Scottish Parliament Region: North East Scotland

Cases 200600514 & 200800120: Tayside NHS Board and a Medical Practice, Tayside NHS Board

Summary of Investigation

Category

Health: GP and District Nursing Services; Clinical Treatment; Diagnosis; Record-keeping and the transfer of information between medical professionals

Overview

The complainant, Ms C, raised a number of concerns that her late mother (Mrs A) had received inadequate medical post-operative care in her own home from her practice GP (GP 1) and the District Nursing Service (the DNS), before Mrs A was re-admitted to a Dundee hospital (the Hospital) and subsequently died.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) GP 1 failed to re-refer Mrs A back to the Hospital when this was requested by a district nurse (*no finding*);

(b) during the period when Mrs A was receiving post-operative care within her home, the district nurses failed to enter relevant details in case notes about Mrs A's condition (*upheld*); and

(c) during the period when Mrs A was receiving post-operative care within her home, the district nurses failed to relay family concerns to the practice GPs (*upheld*).

Redress and recommendations

The Ombudsman recommends that:

(i) GP 1 reflects on Adviser 1 and Adviser 2's comments (see paragraphs 17 to 21) and considers discussing these at her next appraisal;

(ii) the fundamental standards of documentation are considered by the practice and the Board and revisited across the DNS as an outcome of complaints (b) and (c); and

(iii) although the services within the complaint (the Board, the practice and the DNS) have demonstrated a willingness to deal with complaints and identify solutions, from the information reviewed, there is no evidence to suggest

that any of the work/actions identified have fully addressed the fundamental areas of holistic assessment and communication between teams, or been referenced to any professional standards or guidelines in relation to the assessment process, documentation, communication, wound care, care planning and patient held records. Accordingly the Ombudsman recommends that these areas are explored and that she is advised of the outcome.

The Board and the Practice have accepted the recommendations, some have already been implemented and others will be acted on accordingly.

Main Investigation Report

Introduction

1. The Ombudsman received a complaint from Ms C that her late mother (Mrs A) received inadequate medical post-operative care within her own home from her practice GP (GP 1) and the District Nursing Service (the DNS) attached to the practice (the Practice). Mrs A, aged 75, suffered a fall on 9 August 2005 and fractured her left femur. Mrs A was admitted to a Dundee hospital (the Hospital) and underwent surgery on 10 August 2005 for a hip fracture. During her operation, Mrs A had a left dynamic hip screw inserted and was discharged from the Hospital on 16 August 2005. According to Ms C, Mrs A's medical needs were attended to by several district nurses within her own home from 16 August 2005 to 4 September 2005. On 4 September 2005, Mrs A was readmitted to the Hospital as an emergency patient but, sadly, Mrs A died at the Hospital on 6 September 2005 of multiple septicaemia. Ms C stated that, in her view, GP 1 and the DNS had acted inappropriately and complacently toward Mrs A within her home, from 16 August 2005 up to 4 September 2005 during her post-operative period, and had denied Mrs A the chance of a possible recovery.

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

(a) GP 1 failed to re-refer Mrs A back to the Hospital when this was requested by a district nurse;

(b) during the period when Mrs A was receiving post-operative care within her home, the district nurses failed to enter relevant details in case notes about Mrs A's condition; and

(c) during the period when Mrs A was receiving post-operative care within her home, the district nurses failed to relay family concerns to the Practice GPs.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Ms C and Tayside NHS Board (the Board). I have had sight of the Board's complaint file and Mrs A's medical records held at the Practice and the Hospital. The investigation was aided by the Ombudsman's GP medical adviser (Adviser 1) and the Ombudsman's nursing adviser (Adviser 2) who, following their review of all relevant documentation and medical records, provided advice.

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

(a) GP 1 failed to re-refer Mrs A back to the Hospital when this was requested by a district nurse

5. Ms C told me that following Mrs A's accident and surgery, she was discharged from the Hospital on 16 August 2005. Thereafter, all Mrs A's post-operative needs were attended to within her own home by several district nurses, from 16 August 2005 up to 4 September 2005 (see paragraph 1). According to Ms C, on 19 August 2005 one of the district nurses (DN 1) attending Mrs A had a concern regarding Mrs A's wound, which Ms C said had been leaking copious amounts of blood and fluid since her discharge from the Hospital. Ms C advised that DN 1 telephoned the Hospital ward (the Ward) and was advised to get a re-referral via a letter from GP 1. Ms C told me that GP 1 had thereafter suggested continuing to change dressings and had not referred Mrs A to the Hospital. Ms C commented that, in her view, as Mrs A had died from septicaemia, she had been denied the chance of possible recovery as a result of GP 1's actions.

6. As part of my investigation, I asked Adviser 1 for his assessment of this aspect of the complaint.

7. From the GP records (see paragraph 3), Adviser 1 observed that GP 1 had spoken on the telephone to DN 1 on 19 August 2005. Adviser 1 noted the GP 1's record indicated that she was told by DN 1 that Mrs A was well but the lower end of the wound was oozing serous fluid and now blood; the wound was healthy; there was no sign of infection; and the patient was well. According to the GP record, GP 1 advised that DN 1 continued with the dressings, Mrs A should have daily reviews by the district nurses and be reassessed in three days time.

8. Adviser 1 observed that according to a statement made by Ms C on 23 January 2006, she had asked GP 1 at a meeting they had attended on 12 January 2006, why she had not referred Mrs A to the Hospital on 19 August 2005. Adviser 1 stated: '[GP 1] replied that [DN 1] did not relay to her that [DN 1] had spoken to [the Hospital] and that there had been a suggestion that [Mrs A] be referred to [the Hospital].'

9. Adviser 1 observed that DN 1 made a statement dated 14 February 2006 about the events of 19 August 2005, to the effect that she had spoken to the Ward to request a review of Mrs A's wound, as she was concerned with wound exudate, and was told that the Ward would only take this request from a GP. Thereafter, DN 1 stated:

> 'In the presence of [Mr and Mrs A] I then telephoned [the Practice] to speak with a GP for advice, a GP was not available at this time, I left patient's telephone number for a GP to return my call. A short time after [GP 1] returned my call. I informed her that I contacted [the Ward]. [GP 1] asked me what the wound condition was, I described to her that the exudate appeared like fresh blood and that the wound pads were saturated. [GP 1] asked if [Mrs A] had any other symptoms. I described [Mrs A] as lucid with no pain or apparent pyrexia, [GP 1] advised that I repad the wound and leave the clips in situ and a GP would review on Monday 22/8/05. I informed [Mr and Mrs A] of [GP 1]'s plan for wound review and informed them that a district nurse would visit the next day Saturday 20/08/05 to review the wound and also advised them to contact [the DNS] if wound pads became wet before the next review.'

10. Adviser 1 noted that, thereafter, GP 1 had visited Mrs A on 26 August 2005.

11. Adviser 1 also noted that, within a letter from the Board to Ms C dated 25 July 2006, it was stated that at the meeting between Ms C and GP 1 during January 2006, GP 1 had explained to Ms C that patients were not routinely referred back to the Hospital's Orthopaedic Department and when it did happen, it was very dependent on a GP's clinical assessment. At the time, GP 1 did not believe that re-referral was appropriate.

12. Thereafter, from the Practice records, Adviser 1 considered the entries dated 22, 26 and 29 August 2005 and 1, 3 and 4 September 2005. He stated that, within the entry dated 22 August 2005, 'I note the wound swab taken, which shows no growth of bacteria - intimating there to be no infection at that time' and within the entry of 26 August 2005 recording GP 1's visit, 'There is stated to be no evidence of infection, [Mrs A] is assessed to be well, mobile, and pain free'. Adviser 1 further noted that another practice GP (GP 2) had visited Mrs A on 29 August 2005 and records indicated he found there to be no sign of infection but there continued to be a serous discharge with some frank blood staining.

13. From the Practice records dated 1 September 2005, Adviser 1 noted a recorded telephone conversation between a Practice GP (GP 3) and an unidentified person. Adviser 1 linked this telephone discussion to an entry within the DNS records that recorded an unidentified district nurse had 'intimated she would speak with the GP'.

14. The Practice records entry, dated 1 September 2005, stated that the wound swab needed no action as the patient was in hospital. Adviser 2 commented 'I do not fully understand this entry as [Mrs A] was not admitted to [the Hospital] until 4/9/05, but I note the swab report intimates it was taken on 1/9/05 and not reported on until 3/9/05. I would thus assume the result reached the Practice by 4/9/05, and indeed that was the day that [Mrs A] was admitted to [the Hospital]. I have to assume that the incorrect date was put on that entry on the computer'.

15. Thereafter, Adviser 1 considered the following two scenarios and options:

(i) if GP 1 was not told of DN 1's concern and DN 1 had not discussed referral back to the Orthopaedic Department then, on being informed that Mrs A was well (see paragraphs 7 and 8), he would accept GP 1's actions as appropriate, there being no obvious evidence of ill health of Mrs A; and

(ii) alternatively, if GP 1 had been informed that DN 1 was so concerned that she felt that a review by the Orthopaedic Team was needed (see paragraph 9), then he would have expected that GP 1 might have visited Mrs A so as to assess the clinical condition and come to a position where she could make a reasonable assessment. This assessment might have been to continue with dressings to the wound at home (as was, in fact, arranged).

16. Adviser 1 stated that, in his view, the reason GP 1 had not referred Mrs A to the Hospital on 19 August 2005 was that GP 1 had not been told that DN 1 had spoken with the charge nurse as she was concerned that Mrs A needed a hospital assessment (see paragraph 15(i)). If this was the case, then GP 1 would have been reassured by the clinical findings, as reported to her by DN 1, and would have felt that a hospital assessment was not needed (see paragraphs 8 and 9).

17. Adviser 1 considered that it remained an uncertainty, regarding the conversation between DN 1 and GP 1 on 19 August 2005 (see paragraphs 7, 8,

9 and 10). He also stated his concern about the difference in recollection and contemporaneous recording of the telephone conversation between DN 1 and GP 1 on 19 August 2005 (see paragraphs 7, 8, 9 and 10).

18. Adviser 1 stated 'I would believe [GP 1] could possibly have visited [Mrs A] on 19 August 2005 so as to place her in an appropriate position to make an appropriate decision as to the care of [Mrs A]. None the less I would accept that had she done so, the clinical findings would have been similar to those she [GP 1] elicited on 26 August 2005 (see paragraph 12) and thus [Mrs A] would not have warranted admission [to the Hospital] on 19 August 2005'.

19. Adviser 2 has commented that she would have expected to see a request from the nursing staff or an earlier visit by the GP for a follow-up assessment on discharge, following the onset of Mrs A's symptoms (see also paragraph 42).

(a) Conclusion

20. This is clearly a very upsetting case. Ms C considers that, as GP 1 had told DN 1 to continue changing Mrs A's dressings on 19 August 2005 and had not referred her to the Hospital on that day, Mrs A had been denied the chance of a possible recovery and, sadly, died from septicaemia. I have carefully reviewed all the presented documented evidence as detailed in paragraph 3. I share Adviser 1's view that, based on the Practice medical records, there was no evidence to suggest that Mrs A was unwell on 19 August 2005, warranting hospital admission; furthermore, the notes clearly stated there was no infection present (see paragraphs 12 and 14). However, I do share Adviser 1's concerns about the different recollections and recordings of the telephone discussion that took place between DN 1 and GP 1 on 19 August 2005. On this issue I am unable to draw a firm conclusion, as I cannot make a judgement on two different recorded versions of a telephone conversation to which there were no independent witnesses (see paragraph 16). I have acknowledged the difficulty in such circumstances, before reaching a finding on this aspect of the complaint. I have given this and all the reviewed issues very careful consideration, along with my review of the Practice and Hospital medical records, the complaints correspondence and the advice provided by Adviser 1.

21. I have been unable to establish which version of events is accurate in relation to the telephone call of 19 August 2005 and, therefore, I am unable to make a finding on this aspect of the complaint. Nevertheless, the advice I have received is that, even if a visit had been made by GP 1 on that date, it is likely

that the clinical findings would have been the same as those recorded on 26 August 2005 when Mrs A was seen by GP 1 and, accordingly, a hospital referral on 19 August 2005 would not have been warranted. Nevertheless, both Adviser 1 and Adviser 2 have commented on the lack of a follow-up visit by GP 1 on Mrs A's discharge and following the onset of her symptoms. However, GP 1 did not make such an arrangement to visit Mrs A following her discharge from hospital, despite the copious amount of fluid exuding from the wound. I am critical of GP 1's actions in this regard.

(a) Recommendation

22. The Ombudsman recommends that GP 1 reflects on Adviser 1 and Adviser 2's comments (see paragraphs 17 to 21) and considers discussing these at her next appraisal.

(b) During the period when Mrs A was receiving post-operative care within her home, the district nurses failed to enter relevant details in case notes about Mrs A's condition; and (c) During the period when Mrs A was receiving post-operative care within her home, the district nurses failed to relay family concerns to the Practice GPs

23. According to Ms C, Mrs A had many different nurses from the DNS attending to her to change her dressings and Ms C found it 'absolutely shocking that the rest of them [district nurses] did not see that there was something far wrong' (see paragraphs 5 and 9). Furthermore 'my father [Mr A] was mopping blood up from the floor continuously and had to change bedding on several occasions'. Ms C said district nurses were also informed of this but no credence was paid to this and the matter was omitted from notes. Ms C considered the district nurses had dismissed information from the patient's relatives.

24. Adviser 2 firstly considered the background to the complaint. This included Mrs A's previous medical history of osteoarthritis of the right knee, left ventricular hypertrophy, chronic renal impairment and essential hypertension.

25. Adviser 2 observed that on 9 August 2005 Mrs A was admitted via the Accident and Emergency Department of the Hospital to the Ward following a fall, which resulted in a fractured neck of the left femur and lacerations to her face. Thereafter, on 10 August 2005, Mrs A underwent the operation for the fixation of a dynamic hip screw to treat the left hip fracture (see paragraph 1) and was commenced on antibiotics following the operation, to treat a chest

infection. Adviser 2 noted that, after Mrs A underwent orthopaedic surgery on 10 August 2005, her post-operative recovery and rehabilitation went well on the Ward and, thereafter, Mrs A was discharged to her home on 16 August 2005, with a referral to the DNS for follow-up care, to include the removal of clips on 19 August 2005. Adviser 2 stated 'the nursing transfer letter did advise the [DNS] team that [Mrs A]'s wound was leaking but improving and a mepore dressing was in place'.

26. From the Practice records, Adviser 2 noted that throughout their interventions with Mrs A, the DNS recorded variable amounts of bloodstained leakage (but usually copious amounts) from the site of the operation and were required to attend on most days that Mrs A remained at home to renew the dressing. Adviser 2 stated, '[Mrs A]'s dressing required renewing on most days, and on occasion 2/3 times daily due to the amount of leakage that came through the dressing. There was the rare occasion that the wound was dry and did not require changing'.

27. Adviser 2 noted from the Practice records that the DNS team had made telephone contact with Mrs A on 17 August 2005 and visited her at home from 18 August 2005 to 4 September 2005. The DNA team included staff from the evening and Out of Hours DNS teams, leading to a total of 10 staff being involved in the provision of care to Mrs A (see paragraph 1).

28. According to Adviser 2, the DNS telephoned GP 1 on 19 August 2005 (see paragraph 9) and again on 26 August 2005, requesting a review of Mrs A's wound. GP 1 visited Mrs A on 26 August 2005 (see paragraph 12) and additionally recorded that the wound 'continued to produce heavily blood stained exudate' and, if that this continued through to Monday 29 August 2005, there would need to be an orthopaedic review.

29. On 29 August 2005 Adviser 2 observed that Ms C had telephoned the Practice and raised concerns about Mrs A's wound. I have seen from the medical records that Ms C discussed her concerns with GP 1 who then arranged for an assessment that day to be carried out by GP 2. Adviser 2 commented, 'A home visit was carried out the same day by a different GP [GP 2] from the Practice, who noted that [Mrs A] was not concerned about the wound, the concern was being voiced by [Mr A] and [Ms C]. The wound was still leaking at this point and treatment ordered by [GP 2] was to continue with dressings and pads'.

30. From the DNS records dated 1 September 2005, Adviser 2 noted that a second wound swab was taken by a district nurse and on that day, 'The district nurse had a conversation with [GP 3] about the wound swab and [Mrs A]'s amitriptyline dosage. Advice was given over the telephone from [GP 3]. [Mrs A] continued to lose copious amounts of exudate from the wound over the next few days'.

31. Another district nurse noted during their visit to Mrs A on 3 September 2005 that 'she was confused and had some swelling of her hands and face that was thought to be due to the amitriptyline that had commenced earlier, [Mrs A] was advised to stop taking the medication for the time being'.

32. On 4 September 2005, Adviser 2 noted that the laboratory report of the result of the swab taken on 1 September 2005 confirmed 'profuse growth of Staphylococcus Aureus' (see also Adviser 1's comments at paragraph 14) but this was not obtained prior to Mrs A being re-admitted to hospital on 4 September 2005.

33. Adviser 2 observed that on 4 September 2005 Ms C contacted the out-of-hours medical cover (NHS 24) who visited Mrs A on two occasions that day. 'During the first visit, the NHS 24 Doctor [Doctor 1] advised no change to current treatment and for [Mrs A] to be reviewed by her own GP the next day. When [Doctor 1] visited the second time on 4 September 2005 it was identified that [Mrs A] required admission to hospital'.

34. Thereafter, Mrs A was taken to the Hospital with signs of confusion, agitation, shortness of breath and some signs of septicaemia and admitted to the Ward where, despite attempts to treat her presenting symptoms, she died on 6 September 2005 (see paragraph 1).

35. Adviser 2 noted that the Practice investigation into Ms C's complaint included a meeting between Ms C and GP 1 on 12 January 2006 (see paragraph 11), during which 'it was recognised that in order to address the concerns regarding the communication between [GP 1] and the [DNS] it was agreed that there would be a meeting between the DNS team and GPs [of the Practice]'. At this meeting Adviser 2 also noted that GP 1 stated she was of the opinion that she had acted appropriately (see paragraphs 17 and 19).

36. Adviser 2 also observed that the Community Service Manager of NHS Tayside (the Manager), as part of her investigation and findings relating to Community Services, had identified that there was a lack of detail available within the wound care documentation and the entries made in the patient held record and electronic record (Octagon) from the Practice records (see paragraph 35). For clarity, the Board told me that Octagon is not a General Practice System, it is the NHS Tayside electronic District Nursing System, to which the Practice has no direct access. District Nurses have two systems to record nursing care; the patient hand held paper record and the Octagon electronic record. The GPs use their own electronic recording system (EMIS). Furthermore, the Board stated that the Manager did not have access to the Practice electronic system as part of her investigation.

37. Adviser 2 concluded that, following her examination of the information available within the files (see paragraph 3), 'I have to agree [with the Manager] – as there are a total of 23 [DNS] visits recorded in the patient held record (1 of which was not captured on the Octagon system) and 29 [DNS] visits recorded on the electronic system - Octagon (7 of which were not recorded in the patient held record).' Furthermore, 'there is evidence to show that they [the Practice] have communication systems in place to support the DNS, however, evidence available shows little correlation between the care documented in the patient held record and the electronic system (Octagon)' (see paragraph 36).

38. In her view, Adviser 2 stated that the DNS documentation 'fails to meet the necessary standards (refer NMC [Nursing and Midwifery Council]) that would allow access to contemporaneous records. Not all visits are recorded and of those that were entered on the electronic system, the majority of entries are incomplete'. Examples listed by Adviser 2 include: a lack of information in relation to who was completing the entry; time of day that entry was being made; which profession had undertaken the visit; and an account of the finding/care delivered at the time of the visit. Additional areas which also do not appear to have been captured consistently include: conversations between practitioners/patient/carers/investigations; and outcomes of assessment.

39. Furthermore, in Adviser 2's view, the available care planning documents were limited and focussed, in the main, around the wound care required and there was little in the way of additional information to portray the holistic needs of Mrs A. There was mention of the introduction of a new wound care chart and an audit of current practice. In Mrs A's circumstances, there was a wound care

chart in use but it had only two entries by the DNS throughout the course of treatment delivered at home. In addition, Adviser 2 stated, 'The introduction of a new chart cannot detract from the lack of entries made'.

40. Ms C had also complained the DNS dismissed family concerns and was 'not listening to [Mr A] who was telling them that he was continuously mopping up blood from the floor and frequently changing the bed. Only one nurse out of ten showed any concern' (see paragraphs 1, 5 and 21).

41. Adviser 2 considered the review of the DNS documentation which the Manager had carried out (see paragraph 36), when it had been identified there was a lack of information available within the patient held record and the electronic system (including discussion between the DNS and GPs), to capture a full record of activity. Adviser 2 stated, 'The action plan as mentioned earlier is an attempt to address these issues. In my opinion as a nurse, the [DNS] have a joint responsibility with medical staff for the management and safety of their patients. As such I would have expected to see a request from the nursing staff, or an early visit by the GP, for a follow-up assessment on discharge following the onset of [Mrs A]'s symptoms. I cannot see that on this occasion that a follow-up visit occurred within what would be a reasonable timeframe that would have addressed the initial concerns regarding [Mrs A]'s care needs' (see paragraphs 24 and 25).

42. In addition, Adviser 2 noted 'I am aware from the information available to me that there were a number of contacts made with the Practice and Out of Hours Medical Staff by the [DNS] staff and [Mrs A], following which on occasions home visits were made. There is, however, no evidence to suggest that a thorough assessment of [Mrs A]'s needs was undertaken by a Senior Nurse/Case Manager, or that there was a treatment/care plan with clear actions and reviews identifying who would be responsible for clarifying the position with the GP and taking overall co-ordination and review of care required and provided to [Mrs A]. Co-ordination of the care provided and ongoing review is in my experience the responsibility of the Care Manager, unfortunately I was unable to identify who this was from the information available'. Thereafter the Board commented that a senior nurse with 24 hour nursing responsibility for Mrs A was involved in her care and her name was included in the Patient Held Record.

43. Thereafter, Adviser 2 expressed her view that, in her experience, within a team there is usually an opportunity for individual members of the team to discuss cases with peers and, if necessary, to escalate any concerns to a higher level in order to elicit a response to meet the needs of the individual. She added, 'I could see no evidence to suggest that there is any peer support mechanism in place, or if the nurse who identified the initial concern in relation to [Mrs A]'s care [DN 1] had the opportunity to discuss her concerns and the future management of [Mrs A]'s care with a senior nurse. If this had occurred within the team there is no documentation available to support this action' (see paragraph 43).

44. Adviser 2 observed that the Board had stated that not all staff had been interviewed as part of their investigation, including two key members of staff. Adviser 2 expressed her concern about this, 'if these staff were key to the investigation, then additional steps should have been taken in an attempt to rectify this'. Adviser 2 suggested that, in her experience, it proved beneficial to discuss such circumstances with a representative from Human Resources, in order to identify the appropriate approach regarding, for example, access to staff on maternity leave or those who have left the organisation. Furthermore, 'the recall of information as close to the incidents as possible is beneficial for all, as the passage of time alters recollection of events and may well dilute vital information/facts related to the complaint' (see paragraphs 8 and 9).

45. Adviser 2 concluded that, in her view, the Board had failed to investigate thoroughly Ms C's complaints (b) and (c), furthermore, 'not only did they fail to examine additional possibilities relating to the interviewing of staff linked to the complaint, they also identified areas of action that fell short of addressing the main concerns raised by [Ms C].' Adviser 2 also considered that, although work had been undertaken by the services identified within the complaint and the solutions that were required, 'unfortunately from the information available, there is no evidence to suggest that any of the work/actions identified have fully embraced the fundamental areas of holistic assessment and communication between teams, or been referenced to any professional standards/guidelines in relation to - the assessment process, documentation, communication, wound care, care planning and patient held records'. In addition she noted that team working might have been improved or at least demonstrated if a multi-disciplinary record had been fully completed. In the view of Adviser 2, these additional areas would have been required to be explored, in order to fully address the issues highlighted within complaints (b) and (c).

46. Adviser 2 also identified that 'there was no reference to the development of a joint action plan or training programme to ensure that all staff are aware of how to complete the electronic records, access information across teams and agree a process for the escalation of concerns. These actions alongside those additional areas as identified above (see paragraph 46) would have in my opinion, provided an essential platform from which to start and address the areas of concern'.

(b) and (c) Conclusion

47. As previously stated, this is a very upsetting case. In Ms C's view, when Mrs A was receiving medical care within her home, the district nurses failed to relay family concerns to the Practice GPs and also failed to enter some relevant details in case notes about Mrs A's condition. I have reviewed carefully all the relevant documentation as detailed in paragraph 3 and Adviser 2's individual report. I share Adviser 2's analysis that she has identified there was a failure to capture all information within the patient held record and electronic system, to reflect a full record of activity when the district nurses attended to Mrs A within her own home (see paragraphs 38 and 42). Furthermore, there was no evidence to suggest that a thorough assessment of Mrs A's needs was carried out or that a senior person (such as a senior nurse or care manager) had been appointed (or indeed that such an appointment had been considered) to take overall responsibility for the co-ordinating of care for Mrs A, which included the Practice GPs (see paragraphs 43 and 44). This conclusion, coupled with Adviser 2's finding that she saw no evidence of any peer support mechanism in place, linked with her analysis that there was very little documentation to support the activity involved with Mrs A's care (see paragraph 39), leads me to conclude, in the absence of evidence to the contrary, that district nurses had not relayed family concerns to the Practice GPs (see paragraphs 39 and 40). In addition, Adviser 2 opined that the Board failed to investigate the complaint in a thorough manner, as they had failed to examine additional possibilities related to the interviewing of staff linked to the complaint. Furthermore, the areas of action the Board had identified within the complaint fell short of addressing the main concerns raised by Ms C. Accordingly, I uphold complaints (b) and (c).

(b) and (c) Recommendations

48. The Ombudsman recommends that:

(i) the fundamental standards of documentation are considered by the Practice and the Board and revisited across the DNS as an outcome of

complaints (b) and (c). In particular, in relation to the lack of cross referencing between the patient held record and the electronic version, the Practice and the Board should take into account the advice I have received, that team working might have been improved or at least demonstrated if a multi-disciplinary record had been fully completed; and

(ii) although the services within the complaint have demonstrated a willingness to deal with complaints and identify solutions, from the information reviewed, there is no evidence to suggest that any of the work/actions identified have fully addressed the fundamental areas of holistic assessment and communication between teams, or been referenced to any professional standards or guidelines in relation to the assessment process, documentation, communication, wound care, care planning and patient held records. Accordingly the Ombudsman recommends that these areas are explored and that she is advised of the outcome.

49. The Board and the Practice have accepted the recommendations, some have already been implemented and others will be acted on accordingly. The Ombudsman asks that the Board and the Practice notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant (the daughter of Mrs A)
Mrs A	Ms C's late mother
GP 1	Mrs A's doctor at the Practice, who the district nurse (DN 1) telephoned on 19 August 2005 and who visited Mrs A on 26 August 2005
The DNS	District Nursing Service of the Practice
The Practice	Mrs A's local medical practice
The Hospital	The hospital where Mrs A had her operation, was readmitted to and died
The Board	NHS Tayside
Adviser 1	The Ombudsman's GP medical adviser
Adviser 2	The Ombudsman's nursing adviser
DN 1	The district nurse who telephoned Mrs A's doctor on 19 August 2005
The Ward	The ward Mrs A was admitted to at the Hospital
Mr A	Mrs A's husband and Ms C's father
GP 2	The Practice doctor who visited Mrs A on 29 August 2005
GP 3	The Practice doctor who visited Mrs A on 1 September 2005

Doctor 1	The NHS doctor who visited Mrs A twice on 4 September 2005
The Manager	NHS Tayside Community Services Manager

Annex 2

Glossary of terms

Amitriptyline	A medicine that acts on the nerve cells in the brain
Antibiotics	For the treatment of infections by inhibiting or killing off the growth of other micro organisms
Exudate(s)	A term commonly used to describe fluid draining from a wound
Frank Blood Staining	Full blood discharge staining
In situ	In place
Mepore Dressing	A surgical dressing
Out of Hours DNS Teams	The Team referred to in the report works evening and night hours only. Other hours, out with standard surgery times such as weekends and public holiday are covered by mainstream district nursing
Octagon	Electronic record
Pyrexia	Raised temperature
Staphylococcus Aureus	A species of bacterium commonly found on the skin
Serous Fluid	Used in this case to describe bodily fluid that is pale yellow and transparent