Parliament Region: South of Scotland and Lothian

Cases 201001146 & 201001520: Ayrshire and Arran NHS Board and Scottish Ambulance Service

Summary of Investigation

Category

Health: Hospitals; appointments; admissions (delay, cancellation, waiting lists)
Health: Ambulance; communication, staff attitude, dignity, confidentiality

Overview

The complainant (Mrs C) made a complaint about the care and service provided to her husband (Mr C) by the Scottish Ambulance Service (the Service) in transporting Mr C to and from an Endoscopy out-patient appointment at Crosshouse Hospital in Kilmarnock. Mrs C also complained about the care and treatment provided to Mr C by Ayrshire and Arran NHS Board (the Board) while waiting for his out-patient appointment at the Hospital.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the care and service provided to Mr C by the Service were not reasonable (*upheld*); and

(b) the care and treatment provided to Mr C by the Board was not reasonable (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Service	*Completion date*
(i) remind all crews in the South West Division to contact their Area Service Office and await instructions if cancellations on their patient list would mean that other patients would be transported to hospital several hours before their appointment time; and	13 April 2011
(ii) recommendation 2; remind all crews in the South West Division of the importance of passing on relevant information about a patient's needs following an outbound journey, such as whether a	13 April 2011

stretcher facility is required for a return journey, to their Area Service Office.

The Ombudsman recommends that the Board:	*Completion date*
(iii) ensure that a record is made of the time a patient is admitted for their procedure and also of all advice given to patients on admission by nursing staff. This requirement should be incorporated into the new guidance;	13 April 2011
(iv) remind nursing staff of the importance of treating people as individuals, even in a very busy unit, as set out in the NMC Code; and	13 April 2011
(v) provide him with evidence of audit and evaluation of the first six months' operation of the new guidance and action plan for dealing with vulnerable adults arriving for Endoscopy appointments.	12 October 2011

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

Main Investigation Report

Introduction

1. The complainant (Mrs C) made a complaint about the care and service provided to her husband (Mr C) by the Scottish Ambulance Service (the Service) in transporting Mr C to and from an Endoscopy out-patient appointment at Crosshouse Hospital (the Hospital) in Kilmarnock. Mrs C also complained about the care and treatment provided to Mr C by Ayrshire and Arran NHS Board (the Board) while waiting for his out-patient appointment at the Hospital.

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

(a) the care and service provided to Mr C by the Service were not reasonable; and

(b) the care and treatment provided to Mr C by the Board was not reasonable.

3. While considering Mrs C's complaint, my complaints reviewer identified the following specific issues, all of which are dealt with in this report:

- a patient transport vehicle arrived several hours early to take Mr C to the Hospital;
- there was no facility to allow Mr C to lie down in the patient transport vehicle on the return journey;
- there were no nursing staff in the Endoscopy Unit waiting area and Mr C did not see the admitting nurse (the Charge Nurse) until 15:30, which was 30 minutes later than his scheduled appointment time;
- nurses did not speak to Mr and Mrs C regarding other treatment rooms and patients being taken before Mr C;
- a nurse only saw Mr C's morphine pump after he was taken for his procedure;
- no-one approached Mrs C when she lay Mr C down on bench seats and he remained there until he was taken for his procedure; and
- the only conversation Mrs C had with the Endoscopy Unit receptionist (the Receptionist) after she handed in Mr C's appointment card and was asked to take a seat was when Mrs C asked if she could wet Mr C's lips. The Receptionist said she would find out but never returned.

Investigation

4. Investigation of Mrs C's complaint involved reviewing the service and clinical records and correspondence relating to the events. My complaints reviewer also sought the views of a nursing adviser (the Adviser).

5. 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 terms used in this report can be found at Annex 2. Mrs C, the Service and the Board were given an opportunity to comment on a draft of this report.

Background

6. Mr C was a 71-year-old man who was diagnosed with terminal oesophageal cancer in January 2009. He was admitted to St Vincent's Hospice (the Hospice) in Howwood, Renfrewshire, on 18 February 2010 and had an out-patient appointment at the Hospital for a palliative stretching of his oesophagus on 22 February 2010. After the appointment, Mr C was returned to the Hospice where he died later that night.

(a) The care and service provided to Mr C by the Service were not reasonable

7. Mrs C complained to the Service on 14 April 2010 that she and Mr C were collected at 11:00 for Mr C's Endoscopy out-patient appointment which was scheduled for 15:00. Mrs C also complained that Mr C had to sit in his wheelchair for the duration of the return journey from the Hospital. Mrs C said that to treat a terminally ill patient in this way was unacceptable.

8. The Service responded to Mrs C's complaint on 17 June 2010 and said the outbound patient transport crew had been asked to provide an account of what happened. They said they were ahead of schedule that morning and they asked the Hospice staff if Mr C was ready to travel, which the Hospice staff said he was. The Service also said the outbound crew assumed that the Hospital would be able to see Mr C earlier than scheduled but they did not check if this was the case. The Service said staff at the Area Service Office had been advised that they must confirm with hospitals beforehand that they could accommodate a patient arriving early. In addition, the Service said the outbound crew were informed that taking a patient to hospital three hours before their appointment was inappropriate.

9. The Service said the Hospice, which had booked the patient transport, did not advise them of the need for a stretcher to allow Mr C to lie down. Although a stretcher had not been specifically requested, the Service said Mr C was able to lie down on the way to the Hospital as the outbound crew recalled helping him to do so. The vehicle for the return journey did not have a stretcher on board and so Mr C could not lie down. The Service said they had reminded the Hospice of the need to ensure they passed on the full details of a patient's requirements when booking patient transport in future. However, my complaints reviewer contacted the Hospice and was told that they had not heard from the Service on this matter. Following intervention from my office, the Service contacted the Hospice on 12 October 2010 and made specific reference to bookings requiring a stretcher facility. The Service concluded their response to Mrs C's complaint by apologising for any distress caused to her or Mr C.

10. The Service told my office that the patient transport was ahead of schedule on the journey to the Hospital as two patients before Mr C had cancelled. In relation to the facility to lie down, the Service said the outbound crew recalled that Mr C was content to travel in his wheelchair, but Mrs C felt that Mr C should lie down. The Service added that it was unfortunate this information was not passed to the Area Service Office by the outbound crew, which meant that the patient transport for the return journey did not have a stretcher facility. The correct procedure was for any relevant information to be passed on. To prevent this from happening again, the Service said they had made staff at the Area Service Office aware of their responsibility to ensure that, where possible, patients were conveyed with minimum inconvenience. In future similar situations, the Service said crews should contact their Area Service Office and await instructions.

11. The Service records said that the Hospice had booked patient transport on 19 February 2010 for both journeys. The booking records noted that Mr C was of 'C2' mobility, which meant that he required assistance from a two-person crew and transport by ambulance. He was not noted as being of 'Str' mobility, meaning that the patient required to lie down in an ambulance. The Service log sheets for 22 February 2010 confirmed that two patients before Mr C cancelled, which meant that the outbound crew arrived at 10:55 instead of 14:00. They left the Hospice at 11:25 and arrived at the Hospital at 12:00. The log sheets also confirmed that the return crew arrived to collect Mr C from the Hospital ten minutes earlier than scheduled at 16:20 and, because of a delay in his out-

patient appointment, waited until he was ready, leaving the Hospital at 17:40. They arrived back at the Hospice at 18:25.

(a) Conclusion

12. Mr and Mrs C were taken from the Hospice to the Hospital between two and a half to three hours early. The records stated the outbound crew were ahead of schedule, however, they should not have assumed that the Hospital would have been able to accommodate Mr C earlier than scheduled. The crew should have confirmed if this was possible and it was inappropriate to take Mr C to the Hospital so early. The Service records confirmed that a stretcher facility was not noted as required for both journeys. The Service have reminded the Hospice of the need to ensure that such information is passed to them when booking patient transport. However, the Service also confirmed that, as the outbound crew had helped Mr C lie down on a stretcher, they should have passed this information to the Area Service Office so that a stretcher facility was available for the return journey. The failure to communicate the needs of a terminally ill patient was unacceptable and distressing for Mr and Mrs C and, therefore, I uphold this complaint.

(a) Recommendations

13. I recommend that the Service:	*Completion date*
(i) remind all crews in the South West Division to contact their Area Service Office and await instructions if cancellations on their patient list would mean that other patients would be transported to hospital several hours before their appointment time; and	13 April 2011
(ii) remind all crews in the South West Division of the importance of passing on relevant information about a patient's needs following an outbound journey, such as whether a stretcher facility is required for a return journey, to their Area Service Office.	13 April 2011

(b) The care and treatment provided to Mr C by the Board was not reasonable

14. On 14 April 2010, Mrs C complained to the Board that, having arrived at the Hospital by the Service transport at 12:00, Mr C was badly treated in the Endoscopy Unit as he was not appropriately attended to or made comfortable

during the long wait for his scheduled appointment at 15:00. Mrs C also complained that Mr C was not taken for his appointment until 15:45, and that patients from hospices or other hospitals should have priority. Mrs C's view was that the experiences of that afternoon did not help Mr C's situation as he died later that night.

15. In responding to Mrs C's complaint, the Board said that, given the specific procedure to be undertaken, it would have been very difficult to perform it earlier than scheduled. However, they said the Charge Nurse should have explained the reason Mr and Mrs C had to wait and they apologised for this not happening. The Board also said that the nurse did explain that other Endoscopy treatment rooms were being used by other Endoscopists, which was why other patients were taken before Mr C while he and Mrs C were waiting. However, Mrs C told my complaints reviewer that no one spoke to her about this.

16. The Board also expressed their concern that Mrs C complained about Mr C's pain and discomfort during his wait for the procedure. They said the Charge Nurse noted Mr C had been transferred from the Hospice with a morphine pump and she assumed it was connected but should have ensured this was the case. They also said that, although Endoscopy Unit nurses did not have authority to prescribe pain relief and would not normally interfere with the functioning of a morphine pump, the Charge Nurse should have been able to advise Mrs C on the use of the pump and they apologised for this not being done. Mrs C challenged this, saying that if a nurse had spoken to her, she would have assured the nurse that she could have given Mr C paracetamol if she had some water. Mrs C also said she only saw the Charge Nurse at 15:30.

17. The Board said they were disappointed that nursing and reception staff did not recognise the implications of the lengthy wait given Mr C's condition and they would have expected nursing staff to consider whether he could have been made more comfortable in another area. They said the Charge Nurse saw Mr C lie down due to his discomfort and so arranged for him to be taken through to the admission area to lie on a trolley. Mrs C challenged this, saying no nurse approached her or Mr C as there were no nursing staff present in the waiting area and Mr C was only moved when it was time for him to be taken through for

his procedure[1]. The Board said it appeared there had been a communication breakdown between reception staff and admitting nurses which meant Mr C's situation was not highlighted and that, as a result of Mrs C's complaint, they had developed a new approach to managing vulnerable patients in the Endoscopy Unit.

18. In their response to my office's enquiries, the Board said the waiting area was a public area staffed by receptionists and, therefore, no nurses were allocated to that area. The Charge Nurse was confident she noticed Mr C being laid down on bench seats just after 14:00 as she was passing through the area and, at that time, she took Mr C through to the admitting room, although there was no nursing record to confirm this. The Charge Nurse was also confident that, when she admitted Mr C, she advised him and Mrs C that other patients might appear to be taken before Mr C, as that was a standard phrase used at the end of every Endoscopy admission process. Again, there was no nursing record to confirm this. In relation to pain relief, the Board said Mr C could not have taken oral paracetamol as he was fasting in advance of the procedure and that, had he requested additional pain relief, the Charge Nurse would have spoken with the Consultant Surgeon to request appropriate intravenous or intramuscular analgesia.

19. As Mrs C had not previously raised the issue of asking the Receptionist if she could wet Mr C's lips as he had no saliva, the Board looked into this matter as a result of my office's enquiry. The Charge Nurse interviewed the Receptionist, who had no recollection of this event. However, the Board apologised if the Receptionist did fail to return with an answer. The Board's overall view was that no particular staff member failed Mr C on 22 February 2010, however, there were a number of learning outcomes which

[1] In commenting on a draft of this report, the Board said they accepted there was a difference of opinion with Mrs C regarding the exact time which Mr C was taken through to the Endoscopy Unit and that there was no documented time to support the Board's view. However, they also said that had it been the case that Mr C was only moved through when it was time for him to be taken through for his procedure, he would have waited considerably longer in the waiting area. They stated their view that Mr C was moved through to the trolleys in the admitting area in advance of the procedure when his poorly condition in the reception area was recognised. Although this meant that he had a longer than normal wait on the trolley, it was felt that this was a more appropriate and comfortable environment for him. They added that it may be that Mrs C considered this move into the trolley area as part of the normal process and did not appreciate that they would in other circumstances have waited longer in the waiting area. I note the Board's comments, however, my office has not been provided with records to support this view.

resulted in a new protocol for vulnerable patients being admitted to the Endoscopy Unit.

20. In a statement for the Board during their investigation of Mrs C's complaint, the Charge Nurse said the admission nurses did not know that Mr C had arrived early for the afternoon list. She also said that Mr C was admitted at 14:00, taken for the procedure at 15:45 and waited in the recovery area until approximately 18:00. Overall, the Charge Nurse's view was that they could have provided better care for Mr C.

21. The Board provided my office with a copy of their new Guidance on the Care of Out-patient Vulnerable Adults arriving at the Endoscopy Unit (the Guidance) and their Action Plan for Patients Pathway Evaluation of comfort and identification of vulnerable adults (the Action Plan). These documents made clear the need for reception staff to alert Endoscopy Unit admission nurses to a patient's arrival via the Service transport. They defined the meaning of a vulnerable adult and said that, however they arrived, patients should be identified for assessment by the admission nurses for their ability to wait in the reception area, if they needed to be admitted to a different waiting area and whether their comfort and pain management needs were being met. The assessments and actions would be documented in the nursing pathway patient form. The Guidance and Action Plan were shared with Endoscopy Unit nursing and reception staff.

22. The records provided by the Board did not record the time Mr C was admitted for the procedure. The records noted that the procedure commenced at 16:00 and was completed at 16:15.

23. The Adviser accepted the Board's explanation of why Mr C's appointment was scheduled at the end of that day's appointments and could not be changed on the day, however, she said it was unacceptable for him to have to wait in the reception area for several hours. The Adviser also said that the Charge Nurse's statement demonstrated reflection on practice and that lessons have been learned. However, the Adviser was of the view that the Board should be reminded that, even in a very busy unit, an individual patient's needs must be met as stated in the Nursing and Midwifery Council Code: Standards of conduct, performance and ethics for nurses and midwives (the NMC Code). Overall, the Adviser said that staff failed to recognise how poorly Mr C was,

given his age and illness, and he was left sitting in a busy waiting room in pain and discomfort.

(b) Conclusion

24. The Board explained that nursing staff were not allocated to the waiting area at the Endoscopy Unit reception and so no staff would have been present there, unless passing through. Mrs C said she and Mr C did not see the Charge Nurse until 15:30. The Charge Nurse said she saw Mr and Mrs C at 14:00. There is no written record of the exact time Mr C was taken through to the Endoscopy Unit for his procedure, which I would have expected to see in nursing notes or possibly in the patient care pathway. Therefore, there is no record of what time admission for the procedure took place. The time of Mr C's admission for his procedure should have been recorded.

25. Mrs C said that no one advised her about other treatment rooms and patients being taken before Mr C. The Charge Nurse said she did this at the end of the Endoscopy Unit admission process. I consider it would have been helpful for Mrs C to have been advised of this when she and Mr C arrived at the reception desk, to have managed their expectations at an earlier time. There is no record that Mr and Mrs C were advised as the Board claim. This should have been recorded.

26. Mrs C said that no one spoke to her about Mr C's morphine pump in the waiting area and, therefore, nursing staff did not notice it until he was taken for his procedure. The Charge Nurse said she asked what medication Mr C was on and she was told he was on a morphine pump. There is a record of the morphine pump in the Patient Care Pathway, but there is no record of what time this was noted. The Board's response is clear, that the Charge Nurse should have ensured that Mr C's morphine pump was functioning. The time Mr C's morphine pump was noted should have been recorded.

27. Mrs C said that no-one approached her to assist Mr C until it was time for his procedure. The Charge Nurse said she was passing through at 14:00 and saw Mr C being moved on to bench seats and about to lie down, at which point she went to ensure the room for admission was empty and took him through for admission. As noted above, there is no record of what time this took place. The time of Mr C's admission for his procedure should have been recorded.

28. Mr C's mouth was dry, but he was fasting in advance of his procedure, and so Mrs C asked whether she could wet his lips. The Receptionist said she could not recall this event. A record of this request should have been made and dealt with by nursing staff.

29. The Board have identified a number of failings and apologised to Mrs C for them, in particular that nursing and reception staff did not recognise the implications of the lengthy wait, given Mr C's condition. The Adviser also made this point, saying it was unacceptable for Mr C to have waited in the reception area, in pain and discomfort, for several hours, referring to the NMC Code. While I note the action taken by the Board in issuing the Guidance and Action Plan, I am of the view that the care provided to Mr C on 22 February 2010 was not reasonable and, therefore, I uphold this complaint.

(b) Recommendations

30. I recommend that the [authority]:	*Completion date*
(i) ensure that a record is made of the time a patient is admitted for their procedure and also of all advice given to patients on admission by nursing staff. This requirement should be incorporated into the new guidance;	13 April 2011
(ii) remind nursing staff of the importance of treating people as individuals, even in a very busy unit, as set out in the NMC Code; and	13 April 2011
(iii) provide him with evidence of audit and evaluation of the first six months' operation of the new guidance and action plan for dealing with vulnerable adults arriving for Endoscopy appointments.	12 October 2011

31. The Board and the Service have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board and the Service notify him when the recommendations have been implemented.

Ombudsman's comment

32. When patients are in need of care, they do not consciously approach individual agencies for the specific care that such agencies provide – they approach the NHS. How the NHS is structured is, rightly, not their concern. Mr C received very poor service, care and treatment from the NHS on

22 February 2010. From being collected too early by the Service patient transport, enduring a long, painful and uncomfortable wait for his procedure at the Hospital, and being returned to the Hospice by inappropriate transport, I consider there was a catastrophic failure of the continuum of care that Mr C expected to receive. I believe that both agencies in this report still have lessons to learn about communicating within and between NHS organisations and treating all patients with the dignity and respect they deserve, especially terminally ill patients like Mr C.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	The complainant's husband
The Service	Scottish Ambulance Service
The Hospital	Crosshouse Hospital, Kilmarnock
The Board	Ayrshire and Arran NHS Board
The Charge Nurse	The Endoscopy Unit Charge Nurse, who admitted Mr C
The Receptionist	The Endoscopy Unit receptionist
The Adviser	A nursing adviser to the Ombudsman
The Hospice	St Vincent's Hospice, Howwood, Renfrewshire
The Guidance	Guidance on the Care of Out-patient Vulnerable Adults arriving at the Endoscopy Unit
The Action Plan	Action Plan for Patients Pathway Evaluation of comfort and identification of vulnerable adults
The NMC Code	Nursing and Midwifery Council Code: Standards of conduct, performance and ethics for nurses and midwives

Annex 2

Glossary of terms

Analgesia	The absence of the sense of pain while remaining conscious, achieved by pain relieving drugs
Endoscopy	Using an instrument to examine the interior of a hollow organ or cavity of the body
Oesophagus	A muscular tube through which food passes from the top of the throat to the stomach

Annex 3

List of legislation and policies considered

Crosshouse Hospital Guidance on the Care of Out-patient Vulnerable Adults arriving at the Endoscopy Unit

Crosshouse Hospital Endoscopy Unit Action Plan for Patients Pathway Evaluation of comfort and identification of vulnerable adults

Nursing and Midwifery Council Code: Standards of conduct, performance and ethics for nurses and midwives