Scottish Parliament Region: Glasgow

Case 200800720: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category

Health: Hospitals; Care of the Elderly; treatment and diagnosis

Overview

The complainant Mr C[1], was unhappy with the care provided to his late mother, Mrs A. Mrs A had been admitted to the Victoria Infirmary (the Hospital) following a fall. Shortly after her admission, the Hospital identified an outbreak of the winter vomiting virus in the ward to which Mrs A had been admitted (Ward A). While there, Mrs A was diagnosed with an infection and her condition deteriorated. Sadly, Mrs A died a few days after moving from Ward A to Ward B. Mr C said he was concerned about the care and treatment provided to Mrs A and that he and his family had been distressed by the way Mrs A had been cared for after it became clear she was unlikely to recover. He said Mrs A had been moved into an open ward (Ward B) and the curtains around her bed left open. Mr C also raised complaints about matters relating to the closure of Ward A and stated that the Hospital had failed to ensure the public was aware there was an outbreak of infection. He also said he had been concerned about the general level of hygiene in and around Ward A.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the care and treatment provided to Mrs A was inadequate (*upheld*);
(b) there was insufficient care taken by staff handling an outbreak of infection in Ward A (*upheld*);
(c) the level of hygiene in and around the ward was inadequate (*no finding)*;
(d) there were significant failures in communication about the effect on Mrs A of the infection and the serious nature of Mrs A's condition (*upheld*);
(e) there was a failure to ensure Mrs A's dignity (*upheld*); and
(f) the Board did not respond appropriately to the complaint (*upheld*).

[1] The complaint was made by the late Mrs A's family. Mr C was my main point of contact during the investigation.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) use a root cause analysis or similar tool to examine the reasons for the clinical failures identified in treating Mrs A's diarrhoea and managing her fluid intake;

(ii) provide clear evidence over the next 12 months that the new policy on professional standards of record-keeping is having significant improvements on the quality of documentation;

(iii) provide the Ombudsman with evidence that the initiatives underway on infection control should prevent a recurrence of the failings identified in this report;

(iv) use this complaint as part of their own ongoing programmes to improve cleanliness and, in particular, consider how hygiene standards can be tracked and monitored and how visitors and patients can be encouraged to feel they can approach staff about any concerns they have;

(v) share with the Ombudsman the results of patient and staff surveys on communication over the next 12 months and the audit of communication following report 200600345 and any action taken as a result;

(vi) keep the Ombudsman informed of the progress of implementation of the Liverpool Care Pathway over the next 12 months;

(vii) provide evidence of the actions being taken to ensure individual patient dignity until the Hospital is closed;

(viii) ensure that guidance to complaint handling staff emphasises the need for full disclosure of relevant information; and

(ix) make a full, detailed apology to Mr C and his family for the failings identified in this report.

The Board have accepted the recommendations and will act on them accordingly[2].

[2] In response to a draft of this report, the Board provided detailed information about a number of actions already taken, including developments on communication, documentation and environmental audit.

Main Investigation Report

Introduction

1. Mrs A, who was aged 88 at the time, was admitted as an emergency to the Victoria Infirmary (the Hospital) following one or possibly more falls at home on 15 December 2007. She was admitted into a receiving ward (Ward A).

2. Shortly after Mrs A's admission to Ward A, it was noted that there appeared to be an infection in the ward, affecting more than one patient. This was identified as the winter vomiting virus. The decision was made to close Ward A to new admissions. This meant that new patients were not admitted and patients already in the ward were not to be transferred until the infection had been controlled. Ward A remained open to visitors. On 16 December 2007 Mrs A was noted to be unwell. She was also diagnosed as having a fracture and an operation was carried out on 18 December 2007.

3. Unfortunately, Mrs A's condition deteriorated further. Ward A was reopened on 24 December 2007 and Mrs A was transferred to an open ward (Ward B) that day. Sadly, she died there on 27 December 2007. Following Mrs A's death, her son, Mr C raised concerns about the care provided to Mrs A in relation to the areas of communication, hygiene, the management of the ward closure and a failure to ensure Mrs A's dignity as her condition deteriorated. He also had concerns about the response to his complaint and said he did not receive further comments, as promised, about the cause of Mrs A's death following discussion about the death certificate. Mr C also said, while the Greater Glasgow and Clyde NHS Board (the Board) had accepted some failings and apologised for these, there was very limited information about actions the Board had said they would take to ensure these failings would not recur.

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

(a) the care and treatment provided to Mrs A was inadequate;
(b) there was insufficient care taken by staff handling an outbreak of infection in Ward A;
(c) the level of hygiene in and around the ward was inadequate;
(d) there were significant failures in communication about the effect on Mrs A of the infection and the serious nature of Mrs A's condition;
(e) there was a failure to ensure Mrs A's dignity; and
(f) the Board did not respond appropriately to the complaint.

Investigation

5. The investigation of this complaint involved obtaining all the background documentation relating to the complaint and Mrs A's medical records. Advice was also obtained from medical and nursing advisers (Adviser 1 and Adviser 2, respectively) to the Ombudsman. As a result of the advice, further enquiries were made of the Board. The abbreviations used in the report are explained in Annex 1 and a glossary of terms used in the report is explained in Annex 2.

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

(a) The care and treatment provided to Mrs A was inadequate

7. Mrs A was admitted to Ward A on 15 December 2007 with pain in her right hip and reduced mobility after having suffered one or more falls at home. Mrs A had been a non-insulin dependent diabetic for some years, her renal (kidney) function was impaired and she had a previous history of recurrent urinary tract infections (UTIs). At the time of admission, Mrs A was noted to be confused. On 16 December, she was showing signs of infection and began to suffer from diarrhoea. Mrs A was given antibiotics and analysis was taken of both urine and stool samples. The urine tests showed she was suffering from an infection which was common to those who had recurrent UTIs but was only sensitive to one antibiotic - ciproflaxacin. Mrs A was not started on ciprofloxacin until 23 December 2007. The stool samples were negative for both Noro virus (more commonly known as winter vomiting virus) and C Difficile. Mrs A suffered from only one recorded instance of vomiting during her stay.

8. Following x-rays, Mrs A was diagnosed with a fracture and an operation was carried out on 18 December 2007. No further stool samples were taken but on 23 December a urine sample was taken, which subsequently showed she had a second infection which was also only sensitive to ciproflaxacin.

9. On 23 December 2007, nursing staff asked for a review of Mrs A as her blood pressure had lowered. Mrs A was noted to have a tender abdomen and the advice of senior colleagues was sought. It was considered that Mrs A's deterioration was caused by renal failure, due to a combination of the UTI and gastroenteritis (generally defined as inflammation of the stomach and bowel which can cause vomiting and diarrhoea – it often has a viral cause). Mrs A's condition was discussed with her family, who were informed that treatment with

fluids and antibiotics would continue but that it would not be appropriate to treat more actively or attempt to resuscitate Mrs A, given her deterioration. Mrs A was transferred to Ward B the next day. She died there a few days later on 27 December 2007. The cause of death was given in the death certificate as sepsis (an infection of the blood stream which it was thought was linked to the UTI) and UTI, with diabetes as a secondary cause.

10. In their response to the family's concerns about the care and treatment provided to Mrs A, the Board said there was no specific treatment for the diarrhoea and vomiting virus. The Board described the treatment given for the UTI and to support Mrs A's fluid intake. They also explained that, in the opinion of the consultant geriatrician who had treated Mrs A (the Consultant), the cause of death was acute renal failure rather than the infections alone. The Board said that the problem which had occurred was that Mrs A's pre-existing chronic renal failure had been exacerbated by a loss of fluids and reduction in blood pressure. These were directly attributed to the urine and viral infections from which she had suffered. The Consultant would, in these circumstances, have advised a different entry in the death certificate, which highlighted the renal failure. Following a meeting, Mr C was told the Consultant would write in more detail about this. This did not happen.

11. In their response to my enquiries, the Board said that the Consultant apologised for not contacting the family. This had been an administrative error. She provided her comments direct to me and said the most likely reason that renal failure was not on the certificate was because of the timing of Mrs A's death, during a holiday period. The clinician responsible for completing the certificate had not been involved in Mrs A's previous care and the most recent notes in Mrs A's records would have indicated that the diagnosis was septic shock secondary to UTI. Following Mrs A's death, the Consultant had reviewed the entry because of concerns raised and this at this point had suggested renal failure should have been included. She also indicated at one point that C Difficile could also have been mentioned. In response to a draft of this report, the Consultant accepted the reference to C Difficile was an error and there was no evidence that Mrs A had ever had this infection. The Consultant apologised for this.

12. Adviser 1 reviewed the clinical records, complaint correspondence and additional comments by the Consultant. He was concerned about a number of points.

13. Adviser 1 said that although Mrs A was suffering from an infection sensitive only to one antibiotic, she was given a different antibiotic which would have been ineffective for a full week – from 16 to 23 December 2007. There was a note on file that results of the urine and stool tests would be returned from the lab in two days, so it is not clear from the records what the reason was for this delay. Adviser 1 noted that, although the wrong antibiotic was given, it had been felt by those treating her that Mrs A's infection had improved during this time. The second infection was treated appropriately.

14. Having reviewed the clinical records, Adviser 1 did not consider Mrs A had contracted the winter vomiting virus. While this was not an unreasonable initial diagnosis, given this was affecting other patients in the ward, he explained that the pattern of Mrs A's symptoms did not fit: a stool test was negative and there was no evidence of severe vomiting. In his view, the vomiting she suffered from was likely to have been linked to the UTI. He noted that, despite Mrs A continuing to suffer from diarrhoea, no further stools were sent for analysis and no binding agent prescribed to control Mrs A's loose motions.

15. Adviser 1 agreed with the Consultant that the likely cause of death was the sepsis and low blood pressure, alongside impaired renal function. He also agreed that fluid loss and inadequate intake had played a role in this. The Consultant had speculated in an internal report prepared in response to Mr C's complaint whether the fluid loss experienced by Mrs A could have been better managed and noted some differences between fluid intake as prescribed and the fluid intake chart.

16. Adviser 1 considered the fluid intake charts in detail. The charts for Mrs A's oral intake were not completed fully. Mrs A was also receiving fluid intravenously (IV fluids) during her admission. He noted that on 17 and 18 December she received approximately 1500mls over approximately 24 hours and approximately 2000mls over the next 48 hours. Mrs A was suffering from watery stools at the time. Mrs A was then supposed to have been receiving IV fluids at a rate of 3000mls over a 24 hour period but from 21 to 22 December she only received 2000mls over a 36 hour period. When she deteriorated on 23 December, IV fluid was increased to four hourly from 02:00 and she did receive the correct amount over the next 24 hours. Adviser 1 noted the charts were subsequently difficult to follow but he said the amount Mrs A appeared to have received over approximately the next 48 hours was likely to have been 2000mls. He said a reduction, at this stage, would have been reasonable,

given that there had been a reduction in treatment. Having reviewed all the fluid charts, Adviser 1 concluded that the Consultant had been correct to question them and there had been inadequate management of Mrs A's fluid intake.

17. Adviser 1 noted that the kidney function tests for the ten-day period from admission to 25 December 2007 showed a rapidly deteriorating picture. He noted that this was in the period where her IV fluid intake was insufficient and oral intake not recorded.

18. Adviser 1 added that because Mrs A's gastroenteritis had been attributed to the Noro virus, Mrs A's gastroenteritis was never treated (see paragraph 14). The fluid loss this caused was, as has been noted, never adequately replaced and the resulting low blood volume and low blood pressure from dehydration worsened Mrs A's pre-existing kidney problems.

19. Adviser 2 considered the nursing documentation within the clinical records. She was concerned about the adequacy of these. She said there was a poor initial nursing assessment and this was compounded by a general lack of assessments which she would have expected as standard, for example: manual handling; nutritional assessment; or assessment of Mrs A's confusion. She was also critical of the assessments which were carried out. She noted a pressure ulcer risk assessment was carried out on 15 December 2007 but, despite a high score, no further action was taken. The nursing care plan and record used gave very little information and in some instances were contradictory.

20. Concerns about record-keeping have been raised in previous reports, 200503669 and 200500103, dealing with complaints about the Board (published in March 2007 and June 2007 respectively). Given this, I asked the Board for their comments on actions taken in response to those reports. The Board provided me with a draft of their new policy in relation to professional standards of record-keeping, which was in the process of being launched as this report was being written.

(a) Conclusion

21. In the absence of tests following the negative stool samples, it is not clear what caused Mrs A's gastroenteritis and whether this did have a viral cause or not. The Board have said that it was not possible to treat a virus and Adviser 1 has accepted the initial diagnosis was not unreasonable.

22. However, it is possible to treat symptoms and no medication was given to Mrs A to help with her diarrhoea. The Consultant had already queried the management of Mrs A's fluid intake before this complaint was received by this office. Adviser 1 has explained that this concern was well-founded. He has also said that, following the negative stool results, more effort should have been made to confirm the cause of Mrs A's symptoms.

23. Unfortunately, the failure to manage Mrs A's fluid intake and diarrhoea would have caused dehydration. Adviser 1 has explained the likely effect of this on someone with pre-existing kidney problems. Consultant 1 also highlighted these. Adviser 1 also noted there was some delay in treating Mrs A's UTI with the appropriate antibiotic.

24. While the failings identified in the management of Mrs A's symptoms are the most significant finding under this heading, I was also concerned at the comments made by Adviser 2. I accept that it can be difficult to manage an infection outbreak but it appears that basic nursing assessments were not made and nursing documentation not recorded. On the basis of the failings identified by both Adviser 1 and Adviser 2, I uphold this complaint.

25. Concerns about documentation in relation to nursing care had been expressed some months previously by this office. While I note that action has been taken, I require some reassurance from the Board that significant improvements are being made in this area. This is reflected in the recommendations.

(a) Recommendations

26. The Ombudsman recommends that the Board:

(i) use a root cause analysis or similar tool to examine the reasons for the clinical failures identified in treating Mrs A's diarrhoea and managing her fluid intake; and

(ii) provide clear evidence over the next 12 months that the new policy on professional standards of record-keeping is having significant improvements on the quality of documentation.

(b) There was insufficient care taken by staff handling an outbreak of infection in Ward A

27. Ward A was closed after an outbreak of winter vomiting virus had been identified. While patients were not moved in or out of the ward, it remained open to visitors. In their response to Mr C's complaint, the Board had said it was their practice to put a notice on the door to inform relatives to speak to staff; and that leaflets would also have been at the ward entrance to provide information. In their complaint, Mrs A's family said in their experience they had not been informed the ward was closed and that there was no infection control note at the door of the ward. The door was left open and it was accepted by the Board that the note may have not been visible as a result.

28. In my enquiries, I asked the Board for details of their policies and evidence of the monitoring of this particular outbreak. The Board provided the policies and explained these were monitored through both environmental audits, where an Infection Control Nurse (ICN) would assess compliance, and that standard precautions were also audited. Ward A had been audited on 20 June 2008 (six months after the period of Mrs A's admission) and scored 81%, which put this ward in the Green category (no action required).

29. The Board said the outbreak in December 2007 had been monitored in line with their infection control policy. There was daily contact between ward staff and an ICN who visited to check recommendations were in place. Daily outbreak control meetings were held. The decision to close and reopen Ward A was in line with the policy, which states that a ward should not open until 48 hours after the last new case and after a terminal clean and screen change. In response to concerns about visitors not being aware a ward was closed, the Hospital had brought in new procedures and a member of the nursing team would now be present at the entrance of any closed ward to explain the situation and provide leaflets to visitors at the start of visiting time.

30. Advisers 1 and 2 were both critical of the management of this outbreak. Adviser 1 said it was clear that Mrs A's family were not informed of the reason for the closure of Ward A and the Hospital did not publicise the situation adequately. Adviser 2 also noted that there was no evidence in the clinical records of verbal communication with relatives and added that there was a lack of information in care plans or the evaluation of care to indicate how nursing staff were delivering best practice care to Mrs A, given the infection in Ward A. For example, Adviser 2 noted there was no information on Mrs A's clinical

records relating to barrier nursing a patient with a perceived infection. There was no evidence of a handover between the wards when Mrs A was moved and it was not clear why it was felt Mrs A could be moved, although it seemed she was still suffering from an infection, or how this would be dealt with in an open ward. Adviser 1 also felt the transfer from Ward A to Ward B had not been well managed.

(b) Conclusion

31. Adviser 1 and Adviser 2 have both noted that there was no direct evidence about how the outbreak was managed. The Board have explained the process which should have been followed. In response to a draft of this report, they provided minutes of meeting held by the infection control team during the outbreak. This provided evidence that, as the outbreak progressed, visiting restrictions were introduced and towards the end of the outbreak (late December) contingency planning was in place. While this did provide additional evidence of monitoring and Adviser 2 noted the improvement made during the outbreak, Adviser 2 remained of the view that the management of the outbreak could have been improved and remained concerned that there was no evidence in Mrs A's records of communication with her family about the outbreak or that thought was given to how her care should be managed, to protect both her and other patients. In the circumstances, I uphold this complaint.

32. While I uphold this complaint, I am aware that the management of Infection Control has had a high profile in the NHS in Scotland since the incident described in this report and that a number of major initiatives led by the Scottish Government Health Directorates are underway. I have taken this into account when making the following recommendation.

(b) Recommendation

33. The Ombudsman recommends that the Board provide him with evidence that the initiatives underway on infection control should prevent a recurrence of the failings identified in this report.

(c) The level of hygiene in and around the ward was inadequate

34. As well as concerns about infection control, Mr C raised concerns about the level of general hygiene in and around Ward A. He told the Board that a sandwich pack had been left lying open; they had found a soiled pad on a chair when visiting; dirty clothing had been placed alongside personal items when Mrs A was moved; excrement was noted to be on a chair over the period of a

whole day; and Mr C had found the public toilets were blocked with no toilet paper.

35. In their response to Mr C's concerns, the Board confirmed that a number of these matters should not have occurred: pads should have been removed; the chair cleaned; soiled clothing should not have been placed in the bag; and the toilets should have been of an acceptable standard. However, they had no record of the failings being raised at the time and, therefore, could not comment in detail. However, they said appropriate staff had now been informed. They said patients sometimes did keep food with them if they had not been able to finish it at meal times. In response to my enquiries, the Board said that because of the high throughput for the public toilets they had a higher frequency of cleaning than that recommended by the Scottish National Cleaning Specification. They had also added extra dispensers to ensure adequate supply of soap, towels, and toilet rolls. However, they also said they had an ongoing challenge, as vandalism to these dispensers occurred regularly.

36. In 2008, NHS Scotland commissioned an independent audit of cleanliness in hospitals and compliance with the National Cleaning Specification. The three sites audited in the Board area passed the audit and the public review system introduced by the Board was seen by the auditors as an example of good practice. This system was designed to include public feedback in the Board's own monitoring process.

37. The auditors noted that, while it was not formally in the monitoring framework, public circulation areas were noted to be 'visually below' the appropriate standard.

(c) Conclusion

38. The Board have said that the concerns about hygiene were not raised with them direct at the time. They have, however, accepted that the matters raised by Mr C should not have occurred and have raised this with appropriate staff. I understand why this was not raised at the time by Mr C and his family, given that their primary concern was Mrs A and the limited direct contact with staff. However, this meant staff did not have a chance to investigate and respond to the concerns directly. Given this, I have made no finding on this complaint.

39. While I have not come to a finding on this heading, I am aware that hygiene in hospitals is of particular concern to the public. I also have noted the

concerns about public circulation areas mentioned in the independent audit which echo the concerns raised by Mr C.

40. Maintaining the cleanliness of busy, public areas is a challenge for any organisation and it is sad to learn of the problems the Board have had with vandalism. I was pleased to note that the Board do seek to clean these areas more regularly than required by national standards. I have also noted the positive comments in the independent audit about the Board's commitment to involving the public in reviewing cleanliness. I have taken these into account while making the following recommendation.

(c) Recommendation

41. The Ombudsman recommends that the Board use this complaint as part of their own ongoing programmes to improve cleanliness and, in particular, that they consider how hygiene standards can be tracked and monitored and how visitors and patients can be encouraged to feel they can approach staff about any concerns they have.

(d) There were significant failures in communication about the effect on Mrs A of the infection and the serious nature of Mrs A's condition

42. Mr C said the first indication the family had of the serious nature of Mrs A's condition was on 23 December 2007, when they were told that she was dying. He said no effort had been made by staff to speak to them before this time. Mr C said also that staff did not discuss this further with them following Mrs A's transfer to Ward B and they had no more contact with clinical staff until Mrs A's death. Mr C said he felt that, in particular, they should have been informed earlier of the possible, serious effects of the combination of the infections she had been diagnosed with shortly after entering Ward A and her pre-existing illness.

43. Adviser 1 and Adviser 2 both commented on the lack of recording of communication in the notes. Adviser 1 added that, from their complaint response, the Board had acknowledged that Mrs A's family were not approached by medical or nursing staff in the first few days. The Board had apologised for this. Adviser 1 said the notes taken of the attempts to explain the situation to Mrs A's family on 23 December 2007 were, by contrast, exemplary. Mr C said they had been confused by some of the information and felt the information given by different staff had been contradictory. Adviser 1 said he felt the problems experienced were likely linked to the inherent difficulty

of taking in complex and terrible news. There was no note of any further contact with Mrs A's family before or after 23 December 2007.

44. In their response to Mr C, the Board accepted that there had been problems with visiting time coinciding with staff turnover time, which made it difficult for staff and visitors to communicate. They had now extended visiting times as a result. As stated above, the Board apologised for the lack of contact with medical staff prior to 23 December 2007. The Board also said, in a meeting with Mr C, that there would be a tangible outcome to his complaint. He was told that, as well as general feedback, training sessions would be held and staff would be encouraged to be proactive in communicating with family members.

45. In my enquiries to the Board, I asked them to detail actions they had taken in connection with this complaint, as well as action taken following reports 200501476 and 200702258 (published in December 2007 and July 2008), which both raised concerns about communication with relatives. Report 200600345 (published in May 2008) set out in detail how communication should be recorded.

46. The Board provided a detailed response to my enquiries, including evidence of initiatives relating to the reports and this complaint and also other initiatives which would have a bearing on these issues. They provided details of training sessions; explained that staff in the Hospital were piloting a new corporate initiative around communication and complaint handling; said that communication issues were being taking forward as part of work relating to the customer care framework; and told me that Mr C's complaint had been discussed with the Senior Charge Nurse in Ward A. As part of this discussion, they had reinforced the need for proactive communication. Two education days had been held for new staff in the reception area dealing with communication and the hospital chaplain had been involved to ensure staff had tools to help when passing on difficult or sensitive information. Patient and staff surveys had been designed to gauge satisfaction with communication. An audit of communication records had been held in late 2008, following report 200600345. The results of this audit were not available at the time of drafting of this report.

(d) Conclusion

47. Communication with the family of patients is always important. In this case, given Mrs A's deteriorating condition, a ward closure because of a

hospital infection and the knowledge Mrs A would not recover, this should have been a clear, understood priority for all staff. It is not clear why appropriate communication did not occur.

48. The Board have apologised for one aspect of the communication failing, from medical staff prior to 23 December 2007. However, there was clear evidence of a lack of communication from staff throughout Mrs A's stay in the Hospital. Given the lack of any previous contact, I am not surprised that the efforts made to communicate on 23 December 2007, however well-intentioned, left the family confused. There was no subsequent attempt at contact. In all the circumstances, I uphold this complaint.

49. While I am upholding this complaint, the Board have demonstrated that a number of initiatives were in place to improve communication in response to reports published at the time or after the events described. The recommendation made reflects this.

(d) Recommendation

50. The Ombudsman recommends that the Board share with him the results of patient and staff surveys on communication over the next 12 months and the audit of communication following report 200600345 and any action taken as a result.

(e) There was a failure to ensure Mrs A's dignity

51. Mr C said that, shortly after they had been informed Mrs A was dying, she had been moved to an open ward (Ward B). Staff there did not appear to be aware of Mrs A's condition. No curtains had been drawn to ensure Mrs A had some privacy in her final hours.

52. In their response, the Board said there had been a complete handover between the wards. They explained that there was a limited number of single rooms, which tended to be required for patients who need treated in isolation. The Board said this would be improved when the Hospital closed in 2015. They accepted curtains should have been drawn and recognition made by staff about Mrs A's condition.

53. I asked the Board to comment on how they ensured the dignity of patients who were dying and, in my enquiries, referred to report 200600459 which dealt with issues surrounding the care of the dying, which was published in August

2007. The Board provided details of their implementation of the Liverpool Care Pathway[3]. The implementation process for each ward takes six months and was implemented or in the process of being implemented in 24% of wards in the Board's area. Medical wards and medicine for the elderly would be prioritised in 2009.

(e) Conclusion

54. Since these events, the Board have moved to implement the Liverpool Care Pathway, which is a recognised and well respected programme.

55. While I note the positive developments and this is, again, reflected in my recommendation, Mrs A and her family deserved greater care and respect. The issue was not just the layout of the ward but also the fact that there was very little recognition and support from staff at such a difficult time, which left Mrs A's family feeling isolated, and there was a lack of dignity afforded to Mrs A in her final hours (see paragraph 51). In all the circumstances, I uphold this complaint.

(e) Recommendations

56. The Ombudsman recommends that:

(i) the Board keep him informed of the progress of implementation of the Liverpool Care Pathway over the next 12 months; and

(ii) provide evidence of the actions being taken to ensure individual patient dignity until the Hospital is closed.

(f) The Board did not respond appropriately to the complaint

57. Mr C met with the Consultant on 3 January 2008 to discuss the family's concerns. In a letter dated 7 January 2008, they said they accepted the account of the surgery (see paragraph 2) but wished to complain about a number of issues. They received a letter of response, dated 25 February 2008, which set out details of Mrs A's care and responded to the issues raised. Mr C remained unhappy with this and a further meeting was held on 24 April 2008. At that meeting, Mr C asked why he had been told the Consultant would have noted a different cause of death (a point made in the letter). He was told the Consultant would write to him direct on this.

[3] The pathway consists of a linked series of guidance, policies and documentation which was developed to transfer the hospice model of care into the hospital setting. More details can be found on the Liverpool Care Pathway website – www.mcpil.org.uk/frontpage.

58. In coming to the Ombudsman's office, Mr C said he felt that, while some errors had been accepted and apology made for these, there was insufficient detail about action taken to reassure him and his family that there would not be a recurrence.

59. Adviser 1 commented on the response. He felt that the response that the importance of communication would be emphasised to staff was insufficient given the concerns raised and that a clear plan of action should have been set out. Adviser 1 also felt that, given the Consultant's concerns, it would have been good practice for her to have attended the second meeting. Adviser 2 also noted that, while failings were identified, there was little detail of the actions that would be taken.

(f) Conclusion

60. Complainants frequently advise that the reason they have come to this office with their concerns is a desire to ensure that the problems they have experienced do not happen again. The response to Mr C's complaint details the care given and does apologise for communication failures. However, there is very little detail about what will be done in future. More of this was supplied to me in the course of my investigation. However, it would have been helpful for Mr C to have also been informed of this.

61. As well as the criticisms made by Adviser 1 and Adviser 2, I have noted elsewhere in this report that a critical report was made by the Consultant in the course of the Board's handling of this complaint (see paragraph 15). Mr C had raised concerns about the management of Mrs A's fluid intake. The letter to him about his complaint details the fluids given but nowhere explains that the Consultant had concerns about this. Therefore, this point was not fully addressed and I am critical of this. The Board have also already accepted that there was an administrative error which meant that the Consultant did not write to Mr C about the death certification. In all the circumstances, I uphold this complaint.

(f) Recommendations

62. The Ombudsman recommends that the Board:

(i) ensure that guidance to complaint handling staff emphasises the need for full disclosure of relevant information;

63. The Ombudsman further recommends that the Board make a full, detailed apology to Mr C and his family for the failings identified in this report.

64. The Board have accepted the recommendations and will act on them 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
Mrs A	The aggrieved, Mr C's late mother
The Hospital	The Victoria Infirmary
The Board	Greater Glasgow and Clyde NHS Board
Adviser 1	Medical adviser
Adviser 2	Nursing adviser
The Consultant	A geriatric consultant who treated Mrs A
Ward A	Receiving ward
Ward B	The ward to which Mrs A was transferred
UTI	Urinary tract infection
IV	Intravenous
ICN	Infection Control Nurse

Annex 2

Glossary of terms

Clostridium difficile (C Difficile)	A bacterium which is one of the most common causes of infection of the large bowel (colon); now recognised as the chief cause of hospital acquired diarrhoea in Europe
Gastroenteritis	Inflammation of the stomach and bowel which can cause vomiting and diarrhoea – it often has a viral cause
Noro virus	A viral infection more commonly known as winter vomiting virus
Renal	Kidney
Sepsis	An infection of the blood stream