion would be speculative. In the circumstances, I consider that the evidence in this case is not strong enough to reach a sound judgement on whether or not issues were raised by Mrs A's family and, if they were, whether they were acted upon. I also

do not feel there is any evidence strong enough to determine the availability of staff. In the circumstances, I make no finding on this complaint.

(c) A nurse acted inappropriately by trying to remove Mrs A's ring without a local anaesthetic

32. Mrs C said that, at the time of her admission, Mrs A was awaiting an operation to release her fingers, which were permanently clenched. Mrs C said Mrs A's wedding ring was biting into her skin and that a nurse had tried to remove it without any pain-relief in the knowledge that this procedure should have been done using a local anaesthetic. Mrs C said Mrs A had told her that she experienced pain like she had never experienced before when the nurse tried to remove the ring.

33. In response to the complaint, the Board said medical staff had initially asked nursing staff to remove Mrs A's ring and that an experienced nurse had tried to do this. The Board said, however, that because of the pain this caused, Mrs A was referred to medical staff who then used a local anaesthetic to remove the ring.

34. I asked for the Adviser's comments on this complaint. Based on her review of the clinical records she provided me with the comments summarised at paragraphs 35 to 37 below.

35. A physiotherapist (the Physiotherapist) saw Mrs A on 10 October 2006 and noted that the wedding band was cutting into her left ring-finger which was very painful. She noted that the ring needed to be removed. The note stated:

> '[Left] hand fixed in flex [at] fingers … wedding band cutting large pressure sore in [left] ring finger – very painful.'

On 11 October 2006, the Physiotherapist again noted that the ring was very painful. She noted that she was unable to remove the ring and that removal should occur under local anaesthetic the following day. The note of a multi-disciplinary team meeting on the same date recorded:

> 'Wedding ring stuck on finger. Not tolerating ring cutter … Remove ring tomorrow under LA [local anaesthetic].'

On 13 October 2006, the clinical records note that a doctor removed the ring under local anaesthetic.

36. There was nothing in the nursing records about the nurse's attempt to remove the ring and, therefore, there was no way of knowing how long the nurse persisted in trying to remove the ring before deciding this needed to be done by a doctor.

37. The Adviser noted that, according to the Physiotherapist, Mrs A's left ring-finger was ulcerated prior to the first attempt at removal. The Adviser stated that, while it would be normal practice for a nurse to remove a ring without local anaesthetic, and while she noted that a doctor had asked a nurse to do this on this occasion, she considered it would have been better practice for a local anaesthetic to be used in the first instance in these particular circumstances. This was particularly because the description of the finger in the clinical records indicated that the finger was painfully ulcerated prior to removal and this should have indicated the need for local anaesthetic to be used.

(c) Conclusion

38. I note the Adviser's view that, in the circumstances and considering the condition Mrs A's finger was in, it would have been more appropriate to use a local anaesthetic to remove the ring in the first instance. I accept this advice and, consequently, I uphold this complaint.

(c) Recommendation

39. The Ombudsman recommends that the Board:

(i) apologise to Mrs A and her family for attempting to remove her ring without local anaesthetic and for the distress this caused; and

(ii) put measures in place to ensure that, where the condition of a finger is clearly such that removal of a ring will be painful, removal should be carried out with the use of a local anaesthetic.

(d) As a result of the poor care Mrs A received, her health and general condition deteriorated during her stay at the Hospital

40. Mrs C said that, despite the fact that Mrs A was a serious falls risk, she was allowed to fall on a number of occasions while in the Hospital. She said that she sustained a number of injuries while in the care of the Hospital, such as scrapes and cuts on her legs and cuts and bruising on her forehead, which Mrs C believed was indicative of inadequate supervision. Mrs C pointed out that when she was admitted to the Hospital, Mrs A was in good health and in good condition, despite her broken hip. She said, however, that when Mrs A was discharged to a nursing home, staff there were surprised at her condition.

They reported that her clothes were unkempt, she had forehead cuts and bruising which were not adequately dressed and the finger on which her ring had been was ulcerated and in need of attention. Mrs C also told me that Mrs A's weight had improved significantly, her injuries had healed and her general appearance had improved within a short time of being discharged from the Hospital.

41. In response to the complaint, the Board said that Mrs A had been identified as a falls risk. They said this was documented in her notes and an alert placed above her bed. They said the Hospital had clear protocols for identifying and looking after patients who were at risk of falling and because the Ward was an orthopaedic rehabilitation ward a high number of patients were identified as being at risk. The Board explained that patients at risk of falling had their status reviewed weekly and were also assessed by the physiotherapy team. They said that while staff tried to minimise the risk of patients falling it was not always possible for this to happen, especially where patients were considered to be at high risk.

42. I asked the Adviser for her comments on the complaint. Her advice is summarised at paragraphs 43 to 46 below.

43. On 17 August 2006, the Physiotherapist contacted the nursing home that Mrs A resided at prior to her admission to the Hospital. She recorded that Mrs A had suffered 17 falls in the period between January 2006 and July 2006. The Physiotherapist's view was the rehabilitation potential was low. The clinical records show that the following day the Physiotherapist discussed discharge planning with Mrs A's son and the records state:

> 'He [Mrs A's son] feels that [Mrs A] would be better placed in a nursing home, as she had been struggling in [former nursing home] with mobility even prior to hip [operation].'

The Adviser said that these factors showed that Mrs A was losing ground in terms of her health before she was admitted to the Hospital.

44. The clinical records were comprehensive and of good quality. They show:

- there were weekly multi-disciplinary meetings where Mrs A's progress was discussed;
- there were regular falls risk assessments;
- appropriate nutritional screening;

- appropriate weight charts;
- regular input from the Physiotherapist;
- input from a dietician; and
- daily review by medical staff and further review when her condition was noted as changing or following an incident.

45. There was evidence in the records that nursing staff provided Mrs A with appropriate care and attempted to keep Mrs A as safe as possible but that, despite this, the pattern of falls that had been observed prior to admission continued during her stay at the Hospital. Mrs A also developed a urinary tract infection, which was appropriately treated with antibiotics, but which meant that she required the toilet frequently and this would have prompted her to get up. The injuries that were observed on discharge, such as abrasions and bruising, were the result of falls that occurred at the Hospital.

46. The Adviser told me that she could find no evidence of deficits in Mrs A's care that impacted on how well, or otherwise, she was on any particular day. Indeed, the Adviser was of the view that the standard of care provided to Mrs A was more than adequate.

47. In commenting on a draft of this report, Mrs C disagreed with the Adviser's view that Mrs A's was losing ground in terms of her health before her admission to hospital. She said that she was periodically advised that apart from mild dementia, Mrs A's general health, eating, diet, hygiene, mental alertness and general appearance were very good up to the time of her admission. In addition, Mrs C disagreed that the fact that the family felt Mrs A would be safer in a nursing home indicated that her condition had been deteriorating. Rather, this was felt to be a way to ensure that Mrs A could maintain as much independence as possible.

(d) Conclusion

48. It is clear that Mrs A's condition did deteriorate while she was a patient at the Hospital. There is a difference of opinion between Mrs C and the Adviser regarding whether this deterioration began before or after Mrs C was admitted to the Hospital. However, the Adviser, whose advice I accept, is of the view that the deterioration in Mrs A's health cannot be related to any failures in care provided by the Board. Indeed, the Adviser considers that the standard of care provided to Mrs A was more than adequate. Consequently, I do not uphold this complaint.

49. The Board have accepted the Ombudsman's recommendations and will act on the accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mrs A	The aggrieved, Mrs C's mother
The Hospital	Royal Victoria Hospital
The Board	Lothian NHS Board
The Adviser	One of the Ombudsman's clinical advisers
The Protocols	The Board's Hygiene and Cleaning Protocols
The Cleaning Records	The Board's Cleaning Records
The Ward	The ward to which Mrs A was admitted
The Infection Audits	The Board's 'Healthcare Acquired Infection: What to Look For' Audits
The Environment Audit	The Board's 'Observation of Environment and Fundamental Care' Audit
The Monitoring Documentation	The Board's Cleaning Services Monitoring Documentation
The Physiotherapist	The physiotherapist who treated Mrs A