Scottish Parliament Region: Mid Scotland and Fife

Case 200502602: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; Care of the elderly; clinical treatment/diagnosis; nursing/nursing care; record-keeping; complaints handling

Overview

The complainant, Mrs C, raised concerns that her late father (Mr A) had not received adequate and appropriate care and treatment from Fife NHS Board (the Board), that the Board had not adequately responded to her complaints and that the action plan generated as a result of her complaints was not adequate.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr A's medical treatment and care were inadequate and unsatisfactory in:
  (i) the Urology Department of Queen Margaret Hospital, Dunfermline (*upheld*);
  (ii) the Accident and Emergency Department of The Victoria Hospital, Kirkcaldy (*not upheld*);
  (iii) Ward 14 of The Victoria Hospital, Kirkcaldy (*not upheld*); and
  (iv) Ward 2 of Glenrothes Hospital (*upheld*);

(b) the Board did not adequately respond to Mrs C's complaints *(partially upheld)*; and

(c) the action plan generated as a result of Mrs C's complaints was not adequate *(partially upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mr A's family for the inadequate care and treatment Mr A received at the Urology Department of Queen Margaret Hospital, Dunfermline and in Ward 2 of Glenrothes Hospital;

(ii) review their procedures on the investigation of symptoms of cancer of the prostate;

(iii) satisfy themselves that Specialist Urology Nurse and the Urologist have the appropriate competencies to carry out the care required by patients presenting with the symptoms of cancer of the prostate;

(iv) put in place a firm timescale for when patients in all areas of Glenrothes Hospital will have access to a call bell system;

(v) review their procedures for the communication of information between departments and wards and the procedures ward staff follow when assessing a patient's well-being on the ward;

(vi) review their procedures and guidance for the recommendation of catheterisation, and emphasise these to staff in Ward 2 of Glenrothes Hospital;

(vii) undertake a full audit of their record-keeping procedures, guidance and training, and strengthen these as necessary; and

(viii) introduce guidance to all staff regarding how to respond to requests for statements on complaints, with specific reference to consulting medical or nursing notes when dealing with events which they were not personally party to.

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

Main Investigation Report

Introduction

1. On 16 December 2005 the Ombudsman received a complaint from Mrs C, the daughter of a man (Mr A) who had passed away in August 2005. Mrs C complained that her father had not received adequate and appropriate care and treatment from Fife NHS Board (the Board), that the Board had not adequately responded to her complaints and that the action plan generated as a result of her complaints was not adequate.

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

(a) Mr A's medical treatment and care were inadequate and unsatisfactory in:
   (i) the Urology Department of Queen Margaret Hospital, Dunfermline;
   (ii) the Accident and Emergency Department of The Victoria Hospital, Kirkcaldy;
   (iii) Ward 14 of The Victoria Hospital, Kirkcaldy; and
   (iv) Ward 2 of Glenrothes Hospital;

(b) the Board did not adequately respond to Mrs C's complaints; and

(c) the action plan generated as a result of Mrs C's complaints was not adequate.

Investigation

3. The investigation of these complaints involved obtaining and examining the relevant medical and nursing records and complaint file from the Board. I have reviewed the copies of correspondence between the Board and Mrs C and internal correspondence of the Board. I have also sought the views of clinical advisers to the Ombudsman (the Medical Adviser and the Urology Adviser). I have set out my findings of fact and conclusion. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. The terms used to describe other people referred to in the report are noted in Annex 1 and a glossary of the medical terms used is noted in Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of the report.

(a)(i) Mr A's medical treatment and care were inadequate and unsatisfactory in the Urology Department of Queen Margaret Hospital, Dunfermline

4. Mr A, a 79 year-old-man, was referred by his GP to the Urology Department at Queen Margaret Hospital in Dunfermline in Spring 2005. Prior to

an appointment with a urologist, he was seen on 11 and 20 April 2005 by a Specialist Urology Nurse.

5. On 11 April a digital rectal examination was carried out. Mr A's prostate was found to be moderate in size, hard in consistency and noted as being 'nodular irregular'. Urine and creatinine blood levels were noted as normal but the Specialist Urology Nurse noted the Prostate Specific Antigen (PSA) as high. The Specialist Urology Nurse noted that Mr A should be reviewed urgently by the Urologist to discuss a possible transurethral resection of the prostate (TURP) and advised Mr A to self-catheterise. On 20 April Mr A was supplied with catheters and taught how to self-catheterise. He was advised if he had any problems, to contact the Specialist Urology Nurse by telephone for assistance. On one occasion Mr A's wife (Mrs A) did make contact and she felt the Specialist Urology Nurse was abrupt and of no assistance, and told Mrs A that she could not spend much time talking to her as she was running a clinic at the time.

6. When Mrs C raised this issue with the Board, they acknowledged that the response of the Specialist Urology Nurse was rushed. They advised Mrs C that the Specialist Urology Nurse had subsequently called Mrs A back and discussed the concerns she had more fully. They explained that the Specialist Urology Nurse had undertaken to divert her telephone to voicemail during clinics to avoid a recurrence of such an incident.

7. Mr A's appointment with the Urologist took place on 4 May 2005. It was decided that Mr A should undergo a TURP and this was scheduled, on a 'soon' waiting list, for the end of July 2005.

8. Mrs C complained that Mr A was not examined appropriately at the Urology Department and was particularly concerned that no blood specimens were taken. The Board told Mrs C that blood specimens were taken from Mr A on 11 April 2005 and that there was no indication that the blood tests should be repeated thereafter. The Urologist explained that the PSA result was common for Mr A's age group, that there was no histological proof that the source of Mr A's cancer was prostate and that the subsequent rapid development of Mr A's cancer of the prostate in the presence of a low PSA indicated the presence of a very aggressive disease. The Board concluded that the Urology Department's investigations of Mr A and the subsequent plan of care were appropriate.

9. I sought the advice of the Urology Adviser regarding Mr A's care and treatment by the Urology Department. In relation to the Specialist Urology Nurse, the Urology Adviser told me that Mr A had been properly referred to the consultant Urologist for urgent attention. However, he felt other aspects of the care and treatment Mr A had received at his appointments with the Specialist Urology Nurse were below the standard Mr A was reasonably entitled to expect. The Urology Adviser felt that the result of the PSA was above the normal range and this, in combination with the findings of the digital rectal examination, were indicative of possible cancer of the prostate. He noted that this possibility was not written down by the Specialist Urology Nurse, nor was there any evidence that it had been discussed with the Urologist. He would have expected that an image of the whole urinary tract would have been made in a man suspected of having bladder outflow obstruction, and noted that there was a tick box for this on the pro-forma that the Specialist Urology Nurse completed. He also had reservations about the decision to proceed Mr A directly to self-catheterisation given his physical findings, symptoms and age, but acknowledged that this view would not be held by all clinicians.

10. The Urology Adviser considered that the Urologist had seen Mr A commendably soon but also felt that aspects of the care and treatment that he received from the Urologist were below the standard he was reasonably entitled to expect. He told me that he felt the Urologist should have conducted a physical examination of Mr A's prostate and, similar to his opinion of the actions of the Specialist Urology Nurse, he felt that the Urologist should have undertaken imaging of Mr A's whole urinary tract. The Urology Adviser felt that the Urologist should have concluded from the information supplied by the Specialist Urology Nurse that Mr A may have had cancer of the prostate, placed him on an 'urgent' waiting list and arranged for biopsies to be taken from Mr A's prostate. He felt, on the balance of probabilities, that such biopsies would have led to a positive diagnosis of cancer of the prostate.

11. The Urology Adviser made clear that Mr A's disease was unusual in that the degree of PSA elevation was not as marked as would usually be the case and that, in the event that a positive diagnosis had been made in May 2005, it is likely that the clinical outcome would not have been altered and Mr A would still have passed away soon afterwards.

(a)(i) Conclusion

12. While it was correct for the Specialist Urology Nurse to refer Mr A to the Urologist for an urgent appointment and commendable that this appointment was arranged quickly, I concur with the Urology Adviser that other aspects of Mr A's treatment and care by the Urology Department at Queen Margaret Hospital were inadequate. The Specialist Urology Nurse should have concluded from the PSA and digital rectal examination that Mr A possibly suffered from cancer of the prostate. If this possibility was concluded by the Specialist Urology Nurse it should have been noted or communicated to the Urologist. Further, the Urologist should have reached this conclusion based on the information that the Specialist Urology Nurse supplied. Both the Specialist Urology Nurse and the Urologist should have made an image of Mr A's urinary tract and the Urologist should have performed a physical examination of Mr A's prostate. Had these actions been undertaken it is likely that a positive diagnosis of Mr A's cancer would have been made in May 2005. While I accept that this earlier diagnosis would have been unlikely to have altered the clinical outcome, Mr A did not receive care and treatment in the Urology Department to the standard he was entitled to expect and, therefore, I uphold the complaint.

(a)(i) Recommendations

13. The Ombudsman recommends that the Board:

(i) apologise to Mr A's family for the inadequate care and treatment Mr A received at the Urology Department of Queen Margaret Hospital, Dunfermline;

(ii) review their procedures on the investigation of symptoms of cancer of the prostate; and

(iii) satisfy themselves that Specialist Urology Nurse and the Urologist have the appropriate competencies to carry out the care required by patients presenting with the symptoms of cancer of the prostate;

(a)(ii) Mr A's medical treatment and care were inadequate and unsatisfactory in the Accident and Emergency Department of The Victoria Hospital, Kirkcaldy

14. On 24 May 2005, while waiting for the surgical appointment for a TURP, Mr A attended the Accident and Emergency Department at Victoria Hospital, Kirkcaldy following an injury to his arm. He arrived, along with Mrs C, at 16:30 and was eventually seen and discharged at 21:30. Mrs C complained to the Board about the length of time that Mr A had waited to be seen, that he was not

communicated to appropriately and that no x-ray was taken, which she felt would have led to a diagnosis of cancer.

15. In responding to Mrs C's complaints the Board acknowledged that Mr A had been assessed as being required to be seen within 2 hours of his arrival but that it had taken far longer than this for him to be seen and explained that this was due to the department being extremely busy and there being a need to prioritise patients based on their clinical condition. The Board's response expressed regret that Mr A and Mrs C were not kept informed of the situation in the department while they were waiting and noted that staff had been reminded of the need to communicate regularly with patients and relatives in these circumstances. With regard to the taking of x-rays the Board acknowledged that an x-ray may have accelerated the diagnosis of cancer, but the circumstances of his presentation at the Accident and Emergency Department on that occasion did not indicate that an x-ray would be required.

16. I sought the opinion of the Medical Adviser on the issue of the x-ray. He advised me that the decision to take an x-ray was based on whether there was evidence of bone injury. He acknowledged the possibility of an x-ray indicating that cancer had spread but felt that, given a later isotope bone scan did not indicate this, this was unlikely.

(a)(ii) Conclusion

17. The Board have appropriately acknowledged and explained the delay in Mr A being seen in the Accident and Emergency Department. The Board have appropriately acknowledged and expressed regret that communication with Mrs C was not of the standard they would expect and have taken appropriate action to ensure there is no repeat of this situation. Finally, the Board have reasonably explained to Mrs C why no x-ray was taken during Mr A's time in the department. Given the above, I do not uphold the complaint.

(a)(iii) Mr A's medical treatment and care were inadequate and unsatisfactory in Ward 14 of The Victoria Hospital, Kirkcaldy

18. Mr A's condition deteriorated and his GP referred him to Queen Margaret Hospital, and he was subsequently referred to the Oncology Department of the Western General Hospital in Edinburgh where cancer of the prostate was diagnosed. Mr A underwent radiotherapy and was cared for at home for a few weeks until 30 July 2005 when his GP referred him to The Victoria Hospital in

Kirkcaldy. Mr A was admitted to Ward 14 and transferred to Ward 11 the following day.

19. Mrs C raised concerns with the Board about the care and treatment Mr A had received in Ward 14. She felt that Mr A's comfort and personal hygiene had been neglected, that the management of the ward was not adequate and that the staff did not show reasonable interest or knowledge of Mr A and his condition when discussing matters with his family.

20. Mrs C complained that during a visit she made to Mr A in Ward 14 he was not wearing his own pyjamas and had not been shaved, that the staff were not enforcing the rules regarding the number of visitors allowed per patient, that the ward was unacceptably noisy due to staff use of a radio and that staff were not wearing name badges. Mrs C also complained that, during a later visit to Ward 14 by Mrs A, Mr A was found in a chair next to his bed, which had been stripped of bedclothes, complaining of pain. Mrs C complained that when Mrs A asked about increasing Mr A's pain relief the staff were not willing to undertake this, that they were initially unwilling to re-make Mr A's bed and transfer him back to it, and that Mrs A was unreasonably asked to remain in The Victoria Hospital to assist with Mr A's transfer to Ward 11.

21. The Board explained to Mrs C that the staff had decided to dress Mr A in hospital gowns rather than his own pyjamas due to his incontinence. Their intention was to preserve his own pyjamas in the hope that they could be used subsequently if his incontinence could be managed. The Board explained that, as an admissions ward, Ward 14 could be very busy and the enforcement of the rule on the maximum number of visitors per patient could be difficult to achieve. The Board apologised for the noise level Mrs C had found in Ward 14 and explained that in the absence of a television or sitting room in the ward, the radio could be used at the request of patients. The Board acknowledged that steps would require to be taken to address the staff attitude and behaviour issues. The Board explained that the staff recalled that Mr A had asked to get out of bed prior to Mrs A's visit and that the bed had been stripped due to his incontinence. The staff had not re-made the bed as they anticipated Mr A would be transferred to Ward 11 soon afterwards. As a result of their investigations the Board had concluded that the staff were not aware that Mr A was in any discomfort until approached by Mrs A regarding moving him back into bed and that he was moved back into bed shortly afterwards. The Board also explained that there was some confusion between the nursing and medical

staff regarding Mr A's transfer to Ward 11 and this may have contributed to the impression that staff were not knowledgeable about Mr A and his condition.

22. The Board compiled an action plan and also took other steps to address the concerns Mrs C had raised. In relation to Ward 14 the Board arranged training sessions for the staff to address issues of attitude and behaviour. The importance of meeting the personal hygiene needs of patients was emphasised in these sessions. Nightshirts had also been purchased for use in Ward 14 to address issues regarding incontinent patients' dignity. The Clinical Nurse Manager and Director of Nursing carried out several 'spot checks' on the noise level in Ward 14 following Mrs C's complaints, and these were found to be acceptable at all times. No further concerns have been raised concerning this matter since Mrs C's complaints were investigated. The action plan required that a memo be sent to all ward departments to remind staff of the need to wear identification at all times, and this was done in September 2005, with random checks of identification display ongoing afterwards. Mrs C's complaints were brought to the attention of Ward 14 staff and a 'good attitude' training package was delivered to them in late 2005.

(a)(iii) Conclusion

23. The Board have reasonably explained the circumstances leading to the complaints Mrs C raised about Mr A's care and treatment in Ward 14. The Board have, commendably, taken steps to address Mrs C's concerns about other issues in Ward 14. Therefore, I do not uphold the complaint.

(a)(iv) Mr A's medical treatment and care were inadequate and unsatisfactory in Ward 2 of Glenrothes Hospital

24. Mr A was admitted to Ward 11 of The Victoria Hospital on 31 July 2005. On 2 August 2005, Mr A's condition was discussed with his family and it was agreed that cardio-pulmonary resuscitation (CPR) would not be appropriate should the need arise, and that it would be appropriate to transfer Mr A to Ward 2 in Glenrothes Hospital. Mr A was admitted to Ward 2 on 4 August 2005.

25. Mrs C raised concerns with the Board regarding Mr A's care and treatment and the attitude of the staff during Mr A's time in Ward 2 of Glenrothes Hospital. Subsequently, she raised issues about inconsistencies she perceived in the records relating to Mr A's time in Ward 2.

26. Mrs C complained that there was no record of Mr A's admission to Ward 2. I sought the advice of the Medical Adviser on this point and he told me that Mr A's admission was documented in the medical and nursing notes. However, he raised concerns that the notes were inadequately labelled as they lacked clear detail of what hospital or ward they related to. In reviewing Mr A's notes, the Medical Adviser raised concerns that there was no clear plan of care for Mr A or determination regarding his future management.

27. Mrs C complained that the reason given in Mr A's notes for admission to Ward 2 was not credible given his condition at the time. Mrs C referred to the admission sheet in Mr A's nursing notes wherein the reason for admission is indicated as 'Assessment and Rehabilitation'. I sought the Medical Adviser's opinion on this, and he advised me that the separate medical notes state clearly that Mr A's reason for admission was 'for palliative care' and that he believed this to be the more accurate and appropriate reason for admission. I asked the Board about this issue and they confirmed that the reason for admission was for palliative care and passed on their apologies to Mrs C for the confusion around this point.

28. Mrs C complained that a single shared assessment was completed for Mr A but was not sent to the Social Work Department of Fife Council. I asked the Board why the single shared assessment was not sent. The Board told me they were unable to determine why it had not been sent and acknowledged that it should have been. The Board have brought this matter to the attention of staff and reiterated the importance of not only completing required documentation but also ensuring it is appropriately followed up.

29. Mrs C complained that the procedures for dispensing controlled medication were not followed in Ward 2. I sought the advice of the Medical Adviser on this point. He told me that there was no evidence from the available notes that there had been poor nursing practice in this respect. However, he raised concerns that the nursing notes indicated that two types of controlled medication had been expected to be delivered to the ward on 5 August 2005 but that these were, in fact, delivered to the hospital reception where they were not appropriately signed for. I asked the Board for their comments on this and they advised me that their procedures had not been adhered to on this occasion. The pharmacy had been advised of the incident and the issue and correct procedures brought to the attention of the taxi driver who had delivered

the medication. The Board advised me that there had been no subsequent incidents of this nature.

30. Mrs C complained that she believed there were omissions in Mr A's medical notes. She made reference to the records of 4 August 2005 indicating that Mr A had not received any pain relief that day, and other omissions of nutritional intake, care plan completion and general nursing records for a number of days. I sought the Medical Adviser's opinion on these points. With reference to Mr A's pain relief on 4 August 2005 he told me that it was apparent Mr A's drugs were to be dispensed remotely and transferred to Ward 2 by taxi. These did not arrive until 5 August 2005, however, the Medical Adviser did not believe that pain relief was withheld for all of this period as there was a record of a single dose of oral morphine having been administered at 06:55 on 5 August 2005. The Medical Adviser raised concerns about the provision of drugs to Mr A and told me that the arrangements for remote dispensing of drugs to ensure the timely treatment of Mr A had failed in this case. The Board told me that staff had been reminded to check that an adequate supply of prescribed medication was available as soon as a patient's admission was confirmed and their needs were known. With regard to the other omissions Mrs C complained of, the Medical Adviser told me that these omissions were symptomatic of the poor standard of record-keeping he had seen throughout the Board's notes.

31. Mrs C complained that the notes recorded that Mr A's family had been advised that he had fallen on 12 August 2005 while the family were not aware of it until they accessed his records. The Board had advised me that they had clarified the process to be followed when a patient falls in hospital to ensure that all staff were aware of what actions require to be taken.

32. Mrs C complained that staff had ignored her father's requests to use the toilet. The Board told Mrs C that the staff's recollection of events was that Mr A would occasionally ask to use the toilet, be taken and shortly thereafter ask to use the toilet again. On these occasions the staff would remind Mr A that he had just used the toilet and offer to take him later. As noted in paragraph 23 the Board compiled an action plan to address some of the issues raised by Mrs C's complaints. The plan included a provision to clarify staff's understanding of prostatic disease and it was noted in December 2005 that the Lead Nurse had clarified that the staff were aware of the increase in urinary frequency as a result of prostatic conditions.

33. Mrs C complained that staff had not given Mr A access to his nurse call bell. The Board explained that Mr A had regularly expressed a preference to spend time watching television in the bay area of the ward where there was no access to a call bell system. The action plan included provision to carry out an environmental audit to determine areas where there was no access to the call bell system within wards and to thereafter discuss the means of reaching a solution. The Board advised me that the assessment has been completed and resources have been allocated to fund the necessary work within all the dayrooms at the Glenrothes Hospital. However, no date has yet been set for the work to be carried out and, in the meantime, staff have been made aware of the need to supervise patients within areas of the wards where no call bell system is available

34. Mrs C complained that staff had not assisted Mr A to sit up to drink and that he did not eat meals in the dining area. The Board told Mrs C that staff encouraged Mr A to have meals in the dining area but that he stated his preference was to have his meals in the ward area.

35. Mrs C complained that staff allowed Mr A to remain undressed for unacceptable periods of time and she cited a particular occasion when a relative visited Mr A and found him not wearing his trousers. The Board told Mrs C that it could be difficult when a patient is confused to prevent them undressing and when the ward is busy it may not be possible to provide constant supervision and immediate assistance with dressing. The Board said that staff were aware that Mr A removed his clothing on occasion and reminded him not to do so and assisted him to re-dress. The Board acknowledged the upset caused by the specific incident Mrs C referred to.

36. Mrs C complained that a nurse had told her that staff were not aware of Mr A's foot splint and that as a result it had been broken for some days before being replaced. The Board acknowledged that this represented a communication issue that they aimed to address in the action plan. I sought the advice of the Medical Adviser on this complaint and he advised me that the failure to replace the splint may have prevented mobility to some degree but Mr A's general condition was such that the absence of the splint was not of significant medical importance.

37. Mrs C was told that patients in Ward 2 would be bathed only once each week and that Mr A would be bathed on a Thursday. Mrs C complained that the

frequency of bathing was unacceptable and that the information she had been given that Mr A would be bathed on a Thursday was contradictory to the information in his care plan wherein it was noted he would be bathed on a Wednesday. The Board agreed with Mrs C that the frequency of bathing was not acceptable. The Board advised me that issues relating to personal hygiene were raised with staff at the time of the complaint and was emphasised in subsequent training sessions.

38. Mrs C complained that staff in Ward 2 had shouted at Mr A and made him feel degraded and frightened and that Mr A's family had to wait one week before being able to speak to medical staff in the ward, that staff were often difficult to locate and that Mr A was able to walk around the ward and other parts of the hospital at night without the staff being aware of this. In the action plan the Board committed to bringing Mrs C's complaints to the attention of Ward 2 staff and a 'good attitude' training package had been begun to be delivered to all staff within Glenrothes Hospital. Additionally, a nursing review was completed in November 2005 and agreement was reached to increase the staffing levels for Ward 2.

39. Mrs C complained that Mr A had become incontinent during his stay in Ward 2. I sought the advice of the Medical Adviser on this point. He told me that the combination of confusion, cancer of the prostate and constipation that Mr A suffered would make urinary incontinence an unavoidable problem. The Medical Adviser did raise concerns about the way this problem was dealt with in Ward 2 and contrasted it unfavourably with the bladder catheterisation subsequently undertaken in Ward 11 at The Victoria Hospital.

40. Mrs C complained that, during a visit to Mr A, a Senior Charge Nurse told her that staff had 'lost' Mr A on two occasions. Mrs C was subsequently told that the Senior Charge Nurse had confused Mr A with another patient. The Board told me that the Senior Charge Nurse did not recall the conversation and that no documentation relating to it existed. The Board explained that the issue of communicating accurate information was addressed in staff training sessions and apologised for the distress this incident caused Mrs C.

41. Mrs C complained that Mr A was woken unacceptably early in Ward 2. The Board told me that the action plan addressed the issue of patients having a choice of when to be woken in the morning and, where possible, this would be undertaken. The Board also advised that the work they had undertaken with

patients as a result of the action plan had not identified this as a widespread issue.

(a)(iv) Conclusion

42. The following aspects of Mr A's care and treatment in Ward 2 that Mrs C has complained about were reasonable and acceptable:

- there was a record of Mr A's admission to Ward 2; and
- the Board have reasonably explained why Mr A did not eat meals in the dining area.

43. I have been unable to reach a conclusion on the following complaints Mrs C has raised due to an absence of any objective record of events:

- Mr A's family not being told about a fall he suffered;
- staff not agreeing to Mr A's requests to use the toilet;
- the behaviour of staff towards Mr A; and
- a Senior Charge Nurse telling Mrs C that Mr A had been 'lost' by staff.

I note that in respect of several of these complaints the Board have, nonetheless, taken steps to address Mrs C's concerns.

44. My investigations of the remaining complaints Mrs C raised about Ward 2 have revealed serious issues about the care and treatment Mr A received while in the ward. I am concerned about the following:

- patients in Ward 2 can be in areas without access to a call bell system;
- Mr A's foot splint was broken for some days before staff became aware of it;
- hygiene arrangements were not acceptable in the ward;
- staff were hard to locate in the ward;
- Mr A was able to leave his bed at night without staff being aware; and
- bladder catheterisation was not undertaken when Mr A became incontinent.

45. I am also concerned about the following administrative issues that emerged during my investigation of Mrs C's complaints:

- Mr A's notes were inadequately labelled;
- the notes give two different reasons for his admission to Ward 2;
- there was no clear plan of care or indication of thought being given to Mr A's future care;

- the single shared assessment was completed but not sent to the Social Work Department;
- an adequate supply of Mr A's prescribed medication was not available in a reasonable time at Glenrothes Hospital;
- controlled medication was delivered to Glenrothes Hospital but not properly signed for on receipt; and
- Mrs C was given contradictory information to that which was in Mr A's care plan without being provided with a reasonable explanation by the staff.

Also, the standard of record-keeping in the Board's notes was generally poor.

46. Given the above, I uphold the complaint that the medical care and treatment Mr A received in Ward 2 was inadequate and unsatisfactory.

(a)(iv) Recommendations

47. Some of the issues involved in this case have already been remedied by the Board. The Ombudsman notes that the Board have taken appropriate steps through their action plan to address the following issues:

- Mr A's family not being aware of a fall he suffered;
- staff not agreeing to Mr A's requests to use the toilet;
- the behaviour of staff towards Mr A;
- Mrs C's beliefs that a Senior Charge Nurse gave her inaccurate information;
- the hygiene arrangements in the ward;
- the staffing levels in the ward; and
- staff visibility on the ward.

48. The Board have also appropriately acknowledged and taken action regarding the following:

- the confusion in the notes over the reason for Mr A's admission to Ward 2;
- the single shared assessment not being sent;
- Mr A's prescribed medication not being adequately available when he was admitted to Ward 2; and
- the procedures for the delivery of controlled medication not being adhered to.

The Ombudsman commends the Board for these actions.

49. The Board have made plans to ensure that patients in all areas of Glenrothes Hospital have access to a call bell system, however, the Ombudsman recommends that a firm timescale is put in place for when this will be achieved.

50. Staff were not aware of Mr A's foot splint, or that it was broken for several days. Therefore, the Ombudsman recommends that the Board review their procedures for the communication of information between departments and wards and the procedures ward staff follow when assessing a patient's well-being on the ward.

51. Mr A should have been catheterised following the development of incontinence during his stay in Ward 2, and the Ombudsman recommends that the Board's procedures and guidance for catheterisation are reviewed in light of this, and the appropriate procedures and guidance emphasised to staff in Ward 2 of Glenrothes Hospital.

52. A number of the issues Mrs C complained about led to my conclusion that record-keeping in a number of the departments Mr A came in contact with was poor. Therefore, the Ombudsman recommends the Board undertake a full audit of their record-keeping procedures, guidance and training, and strengthen these as necessary. The Ombudsman asks that the Board advise her when these actions have been completed and what further actions it will take as a result.

53. Finally, the Ombudsman recommends that the Board apologise to Mr A's family for the inadequate and unsatisfactory care and treatment Mr A received while in Ward 2 of Glenrothes Hospital.

(b) The Board did not adequately respond to Mrs C's complaints

54. Mrs C first raised a formal complaint with the Board on 3 August 2005 when she wrote to the Chief Executive to complain about her father's care and treatment in the Urology Department, the Accident and Emergency Department and Ward 14 of Victoria Hospital. This letter was acknowledged on 5 August 2005, with an expression of regret that Mrs C had reason to complain and an offer of a meeting if Mrs C wished, by the Acting Medical Director and on 8 August 2005, with a similar expression of regret and offer to meet, by the Patient Relations Manager. Mrs C was advised that an investigation would be made of her complaints and given details of how she could contact the Board with any questions she might have before the investigation was concluded.

55. On 10 August 2005 the Chief Executive sent a short letter to Mrs C acknowledging her complaint and erroneously passing on his condolences on Mr A's death.

56. On 14 August Mrs C approached a Senior Charge Nurse in Ward 2 and made complaints to her regarding Mr A's care and treatment in the ward.

57. On 15 August 2005 Mrs C's brother wrote to the Chief Executive complaining that the letters Mrs C had received from the Acting Medical Director and the Patient Relations Manager did not contain any reply of substance to his sister's complaints nor any indication of when a full reply would be received. He also complained about the Chief Executive's letter of 10 August 2005 and the hurt his error had caused.

58. On 16 August 2005 Mrs C wrote to the Chief Executive commenting on the error he had made in his letter of 10 August 2005 and raising further complaints about Mr A's care and treatment in Ward 2 of Glenrothes Hospital. On the same day the Chief Executive wrote to Mrs C offering his sincere apologies for the error he had made in his letter of 10 August 2005. He accepted that he had totally misunderstood the situation and expressed deep regret for the distress his error had caused. This letter was hand-written by the Chief Executive.

59. The Acting Medical Director also wrote to Mrs C on 16 August 2005. He explained that the Board had tried to contact Mrs C directly on receipt of her first letter but were unsuccessful. He explained the process for investigation and his understanding that Mr A would be transferred back to Ward 11 in The Victoria Hospital following Mrs C's discussions with the clinician responsible for Mr A's care. He repeated his offer to meet with Mrs C at any time and explained that he could not give a definite timescale for the completion of the investigation due to the leave commitments of staff.

60. A meeting was arranged between Mrs C, her brother, the Patient Relations Manager, the Acting Medical Director and the Director of Nursing on 7 September 2005. Mrs C asked to see copies of the responses received from staff as part of the investigation. This was agreed to and copies of these responses were passed to Mrs C.

61. On 19 September 2005 the Director of Nursing wrote to Mrs C with a response to her letters and the further concerns and complaints raised at the meeting. The Director of Nursing also apologised for the delay in responding.

62. On 21 September 2005 a meeting was held between Mrs C and the Patient Relations Manager to discuss concerns Mrs C had following receipt of the responses of individual staff members. A further meeting was held on 4 October 2005 between Mrs C, the Chief Executive and the Patient Relations Manager. The Chief Executive wrote to Mrs C on 24 October 2005 enclosing a copy of the action plan that had been generated as a result of her complaints.

63. Mrs C continued to have concerns, with specific reference to Ward 2 of Glenrothes Hospital and the monitoring mechanisms in the action plan. A further meeting was arranged between Mrs C, the General Manager of North East Fife and Glenrothes Community Health Partnership (the General Manager) and the Lead Nurse at Glenrothes Hospital on 24 November 2005. The action plan was subsequently revised following the meeting and the General Manager supplied Mrs C with a copy of this on 7 December 2005.

64. On 16 December 2005 Mrs C brought her complaint to the Ombudsman's office.

65. Mrs C complained that when she had made a complaint in Ward 2 on 14 August 2005, the Senior Charge Nurse had not properly followed the Board's complaints procedures.

66. The Board told me that when a complaint is received by a member of staff in a ward the key staff involved should be identified and, where possible, enter into a discussion with the complainant. Staff have been encouraged to invest time in dealing with complaints at a local level with the aim of resolving issues quickly and avoiding ongoing concerns. Staff have been made aware that support from line managers or Patient Relations staff is available to them when dealing with complaints. If a complainant indicates that they wish to make a formal complaint, staff should provide information about making contact with Patient Relations staff.

67. The Board told me that the Senior Charge Nurse did raise Mrs C's concerns with all the appropriate staff following their discussion on 14 August 2005. The Board regret that no record of these staff discussions was

made. The Board told me that the Senior Charge Nurse has since reflected on her actions and is now aware that it might have been useful to advise her line manager when it was clear that Mrs C remained dissatisfied. She has also been made aware of the importance of keeping records of discussions and actions taken following the receipt of a complaint. The Board told me that the Patient Liaison staff have provided guidance and training to staff in Glenrothes Hospital regarding dealing with complaints. I have had sight of this guidance. The Senior Charge Nurse has subsequently handled complaints and been able to resolve them locally.

68. Mrs C complained that the Board sent her inaccurate letters during the complaints process. This related to inaccuracies Mrs C perceived in some of the individual staff responses during the investigation and in the Acting Medical Director's letter of 16 August 2005 as well as the error the Chief Executive had made in his letter of 10 August 2005.

69. The individual responses contained some statements that Mrs C believed to be inaccurate, relating to timings of treatment, episodes during her father's care in Ward 14 of The Victoria Hospital and Ward 2 of Glenrothes Hospital and the knowledge the staff had of various issues involved in the complaint. The Acting Medical Director's letter stated that Mrs C had met with the clinician responsible for agreeing to transfer Mr A from Ward 2 of Glenrothes Hospital back to Ward 11 of The Victoria Hospital when this had not happened.

70. Mrs C complained that Mr A's notes were not consulted by the Lead Nurse at Glenrothes Hospital before she made her statement to the Board's investigator. The statement of the Lead Nurse contained reference to incidents at which she was not present. At the meeting on 24 November 2005, the Lead Nurse confirmed that she had not consulted Mr A's notes before making her statement.

71. Mrs C complained that the correspondence she received from the Board and the internal statements given to the Board's investigation were not of an acceptable grammatical standard. There were some grammatical errors in the correspondence Mrs C received and the internal statements. The letter of 16 August 2005 from the Acting Medical Director contained the sentence 'I have forwarded the further two letter who will investigate the additional issues around Ward 2 at Glenrothes.'

(b) Conclusion

72. Mrs C's complained that her complaints to the Board were not adequately responded to. When Mrs C complained to the Senior Charge Nurse in Ward 2, I consider that the Board's procedure was not adhered to. However, the Board have subsequently taken appropriate action to address this.

73. Clearly, the Chief Executive's letter of 10 August 2005 contained a regrettable inaccuracy, however, his subsequent letter made an appropriate apology for this error. The Acting Medical Director's letter of 10 August 2005 also contained an inaccuracy, but this was a minor error and had no bearing on the subsequent handling of Mrs C's complaints. Mrs C believed some of the statements provided by staff to the Board's investigation contained inaccuracies. Like the Acting Medical Director's inaccuracy, some of these were minor and had no subsequent bearing on the handling of Mrs C's complaints. Others are more matters of interpretation and viewpoint than accuracy, and it has not been possible for me to reach a finding on these points.

74. The Lead Nurse confirmed that she had not consulted Mr A's medical and nursing notes before she wrote her statement to the investigation. I consider that this was not acceptable given that the content of the statement referred extensively to Mr A's nursing care in Ward 2.

75. Finally, although the correspondence Mrs C received did contain some grammatical errors, the correspondence was of an acceptable standard. Similarly the internal statements also contained some grammatical errors but this too was of an acceptable standard and the member of staff compiling a response to Mrs C would have had the opportunity to clarify any points with the staff. The specific sentence in the Acting Medical Director's response is not clear, but in context it would be reasonably understood that he had forwarded the further two letters to the member of staff responsible for compiling a response to Mrs C.

76. Overall the formal complaints handling was of a high standard and the Board demonstrated a commendable attitude to responding to and addressing Mrs C's complaints. However, the Senior Charge Nurse did not follow the correct procedure in dealing with Mrs C's informal complaint and the Lead Nurse did not adequately consider her response to Mrs C's complaint. In view of the circumstances, I, therefore, partially uphold the complaint.

(b) Recommendations

77. As noted in paragraph 67 above, the Board have taken steps to ensure the Senior Charge Nurse and other staff are aware of the procedure for receiving informal complaints and to ensure that a similar situation does not recur and the Ombudsman commends the Board for these actions. In relation to the Lead Nurse not adequately considering her response to Mrs C's complaint, the Ombudsman recommends that the Board introduce guidance to all staff regarding how to respond to requests for statements on complaints, with specific reference to consulting medical or nursing notes when dealing with events to which they were not party to.

(c) The action plan generated as a result of Mrs C's complaints was not adequate

78. Mrs C felt that the Board staff she communicated with during the complaints process were 'telling her what she wanted to hear' and that the action plan generated as a result of her complaints was not sufficiently robust in terms of the monitoring of the action points and tackling the attitudes of staff.

79. I have had sight of the action plan and have detailed in this report where it refers to specific complaints that Mrs C made. I have asked the Board for updates on how the specific actions have been undertaken. These have been provided to me, and I have shared these with Mrs C.

(c) Conclusion

80. As noted above, I have concluded that the action plan does reasonably address the issues Mrs C had raised about Mr A's care and treatment in the Accident and Emergency Department, Ward 14 of The Victoria Hospital and to some extent in Ward 2 of Glenrothes Hospital. However, I have noted above where the action plan does not adequately address the concerns Mrs C raised and I have made appropriate recommendations to remedy this. While, as noted in paragraph 78 above, the Board have demonstrated a commendable attitude towards Mrs C's complaints, the action plan did not fully remedy all of the points of complaint that it addressed. Therefore, I partially uphold the complaint.

(c) Recommendations

81. The Ombudsman's recommendations at paragraphs 49 to 53 and paragraph 77 address the failings I have identified in the Board's actions plan. The Ombudsman has no further recommendations.

82. The Board have accepted the recommendations and will act on them 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, daughter of Mr A.
Mr A	The complainant's father
The Board	Fife NHS Board
The Medical Adviser	The clinical adviser to the Ombudsman
The Urology Adviser	A clinical adviser to the Ombudsman specialising in Urology issues
GP	General Practitioner
PSA	Prostate Specific Antigen
TURP	Transurethral resection of the prostate
Mrs A	The complainant's mother
CPR	Cardio-pulmonary resuscitation
The General Manager	The General Manager of North East Fife and Glenrothes Community Health Partnership

Annex 2

Glossary of terms

Cardio-pulmonary resuscitation (CPR)	An emergency medical procedure for a victim of cardiac or, in some cases, respiratory arrest
Creatinine blood levels	Tests on the levels of creatinine in the blood are made to measure kidney function
Histological	Relating to studies of tissue
Prostate Specific Antigen (PSA)	A protein produced by the cells of the prostate gland, present in small quantities in the blood of healthy males, and is often elevated in the presence of prostate cancer and in other prostate disorders
Single shared assessment	A document compiled by one body and shared with others with responsibilities for an individual requiring complimentary assistance from those bodies
Transurethral resection of the prostate (TURP)	A procedure involving the cutting away of part of the prostate to stop it pinching the urethra and ease urine flow