Scottish Parliament Region: Lothian

Case 200703108: Lothian NHS Board

Summary of Investigation

Category

Health: Hospitals; care of the elderly; care and treatment

Overview

The complainant (Mr C) raised a number of concerns about the care and treatment his late mother (Mrs A) received while a patient in Ward 8 (the Ward) of the Royal Victoria Hospital, Edinburgh (the Hospital). Mrs A died, aged 82-years-old, on 7 May 2007 in the Hospital. The complaint is brought by Mr C on behalf of himself, his sister (Mrs D) and other family members. Mr C and his family were also unhappy with the way in which Lothian NHS Board (the Board) dealt with their complaint.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C and his family were given conflicting reasons by nursing staff for Mrs A's move to a two bedded room in the Ward (*upheld*);
(b) the language used by nursing staff about Mrs A was inappropriate (*upheld*);
(c) the attitude of a staff nurse on the Ward was unacceptable (*no finding*);
(d) the attitude of nursing staff towards mobilising Mrs A was reprimanding in manner and unreasonable (*not upheld*);
(e) the temperature in the Ward was high and uncomfortable (*upheld*);
(f) the conditions in the two bedded room contributed to the speed of Mrs A's decline in the final days of her life (*not upheld*); and
(g) the Board failed to handle the complaint from Mr C and his family appropriately (*partially upheld*).

Redress and recommendations

The Ombudsman recommends that Lothian NHS Board (the Board):

(i) issue Mr C, Mrs D and their family with a formal written apology for the failings identified in heads of complaint (a), (b), (e) and (g) of this report; and

(ii) audit and update the Action Plan in one year and share the findings with the Ombudsman's office.

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

Main Investigation Report

Introduction

1. The complainant (Mr C) complained, on behalf of himself and his family, in writing to Lothian NHS Board (the Board) in October and November 2007. In his complaint he raised a number of issues concerning his late mother (Mrs A)'s care and treatment while a patient in the Royal Victoria Hospital, Edinburgh (the Hospital) between 29 April and 7 May 2007. In particular, Mr C complained about the reasons given by nursing staff for Mrs A's move from the main part of Ward 8 (the Ward) to a two bedded room within the Ward (the Room); the conduct and attitude of nursing staff and the unbearably warm temperature in the Room, which Mr C said led to Mrs A developing dehydration and the speed of her decline in the final days of her life.

2. The Board responded to Mr C's complaint in a letter dated 11 January 2008. According to the Board, Mrs A had a very complex medical history including osteoporosis, significant chronic bronchitis and heart disease including angina, heart attack and severe heart failure. The Board said that prior to Mrs A's admission to the Hospital in March 2007 she had several previous prolonged admissions in the previous two years. Mrs A had originally been admitted to the Western General Hospital with back pain, secondary to a recent vertebral fracture and deteriorating mobility, and was transferred to the Hospital for further rehabilitation to review her home circumstances. Mrs A succumbed to a chest infection at the beginning of May 2007, the third since her admission, and died on 7 May 2007. The letter addressed the various issues of concern raised by Mr C and apologised that Mrs A's stay in the Hospital did not meet his expectations. The Board offered to meet with Mr C to discuss his concerns.

3. Mr C and his family were dissatisfied with the Board's response which they felt failed to address their concerns, was contradictory and contained untruths and errors. Mr C complained to the Ombudsman's office in March 2008.

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

(a) Mr C and his family were given conflicting reasons by nursing staff for Mrs A's move to a two bedded room in the Ward;
(b) the language used by nursing staff about Mrs A was inappropriate;
(c) the attitude of a staff nurse on the Ward was unacceptable;

(d) the attitude of nursing staff towards mobilising Mrs A was reprimanding in manner and unreasonable;
(e) the temperature in the Ward was high and uncomfortable;
(f) the conditions in the two bedded room contributed to the speed of Mrs A's decline in the final days of her life; and
(g) the Board failed to handle the complaint from Mr C and his family appropriately.

Investigation

5. In order to investigate this complaint, I reviewed all of the complaint correspondence between Mr C and the Board. I also corresponded with the Board, reviewed their clinical records for Mrs A and sought professional medical advice from one of the Ombudsman's nursing advisers (the Adviser). I also met with Mr C and his sister (Mrs D). The Adviser was present at the meeting. To assist with my investigation, the Adviser and I visited the Hospital, in particular, we viewed the Ward and the Room where Mrs A was a patient. We also met with the Staff Nurse, a charge nurse on the Ward (the Charge Nurse) and the Site and Clinical Nurse Manager of the Hospital (the Nurse Manager). Furthermore, I arranged for Mr C and Mrs D and two other members of their family to meet with representatives of the Board in my office. This included the Chief Nurse and Head of Service of the Board's Directorate of General Medicine (the Chief Nurse), who had investigated and responded to Mr C's letter of complaint to the Board and a consultant who works on the Ward (the Consultant). The Adviser and I also took part in this meeting. An Action Plan which set out the action the Board have taken to address Mr C's complaint (the Action Plan) was discussed.

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) Mr C and his family were given conflicting reasons by nursing staff for Mrs A's move to a two bedded room in the Ward

7. On 29 April 2007 Mrs A was moved from the main section of the Ward to the Room, which was situated within the Ward. Mr C complained that he and his family were given conflicting reasons by nursing staff for Mrs A's move. Mr C and his family said they were initially told the bed Mrs A had occupied in the Ward was needed for another patient who required a lifting hoist. However, Mr C and his family later learned at a meeting with the Charge Nurse, who they

considered to be 'honest', 'apologetic' and 'very sincere', on 5 May 2007 that the reason Mrs A was moved to the Room was because she was a noisy patient and other patients in the Ward had complained.

8. The Board in their initial response to Mr C's complaint explained that there were several reasons for Mrs A's move to the Room. They had taken into account both Mrs A's needs and those of another patient who required the use of a lifting hoist. The Board said there had been a number of 'advantages' to Mrs A being moved to the Room. It was directly opposite the nurses' station and the treatment room so they could observe Mrs A and attend to her as soon as possible. The Room was quieter and, therefore, better for a patient such as Mrs A who suffered anxiety and agitation and was nearer to a single toilet.

9. During my meeting with the Staff Nurse, she told me that the main reason for Mrs A being moved into the Room was because she suffered with agitated depression and other patients had complained about her behaviour. The Charge Nurse told me, when I met with her, that Mrs A did not sleep, shouted out during the night and her behaviour disturbed other patients in the Ward. The doctor had put Mrs A on anti-depression medication which initially helped. However, she became more and more agitated. Although the main reason for Mrs A's move to the Room was because they had to give consideration to both Mrs A and the other patients in the Ward, this was not the only reason. Another patient in the Ward had needed a lifting hoist and a hoist could be used with the bed which Mrs A had occupied in the main part of the Ward. However, she said that Mrs A was a good candidate for the Room because it had a quiet atmosphere and it is visible to nursing staff who can see patients in their bed. The move was also beneficial for all of the patients, including Mrs A.

10. At the meeting held in my office, the Chief Nurse, on behalf of the Board, accepted that Mr C and his family did not appear to have been given the primary reason for Mrs A being moved to the Room, which was that other patients in the Ward were complaining about the noise which Mrs A made. However, the Chief Nurse said that the move had coincided with another patient requiring a bed move because she required a hoist.

11. The advice I received from the Adviser is that the Charge Nurse had to take into account the needs of all the patients in the Ward. In her view, the decision to move Mrs A to the Room for the benefit of the other patients in the Ward was reasonable. However, the Adviser had commented that the reason

for the move should have been documented at the time and communicated to staff as well as being discussed with Mrs A and her family. Patients and or relatives should whenever possible be involved in their care. In the Adviser's view, it appeared that there was miscommunication between the nursing staff and Mr C and his family as to the different reasons given for Mrs A's move to the Room.

(a) Conclusion

12. I am satisfied that until Mr C and Mrs D met with the Charge Nurse on 5 May 2009, the Ward staff did not explain the entire reasons for Mrs A's move to the Room to her family. The Board have conceded that communication with Mrs A's family was not done well and the standard of documentation in Mrs A's medical notes was variable. Therefore, based on this and the advice I have received from the Adviser, which I accept, I uphold this complaint.

13. Following upon Mr C's complaint the Board produced the Action Plan, which they subsequently updated in May 2009. Copies have been provided to the Ombudsman's office and also to Mr C and his family. The Action Plan sets out the action taken to address the issues arising from Mr C's complaint and to prevent a recurrence of the incidents complained about.

14. In respect of communication, staff now involve patients, relatives and their carers in care planning, as appropriate. The Charge Nurse had changed shift patterns so there is now a visible charge nurse on the Ward during visiting times that relatives can speak to so as to get an update on patients' progress. Furthermore, the Chief Nurse in her meeting with Mr C and his family accepted the importance of staff being truthful with families about the reasons why their relative was being moved and said and that this had been a learning point for staff.

15. With regard to the variable standard of documentation, there has been an audit and review of the standard of record-keeping in the Ward. Action has been taken to make staff aware of the importance of accurate record-keeping and that it meets minimum standards set out by the Nursing and Midwifery Council. Charge nurses have been actively involved in the review and development of documentation. Two senior nurses on the Ward also conduct monthly snapshot audits of patient records.

(a) Recommendations

16. Whilst recognising the action the Board have taken following the complaint, nevertheless, given the failings in communication identified in this complaint, the specific recommendations that the Ombudsman is making, resulting from the investigation of this complaint, is the Board should:

(i) issue Mr C, Mrs D and their family with a formal written apology for these failings; and

(ii) audit and update the Action Plan in one year and share the findings with the Ombudsman's office.

(b) The language used by nursing staff about Mrs A was inappropriate

17. Mr C and his family were unhappy with the language used by nursing staff in the Ward to describe Mrs A. It is recorded in Mrs A's notes that she was 'noisy and demanding' and 'remains very noisy and disruptive'.

18. The Board have accepted that the use of such language by nursing staff was inappropriate and unacceptable and apologised for its use. The Chief Nurse said that she, the Charge Nurse and the rest of the Ward team were very concerned to learn of the words used by nursing staff to describe Mrs A. They recognised some insensitive words had been used about Mrs A.

19. The Adviser has told me that education and training of nursing staff in values based care which supports a person centred compassionate approach to communication with patients and their relatives is vital. In her view, the emotive and often negative language used to describe Mrs A in the medical notes is not helpful and suggests a culture where older people are not valued as partners in their care and rehabilitation.

(b) Conclusion

20. The Board have accepted that language used to describe Mrs A was inappropriate and unacceptable. Therefore, I uphold this part of the complaint.

21. The Chief Nurse said that when Mr C's complaint was received this had been discussed at the Ward meetings and guidance on new and appropriate words to use had been introduced. Included in staff training are customer care sessions and how patients and relatives would wish to be spoken to. This has proved very positive and has made staff look at their own practice.

(b) Recommendations

22. Whilst recognising the action the Board have taken following the complaint, nevertheless, given the use of inappropriate language to describe Mrs A as identified in this report, the specific recommendations that the Ombudsman is making, resulting from the investigation of this complaint, is that the Board should:

(i) issue Mr C, Mrs D and their family with a formal written apology for these failings; and

(ii) audit and update the Action Plan in one year and share the findings with the Ombudsman's office.

(c) The attitude of a staff nurse on the Ward was unacceptable

23. On 5 May 2007, Mr C said he visited his mother during the afternoon visit. Mrs A asked to use the bathroom. He, therefore, approached the Staff Nurse for assistance. According to Mr C, the Staff Nurse entered the Room with a 'goading' attitude towards his mother. In his opinion, the Staff Nurse could not determine the great frailty of Mrs A and accused Mrs A of being an 'attention seeker'. At the evening visit on the same day, Mr C's niece (Miss E) visited Mrs A. According to Miss E she witnessed the Staff Nurse let Mrs A fall whilst taking her from the bathroom back to her bed. The family believe that the Staff Nurse did not act appropriately on this occasion and let Mrs A fall.

24. In the Board's response to Mr C, the Staff Nurse said that she could not fully remember her conversation with Mr C. However, she was quite clear that she would not commonly use the phrase 'attention seeker'.

25. The Staff Nurse told me that the Ward physiotherapist decided that nursing staff should try to mobilise Mrs A and the consultant responsible for Mrs A agreed with this. However, this proved to be very difficult. In her view, there was a reluctance and lack of motivation on the part of Mrs A. Mrs A could walk with the use of a zimmer frame. Although Mrs A was capable of walking to and from her bed to the toilet, she was reluctant to do so.

26. The Staff Nurse said she recalled the incident when Mrs A's granddaughter, Miss E, visited her grandmother. Mrs A needed to use the toilet. She had taken Mrs A to use the toilet on more than one occasion. Mrs A walked to the toilet. As they were returning to Mrs A's bed, Mrs A just sat down on the floor. The Staff Nurse admitted that she was frustrated by Mrs A's

actions. However, she said she did not run away and leave her on the floor. She got a member of the clinical support staff to assist her and she reported what had happened to the doctor. There was no warning, Mrs A just sat down. At the time Miss E did not say anything. When the Staff Nurse heard about the complaint she was shocked and very upset. She was very sorry Mr C and his family were unhappy with her care of Mrs A.

27. This is disputed by Miss E. In a written statement to the Ombudsman's office, she said that when Mrs A had requested a commode this was refused by the Staff Nurse who told her she would have to walk to the bathroom. It took Mrs A several attempts to get out of her chair and to stand up. On Mrs A's return from the bathroom, Mrs A said she was going to fall. The Staff Nurse said that she was not going to fall and told her just to walk to the bed. The Staff Nurse would not allow Miss E to assist her grandmother. Mrs A said again that she was going to fall. She then fell to the ground. As Mrs A lay on the ground, the Staff Nurse's face showed signs of 'annoyance and frustration' that she was going to have to help Mrs A. Miss E considered the Staff Nurse's behaviour to be 'cruel'.

28. The Chief Nurse and the Nurse Manager said on the grounds of staff confidentiality there were limitations to what they could discuss about the action taken in relation to individual members of staff. However, they confirmed the comments which the Staff Nurse was alleged to have made about Mrs A had been discussed with her. The Nurse Manager and the Chief Nurse said that staff, such as the Staff Nurse, can come from different cultural backgrounds and that the different culture may have had something to do with the way the Staff Nurse had come across to Mr C and his family, but the Board have also acknowledged that training and supervision of their staff do address these issues.

29. The Nurse Manager said she had discussed the allegations about the Staff Nurse with senior staff and their view was that the behaviour that Mr C and his family say they experienced was unusual. Since the complaint had been made the Staff Nurse had been on customer care programmes. She had also gone through and will continue to go through appraisal processes, covering both professional and behavioural matters.

30. The Consultant said that he works in the Ward. He said that the Staff Nurse comes straight to him for advice. She was considered to be highly

professional and a capable individual. He also provided a written testimonial in which he described the Staff Nurse to be an 'exceptionally dedicated and compassionate nurse'.

31. The Adviser has told me that in her opinion experienced staff should be able to assess when older people are too unwell to walk to and from the toilet and provide a commode instead. The Staff Nurse was probably acting in the best interests of Mrs A by encouraging her to walk. The Moving and Handling Policies across NHS Scotland inform staff that if a patient appears to be losing balance and is likely to fall, then they should be supported to sit down on the floor in a controlled manner. This action is good practice.

(c) Conclusion

32. On occasions it is the case that there are some aspects of a complaint that concern matters where it will not be possible to allow appropriate conclusions to be reached. What happened on both of the occasions during the afternoon and evening visits on 5 May 2007 are such incidents. The circumstances of what happened are disputed. I am not aware of any independent witnesses witnessing what occurred and, as a result, it would not be possible to reach defensible conclusions on this matter. In the circumstances, while I recognise Mr C and his family's strength of feeling about the incidents on 5 May 2007, which I accept are genuinely held, I am unable to reach a conclusion on this complaint and I make no finding.

(c) Recommendations

33. The Ombudsman has no recommendation to make on this complaint. However, I have noted the action the Board and, in particular, the management of the Ward have taken with respect to education and training, particularly in relation to how staff talk and interact with patients, their relatives and carers.

(d) The attitude of nursing staff towards mobilising Mrs A was reprimanding in manner and unreasonable

34. During the course of my investigation of the complaint, Mr C said that he and Mrs D accepted that their mother could be 'demanding' because of the medication she was on. However, they considered there was a lack of constructive encouragement for their mother to mobilise on the Ward. In their opinion there was a 'telling off attitude' toward their mother, particularly when she was exhausted and they found this to be very distressing.

35. Mrs A's medical notes state that whilst a patient in the Ward she was being seen by a physiotherapist and an occupational therapist. According to Mrs A's notes she was 'reluctant to do much for herself' and had 'poor motivation'. There is evidence that Mrs A was to be encouraged to mobilise on the Ward by nursing staff.

36. The Consultant said that as regards staff attitude towards patients, when rehabilitating patients there is often a fine line between pushing and encouraging a patient.

37. The advice I have received from the Adviser is that Mrs A's medical notes show that she was cared for by a multi-disciplinary team. There is good evidence in the notes of multi-disciplinary assessment, ongoing care and treatment and team meetings. Mrs A's multi-disciplinary patient record is considered good practice and should enhance communication between members of the team. The notes made by the multi-disciplinary team suggest that Mrs A was reluctant to walk and on a number of occasions refused to participate in her therapies. Older people often do lack confidence in walking and part of the team care planning would be to encourage Mrs A to mobilise and provide assistance when required. Promoting independence is an integral part of the rehabilitation process and the actions of staff in relation to promoting mobility were good. The Adviser also supported the opinion of the Consultant that there is a fine line between pushing and encouraging a patient who is reluctant to mobilise.

(d) Conclusion

38. The records show that Mrs A was reluctant to mobilise but that it was necessary for her rehabilitation she should do so. It is clear there is often a fine line between what is regarded as pushing and what is regarded as encouraging a patient who is reluctant to mobilise. What may have appeared to Mr C and his family as pushing and 'telling off', staff regarded as encouragement. Based on the evidence and the clinical advice I have received, I am not persuaded that nursing staff on the Ward acted unreasonably when mobilising Mrs A. Therefore, I do not uphold this part of the complaint.

(d) Recommendations

39. In view of the conclusion I have reached, the Ombudsman has no recommendation to make on this complaint. Nevertheless, as I have referred to above in heads of complaint (b) and (c), I have noted the action that has been

taken by the Board and the lessons learned in relation to how staff communicate with patients and their relatives.

(e) The temperature in the Ward was high and uncomfortable

40. The week beginning 30 April 2007, according to Mr C and Mrs D, was one of the warmest weeks of the year. Mr C said the Room was excessively hot and he had complained to the Ward staff about the excessive heat Mrs A had to endure. He and his family believe the week Mrs A spent in the Room hastened her decline in her final days. She was only moved on Sunday 6 May 2007 after they complained the night before to the Charge Nurse. Mr C and his family said they regret that the Ward staff did not realise throughout the week the conditions their mother had to endure in the Room and thus moved her out of the Room sooner.

41. The Board in their response to Mr C's complaint acknowledged that the temperature in the Ward could rise significantly in the summer months and that the Ward temperature was difficult for staff to control. They said that unfortunately they did not have blinds or air conditioning and, therefore, they often needed to draw the curtains, use fans and occasionally open the windows, but the latter option was not liked by many patients.

42. The Charge Nurse told me that staff had previously complained about the heat in the Ward and this was being monitored by the Board's estates department. She had previously asked for blinds for the window in the Room. She said the Room was cool in the morning and in the evening. However, during the day the heat did build up in the Room. The windows open but only up to a certain height. However, there are plenty of fans and there is a maintenance programme ongoing.

43. The Staff Nurse also conceded there had been staff issues about the temperature in the Ward as there are a lot of windows. She said that in summer the Room where Mrs A was a patient could become very hot. When this happened staff offered to open the windows for patients and fans were provided. In Mrs A's case she said they opened the window frequently and provided a fan.

44. The Chief Nurse said that the Board had received no complaints from other patients or their relatives about the Room since Mr C had made his

complaint. However, following Mr C's complaint, solar film had been placed over the windows in the Ward.

45. As I stated above, accompanied by the Adviser, I viewed both the Ward and, in particular, the Room which Mrs A occupied during the last week of her life. We visited on a morning in November 2008. The Room had in my view just enough space for two beds. It had a large picture window overlooking a garden area. The bed that Mrs A had occupied was beside the window. There were no blinds on the window. Despite the fact that it was November, the Room was warm and filled with brilliant sunshine. There is also a large window separating the Room from the Ward. The Room is next to the nurses' station.

(e) Conclusion

46. I am satisfied that prior to Mrs A's occupation of the Room there had been an ongoing problem with the temperature in the Ward and, in particular the Room, in warm weather, which nursing staff and the Board's estates department were aware of. Therefore, I am of the view that the Room, during the week it was occupied by Mrs A, would have been hot and extremely uncomfortable for Mrs A, who was frail and in poor health. I, therefore, uphold this complaint.

(e) Recommendations

47. I refer to the Action Plan. A number of steps have been taken by the Board to address issues arising from this part of Mr C's complaint. This has included the fitting of reflective solar film on the windows of the Ward; the estates department monitoring the heat and humidity of the Ward and a review of the use of the Room as a two bedded bay to a single bedded bay in extreme hot weather to allow for more air circulation. To assist with this, as at May 2009, a single en-suite room has been created in the Ward to improve the flexibility of the Ward accommodation. A quarterly meeting of the multi-disciplinary team to discuss the Ward environment also now takes place.

48. I acknowledge the action the Board have taken to improve the temperature and the comfort of patients in the Ward and, in particular, the Room. However, in my view, action could and should have been taken earlier to address this problem since it had been known to the Board prior to Mr C's complaint.

49. In view of the unacceptable conditions which Mrs A endured in the Room during the last week of her life, the specific recommendations that the Ombudsman is making, resulting from the investigation of this complaint, is the Board should:

(i) issue Mr C, Mrs D and their family with a formal written apology for these failings; and

(ii) audit and update the Action Plan in one year and share the findings with the Ombudsman's office.

(f) The conditions in the two bedded room contributed to the speed of Mrs A's decline in the final days of her life

50. Mr C and his family believe Mrs A should never have been moved to the Room as she could not cope there due to her increasingly frail condition. They consider there was a lack of supervision during the week she spent in the Room. Mrs A was very deaf and it appeared to them that this had not been taken into consideration by the nursing staff when dealing with her. They believe their mother became dehydrated because of the heat in the Room and her inability to access fluids because of her frail condition. In particular, they said that their mother liked to drink milk and in the heat of the Room they believe the milk would have soured very quickly and been undrinkable. When they visited Mrs A on Saturday 5 May 2007 they were distressed to find their mother slumped in a chair in a state of undress. She appeared frail, distressed, dehydrated, exhausted and the Room temperature was an unbearable 90 degrees. Previously, Mrs A had been a determined and independent lady. Following a meeting with the Charge Nurse where they expressed their great concern, Mrs A was moved to a single room. Mr C and his family believed that the extreme Room temperature and lack of fluids increased Mrs A's susceptibility to infection and had hastened her death. They believe that the conditions Mrs A had to endure in the Room during the last week of her life were totally unacceptable.

51. The Charge Nurse told me that Mrs A was capable of asking for a drink and if nursing staff had considered her deafness an issue then they would have provided communicators. There was no indication of dehydration. She was seeing the dietician. Patients are given milk at 18:00 and get drinks at every meal time. Drinks are also given to patients at 11:00 and 15:00. In addition, patients have a jug of water twice a day and are also given juice to drink.

52. The Staff Nurse told me that Mrs A was never left unattended for long periods of time. Nursing staff and domestics were in the Room quite often. Apart from being able to view the Room from the Ward, it has a large window separating the Room from the Ward, the door to the Room was always open and there was another patient in the Room.

53. The Board said that although Mrs A felt uncomfortable in the heat and that it may have to an extent contributed to her level of hydration, the consultant on the Ward did not accept that it hastened Mrs A's death. Mrs A had complex medical problems and her frailty and susceptibility to infection were the cause of her ultimate decline.

54. The advice I received from the Adviser is that, whilst the Charge Nurse has stated there was no indication of dehydration, she is of the view that excess heat could have contributed to Mrs A's level of dehydration and frailty. However, she agrees with the Board that these conditions did not hasten Mrs A's death. The Adviser considers the actions of the Charge Nurse, following her meeting with Mrs A's relatives expressing their disquiet about the Room, to move Mrs A to a single room was reasonable.

(f) Conclusion

55. From my observation and that of the Adviser, the Room is next to the nurses' station and patients in the Room are clearly visible to nursing staff. I am, therefore, unable to conclude that there would have been a lack of supervision of Mrs A by nursing staff.

56. I recognise how understandably distressing the last week of Mrs A's life was for Mr C and his family and their strength of anger and ongoing distress about their mother's care and treatment during this time. However, the Adviser has told me, that whilst excess heat could have contributed to Mrs A's dehydration and frailty, she agrees with the Board that the conditions in the Room, however unacceptably warm they were, did not hasten Mrs A's death. I accept that advice.

57. Based on the clinical advice I have received, which I accept, I conclude that the unacceptable temperature in the Room could have contributed to Mrs A's level of dehydration. However, I am unable, based on this clinical advice to conclude that these circumstances hastened Mrs A's death. For that reason, I do not uphold this complaint.

(f) Recommendations

58. In view of the conclusion I have reached, the Ombudsman has no recommendation to make on this complaint.

(g) The Board failed to handle the complaint from Mr C and his family appropriately

59. On 11 January 2008 the Board wrote a letter to Mr C in which they set out their response to his complaint concerning Mrs A's care and treatment and offered him a meeting with a member of the Board's Clinical Management or Nursing Management Team to discuss the complaint. This was declined by Mr C who said that he and his family were 'stunned' by the content of the letter. Mr C said in his family's opinion there had been a 'remarkable lack of an apology' in the letter. Mr C said that he felt that the questions and concerns they had raised about their mother's care and treatment were either unanswered or the replies were vague. In addition, they considered certain information provided in the response was 'contradictory, inaccurate and untrue'. They felt the letter made them out to be 'wrong on all counts' and the stance taken by the Board with regard to their complaint was one of 'intransigence'. They considered the Board's offer of a meeting to be a 'standard' offer and not a genuine attempt to address their complaint. Therefore, because of this, Mr C and his family felt unable to take up the Board's offer of a meeting to discuss the complaint.

60. During the course of my investigation, the Board made another offer to meet with Mr C and his family to discuss the complaint. A meeting took place in the Ombudsman's office. Mr C, Mrs D and two members of their family were present as well as three representatives from the Board. The Adviser and I were also present.

61. The Chief Nurse said that the Board took complaints very seriously. She was, therefore, very concerned when she learned that Mr C and his family considered that the Board had not taken their complaint seriously. The Chief Nurse then discussed the letter dated 11 January 2008 which she had issued, on behalf of the Board, to Mr C following his complaint. The Chief Nurse said that when she was dealing with the complaint some of the information that should have been in Mrs A's medical records was not there. There was a variable standard of documentation. She also said that when a complaint was received months after an event complained of, such as was the case with

Mr C's complaint, people's memories fade and this can make it difficult to respond to certain aspects of a complaint.

62. The Chief Nurse said that in the two years since the complaint had been made by Mr C, practice has evolved. Now if she received a complaint, such as she received from Mr C and his family, before issuing a written response, she would immediately telephone the person making the complaint to discuss it with them. She was sorry if Mr C and his family found the letter patronising or they did not agree with some of the language she had used in her response letter.

63. The Consultant said that there had been a change of practice on the Ward. If patients' relatives, particularly where a patient has died, have questions or queries they are given a number of the consultant's secretary so they can arrange an appointment with the consultant to discuss their relative's care and treatment.

64. The Board offered Mr C and Mrs D the opportunity of revisiting the Ward to see for themselves the changes that had been made. This was declined.

(g) Conclusion

65. I accept that the Board did provide a detailed response to Mr C's complaint and made an offer to meet with him and his family. However, the Board have accepted that they could have handled Mr C's complaint better and if they received such a complaint now would deal with it differently. Therefore, I uphold the complaint in part.

66. However, I welcome the evidence of lessons learned by the Board in dealing with Mr C's complaint.

(g) Recommendation

67. Given that the Board have accepted there were failings in the way they dealt with Mr C's complaint, the specific recommendation that the Ombudsman is making, resulting from the investigation of this complaint, is the Board should issue Mr C, Mrs D and their family with a formal written apology for these failings.

68. 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
The Board	Lothian NHS Board
Mrs A	Mr C's late mother, the aggrieved
The Hospital	The Royal Victoria Hospital, Edinburgh
The Ward	Ward 8 of the Hospital
The Room	The two bedded room in the Ward
The Staff Nurse	A staff nurse on the Ward
The Adviser	Nursing adviser to the Ombudsman
Mrs D	Mrs A's daughter
The Charge Nurse	A charge nurse on the Ward
The Nurse Manager	The Site and Clinical Nurse Manager of the Hospital
The Chief Nurse	Chief Nurse and Head of Service of the Board's Directorate of General Medicine
The Consultant	Consultant physician and Associate Clinical lead on the Ward
The Action Plan	An Action Plan which sets out the action the Board have taken to address Mr C's complaint

Miss E	Mrs A's granddaughter, the daughter of Mrs D