Scottish Parliament Region: Glasgow

Case 200601594: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; care and treatment

Overview

The complainant, Ms C, raised a number of concerns about the care and treatment that her uncle, Mr A, received in Vale of Leven Hospital (Hospital 1), between his admission on 23 January 2006 and his transfer to Gartnaval General Hospital (Hospital 2) on 8 February 2006. Sadly, Mr A died on 8 March 2006.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr A was given inconsistent advice (*no finding*);

(b) Mr A's pain was not managed effectively between 28 January and 8 February 2006 (*upheld*);

(c) Mr A's pressure sore could have been avoided (*upheld*);

(d) Mr A should have been referred to the vascular surgeons more quickly (*upheld*);

(e) Mr A's room was not clean and this contributed to his illness (*not upheld*); and

(f) Mr A was inappropriately referred to as a problem patient (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) remind staff of the need to ensure they respond in full to formal complaints;

(ii) ensure that the clinical team responsible for Mr A's care in Hospital 1:

(a) review this report; consider what lessons can be learned from Mr A's experience and review how pain is managed effectively;

(b) are aware of the need for accurate records to be kept; and

(c) utilise best practice statements on *Pressure Ulcer Prevention* and the *Treatment and Management of Pressure Ulcers* issued by NHS Quality Improvement Scotland (March 2005 and November 2005);

(iii) audit the use of MRSA screening on Ward 14 and report back to her proof of review and change in practice;
(iv) ensure that the clinical team consider the lessons to be learned as a result of the failings identified in this report and report back to her changes in practice put in place as a result; and
(v) apologise to Ms C fully and formally for the failings identified in this report;

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

Main Investigation Report

Introduction

1. Ms C held a power of welfare attorney for her uncle, Mr A. Mr A, who was 74 years old and diabetic at the time of his admission to hospital, lived alone and managed well with his activities of daily living, requiring some help from social services with shopping. He had suffered from ulcers on both legs for some time and walked with difficulty, using a zimmer frame. In addition to care provided by his GP practice, he was being seen by the vascular out-patient department at Gartnaval General Hospital (Hospital 2) and had also attended dermatology out-patient clinics in the past. When his leg ulcers worsened, Mr A's GP referred him to Vale of Leven Hospital (Hospital 1), where he was given antibiotics but he was not admitted because of a bed shortage at that time (19 January 2006). He was admitted to Hospital 1 the following week (23 January 2006) for more intensive treatment of his ulcers, which had become infected and had further reduced his already poor mobility. Mr A remained in Hospital 1 until he was transferred to Hospital 2 on 8 February 2006 for amputation of his foot. Following his transfer, however, he was found to have a large pressure sore on his lower back which was infected and which required surgery on 28 February 2006. Mr A's planned surgery required to be postponed until the pressure sore could be treated and was never carried out because Mr A died on 8 March 2006. Mr A's death certificate stated that the principal causes of his death were acute respiratory failure, septicaemia and sacral necrotising fasciitis.

2. On 25 March 2006 Ms C complained to Hospital 1 about her uncle's care and treatment during his stay there but remained dissatisfied by the response. Ms C, therefore, complained to the Ombudsman on 28 August 2006.

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

(a) Mr A was given inconsistent advice;
(b) Mr A's pain was not managed effectively between 28 January and 8 February 2006;
(c) Mr A's pressure sore could have been avoided;
(d) Mr A should have been referred to the vascular surgeons more quickly;
(e) Mr A's room was not clean and this contributed to his illness; and
(f) Mr A was inappropriately referred to as a problem patient.

Investigation

4. In order to investigate this complaint I have had access to Mr A's medical records and further information from both Hospital 1 and Hospital 2 and the correspondence relating to the complaint. I have received clinical advice from two nursing advisers (Adviser 1 and Adviser 2) and an adviser who is a hospital consultant (Adviser 3). I have referred to the guidance listed in Annex 3 to this report. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and Greater Glasgow and Clyde NHS Board (the Board) were given an opportunity to comment on a draft of this report.

(a) Mr A was given inconsistent advice

5. Ms C said that, following her uncle's admission to hospital on 23 January 2006, she went to visit him on 25 January 2006. Mr A's dressings had been removed from his legs as he was waiting for the consultant dermatologist (Consultant 1) to see him. Ms C said that she was shocked and horrified to see the state of Mr A's legs which were much worse than she had ever known them to be. Ms C said that she spoke to Consultant 1 after he had seen her uncle and he stressed that her uncle must elevate his legs.

6. The following day (26 January 2006) Ms C visited again, this time with her mother, Mr A's sister, and found Mr A sitting in a chair in the middle of the ward. Ms C said that her uncle had arthritic hands and such poor eyesight he was almost blind. He was very distressed, which upset her mother and caused her to be very concerned. On making enquiries as to why Mr A had been left like this, Ms C said that she was told it was to encourage him to walk to the toilet by himself. Ms C said that was not consistent with Consultant 1's advice.

7. The Director of Service Delivery, when responding to Ms C's complaint, made reference only to the position after Mr A had been transferred to Ward 14 on 28 January 2006. In response to my enquiries, the Corporate Administration Manager agreed that Consultant 1 advised Mr A to elevate his legs where possible but it is clearly documented in the nursing notes on 25 January 2006 that he was unable to do so because he was in too much pain. On 26 January 2006 it is also clearly documented that Mr A was still unable to elevate his feet due to pain, which the medical staff were attempting to control. It is recorded in the notes that Mr A was unable to weight bear on 26 January 2006 and so would have been unable to walk to the toilet unaided. On 27 January 2006, however, Mr A did manage to walk to the toilet with a

zimmer and assistance from two staff. Mr A was not being encouraged to walk unaided and a note made of the family's concern that he was unable to mobilise independently demonstrated that they were aware of this.

8. Adviser 1 said that Mr A was first admitted to Ward 3 which is the Medical Admissions Ward, where most patients with acute problems are admitted to stabilise their condition in preparation for discharge or transfer to a more appropriate ward. Mr A was in Ward 3 from 23 January until he was transferred to Ward 14 on 28 January 2006. Adviser 2 agreed that, among other things, Consultant 1 had recommended leg elevation. Adviser 2 said that, according to the nursing notes, Mr A was unable to weight bear on 26 January 2006 and had required to be hoisted. There is nothing in the notes to indicate if or why Mr A was sitting in the middle of the ward, as described by Ms C, and Adviser 1 said she could not comment on that.

(a) Conclusion

9. Unfortunately there are no entries in Mr A's clinical notes to explain if or why Mr A should be sitting in the middle of the floor in the medical admissions ward and, although Ms C raised this as part of her complaint to the Board, it was not responded to at that time. For these reasons, I am unable to make a finding in relation to this complaint. Nevertheless, I am concerned about the lack of a formal response to Ms C's complaint on this score.

(a) Recommendation

10. The Ombudsman recommends that the Board remind staff of the need to ensure they respond in full to formal complaints.

(b) Mr A's pain was not managed effectively between 28 January and 8 February 2006

11. Ms C said that when she went to visit her uncle on 28 January 2006 he had been moved to Ward 14. He was in a single room and his condition was obviously deteriorating. He was in considerable pain, was distressed and complaining bitterly. On her subsequent visits, up to his transfer to Hospital 2 on 8 February 2006, Ms C said that he suffered excruciating pain despite his medication.

12. On 31 May 2006 the Director of Service Delivery wrote to Ms C in response to her formal complaint. She said that Mr A's leg ulcers had continued to deteriorate during his stay and his pain had increased.

13. I asked NHS Greater Glasgow and Clyde for the prescription charts relating to Mr A's stay in Hospital 1 but on 9 August 2007 the Head of Administration wrote to say that, despite an extensive search, they could not locate them.

14. Adviser 2 noted that Consultant 1 had advised analgesia for Mr A when he saw him on 26 January 2006. Adviser 2 said that Mr A had had difficulty in complying with his treatment plan and that appeared to be related to his pain experience. Adviser 3 said that Mr A complained of much more pain in his legs which required opiate painkillers. While these relieved his pain to some extent, Mr A had much more difficulty mobilising. It was noted by nursing staff on 28 January 2006 that this concerned Mr A's family. Adviser 2 said that it was difficult to comment on administration of pain relief without the drug prescription charts but there are recordings in the nursing notes in relation to analgesia being given regularly and prior to dressing changes in particular. Adviser 2 said that it would have been good practice to have maintained an accurate pain assessment and scoring record. Adviser 2 said that frequent assessment of pain is necessary to identify what the current pain experience means to the patient and measurements can assist professionals in providing pain relief through pharmacological and non-pharmacological methods. Given the apparent difficulty in managing Mr A's pain, it would also have been good practice to have sought advice from expert practitioners in acute pain management. Adviser 3 agreed with Adviser 2 that there was no evidence that Mr A's severe pain was managed in a strategic or planned way.

(b) Conclusion

15. It is clearly unsatisfactory that the prescription charts could not be located and Adviser 2 noted the absence of a pain assessment and scoring record. It is clear, however, both from what Ms C said in her complaint and from the evidence in the nursing notes about Mr A's difficulties in complying with his treatment regime, that pain was causing him severe difficulties. The advice I have received is that there is no evidence that Mr A's severe pain was managed in a strategic or planned way. I, therefore, uphold this complaint.

(b) Recommendation

16. The Ombudsman recommends that Board ensure that the clinical team responsible for Mr A's care in Hospital 1 review this report; consider what

lessons can be learned from Mr A's experience and review how pain is managed effectively.

(c) Mr A's pressure sore could have been avoided

17. Ms C said that when her uncle was transferred to Hospital 2 he was found to have a pressure sore on his lower back. This had become infected to such an extent that Mr A's planned operation had to be postponed until it could be treated. The treatment involved surgery, during which it was discovered that the extent of the sore was greater than previously thought and all effort from that time went on trying to recover the situation. That proved to be impossible and Mr A died on 8 March 2006. Ms C said that with good nursing care and proper equipment, pressure sores should be a thing of the past.

18. In response to Ms C's complaint, the Director of Service Delivery said that Mr A was identified as at high risk of pressure sores and was nursed on an appropriate airflow mattress. When he was in bed, he was encouraged to change his position hourly. Unfortunately, Mr A was reluctant to alter his position and was non-complaint with the advice and instructions given by staff. On 5 February 2006 it was noted that the skin on Mr A's left buttock was discoloured and this was dressed using an allevyn sacrum dressing. The area was re-dressed on 7 February 2006 and was noted to have deteriorated. Mr A was transferred to Hospital 2 on 8 February 2006, with no further deterioration having been recorded. The Director of Service Delivery agreed that pressure sores are avoidable but said that, although Mr A was nursed on an appropriate airflow mattress, he continued to be non-complaint with his care and refused position changes. The Director of Service Delivery said they were sorry but they had been unable to avoid Mr A developing a pressure sore.

19. In her complaint to the Ombudsman, Ms C said that when she visited Mr A initially in Hospital 1 she always found him sitting on a hard chair. He sat in this chair day and night because the pain in his legs was so great. Following bleeding from his leg ulcers he was put to bed and he remained there, unable to move himself. There was no monkey pole on his bed and insufficient pillows which meant that he could not sit up and eat. He became incontinent due to his inability to locate and manoeuvre the bottle in time as he also suffered from urgency of micturition. Ms C said that on 7 February 2006 Mr A said he had noticed blood on his incontinence pad when he was being changed and he thought that his old pilonidal sinus had flared up again. The nurses had assured Ms C that there was no problem. Ms C said that her uncle was in the

same position in bed every time she visited him: on his back, low on his pillows and unable to use his table. Ms C said that Mr A was not nursed on an airflow mattress. On 8 February 2006 Mr A was transferred to Hospital 2. When she visited him that evening he was being nursed on an airflow mattress. She was informed that his condition was very poor; he was catheterised; having IV fluids; and being nursed on an airflow mattress because he had a sacral pressure sore.

20. Adviser 2 said that when Mr A was admitted to Hospital 1 a pressure sore assessment was undertaken. The risk assessment score was 19, indicating that Mr A was at high risk of developing a pressure sore. Adviser 2 said that there was no documented plan of care as a result of the risk assessment and no evidence of re-assessment of risk while Mr A remained in Ward 3. Adviser 2 said that was not acceptable, given the fact that Mr A had been identified as being at high risk of developing pressure sores.

21. Adviser 2 said that, following Mr A's transfer to Ward 14, his pressure sore risk was calculated as 23 on both 4 and 5 February 2006. A care plan (undated) had been developed because of Mr A's reduced mobility and included in the plan was a description of the need to encourage positional change every two hours. Adviser 2 said, however, that it is important to note that the identified goal in the care plan was 'to improve mobility and reduce the risk of falls'. There was no specific care plan related to Mr A's risk of pressure sore development and the intervention planned to minimise that risk. Adviser 2 again said that was unacceptable.

22. Adviser 2 said that the first reference to Mr A's pressure areas was on 4 February 2006, when it was stated that his bottom was looking red. On 5 February 2006 an area of discolouration was noted on the left buttock and bleeding had also been evident. It was noted that Mr A was encouraged to lie on his side but he did not tolerate that well. On 7 February 2006 the nursing evaluation sheet includes an entry indicating that the skin on Mr A's scrotum was breaking down. His sacral sore was redressed with a foam dressing, with a non-adherent wound contact layer, foam based central layer and a bacteria and waterproof outer layer suitable for light to moderate exuding wounds. Adviser 2 said that dressing was appropriate.

23. Adviser 2 said that Mr A was at high to very high risk of developing pressure sores during his stay in Hospital 1 and, because of this, interventions

should have been employed to minimise the risk. Adviser 2 said that, even with appropriate interventions, it is not always possible to prevent pressure sores from developing, particularly when, as in Mr A's case, the patient has difficulty in complying with the interventions to reduce the risk. Adviser 2 said that following a risk assessment, however, interventions should have been planned according to the identified risk scoring and Adviser 2 said that there should have been findings noted from skin inspection indicating further action required and taken. In Mr A's case that should have included: evidence of further examination of erythema (non-specific redness of the skin that can be localised or generalised in nature); evidence that position changes were carried out; the use of assistive devices to assist patients re-positioning in bed (for example the use of profiling beds); use of a special pressure relieving mattress; and the appropriate pressure redistributing equipment for use when the patient is sat in a chair. She also advised that there should have been consideration of nutritional status and its potential impact on pressure sore development and management and appropriate moving and handling according to a risk assessment. In addition, if a pressure sore is present Adviser 2 said that it should be graded in accordance with one of several grading scales available, for example, Stirling Pressure Sore Severity Scale or the European Pressure Ulcer Advisory Panel guide to pressure ulcer grading. Other key factors should also have been considered, for example, Mr A's pain experience and control and issues that may affect concordance with the care plan.

24. Adviser 2 noted that in her statement the ward sister said that an airflow mattress was in use, however, as the sister was not on duty during Mr A's stay on Ward 14 this evidence must have been based on information given to her by members of the nursing team. Adviser 1 and Adviser 2 agree that Ms C, a registered nurse, would have recognised a pressure-relieving mattress. There was also nothing in the notes to indicate that an airflow mattress and/or a cushion in the chair was used.

25. Adviser 2 noted that Mr A spent a considerable amount of time sitting in his chair, especially at night (he had also slept in his chair at night at home). This was his expressed wish because it contributed to relief of his pain and was the most comfortable position for him. A pressure-relieving cushion does not appear to have been supplied and Adviser 2 was concerned that may have contributed to the development of Mr A's sacral sore. Adviser 2 said that nursing staff did attempt to discourage Mr A from sitting in his chair and there was evidence that efforts were made to encourage him to change his position

while in bed. Mr A could not tolerate this and it was recorded in the nursing noted that he was 'non-compliant'. There are, however, no entries in the nursing notes to indicate the level of engagement of Mr A in his care plan or any indication that efforts were made to explore the reason for his difficulty in changing, or tolerating a change of, position. Adviser 3 confirmed that sepsis and renal failure as a result of necrotising fasciitis in the pressure sore contributed to Mr A's death. When reviewing the records, Adviser 2 said that there was clear evidence of poor record-keeping, particularly in terms of care planning, and lack of documentation in relation to the use of appropriate equipment (see paragraph 23). Adviser 2 said that contemporaneous records are the highest form of evidence of care delivery and good record-keeping is the mark of a skilled and safe practitioner.

(c) Conclusion

26. While I accept Adviser 2's statement that it is not always possible to avoid patients developing pressure ulcers, it is clear that a great deal more could have been done to minimise the risk of Mr A developing one. After Mr A was identified as being at high/very high risk, there was no evidence of a plan to deal with the risk, which Adviser 2 said is unacceptable. Adviser 2 identified a number of things which she would have expected to see in the clinical records but which were not there. In addition, Adviser 2 was critical that pressure-redistributing equipment was not used, either when Mr A was sitting in his chair or when he was in bed. It is not possible to say for certain but, on a balance of probabilities, I consider it likely that if all the measures identified by Adviser 2 had been taken, Mr A may have avoided developing a pressure sore. I, therefore, uphold this complaint.

(c) Recommendation

27. The Ombudsman recommends that the Board ensure that the clinical team responsible for Mr A's care in Hospital 1 are aware of the need for accurate records to be kept and utilise best practice statements on Pressure Ulcer Prevention and the Treatment and Management of Pressure Ulcers issued by NHS Quality Improvement Scotland (March 2005 and November 2005).

(d) Mr A should have been referred to the vascular surgeons more quickly

28. In her complaint Ms C queried why Mr A was transferred to Ward 14 on 28 January 2006 when he had an acute medical condition and why it took so

long for him to be referred to the vascular surgeons. She said that by the time her uncle was admitted to Hospital 2 she was told that his condition was very poor.

29. In response to the complaint, the Director of Service Delivery said that Mr A was referred to Ward 14 because the care he required was mainly nursing, assessment of his vascular risk and observations while on antibiotic therapy. He was reviewed by Consultant 1, who gave specific advice about his care and treatment and also advised contact with the vascular surgeon at Hospital 2. This advice was followed. An entry in the nursing records indicated a referral to the vascular surgeons at Hospital 2 was made on 26 January 2006. Mr A was also reviewed by the tissue viability nurse. Unfortunately, Mr A's condition had continued to deteriorate.

30. Adviser 3 said that Mr A was transferred to Ward 14 and this was recorded by the Ward 3 nursing staff as 'due to bed management', ie, for administrative reasons and recorded as admitted by Ward 14 staff 'for rehabilitation and management of chronic ulcers'. The consultant physician in Ward 14 (Consultant 2), in her submission to the Board, said that she was not involved in the decision to transfer Mr A to ward14. Adviser 3 said that this also suggested an administrative decision taken by nursing staff or the hospital bed manager rather that a clinical one, which would have involved Consultant 2 beforehand. In her submission, Consultant 2 proposed that as Mr A required only 'nursing care' she concurred with the decision. Adviser 3 said that was in contrast to the fact that a vascular surgical referral had been made (see paragraph 29) because of Mr A's worsening condition rather that just 'nursing care' or even rehabilitation. Consultant 1 said that Mr A's GP had sent Mr A to hospital because, in his assessment, which Consultant 1 agreed with, there were overriding features other than straightforward vascular surgery in the management of Mr A. Consultant 1 did not say what these features were. Adviser 3 said that the reason for Mr A's transfer appeared to have been rationalised post hoc as clinical by the doctors and the Board but the evidence suggested that the reason at the time was more administrative than clinical. Adviser 3 said that transfer to Ward 14 was probably well meant but was not reasonable, given that Mr A had rapid deterioration in his feet and severe pain, which should have triggered an urgent referral to the vascular surgeons at Hospital 2 rather than transfer to a rehabilitation ward.

31. Adviser 3 said that the condition of Mr A's ulcers worsened on Ward 14 and his mood became low and his dependency increased but there is no evidence that it was recognised that a more urgent referral to the vascular surgeons was required. Adviser 3 said that a delay of 13 days for a vascular surgical review was unreasonable in the face of a rapidly deteriorating situation, increasing ischaemic pain and advancing necrosis of Mr A's toes. Adviser 3 said that it was difficult to be categorical about it but, on the basis that Mr A's left foot was rapidly becoming gangrenous and increasingly painful during the period he was in Hospital 1, that would indicate to him that had an earlier surgical intervention taken place, ie, transfer of Mr A to the vascular surgeons at Hospital 2 rather than to Ward 14 on 28 January 2006, the development of more serious infection and debility might have been prevented.

(d) Conclusion

32. It is clear from the records that Consultant 1 recommended on 25 January 2006, while Mr A was still in ward3, that he should be referred to the vascular surgeons at Hospital 2. An entry in the nursing records indicated that the referral was made on 26 January 2006. On 28 January 2006, however, Mr A was transferred to Ward 14. On 30 January 2006 it was noted in the records that Mr A's appointment with the vascular team was on 8 February 2006. Mr A was admitted to Hospital 2 from the vascular out-patients clinic the same day. Adviser 3 said that it should have been recognised that Mr A required to be seen more quickly for vascular review. I uphold this complaint.

(d) Recommendation

33. The Ombudsman recommends that the Board ensure that the clinical team consider the lessons to be learned as a result of the failings identified in this report and report back to her changes in practice put in place as a result.

(e) Mr A's room was not clean and this contributed to his illness

34. Ms C complained that Mr A was kept in unhygienic conditions; that his room was cluttered and not clean; and that she found him dirty and unshaven when she visited him. Ms C considered that these factors had contributed to Mr A's infection.

35. The Director of Service Delivery responded to this complaint. She said that Mr A's room was cleaned on a daily basis by domestic staff. The ward is a rehabilitation and assessment ward so staff try to maintain a balance between

promoting independence and ensuring that patients 'all activities of daily life' are attended to. The Director said that no care is reduced or altered because the patient is elderly. Patients are encouraged to self-care where possible, to assist them back to their previous capabilities. The ward sister, in her submission, explained that the single rooms appeared spacious when empty but, when occupied, can appear cluttered with very little. She said that if Ms C provided further details she would be able to investigate the complaint further.

36. In response to my enquiries the Corporate Administration Manager said that Ward 14 was subject to a cleaning audit on 2 February 2006 and achieved 97 percent compliance for cleaning standards.

37. Adviser 3 said that he did not agree with Ms C that the 'clutter' in Mr A's room was unhygienic and, therefore, likely to lead to infection. Adviser 3 said that the MRSA infection and C.Difficile diarrhoea from which Mr A was found to be suffering in Hospital 2 have different and unrelated causes. The first was caused by Mr A being a localised bacterial skin carrier with an open wound and the second to a change in gut flora as a result of the antibiotics used to treat his foot infection. Mr A did not 'catch' the bugs from anywhere or anybody in the hospital and the infections were not a result of shortfalls in care or treatment. The infection of the sacral sore causing necrotising fasciitis is a rare phenomenon and almost exclusively a hospital-acquired infection, particularly in debilitated or immune challenged patients. Mr A was an elderly diabetic, who had already suffered sepsis in large areas of compromised tissue. The infection could not have been predicted and was only identified when surgery was carried out at Hospital 2 on 28 February 2006. Adviser 3 said, however, that he would have expected MRSA screening to have been carried out on Ward 14 because of the presence of infection in Mr A's foot but he could not find any results of tests taken there. Positive skin swabs might have triggered local eradication treatment which might have prevented infection of the sacral sore when the skin actually broke down.

(e) Conclusion

38. Ms C complained that Mr A's room was cluttered and not clean; she found him dirty and unshaven; and she considered that this had contributed to Mr A's deterioration. Adviser 3 said that, in response to Ms C's complaint, the Board said the actions of the staff and the philosophy of the ward reflected the fact that it was a rehabilitation area. Adviser 3 noted, however, that there is no record that this fact or the deterioration in Mr A's condition was ever explained to the

family. Adviser 3 said it was understandable that Ms C should consider that Mr A's deterioration and the lack of assistance given to him were linked. It is clear from the information given by Adviser 3, however, that was not the case. The advice I have received is that the infection from which Mr A was found to be suffering had different and unrelated causes. I have also seen a copy of the cleaning audit carried out on 2 February 2006, which shows a high level of compliance with the required standards of cleanliness. In all of the circumstances, therefore, I do not uphold this complaint. Adviser 3 did, however, consider that Mr A should have been screened for MRSA on Ward 14, in view of his condition and the fact that he was expected to have surgery at Hospital 2.

(e) Recommendation

39. The Ombudsman recommends that the Board audit the use of MRSA screening on Ward 14 and report back to her proof of review and change in practice.

(f) Mr A was inappropriately referred to as a problem patient

40. Ms C said that Mr A was considered by the staff to be a difficult patient and he thought the treatment he was receiving was not appropriate for his circumstances. She said that Mr A was in considerable pain and distress. The family were aware that he was being difficult and had some sympathy for the nursing staff, who said he was uncooperative and did a lot of shouting. Ms C said that her uncle was a quietly spoken, well-educated gentleman and this was totally out of character.

41. Consultant 2 said that the continued deterioration in Mr A's legs did not help Mr A's mood. In response to my enquiries, the Corporate Administration Manager said that there was no evidence of Mr A being referred to as, or considered to have been, a difficult patient. There was evidence that Mr A was non-compliant, which is entirely different. Mr A was obviously unwell and in a lot of pain despite efforts to control this. Because of the pain, he was unable to elevate his legs and he was unable to remain in bed because the pain in his legs was worse when he was lying down. It was difficult to nurse Mr A because of these problems but he was not considered to be a difficult patient.

42. Adviser 3 said that comments were made in the clinical records about Mr A being reluctant to comply with instructions. Adviser 3 said that Mr A's mobility had deteriorated partly because of severe pain and the requirement to

treat this with opiates, which would have made him reluctant, and sepsis from the infected foot ulcers would have debilitated him further. Adviser 3 said that Mr A was very reluctant to do anything except sit in a chair with his legs down and resisted being put to bed or having his feet elevated because of pain. Adviser 3 said that this is typical of patients with painful ulcers caused by poor leg circulation and Mr A should not have been blamed. There was, however, nothing in the records indicating that he was regarded as a 'problem' patient.

(f) Conclusion

43. Adviser 3 has commented that Mr A's mobility had deteriorated partly because of severe pain and other factors contributed to Mr A's subsequent inability to withstand any definitive treatment of his ischaemic foot. While the Board have commented that it was difficult to nurse Mr A because of these problems, there was no evidence in the records that he was regarded as being a 'problem' patient. Having considered the matter carefully I, therefore, do not uphold this complaint.

General recommendation

44. The Ombudsman recommends that the Board apologise to Ms C fully and formally for the failings identified in this report.

45. 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

Ms C	The complainant
Mr A	The complainant's uncle
Hospital 2	Gartnaval General Hospital
Hospital 1	Vale of Leven Hospital
Adviser 1 and Adviser 2	Nursing advisers to the Ombudsman
Adviser 3	An adviser to the Ombudsman who is a hospital consultant
The Board	Greater Glasgow and Clyde NHS Board
Consultant 1	The Consultant Dermatologist at Hospital 1
Consultant 2	The Consultant Physician in Medicine for the Elderly at Ward 14

Annex 2

Glossary of terms

C.Difficile	Clostridium difficile is the major cause of antibiotic-associated diarrhoea and colitis, a healthcare associated intestinal infection that mostly affects elderly patients with other underlying diseases
Erythema	Non-specific redness of the skin that can be localised or generalised in nature
Ischaemic pain	Pain caused by a reduction in blood flow usually in the legs
MRSA (methicillin resistant Staphylococcus aureus)	An organism that is resistant to commonly used antibiotics. Skin colonisation with MRSA is common in the community and, therefore, also in hospitals but is symptomless - this needs to be treated in vulnerable patients. Deep tissue or blood-borne infection with MRSA is always serious and may be fatal
Pilonidal sinus	A sinus tract from which there may be a chronic drainage of pus, due to an embedded tuft of hair most often in the crease between the buttocks
Sepsis	Bacterial infection of the bloodstream

Annex 3

List of legislation and policies considered

Pressure Ulcer Prevention NHS Quality Improvement Scotland (March 2005)

Treatment and Management of Pressure Ulcers NHS Quality Improvement Scotland (November 2005)