**Scottish Parliament Region: Glasgow**

**Case 200702270: Greater Glasgow and Clyde NHS Board**

**Summary of Investigation**

***Category***

Health: Hospital; Care of the Elderly

***Overview***

The complainants raised a number of concerns about the care of their late mother (Mrs A) while she was a patient at Stobhill Hospital, Glasgow and Glasgow Royal Infirmary between January and August 2007. In particular, they raised concerns about unnecessarily prolonged admission due to acquired infections, quality of food, lack of mental and social therapy, management of hearing aids, communication with family members and information about MRSA.

***Specific complaints and conclusions***

The complaint which has been investigated is that Greater Glasgow and Clyde NHS Board (the Board) failed to provide appropriate care to Mrs A between 14 January 2007 and her death on 31 August 2007 (*partially upheld*).

***Redress and recommendations***

The Ombudsman recommends that the Board:

(i) give consideration to the introduction of recorded, validated mental tests on admission for older people (whether the patient is considered confused or not) by way of a base-line assessment to assist in future diagnosis;

(ii) review policy for handling of hearing aids and assistance available particularly in light of Mrs A's experience;

(iii) advise her of the action plan resulting from the November 2007 audit of Ward 45, Ward 46, and Ward 47 at Stobhill Hospital, Glasgow; and

(iv) advise her of the action plan resulting from the Rehabilitation and Assessment Directorate review of the 'patient day'.

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

## Main Investigation Report

### Introduction

1. On 28 November 2007, the Ombudsman received a complaint from the complainants (Ms B and Mrs C) about the care their late mother (Mrs A) received from Greater Glasgow and Clyde NHS Board (the Board) while she was a patient at Stobhill Hospital, Glasgow (Hospital 1) and Glasgow Royal Infirmary (Hospital 2) between 14 January 2007 and her death on 31 August 2007. Ms B and Mrs C raised a number of concerns that their mother had been unnecessarily kept in hospital where she caught numerous infections which contributed to her death. Ms B and Mrs C were also concerned that on the two occasions their mother had been discharged from hospital, her health and wellbeing were so compromised by the lack of proper care during her stays in hospital that she was unable to maintain her previous independent lifestyle and required readmission to hospital. Ms B and Mrs C had previously complained to the Board on 14 September 2007 and received a final response on 8 December 2007 (shortly after they first approached this office with concerns about the time being taken to respond).

2. The complaint from Ms B and Mrs C which I have investigated is that the Board failed to provide appropriate care to Mrs A between 14 January 2007 and her death on 31 August 2007.

### Investigation

3. Investigation of this complaint involved reviewing Mrs A's clinical records and the Board's complaints file. I have also reviewed all the paperwork provided by Ms B and Mrs C. I have sought the views of a nursing adviser (Adviser 1) and a medical adviser (specialising in old-age medicine) (Adviser 2) to the Ombudsman and met with Ms B and Mrs C to discuss these views.

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

### Complaint: The Board failed to provide appropriate care to Mrs A between 14 January 2007 and her death on 31 August 2007

*Background to the complaint*

5. Mrs A had three hospital admissions during the time of this complaint. Mrs A (88-years-old) was first admitted to hospital on 14 January 2007 after

collapsing at home following a dizzy spell. On admission it was recorded that Mrs A was underweight and had a history of weight loss over the last few years. It was also noted that she had recently completed a course of antibiotics for a chest infection prior to her admission that had affected her appetite. Clinical examination found a swelling in the upper part of her stomach for which a number of tests were carried out. No abnormalities were found which effectively eliminated any suspicion of cancer, however, the x-rays showed evidence of chronic bronchitis and emphysema (and scarring from a previous TB infection which had probably occurred in her very early childhood). A CT scan of the brain showed a change in the blood vessels to the brain (this was normal for someone of Mrs A's age) and it was felt that this was most likely the cause of Mrs A's dizziness and fall. Mrs A was given a prescription to alleviate her symptoms of dizziness. Mobility and Occupational Therapy assessments were undertaken towards the end of January 2007 with a view to arranging her discharge back to home with a full care package. However, Mrs A was diagnosed with a chest infection on 2 February 2007 which required her to remain in hospital on IV antibiotics. Mrs A was also reviewed by a dietician who advised monitoring Mrs A's weight. On the 21 March 2007, Mrs A was considered well enough to undergo an upper gastro-intestinal endoscopy (to identify the cause of her ongoing stomach swelling). This revealed some inflammation and medication was prescribed to treat this symptom (again no specific sinister underlying cause was identified). On 1 April 2007, a further chest infection was noted and treatment commenced with antibiotics. A home visit was arranged as a precursor to discharge on 11 April 2007 but it was felt a number of changes were required before Mrs A could return home and a further chest infection delayed matters again. She was finally discharged home on 24 April 2007.

6. Once at home the IRIS (home support) team (the IRIS team) reported that Mrs A had little energy and Mrs A's GP considered whether readmission to hospital might be appropriate. Her GP prescribed anti-depressant medication. Because Mrs A was not keen to return to hospital, the care provided for her at home was increased. On 21 May 2007, Mrs A became trapped behind the bathroom door because of her walking frame (the turn of the door having been one of the alterations made prior to her discharge from hospital) and the nurse assessing Mrs A from the IRIS team felt she should be admitted to hospital. Mrs A was very reluctant to return to Hospital 1 so was admitted to Hospital 2.

7. Following her admission to Hospital 2, the consultant in charge of her care there (Consultant 1) noted Mrs A's wish to return home and the results of all the previous investigations and arranged for her to be discharged home again on 5 June 2007. A routine test performed on admission to Hospital 2 showed that Mrs A was MRSA positive (although this infection was only present on her skin and had not entered her blood stream) and because of this it was necessary to nurse Mrs A in a side room during this admission.

8. Following her discharge home, the IRIS team continued to express concerns about her ability to cope at home and following an episode on 14 June 2007 where she became cold and unresponsive Mrs A's GP decided to admit her back to Hospital 1 to the care of a consultant there (Consultant 2).

9. Consultant 2 noted that Mrs A was frail but not acutely unwell. He was aware that Mrs A had a strong wish to return home but because there were concerns about her mood and motivation once she was at home, he decided to refer her for an Old Age Psychiatric Review. At this point her anti-depressant medication was also reviewed and altered but she was not felt to be significantly depressed. Consultant 2 was concerned about Mrs A's mobility and felt it was necessary for her to undergo rehabilitation therapy before she could be discharged again. It was noted on the rehabilitation ward that Mrs A had developed a chest infection and also that she had become confused – it was felt this might be related to the recent change in anti-depressant medication so this dosage was reduced. Staff continued to be concerned about Mrs A's ability to cope at home and discussions were held with the family on 27 July 2007, and it was agreed that a move to a care home would be the better option. Mrs A developed a further chest infection while waiting for this move to be arranged and at that point her condition deteriorated rapidly and she died on 31 August 2007 of acute onset pneumonia.

*The family's view*

10. Mrs A's family noted that she had nothing seriously wrong with her on her first admission to Hospital 1 – neither emphysema or bronchitis had been previously diagnosed and even if she did have these, it did not affect her health. They told me that Mrs A was able to care for herself with moderate assistance and coped well with daily life. They told me she was mobile and mentally alert but that following her first admission she had been left so worn down by the infections she acquired in hospital, the poor quality of the food and the lack of mental and social stimulation, that she was not able to recover her health

quickly. The family felt her second admission was a result of their mother's debilitated condition and in particular, the changes that had been made to her home layout and the insistence that she use a walking frame, all of which made their mother feel she was an invalid. The family were distressed to discover that Mrs A had contracted MRSA, not least because this meant she was placed in a side room in Hospital 2 to be nursed on her own and this only increased her isolation. The family were also concerned that the numerous changes to her drug therapy were confusing and would not have been necessary if decisions had been made properly in the first instance (for example Mrs A's weight should have made it obvious that a lower dose of the anti-depressant medication was needed). The family also told me that their mother had undergone her psychiatric review without her hearing aid in place (Mrs A was undergoing aural tests that required the hearing aid not be used for five days) and they felt this would have severely limited the ability of the psychiatrist to review their mother properly and should have been delayed until she could use her hearing aid again. They also noted that both her hearing aids had later been broken by staff members who apparently had no experience of her particular type of aid.

11. The family told me that they had met with the consultant responsible for their mother's care (Consultant 3) on two occasions during Mrs A's first admission but were not reassured that he had an understanding of their mother's true condition or that her continued stay in hospital was clinically necessary. Overall the family considered that Mrs A had contracted a number of infections while in hospital that would have been avoided at home, she was treated as an invalid which led to a loss of self-confidence on her part and the whole environment in hospital did nothing to assist her physical or mental health. The family continue to hold this view and following sight of a draft of this report they told me that their mother was 'hospitalised unnecessarily, allowed to become weak, thus leading to her catching numerous infections in an atmosphere of germs which eventually led to her death'.

*The view of the Board*

12. In response to the family's complaints, the Board made a number of specific points and advised of a number of initiatives to address some of the family's concerns.

13. The Board agreed that no specific or new illness was found and that Mrs A was managing well at home prior to her episode of dizziness in January 2007. However, they also noted that Mrs A was very frail and prone to chest infections

because of her underlying chest conditions and that these could also have occurred at home. The Board also noted that Mrs A had been given a high level of support at home after her discharges but that there were concerns about her safety at home and her lack of energy and appetite. The Board expressed regret that the many attempts to support Mrs A at home had been unsuccessful but concluded that the care and treatment she had received was not the cause of her decline.

14. The Board apologised for the damage caused to Mrs A's hearing aids and advised that they were looking into appropriate communication equipment for use within wards.

15. The Board advised that an audit of Hospital 1 took place in November 2007 (this included the wards which Mrs A had been admitted to) and included questions about the meals provided – the results of the audit are being used to inform future improvements to those ward areas.

16. In a previous report (reference: 200600378) this office had recommended to the Board that it give consideration to the introduction of specific policies relating to the provision of mental and social stimulation for longer term patients. In response to Ms B and Mrs C's complaint, the Board advised them that they were reviewing services to introduce more social interaction at ward level. The Board have subsequently provided me with an update on their progress towards achieving a social interaction policy which also overlapped with their review of the need for protected mealtimes and a number of other 'customer care' issues. An exercise in mapping a patient day has been conducted (November 2007) and the report of this (April 2008) has been discussed by the Rehabilitation and Assessment Directorate. An action plan is being produced to take this project forward.

17. In relation to Mrs A's MRSA infection, the Board apologised that this infection had been picked up by a test in Hospital 1 taken shortly before Mrs A's discharge but that this had not been communicated to her family. The Board also noted that improvements to the physical state of the side wards were being made as it was recognised that these were in need of improvement. The Board noted that the infection source could not be traced as Mrs A was not tested immediately on her admission to Hospital 1 so may have had the infection (which can live on the skin without any adverse affect) before she was first admitted).

*The advisers' views*

18. Adviser 2 told me that It is not uncommon for x-ray changes such as those that were seen in Mrs A's films to be commented on late in life with little past history of chest troubles, although he noted that the admission records showed that Mrs A had just had a course of antibiotics for a chest infection before her admission in January 2007.

19. Adviser 2 noted that the Occupational Therapy and physiotherapy assessments in Hospital 1 in February and March 2007 found Mrs A to be confused and unsteady and it was felt that she needed supervision, even if walking with a zimmer frame. She had a combination of poor sight (cataract extractions and retinal haemorrhage in the right eye), muscle weakness, confusion and poor balance, which meant that when she was less aware of objects or surfaces she had difficulty adjusting her gait to make her mobility safer, so she often toppled and fell. The family have said that they do not recognise this view of their mother's condition and it should have been pointed out to them at the time that the small cumulative and worsening effects of her age, frailty, recurrent infections and cognitive impairment underlay her deterioration - which took place despite treatment rather than because of it. The family not unnaturally blamed 'lack of care' as the culprit because they were not made aware of the natural history of the cumulative effects as mentioned above. However, to say that staff treated Mrs A 'as an invalid' is to misunderstand the deterioration in her gait and balance that had occurred prior to her admission in January 2007 and which subsequently required a walking aid. To mobilise her without one would have been too risky.

20. Adviser 2 noted that Mrs A's nutrition was assessed and monitored by nursing staff and a referral to the dietician was made, with further evaluation. He also noted that Mrs A continued to lose weight at home between her admissions as well.

21. Adviser 2 considered that Mrs A's infections would not have been prevented as her family believe by her earlier discharge. The infections were probably related to her frailty and compromised state. Mrs A had appropriate antibiotic courses for recurrent infections in her admissions but these were not, and could not be, 'prevented'. It is true though that Mrs A would also be more predisposed to infections because she was in hospital. However, Mrs A had to be admitted on each occasion, because she was not coping at home, despite

the support she was receiving from her family and the IRIS team. Adviser 2 told me that there was a lack of communication about Mrs A's MRSA colonisation rather than any mismanagement of the MRSA itself and this was at fault.

22. Adviser 2 told me that there is no recorded evidence that the reasoning behind the psychiatric review was communicated to the family. The change of anti-depressant was discussed with Mrs A's daughters. The psychiatric liaison nurse who carried out the review recorded that he had to use writing on a pad to communicate with Mrs A in the absence of her hearing aid. It was recorded that he felt Mrs A had 'impaired insight' but there is no record of a fuller assessment of her mental capacity to make decisions about her future, although this was formally requested in July 2007. Adviser 2 noted that there is no record of any of the mental tests usually carried out in assessing confusion in older people (Abbreviated Mental Test, Mini-Mental Test Score etc). While staff acknowledged Mrs A's 'low mood' on the ward, and this was also noted at home by her GP before the second admission, no simple assessment such as the Geriatric Depression Score questionnaire was recorded on the ward. Adviser 2 considered that it was surprising that these tests were not routinely done on a geriatric/rehabilitation ward. The absence of such a formal recorded mental test makes diagnosis of her confusion speculative. The records suggested that Mrs A's 'insight' and 'mood' changed little, even when her medications were changed. Since she also had had a urine and chest infection being treated at the same time, it is difficult to analyse the contribution of medication and/or infection to her mental state.

23. Adviser 2 concluded that the Board's response failed to communicate adequately to Mrs A's family the influence her mental state and her physical frailty had on Mrs A and her lack of progress in rehabilitation. He felt that this, coupled with a lack of adequate communication by the staff with the family at the time, appeared to be at the heart of this complaint.

24. Adviser 1 noted that when undertaking clinical investigations additional findings may be identified. This was the case for Mrs A who had no significant abnormalities in relation to the initial investigations, but the investigations did reveal clinical changes to suggest evidence of chronic bronchitis. The implication of these findings could have been explained in greater detail to the family and this may have assisted them with the longer term impact and the rationale behind Mrs A's vulnerability to chest infections and necessity to remain in hospital.

25. Adviser 1 told me that Mrs A's daughters made a very strong point about the importance of the quality of food in making a good recovery and this is acknowledged in the Board's recent audit with 'food' being identified as needing to be addressed. Adviser 2 noted that Mrs A did have a rehabilitation plan in place, however, due to her frailty and tiredness she was unable to mobilise for long periods of time. The plan identified that Mrs A required assistance and the type of assistance required. Unfortunately, many patients do not want to bother the staff and, therefore, fail to ask for help when required, as mentioned by Mrs A's daughters as being the case with their mother. This can only really be addressed over time with the staff taking time to explain to the patient why they need to ask for help and that they are happy to be of assistance. Adviser 1 felt that the Board could have referred to the specific work undertaken by the physiotherapist within their response letter rather than make very broad and generalised statements regarding 'patients being encouraged to get up and about'. Adviser 1 considered that the lack of reference to Mrs A's presenting needs and the level of support required in relation to her mobility removed confidence in the response provided, and also gave the impression that an individualised approach was not adopted in responding to this complaint.

26. Adviser 1 considered that there was clear evidence available to show the number of infections that Mrs A contracted in hospital, but that her condition appeared to be such that she was susceptible to infections and could, therefore, have required treatment for the same number and type of infections irrespective of whether she was in hospital or at home.

27. Adviser 1 also commented on the problems encountered by nursing staff in dealing with Mrs A's hearing aid. Adviser 1 told me that the Board's response to this area of the complaint was unreasonable. It is essential that patients like Mrs A who require the use of a hearing aid have access to it. To say that staff on a particular ward were not used to working with the model worn by Mrs A is not acceptable and fails to recognise the level of importance to the patient. This is poor practice. The response provided by the Board gives no indication of what staff should have done when faced with an unfamiliar aid (i.e. where they can find the necessary knowledge) and does nothing to reassure us that this will not happen again.

*Conclusion*

28. It is entirely understandable that Mrs A's family attribute Mrs A's decline to both her repeated infections and the impact of prolonged hospital stays on her general wellbeing. What I must consider is whether her infections could have been avoided by maintaining Mrs A at home, whether it was necessary to care for her in hospital and whether the care provided to her in hospital impacted on her health in other detrimental ways.

29. With respect to the infections, based on the medical advice I have received I have concluded that Mrs A was at increased risk of such infections because of her underlying chest condition and accordingly the infections could not be avoided and would probably have occurred at home as they did in hospital. I acknowledge that Ms B and Mrs C do not agree with this view. I am aware from my conversations with them that they do not agree with the view that their mother's underlying chest conditions had any material impact on her health. I agree with Adviser 1 that there was a lack of communication with Mrs A's family about her conditions at the time of diagnosis. This meant that the opportunity to explain the longer term implications of these conditions on her health was missed.

30. Ms B and Mrs C have understandably questioned if in saying her infections were inevitable the advisers are also saying Mrs A's death was inevitable – they note that Mrs A was still being considered for discharge to a care home and that they were told her chest was clear only two days prior to her death. Again, based on the medical advice I have received I have concluded that while Mrs A's infections compromised her general health making her more prone to further infection and illness, it was a severe, sudden, acute pneumonia which was the cause of her death on 31 August 2007.

31. The second issue I must address is whether it was necessary for Mrs A to be an in-patient given that she had, by everyone's admission, no acute or immediate health problem. The advisers have told me that her initial admission was reasonable and appropriate, as it was necessary to eliminate other more sinister causes for her dizziness. Once her low weight, recent weight loss and possible stomach problem was identified it was also reasonable to seek to find a cause for this. The difficulties that emerged as Mrs A's general wellbeing deteriorated delayed discharge back to home, although it is clearly recognised that she wished to go home and was unhappy in hospital. The IRIS team are specifically in place to reduce the number of failed discharges and they did

increase the support for Mrs A once she was discharged, but felt unable to safely maintain her in the community and she had to be readmitted. Adviser 1 told me that she felt that consideration might have been given sooner to Mrs A's move to a care home but that as it was her clear wish that she return home, it was not unreasonable to try and achieve this first. I conclude that Mrs A's admissions to hospital were for sound clinical reasons and that good attempts were made to discharge Mrs A and maintain her at home.

32. Finally, I must consider whether there were other aspects of Mrs A's care which had an avoidable impact on her health and wellbeing. In relation to Mrs A's infection, the Board have apologised that her family were not given the information about this at the time it was detected. The Board have provided me with copies of the information that is now provided to patients and families and their revised policy for providing this information. This information should have been provided to the family and this was a failure all be it one the Board have recognised, apologised for and addressed for the future. I would also note here that Scottish Government initiatives to trial routine MRSA testing on admission would have assisted in this case as it would have identified for the family whether the infection had occurred prior to Mrs A's first admission and if so prompted earlier discussion of the issues with Mrs A's family.

33. With respect to the quality of food, the Board have identified that this is an issue for patients and are taking steps to address this along with the physical presentation of the side wards and other matters identified in their audit.

34. Adviser 1 was very critical of the damage caused by staff to Mrs A's hearing aid and the lack of a clear plan from the Board to avoid this happening again. I note the Board have already apologised for the damage caused and its impact but I will be seeking evidence that this problem has been addressed for the future.

35. The final major concern of Ms B and Mrs C was the mental welfare of Mrs A both in terms of the lack of social interaction on the ward and the psychiatric review. It does not seem to me to be exceptional that Mrs A did not wish to bother staff, as this is a common view particularly from those of Mrs A's generation. While it was appropriate to nurse Mrs A in a side ward because of her MRSA it is not reasonable to place a patient whose mood is known to be low in such isolation with no planned activities – although I note that there was no planned activities even for those patients on the general ward. The lack of

any formal assessment of Mrs A's mental state on admission (or subsequently) has adversely impacted on the handling of this complaint but more importantly such assessments would have helped inform the need for a psychiatric review as well as that review itself. Such assessments would also have provided an opportunity for discussions with Mrs A's family about the impact of her physical and emotional state on her general wellbeing.

36. I conclude that there were failings in a number of aspects of the overall care provided to Mrs A which impacted on her general mood and physical wellbeing and which could have been improved upon. For this reason, I partially uphold this complaint. The Ombudsman has a number of recommendations to make to inform such improvements and ensure lessons are learned from this complaint.

*Recommendations*

37. The Ombudsman recommends that the Board:

(i) give consideration to the introduction of recorded, validated mental tests on admission for older people (whether the patient is considered confused or not) by way of a base-line assessment to assist in future diagnosis;

(ii) review policy for handling of hearing aids and assistance available particularly in light of Mrs A's experience;

(iii) advise her of the action plan resulting from the November 2007 audit of Ward 45, Ward 46, and Ward 47 at Hospital 1; and

(iv) advise her of the action plan resulting from the Rehabilitation and Assessment Directorate review of the 'patient day'.

38. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her of progress and when the recommendations have been implemented.

**Annex 1**

**Explanation of abbreviations used**

| | |
|---|---|
| Ms B | The complainant (Mrs A's daughter) |
| Mrs C | The complainant (Mrs A's daughter) |
| Mrs A | The aggrieved |
| The Board | Greater Glasgow and Clyde NHS Board |
| Hospital 1 | Stobhill Hospital, Glasgow |
| Hospital 2 | Glasgow Royal Infirmary |
| Adviser 1 | A nursing adviser to the Ombudsman |
| Adviser 2 | A medical (old-age specialist) adviser to the Ombudsman |
| The IRIS team | A multi-disciplinary (home support) team of both NHS and social services staff tasked with reducing failed discharge |
| Consultant 1 | The consultant responsible for Mrs A's care in Hospital 2 |
| Consultant 2 | The consultant responsible for Mrs A's care in Hospital 1 during her second admission there |
| Consultant 3 | The consultant responsible for Mrs A's care in Hospital 1 during her first admission there |