Scottish Parliament Region: North East Scotland

Case 200700577: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; Temporary Cardiothoracic Ward and High Dependency Unit

Overview

The complainant, Mr C, raised a number of concerns regarding his care and treatment during his admission to Aberdeen Royal Infirmary (Hospital 1) for cardiopulmonary bypass surgery. At the time, the High Dependency Unit and the Cardiothoracic Ward where Mr C was treated were housed in temporary accommodation, which Mr C considered to be unsuitable. Mr C required further treatment at another hospital, where it was discovered that he had contracted MRSA. Mr C also complained about how his complaint was handled by the Grampian NHS Board (the Board).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the facilities at Hospital 1 were unsuitable and did not meet minimum standards (*not upheld*);

(b) Mr C was not tested for MRSA before discharge and there were no facilities for quickly diagnosing MRSA and isolating MRSA positive patients (*not upheld*);

(c) there was a lack of cleanliness, no control over the numbers of visitors and handwashing advice was ignored (*not upheld*); and

(d) Mr C's complaints were not handled appropriately (*upheld*).

Redress and recommendation

The Ombudsman recommends that the Board remind staff dealing with complaints of the need to have regard to the NHS complaints procedure timescales.

The Board have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. Mr C was admitted to Aberdeen Royal Infirmary (Hospital 1) on 7 November 2006. Following his operation on 8 November 2006, he was transferred to the High Dependency Unit (the Unit) and subsequently transferred to the Cardiothoracic Ward (the Ward) on 9 November 2006. He was discharged from Hospital 1 on 14 November 2006. Mr C initially complained on 17 November 2006 about the temporary facilities. Mr C later discovered that he had contracted MRSA and made a further complaint about this and also raised additional issues relating to cleanliness, the numbers of visitors permitted, handwashing and about the way that his complaints were handled. Grampian NHS Board (the Board) responded to Mr C's complaints but he remained dissatisfied and complained to the Ombudsman.

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

(a) the facilities at Hospital 1 were unsuitable and did not meet minimum standards;

(b) Mr C was not tested for MRSA before discharge and there were no facilities for quickly diagnosing MRSA and isolating MRSA positive patients;

(c) there was a lack of cleanliness, no control over the numbers of visitors and handwashing advice was ignored; and

(d) Mr C's complaints were not handled appropriately.

Investigation

3. In order to investigate this complaint I have had access to Mr C's clinical records for the period in question and the complaint correspondence. I have obtained clinical advice from advisers to the Ombudsman who are nurses (Adviser 1 and Adviser 3) and a general practitioner (Adviser 2). I also obtained information from the Scottish Government. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1, a glossary of the medical terms is at Annex 2 and a list of the legislation and policies considered is at Annex 3. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) The facilities at Hospital 1 were unsuitable and did not meet minimum standards

4. Mr C complained to the Board that there was no natural daylight; large fans caused the atmosphere to be draughty and cold; automatically closing doors were noisy; the floor space was overcrowded; and there was no television or radio to provide distraction.

5. The Board's Chief Executive responded on 12 December 2006. He agreed that the situation was not ideal. He said that, as a result of urgent fire precaution work which had to be carried out, it had been necessary to temporarily relocate the Ward and the Unit but there were very few options available. An option appraisal was done and, very reluctantly and with many reservations expressed by managers, clinicians and ward staff, it was agreed that the only possible location was a room set aside as an overflow for the intensive therapy unit. It was not ideal but it was close to the theatre suite and cardiac intensive care unit. The location was planned to last for no longer than three months but, due to unforeseen complications during the building work, this had required to be extended. The Chief Executive apologised to Mr C for the lack of facilities which would usually be expected. He said that the newly refurbished facilities had opened at the beginning of December 2006.

6. Mr C wrote again in a letter received by the Board on 5 January 2007. He said that an option appraisal merely identified the least unsatisfactory option. Mr C said he considered that the facilities were unsuitable and did not meet the minimum standards. Mr C's daughters wrote to me to confirm his view of the conditions in the temporary facilities. One daughter said they were very cramped, with beds at a slant to form an aisle down the middle, and her impression was of a makeshift ward. The other daughter said that she was shocked at the accommodation.

7. In correspondence with me, the Chief Executive said that the situation was not ideal. The Unit and Ward had to be moved for immediate fire precaution work. The area to which the Unit was relocated was an extension to the theatre suite for recovering patients following surgery. It was used as an overflow for the intensive care unit when there was pressure on beds. It had also previously been used by the general surgery high dependency unit during a refurbishment. The area had full monitoring facilities and piped oxygen and gases and was close to the theatre suite and cardiac intensive care unit. It was, therefore, appropriate but not ideal and that was appreciated by all involved in accepting

the plan for what was to have been three months. Unfortunately, asbestos which had not been detected in the preliminary survey was found during the work and this resulted in the work taking longer than originally anticipated.

8. The Chief Executive went on to say that the area used for the Unit was used by patients coming directly from theatre following major surgery and that patients would be there for between 24 and 48 hours. He agreed with Mr C that there was no natural light and that was a concern. He said that this was one of the reasons why patients were kept no longer than was necessary in that area. There were difficulties concerning the air conditioning above every bed space and regulating it so that it was comfortable for patients and staff was an issue. Calls to the engineering staff required to be made to assist with the regulation, so a varying temperature was of concern at times. The Chief Executive said he would wish to apologise to Mr C for any discomfort he had felt. He said that beds were put in at a slant rather than straight to allow more room for drip stands and other equipment round the bed. Space was a concern and it was sometimes necessary to move beds, depending on what was needed at the time. Television and radio were not seen as essential, given the condition of the patients, the possibility of patients being disturbed and the short time patients would be in the area. The Chief Executive said that patients were informed about the situation prior to their admission. Mr C, however, told me he had not been informed.

9. I checked the position regarding standards with the Property and Planning Division of the Scottish Government Health Department, who told me that there were no statutory minimum standards laid down for hospital wards.

10. I also sought advice from Adviser 1, who said that the statements provided confirmed that Mr C's description of the ward was accurate. She said, however, that the Board had been open about the dilemma they faced in trying to continue to provide a service when the designated ward required refurbishment. She said that the only other option the Board had would have been to discontinue the service.

11. Adviser 3 said that the provision of accommodation and bed spacing had recently been considered by the Scottish Government and guidance issued in November 2008. The guidance, which related to new in-patient facilities and major refurbishments indicated that the minimum bed space should not be less than 3.6 metres x 3.7metres.

12. I asked the Board why Mr C had not received the information concerning the building work prior to his admission to hospital. The Chief Executive said that, from checking Mr C's case notes, his heart surgery was originally planned for January 2007. However, he developed urinary symptoms which required treatment and the need for an indwelling urinary catheter, which would require to remain in situ. The general surgeon from the hospital where Mr C was receiving treatment for his urinary symptoms (Hospital 2) contacted the consultant cardiothoracic surgeon at Hospital 1 on 6 November 2006 and told him about Mr C's symptoms and requirement for an indwelling catheter. He asked the consultant cardiothoracic surgeon to perform Mr C's heart surgery earlier than the planned date in January 2007. The consultant cardiothoracic surgeon agreed to this and Mr C was admitted the following day, 7 November 2006. His operation was performed on 8 November 2006. The Chief Executive said that, in the circumstances of his admission, there had been no time to send the information out to Mr C in advance.

(a) Conclusion

13. I have considered Mr C's complaint about the facilities in the Unit and Ward carefully because it is clear that the experience was an unpleasant one for him. I have also taken into account, however, the fact that the work was necessary and the Board recognised that the solution identified by the options appraisal was not ideal. I accept that Mr C considered the facilities fell below the minimum standards but there were, at the time, no minimum standards laid down to measure them against. Adviser 1 also accepted that Mr C's description of the Ward was accurate but said that the Board had no choice if they were to continue to provide the service. Given that the Board have apologised to Mr C regarding the facilities and have provided a full explanation of how the decision was made with regard to the temporary facilities, I consider that the explanation is reasonable and I have decided not to uphold Mr C's complaint. It is unfortunate that Mr C did not receive the information forewarning him about the temporary facilities but I am satisfied with the Board's explanation that they did not have time to send it to him because his admission was brought forward at the request of the general surgeon.

(b) Mr C was not tested for MRSA before discharge and there were no facilities for quickly diagnosing MRSA and isolating MRSA positive patients

14. On 13 December 2006, after his discharge from Hospital 1, Mr C was admitted to Hospital 2 for elective biopsy. Screening at that time showed that he was MRSA positive and, at about the same time, his chest wound broke down. Mr C said that on admission to Hospital 1 he was MRSA negative but he was not screened prior to discharge. Mr C said that, had that been done and appropriate treatment offered, it was possible that he might have avoided several weeks of debility and further surgery to the wound; the community nursing staff would have been saved considerable work; and Hospital 2 would not have been exposed unknowingly to contamination. Mr C also stated that there were no facilities for isolating patients who had tested MRSA positive.

15. In response to my enquiries, the Infection Control Manager said that screening for MRSA was focused on admission screening, as national guidelines did not advocate discharge screening. They would also screen patients if there was an ongoing problem within a particular ward or unit. He agreed that on admission to Hospital 1 Mr C was MRSA negative and on admission to Hospital 2 on 13 December 2006 he was positive. The Infection Control Manager said that he had found the type of MRSA for which Mr C had tested positive (Type 15-46/59/75/94/134) was a distinctive but relatively uncommon type, which had not been isolated from any other specimen submitted from the Ward in the months preceding or following Mr C's admission.

16. In correspondence with me, the Chief Executive said that the source of Mr C's MRSA had not been established. He agreed that there were no facilities in the Unit for infected patients. If patients tested positive for MRSA, arrangements were made to accommodate them in a separate location with segregation facilities in the main intensive care unit.

17. Guidance issued by NHS Quality Improvement Scotland in June 2006 recommended that patients should be screened on admission to hospital, as Mr C was. There was no recommendation that patients should be screened again on discharge. It appears, therefore, that Mr C was screened in accordance with the guidelines in operation at the time. The Chief Executive has confirmed that the type of MRSA for which Mr C had tested positive was not isolated from any other specimen taken from the ward Mr C was in in the three month period prior to or following his admission. He said that there was one

similar isolate found during the same period from a GP swab. That patient had been in Hospital 1 but not in any ward associated with Mr C's admission. A total of 3538 swabs were screened during the period.

18. Adviser 2 said that the information provided by the Chief Executive did not preclude Mr C from having become infected with MRSA in Hospital 1. Equally, however, Mr C could have become infected following his discharge and prior to his admission to Hospital 2. Adviser 2 said that, in screening Mr C on admission but not prior to discharge, the Board were following the appropriate policy at that time. Adviser 2 said that it was acceptable for the segregation facilities provided for patients who were found to test positive for MRSA to be located elsewhere.

(b) Conclusion

19. Adviser 2 said that it is not possible to say for certain how Mr C acquired MRSA and from Mr C's correspondence with me it appears that he accepts that is the case. The advice I have received, however, is that the Board were following the appropriate policy with regard to testing for MRSA and the provision of segregation facilities for those found to be infected. I have to be guided by the advice I have received and, in the circumstances, I have decided not to uphold this complaint.

(c) There was a lack of cleanliness, no control over the numbers of visitors and handwashing advice was ignored

20. Mr C said that the facilities were unclean and there was no audit of cleanliness. In their letters to me, Mr C's daughters described dirty, crumpled tissues on the floor and overflowing dirty laundry bags.

21. On 30 March 2007 the Infection Control Manager wrote to Mr C, following telephone conversations he had with him and with the Consultant Medical Microbiologist. (There is no note of these telephone calls but Mr C stated that he raised additional issues relating to the numbers of visitors, handwashing and cleaning.) The Infection Control Manager said that they had issued a card to make patients and visitors alike aware of the fact that the number of visitors should be kept to a minimum (generally accepted by ward managers to be a maximum of two visitors per person at any time) but, if that is not being complied with, the leaflet would require to stipulate the number of visitors when it was reprinted. The ward manager had the responsibility to police the situation. With regard to handwashing, an infection control nurse had been

seconded to the national hand hygiene campaign to undertake audits and address compliance issues. The evidence would be gathered and sent to Health Protection Scotland, who would publish the results. With regard to cleaning, they now carried out environmental audits. The infection control nurses arrived unannounced in areas and used an accredited audit tool to carry out environmental audits. They also carried digital cameras to photograph any areas falling short of the required standard, which provided additional evidence for the managers at performance reviews.

22. In response to my enquiries, the Chief Executive confirmed that regular monitoring of ward cleanliness was carried out by domestic staff supervisors and any issues or concerns raised by patients or nurses was reported to the domestic staff manager. The Chief Executive said that the cleanliness of the Unit was monitored by the nursing staff and when there were issues they were reported to the domestic services manager. There were occasions when no domestic staff appeared when expected but, when this was made known to the domestic services manager, staff were sent. The Director of Facilities had reviewed the monitoring information for domestic issues for the period when Mr C was a patient and there was no record of any serious performance issues relating to domestic services. While there is no direct match between the monitoring dates and the specific rooms occupied by Mr C, there was sufficient information to give an overall picture of the results of their formal monitoring and to conclude that standards were within acceptable limits. The Chief Executive said that no other complaints had been received about this area.

23. I obtained copies of the monitoring information for domestic issues for the period when Mr C was a patient and I asked Adviser 3 to review them. Adviser 3 said that, while some minor failings were identified from the forms such as the cleaning of furniture and fittings, there was no evidence of major failings during the period.

24. The Chief Executive also said that it was not correct to say that there was no auditable system to review cleanliness standards. Since April 2006, the Board had been using the national monitoring tool which all domestic departments in Scotland were obliged to use to assess cleaning standards. The results of monitoring were fully auditable and scores for overall cleanliness calculated. That did not mean that every room was inspected each time they monitored but it gave an overall picture, with specific details for the rooms which were inspected. This was backed up by routine, ongoing checks by supervisors

as part of their normal duties. The Chief Executive said that they had a robust system in place which, although not infallible, was effective.

25. The Chief Executive went on to say that there were local hospital rules about how many visitors were allowed at a bedside, especially in high dependency areas. Under normal circumstances, only two visitors were allowed but there were times when this was ignored by members of the public and even when asked by staff some visitors had refused to leave. There were also special circumstances where flexibility was required but, as far as possible, staff tried to keep to the limit, bearing in mind the condition of patients and events in the area at the time.

26. Adviser 3 said that the Chief Executive's position was reasonable and flexibility was necessary.

27. In his letter to me of 19 November 2008, the Chief Executive said that handwashing was and is a high priority for all staff. Considerable work had been done to stress its importance to staff. Alcohol gels were used throughout Hospital 1 in order to limit the spread of infection by the entire team. Standards were audited by the Infection Control Team.

28. Adviser 2 agreed that, while lack of cleanliness on the Ward, lack of handwashing and numbers of visitors permitted were factors which would increase the risk of infection, the actions which the Board were now taking to try to reduce the risk were appropriate. Adviser 2 also noted that Mr C did not complain about the conditions until after he was discharged, so these matters were not looked into at the time.

(c) Conclusion

29. After his discharge from Hospital 1, Mr C complained about the lack of cleanliness. His daughters also had the impression that the temporary facilities were not clean. The Board, however, said that a review of the monitoring information for the period did not disclose a problem at that time and this was confirmed by Adviser 3. Mr C considered that numbers of visitors should be strictly monitored but the Board explained that flexibility was necessary on occasion. As a general rule, however, visitors should be limited to two per bed. Adviser 3 agreed with the Board's position. The Board described the action they were taking regarding numbers of visitors and encouraging handwashing but said that there were no other complaints regarding these matters. Adviser 2

said that the action being taken by the Board was reasonable. None of these issues was looked into at the time when Mr C was a patient in the Ward and, therefore, there is no other evidence available. In the circumstances, and having considered the matter carefully, I have decided not to uphold this complaint.

(d) Mr C's complaints were not handled appropriately

30. In his complaint to the Ombudsman, Mr C said that he did not consider that his complaints had been handled appropriately, in that it had taken too long to respond to his complaints, all of the issues had not been addressed and the MRSA infection rates he had requested had not been provided.

31. In his letter of 19 November 2007, the Chief Executive said that Mr C's first letter was received on 23 November 2006 and his initial concerns were responded to in a letter dated 12 December 2006. Mr C said that he called on 21 and 25 January 2007, with further areas of concern, and wrote again on 5 and 27 January 2007. A response was sent on 2 April 2007, inviting Mr C to visit and tour the new facilities in the relocated cardiothoracic ward and high dependency unit. The Chief Executive accepted that it took an excessive time to respond to Mr C, which he attributed to staff shortages in the Feedback Service and pressure of work in the units investigating Mr C's concerns. The Chief Executive said that the Infection Control Manager and the Consultant Medical Microbiologist spoke to Mr C by telephone on 29 March 2007, following which the Infection Control Manager wrote to him on 30 March 2007. This letter crossed with a further letter from Mr C. The Chief Executive acknowledged that Mr C wrote to the Infection Control Manager on 25 April 2007 but as a result of an oversight his letter had not been responded to. The Chief Executive apologised for this. The Chief Executive also said that the Board encourages meetings between staff and patients when complaints are not resolved.

(d) Conclusion

32. The NHS complaints process normally requires a response within 20 working days, however, when it appears that the target will not be met the complainant must be informed of the reason for the delay, with an indication of when a response can be expected. In Mr C's case, however, other issues arose after he had submitted his first letter of complaint and this served to prolong the correspondence while the additional issues were addressed. The Chief Executive has acknowledged that during this period there was some delay and that Mr C's letter of 25 April 2007 was not responded to, due to an

oversight. The Chief Executive apologised for this. The Board have been open about the circumstances they faced. I also note that the Infection Control Manager and the Consultant Medical Microbiologist spoke to Mr C and the Infection Control Manager wrote to him. However, while the Board initially responded within the NHS complaints procedure timescale there was a delay in dealing with Mr C's later complaint and the Board did not respond to one of his letters. This was undoubtedly frustrating for Mr C and, in these circumstances, I have decided to uphold this complaint.

(d) Recommendation

33. The Board have already apologised to Mr C but the Ombudsman additionally recommends that the Board remind staff dealing with complaints of the need to have regard to the NHS complaints procedure timescales.

34. The Board have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Hospital 1	Aberdeen Royal Infirmary
The Unit	The temporary high dependency unit
The Ward	The temporary cardiothoracic ward
The Board	Grampian NHS Board
Adviser 1	Adviser to the Ombudsman who is a nurse
Adviser 3	Adviser to the Ombudsman who is a nurse
Adviser 2	Adviser to the Ombudsman who is a General Practitioner
Hospital 2	The hospital where Mr C was receiving treatment for his urinary symptoms

Annex 2

Glossary of terms

Methicillin resistant staphylococcus aureus (MRSA)	Antibiotic resistant bacteria

Annex 3

List of legislation and policies considered

Clinical and cost effectiveness of screening for MRSA NHS Quality Improvement Scotland June 2006

CEL48 (2008) *Provision of Single Room Accommodation and Bed Spacing* The Scottish Government 11 November 2008