Scottish Parliament Region: Glasgow

Case 200700033: Greater Glasgow and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Hospital; Accident and Emergency; General Surgical. Supervision of junior staff and communication with family; complaint handling.

Overview

The complainants (Mr B and Mrs C) raised a number of concerns about the care and treatment of their late mother (Mrs A) during her final admission through Accident and Emergency at Inverclyde Royal Infirmary in February 2006. They were also concerned about the manner in which their complaints had been dealt with by Greater Glasgow and Clyde NHS Board (the Board).

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) failed to provide appropriate care to Mrs A on 14 and 15 February 2006 (*upheld*); and

(b) failed to respond promptly and appropriately to Mr B and Mrs C's complaints (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board apologise in writing to Mr B and Mrs C for the failure to provide appropriate care to Mrs A and her family on the 14 and 15 February 2006 and the failure to respond to their complaints in a timely and effective manner.

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[1] Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde NHS Board) and Highland Health Board. In this report, according to context, the term `the Board' is used to refer to the former Board or Greater Glasgow and Clyde Health Board as its successor. However, the recommendations within this report are directed towards Greater Glasgow and Clyde NHS Board.

The Ombudsman recognises that a number of other changes introduced by the Board and NHS Scotland avoid the need for further recommendation, although she notes with concern the time taken to introduce some of the changes and the negative impact several structural reorganisations had on this complaint.

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

Main Investigation Report

Introduction

1. On 3 April 2007, the Ombudsman received a complaint from (Mrs C) expressing her dissatisfaction at the outcome of complaints submitted to Greater Glasgow and Clyde NHS Board (the Board) by her and her brother (Mr B). The complaints to the Board concerned the care and treatment provided to their late mother (Mrs A) on a number of occasions between October 2005 and her death in Inverclyde Royal Infirmary (the Hospital) on 15 February 2006. Mr B and Mrs C had tried repeatedly over many months to raise their concerns but were unhappy with the written response they finally received on 7 February 2007 and so complained to the Ombudsman.

2. The complaints from Mr B and Mrs C which I have investigated are that the Board:

(a) failed to provide appropriate care to Mrs A on 14 and 15 February 2006; and

(b) failed to respond promptly and appropriately to Mr B and Mrs C's complaints.

3. Mrs C's original complaint to the Board concerned a number of aspects of Mrs A's care during an angiogram on 16 November 2005 and the consequences of this. As the investigation progressed, I advised Mrs C that based on the medical advice I had received from a surgical adviser to the Ombudsman (Adviser 1), I was satisfied with the clinical actions taken on 16 November 2005 and I would not be pursuing that complaint, although I would still be investigating the handling of that complaint. Mrs C acknowledged and accepted that decision although I would note that she remains unhappy with the care provide to her mother.

Investigation

4. Investigation of this complaint involved reviewing Mrs A's clinical records and obtaining the views of Adviser 1, a nursing adviser (Adviser 2) and an Accident and Emergency (A&E) adviser (Adviser 3) to the Ombudsman. I met with senior staff at the Hospital to discuss my concerns and changes in a number of aspects of service provision since the events of this complaint. I have also considered the evidence provided by the Board subsequent to a previous complaint investigated by this office which had a number of aspects in common with this complaint (ref: 200500103).

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C[2] and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to provide appropriate care to Mrs A on 14 and 15 February 2006

Medical Background

6. Mrs A had a history of heart disease, blockages in the leg arteries and diverticulitis. An angiogram conducted in November 2005 resulted in a false aneurysm (swelling at the puncture site) which caused Mrs A considerable pain and reduced mobility and resulted itself in an emergency operation in December 2005. Mrs A went on to develop a vascular ulcer in January 2006 and had a two week admission to the Hospital for administration of intravenous antibiotics, being discharged on 10 February 2006. Mrs A was readmitted to the Hospital surgical team via A&E by her GP at approximately 17:00 on the afternoon of 14 February 2006 with severe stomach pain. She was transferred to a surgical ward at 22:00 where her condition worsened and she died the following afternoon.

Mr B and Mrs C's complaint to the Board

7. Mr B complained to the Board that the nurse who had admitted his mother to A&E (the Nurse) had not assisted her and had simply left his mother and sister to cope alone for several hours. At around 20:00, a junior surgical doctor (the Doctor) had attended his mother and basic tests were undertaken but the Doctor was unable to summon the assistance of a more senior (surgical) doctor and Mrs A was not reviewed by a senior doctor until 22:00, at which time it was considered that her condition had deteriorated too far to be treatable and she was transferred on to the High Dependency Unit. Mr B also noted that his mother's records were not available to staff although she had been an in-patient only a few days previously.

The Board's response

8. In their response to Mr B and Mrs C, the Board noted that the nursing records for Mrs A's admission were incomplete and this prevented them being able to fully respond to the complaint. The Board noted that the level of nursing records was unacceptable and that an audit of records had been undertaken

[2] Mr B had an opportunity, through Mrs C, to comment on a draft of this report.

(with follow-up planned) to ensure records are adequate (see also paragraph 11 below). The Board apologised that the Nurse and other nursing staff had apparently not followed the usual procedure in offering assistance to patients in undressing and more generally, and also apologised that the overall level of nursing was inadequate.

9. The Board noted that the Doctor had tried to contact the on-call senior doctor but had been unable to do so (even when she had asked the switchboard to assist) as the rota had been altered without the information being passed on as needed. The Board apologised for this unnecessary delay and the discomfort caused to Mrs A by this. The Board indicated that on-call arrangements had now been reviewed to avoid a repeat of this.

Mr B and Mrs C's complaint to the Ombudsman

10. Mr B and Mrs C were not satisfied with the response from the Board as they both felt that junior staff were being held accountable for all the admitted failings when senior staff had a responsibility to oversee their staff and address poor or inadequate practice as and when it happens. They also felt that the apology given for Mrs A's discomfort in no way described the considerable pain their mother had experienced. They were also very distressed to learn that a senior member of the surgical team could not be contacted because of a communication breakdown and questioned the efficacy of any system so easily prone to such a significant failing. They were concerned that the problems encountered indicated poor management of the service rather than individual staff incompetence but there seemed to be no plan to address this. They were also extremely distressed that it took almost one year for them to receive the response to their complaint and again felt that this was as a result of poor management (see complaint (b)).

Our Findings

11. This office had previously published a report which raised concerns about the levels of supervision and nursing documentation within A&E at the Hospital (ref: 200500103), as a result of which we had recommended an audit of nursing records. The results of this audit indicated a wide spread problem with record-keeping and the audit was due to be repeated during the time of investigating this complaint. I met with senior staff at the Hospital in June 2008 who provided me with the most recent audit results (from February 2008) which showed a significant improvement in the quality of the record-keeping. The Board's plan is to continue to review those cases where records are not

complete to ascertain where and why the failing has occurred and address this as needed, as well as re-audit on a six monthly basis with on-going staff training in the importance of accurate and complete record-keeping.

12. At the meeting, I also discussed the concerns of Mr B and Mrs C and the advisers about the level of senior supervision and support for junior staff. The advisers had also expressed concern that Mrs A's admission to the surgical ward was delayed because she was regarded by the A&E team as a 'surgical' admission and had simply been left alone by A&E until the surgical team were able to attend. The advisers were concerned that such territorial disputes are detrimental to the experience of patients and potentially dangerous. I was advised by the senior staff that, largely as a result of the Scottish Government's target timescale of no more than four hours from admission to discharge/transfer for all A&E patients, the system now in place (since November 2007) at the Hospital means that if any patient in A&E is not reviewed promptly by the admitting team, there is a senior member of staff (not connected to an individual department) who is responsible for ensuring that that patient is seen and their case progressed as necessary within four hours. This member of staff has the authority to arrange transfers or deploy resources to achieve this. Staff also advised me that A&E have introduced added support for nursing and there is now a lead nurse appointed to ensure nursing staff are not overly concentrated in any one area but that there is adequate cover throughout all aspects of A&E at all times.

13. I would also note that staff at this meeting were very clear that they accepted Mrs A had not received the levels of care she should have done and accepted that there had been failings on the part of the service. They also noted the significant number of organisational changes that this particular area had been through in recent years at all levels, although they did emphasise that they were not seeking to excuse any of the identified failings on this basis (see also complaint (b)).

14. I note too the view of Adviser 1 that earlier review of Mrs A would not have impacted on her prognosis, although of course it would have allowed for earlier and more effective communication with Mrs A's family as well as avoiding the distress caused to Mrs A by the delays.

15. In written correspondence, the Board provided details of the revised system now in place for on-call doctors which uses a single transferable page

passed physically from one on-call doctor to the next and which should ensure that the appropriate doctor is always contactable.

(a) Conclusion

16. There were a number of admitted failings in the care provided to Mrs A on the evening of 14 February 2006. The Board has taken a number of significant steps to address these at a number of levels but none of this was made apparent in the response provided by the Board to Mr B and Mrs C, who remained understandably concerned that the point of their complaint had been missed. While I acknowledge the work done subsequently to address the failings, there were nonetheless failings and I uphold this aspect of the complaint.

(a) Recommendation

17. The Ombudsman recommends that the Board apologise in writing to Mr B and Mrs C for the failure to provide appropriate care to Mrs A and her family on the 14 and 15 February 2006.

18. The Ombudsman recognises that a number of other changes introduced by the Board and NHS Scotland avoid the need for further recommendation, although she notes with concern the time taken to introduce some of the changes and the negative impact several structural reorganisations had on this complaint.

(b) The Board failed to respond promptly and appropriately to Mr B and Mrs C's complaints

19. Mr B and Mrs C initially submitted separate complaints in March 2006 regarding their mother's care in November 2005 and February 2006 – neither had been present at both occasions so felt it more appropriate to handle only the matters they had personally witnessed. However, by mutual request the complaints were combined in May 2006. At that point and with no obvious reason for the delays being given (then or since) the complaint was not progressed until September 2006 with the response not actually being compiled and sent until 7 February 2007.

20. I mentioned above the organisational changes in this area and I am aware from other complaints to this office that the reorganisation of Argyll and Clyde NHS Board which occurred on 1 April 2006 had a significant impact on the complaint handling timescales for those areas transferred to the new Greater

Glasgow and Clyde NHS Board area. At our meeting in June 2008, staff advised me of a number of changes to the complaints handling process that have occurred since Mr B and Mrs C first submitted their complaints. In particular we discussed the routine review of complaints by senior management which now occurs. Staff accepted that there had been significant delays in the handling of these complaints with no acceptable reason for these delays.

21. I noted in conclusion (a) that the response letter eventually provided accepted that there had been failings but did not make clear the action that was being taken to address the failings beyond the immediate staff directly involved. In this respect the response failed to reflect a proper understanding of the nature of the complaint or to provide the reassurance sought by Mr B and Mrs C that the problems were being addressed. More comprehensive details of action taken and planned (not necessarily directly as a consequence of this complaint but of significance to it) would have been of considerable benefit to the resolution of this complaint and I would encourage the Board to consider how such broader knowledge might be usefully included in future complaint responses.

(b) Conclusion

22. The Board have accepted that there were unacceptable delays in the handling of Mr B and Mrs C's complaints. There was also a failure to properly oversee the complaints process and ensure appropriate senior input to progress the complaints in a timely manner. Delays in the complaints process impacted in the credibility of the Board response with the complainants and effectively these delays prevented this complaint being resolved within the NHS process and without recourse to this office (see complaint (b)). I uphold this aspect of the complaint.

(b) Recommendation

23. The Ombudsman recommends that the Board apologise to Mr B and Mrs C for the poor handling of their complaints over an extended period.

24. The Board have accepted all 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 (Mrs A's daughter)
The Board	Greater Glasgow and Clyde NHS Board
Mr B	The complainant (Mrs A's son)
Mrs A	The aggrieved (Mr B and Mrs C's late mother)
The Hospital	Inverclyde Royal Infirmary, Greenock
Adviser 1	A surgical adviser to the Ombudsman
Adviser 2	A nursing adviser to the Ombudsman
Adviser 3	An A&E adviser to the Ombudsman
A&E	Accident and Emergency department
The Nurse	The nurse who admitted Mrs A to A&E
The Doctor	The junior doctor in A&E