Scottish Parliament Region: Glasgow

Case 201002641: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Care of the elderly

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment provided to her aunt (Miss A) including failures in communication. Mrs C was also concerned about the way NHS Greater Glasgow and Clyde (the Board) dealt with her complaint.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the care and treatment provided to Miss A during her admission at Glasgow Royal Infirmary in January 2010 was not reasonable (*upheld*);

(b) the Board's communication with Miss A's family was not reasonable (*upheld*); and

(c) the Board did not deal reasonably with Mrs C's complaints (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) review their procedures to ensure they deal with complaints in accordance with the NHS complaints procedure; and	20 July 2011
(ii) apologise to Mrs C for the failures identified in this report.	20 July 2011

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

Main Investigation Report

Introduction

1. Miss A was admitted to Glasgow Royal Infirmary (Hospital 1) on 10 January 2010 with a urinary tract infection and confusion and discharged on 21 January 2010. Prior to being admitted to Hospital 1, Miss A lived alone with carer visits four times a day. During Miss A's admission, she was diagnosed with and treated for pneumonia. She also developed pressure ulcers. Greater Glasgow and Clyde NHS Board (the Board) had discontinued afternoon visiting on Ward 29 during this period because the lift had broken down and the Board wanted to reduce the amount of traffic in Hospital 1. As Miss A's family were unable to visit in the afternoons and evening visiting occurred at the same time as staff handovers, communication with healthcare professionals about Miss A's care and treatment was difficult. Several days before her discharge, Miss A was transferred to another ward (Ward 3). The family requested that she be provided with an immersion bath before her discharge but this was refused. When Miss A was discharged home on 21 January 2010, she was readmitted later that day by her GP to Stobhill Hospital (Hospital 2) where she died on 9 February 2010 of ischaemia and sepsis.

2. Mrs C said there were failures by the Board in the care and treatment they provided to Miss A, including failures in the way they treated her pressure ulcers and in their communication with Mrs C. Mrs C was also concerned about the way the Board handled her complaint. As a result of these failures, Mrs C said she had been extremely distressed and she had made her complaint to ensure that these failures were acknowledged and addressed.

3. Mrs C complained to the Board on 15 February 2010. The Board responded on 16 April 2010 and Mrs C met the Board to discuss her complaint on 22 June 2010. Mrs C remained unhappy and brought her complaint to my office on 2 October 2010.

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

(a) the care and treatment provided to Miss A during her admission at Hospital 1 in January 2010 was not reasonable;
(b) the Board's communication with Miss A's family was not reasonable; and
(c) the Board did not deal reasonably with Mrs C's complaints.

Investigation

5. My complaints reviewer examined Miss A's clinical records and a copy of the Board's complaint file. She also sought medical advice from a professional nursing adviser (the Adviser) on the clinical aspects of the complaint. Finally, she considered the NHS Complaints Procedure.

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

Board's response to Mrs C's complaint

7. In relation to pressure ulcers, the Board said that when Miss A was admitted, she was assessed as having a moderate risk of developing pressure ulcers. Because Miss A was able to manoeuvre herself in bed, it was deemed unnecessary to provide a special pressure relieving mattress. However, the 'regular' mattresses were a pressure relieving type. During Miss A's admission, she became reluctant to lie on her side and her left heel became discoloured within a matter of hours. This was superficial damage and not dead skin. Special air cushioned boots were utilised to protect both heels from this point. She also developed a superficial sore on her sacrum as a result of being incontinent for a short period. This was monitored during routine pressure area care. The Board said Miss A had developed a right leg embolism which was not linked to the pressure ulcer on her left heel.

8. The Board told Mrs C that afternoon visiting in Ward 29 had been restricted temporarily whilst lift renewal programmes were undertaken. Problems had been encountered with patient movement at peak activity times and visitors were requested not to visit in the afternoon. The Board apologised if this had not been communicated effectively to Mrs C and for any inconvenience caused. The Board reassured Mrs C that ward staff were sensitive to the needs of individuals and would accommodate relatives who identified difficulties with evening visiting hours.

9. The Board apologised that Mrs C felt nursing staff were unapproachable at visiting times. The Board said staff should make every effort to ensure relatives are seen and any problems addressed during visiting times. The Board apologised to Mrs C for the lack of information and courtesy Mrs C may have received and that this had been highlighted to staff to reflect on how they are perceived by visitors and relatives to the ward. The lead nurse was currently

reviewing visiting arrangements in all wards in order to improve accessibility for relatives while ensuring all clinical care needs were addressed. They were also promoting a system where staff proactively provided information for patients' next of kin.

10. Turning to Mrs C's concerns about bathing, the Board said Miss A was fully bed bathed each day. The moving and handling nurse specialist had advised the available area was unsuitable to provide a traditional bath to Miss A. Showering was discussed with Miss A but she declined this on two occasions.

11. In relation to arrangements about discharging Miss A, the Board said that Mrs C was contacted on 15 January 2010 about the expected date of discharge (which was 21 January 2010). The home care team were informed of this and the Board apologised that this had not been communicated to Mrs C. Furthermore, the discharge nurse had spoken to Miss A, her neighbour, and the ambulance crew about her discharge. The discharge nurse had also contacted Mrs C to tell her about some of the details relating to discharge.

12. On 22 June 2010, Mrs C met representatives of the Board, including the consultant physician (the Consultant) responsible for the care and treatment provided to Miss A during her admission, to discuss Mrs C's complaint. The Consultant said Miss A had pneumonia and sepsis when she was admitted and had received the appropriate treatment of fluids and antibiotics. Her discharge plan was in place when she was transferred to Ward 3 on 19 January 2010. The Board said that Miss A had been reviewed by experienced nursing staff on the morning of her discharge and if they had been aware of anything untoward or concerning, they would have highlighted this to medical staff and Miss A would not have been discharged. The Consultant said that when Miss A was admitted to Hospital 2, she had a fast and irregular heartbeat and something clearly had changed in a very short space of time. From the clinical information available, this could not have been predicted that morning. The Consultant said there was nothing to suggest, on the days leading up to her discharge, that anything had changed and he would not have discharged her if he had felt she was at risk. In response to Mrs C's complaint about the failures in communications regarding Miss A's condition, the Consultant apologised for this, saying it was disappointing and it would be taken back to staff as a learning point.

13. The Board said there was no evidence in Miss A's medical notes that they had not been available to staff in Ward 3. In response to Mrs C's complaint that the family had asked on a number of occasions for Miss A to be bathed, no one had said this was not possible due to health and safety. The Board apologised for not explaining the reasons more clearly. The Board also accepted it had been difficult for relatives to seek information at visiting times when there was a change of staff and said procedures were being put in place to address this.

14. On 24 November 2010, the Board wrote to Mrs C apologising for the significant delay in concluding the final part of the complaints process. The Board enclosed an updated file note of the meeting of 22 June 2010 to include Mrs C's comments. The Board explained there had been a delay because they had decided to seek an independent review of Miss A's case notes by the tissue viability nurse specialist. The tissue viability nurse raised concerns about the documentation about Miss A's pressure ulcers. She therefore found it difficult to ascertain actual pressure ulcer damage from Miss A's medical records and there was a lack of documented evidence that care was achieved in managing her pressure ulcers.

15. The Board apologised unreservedly for the failings by staff in this regard and for the stress this had caused. They attached an action plan to show how these failures were being addressed. Finally, the Board offered a meeting with the head of nursing for emergency care medicine to discuss Mrs C's complaint.

16. The action plan identified problems relating to the poor quality of written records, deficient supplementary documentation, the lack of referral to the tissue viability service and the lack of a pressure relieving mattress. The action plan outlined what the Board intended to do to address these problems, which included training and educating staff and carrying out audits to ensure that learning had been disseminated and the correct procedures were being followed.

17. My complaints reviewer made enquiries with the Board about Mrs C's complaint. In response the Board provided further details, expanding on the information they had provided to Mrs C about how they were addressing the failures in communication, record-keeping and treatment raised by Mrs C's complaint. These included further details on: the system the Board were promoting, to ensure staff proactively provided information for patients' next of kin; and the governance arrangements for the action plan, to ensure compliance

by staff and that learning was disseminated. Referring to their handling of Mrs C's complaint, the Board acknowledged that there were 'lengthy process delays' with the management of the complaint. They went on to say that in their final response to Mrs C's complaint, the notes had been amended to incorporate Mrs C's comments and they provided comments from the tissue viability nurse.

(a) The care and treatment provided to Miss A during her admission at Hospital 1 in January 2010 was not reasonable

18. Mrs C complained about failures by the Board to provide reasonable care and treatment, saying that a risk assessment which led to Miss A being allocated a regular mattress was not reasonably carried out and she developed pressure ulcers. Furthermore, Mrs C was unhappy about the Board's decision to move Miss A to another ward prior to discharge and that her medical records were not moved with her. Finally, Mrs C said the Board's decision to discharge Miss A was inappropriate, given her condition at the time of discharge.

Advice received

19. My complaints reviewer asked the Adviser to consider the management of the pressure ulcers by the Board and assess Miss A's condition at the time of her discharge. She also asked the Adviser to assess the adequacy of the action plan drawn up by the Board to address the failures they had acknowledged.

20. The Adviser said she was very critical of the care and treatment of Miss A's pressure ulcer and agreed with the findings of the review by the tissue viability nurse. The tissue viability nurse found that Miss A 'should have had a full risk assessment within six hours of admission' and that 'documentation in general was poor and inaccurate'. Finally, the tissue viability nurse found no evidence that staff had managed the pressure ulcers.

21. In relation to Mrs C's concerns about moving Miss A to another ward several days before discharge, the Adviser said that whilst it was not ideal to move patients, it was often required to manage the bed situation in hospital and was, therefore, a reasonable action. The Adviser went on to say that there was no evidence in Miss A's medical records to suggest the notes were missing. More importantly, there was no evidence of a lack of continuity of care between the two wards.

22. Turning now to Mrs C's complaint about the discharge arrangements and the condition of Miss A when she was discharged, the Adviser said the preparation for discharge was well documented. The plan for discharge included the use of a checklist with appropriate referral to social work and full package of care. It was documented that Mrs C had been contacted about Miss A's discharge and that the discharge liaison sister had been involved in the planning for discharge including liaising between Hospital 1, the ambulance service and social work. The Adviser concluded that the arrangements for discharge were reasonable. On Miss A's condition on discharge, the Adviser said there was very little evidence in the medical notes to indicate that Miss A had deteriorated prior to discharge. Her pneumonia had been treated appropriately with antibiotics. However, it was the Adviser's view that this group of patients often do not tolerate transitional arrangements such as discharge and it may have been that the wait in the discharge lounge, followed by a lengthy ambulance journey and then transfer into the house, may have exhausted Miss A and resulted in deterioration at that time.

23. In summary, the Adviser was particularly critical of the pressure ulcer area care. However, she concluded that the steps the Board took, as set out in their action plan, to address the failures were reasonable.

(a) Conclusion

24. Mrs C complained about the development of pressure ulcers during Miss A's admission and the care and treatment provided to Miss A to address this. I have decided that there were significant failings by the Board in this aspect of Mrs C's complaint. In reaching my decision, I have taken into account the review by the tissue viability nurse, which was very critical of the care and treatment of Miss A's pressure ulcer. This is supported by the advice that I have accepted. I am satisfied that the Board have taken appropriate and reasonable steps to address these failings and I have no recommendations to make.

25. Mrs C also complained that the Board's decision to move Miss A to another ward a few days prior to discharge was inappropriate, as was their decision to discharge her. The advice that I have accepted is that there was no evidence to suggest that moving Miss A to another ward, or the issue of her medical records, had resulted in a lack of continuity of care. I have also concluded that the Board's decision to discharge Miss A was reasonable. I have taken into account the seriousness of her condition when she was

admitted to Hospital 2. However, there was no evidence in the medical notes showing that Miss A had deteriorated prior to discharge and that discharge should have been delayed. The Adviser said it was possible that Miss A may have deteriorated as a result of the transitional arrangements. Even so, that can only be said with the benefit of hindsight and I must judge the reasonableness of the Board's actions on the basis of the evidence available to them at the time.

26. In view of the poor care and treatment in relation to pressure ulcers, I uphold Mrs C's complaint.

(b) The Board's communication with Miss A's family was not reasonable

27. Mrs C complained about failures by the Board in communication, saying that the Board's decision to discourage afternoon visiting at Ward 29 and the timing of shift changeovers prevented Mrs C and the family from receiving meaningful communication about her condition. This meant that Mrs C was not told that Miss A had developed pneumonia. Furthermore, Mrs C complained that the family's request that Miss A be bathed was refused unreasonably.

Advice received

28. My complaints reviewer asked the Adviser to consider whether the communication by the Board was reasonable and whether the action plan drawn up by the Board to address the failures they had acknowledged was adequate.

29. The Adviser said that the nursing handover is an important period for staff to share important information about patients and ensure that information is passed on to ensure continuity of care. However, a balance must be made between staff communication and the needs of patients and relatives. Staff have a responsibility to ensure patients and relatives are fully updated on treatment plans and this should be done in a proactive manner. Furthermore, the Adviser said there was no evidence in the medical notes that the family were spoken to about the diagnosis or treatment for pneumonia. The entries in the notes focused on the discharge date and the arrangements to be made. However, the Adviser concluded that the Board's action plan, which was drawn up to address these failures, was reasonable.

30. Referring to Mrs C's complaint about the Board's failure to provide an immersion bath to Miss A, the Adviser said that the Board's response, which

focused on health and safety issues, was reasonable. The Adviser said the use of an immersion bath is much less common due to requirements for cleaning between patients. Newer accommodation tended to have shower facilities, due to restrictions for space to allow for hoist and other devices which may be required.

31. In summary, the Adviser said the overall communication by the Board was poor and did not provide assurance that the nursing care was meeting the individualised care needs of Miss A, who was elderly and frail. Good communication, including keeping the patient and their carers fully informed and up-to-date about the patient's condition and treatment provided, was good practice. However, she concluded that the steps the Board took, as set out in their action plan, to address the failures were reasonable.

(b) Conclusion

32. Mrs C complained about failures by the Board in communicating with her. The advice I have accepted is that the Board's explanations about why they did not bathe Miss A was reasonable, but that overall communication fell below a standard which was reasonable. I am particularly critical of this, given that Miss A was noted to be confused on her admission, and the impetus was on staff to keep Mrs C fully informed about her condition and treatment provided. Effective communication with patients' families is not only good practice, but an integral part in providing an acceptable standard of care to patients.

33. In view of the above, I uphold the complaint. I am satisfied that the Board has taken reasonable steps to address the failures of communication in this aspect of Mrs C's complaint and I have no recommendations to make.

(c) The Board did not deal reasonably with Mrs C's complaints

34. Mrs C complained that the Board's response to her complaints was delayed and they took an unreasonable amount of time to provide Mrs C with the minutes of the meeting of 22 June 2010. Furthermore, Mrs C said the meeting note did not reflect accurately the content of the meeting because it did not refer to the acrimonious nature of the meeting or the discussion of the assessment which Mrs C felt was not reasonably undertaken. Finally, Mrs C said the Board did not respond to her email of 27 August 2010 or provide the tissue viability opinion they had advised they would in their email of 20 August 2010.

NHS Complaints Procedure

35. Section 57 and 58 of the NHS Complaints Procedure states:

> 'It is important that a timely and effective response is provided in order to resolve the complaint, and to avoid escalation. An investigation of the complaint should therefore be completed, wherever possible, within 20 working days following the date of receipt of the complaint. Where it appears the 20 day target will not be met, the person making the complaint ... must be informed of the reason for the delay with an indication of when a response can be expected. The investigation should not, normally, be extended by more than a further 20 working days.
>
> While it may be necessary to ask the person making the complaint to agree to the investigation being extended beyond 40 working days ... they should be given a full explanation in writing of the progress of the investigation, the reason for the requested further extension, and an indication of when a final response can be expected. The letter should also indicate that the Ombudsman may be able to review the case at this stage if they do not accept the reasons for the requested extension.'

36. The complaint file showed that the Board acknowledged Mrs C's complaint on 16 February 2010. On 26 March 2010, the Board wrote to Mrs C saying that they were continuing their investigation into Mrs C's complaint and apologised for the delay. The Board responded to Mrs C's complaint on 16 April 2010. Mrs C was dissatisfied with the response because it did not address fundamental concerns she had raised with them about Miss A's condition on discharge, and other discharge arrangements, and Mrs C contacted the Board on 14 May 2010 to arrange a meeting with them. This meeting was held on 22 June 2010 and a note of the meeting was drafted. The Board also made arrangements at this time for a tissue viability nurse to review the care and treatment provided to Miss A in relation to her pressure ulcers.

37. The complaint file showed that staff from the Board's complaints office had pursued a report from the tissue viability nurse through July and August. During this period, Mrs C emailed the Board on 17 August 2010 to complain that she had not yet received a copy of the note of the meeting and that Board staff present at the meeting had already had an opportunity to amend the note. The Board responded that day to apologise for the delay and said they hoped to be in a position to send Mrs C the note within a few days and any amendments Mrs C had could be incorporated. On 20 August 2010, the Board sent Mrs C a

copy of the note and told Mrs C that they were seeking an opinion from the tissue viability nurse about Mrs C's concerns regarding Miss A's pressure ulcers. Mrs C provided comments to the Board about the note of the meeting on 27 August 2010 and asked them if the complaints procedure had now been exhausted, as she wanted to consider sending her complaint to my office. On 3 September 2010, the tissue viability nurse wrote to the complaints officer about her review of Miss A's pressure ulcers.

38. Mrs C emailed the Board on 13 September 2010 seeking a response to her email of 27 August 2010. The Board responded that day and apologised for the delay saying that a final response, including comments from the tissue viability nurse, should be with Mrs C by the end of the week. On 24 September, Mrs C emailed the Board again and the Board told Mrs C on 29 September 2010 that there had been significant delays in responding, for which they apologised unreservedly, but they had not intended to block progress and would endeavour to reply to Mrs C as soon as possible. By 11 October, an action plan had been drafted by the tissue viability nurse to address the failures identified by Mrs C's complaint. On 24 November 2010, the Board wrote to Mrs C with their final response to Mrs C's complaint that included an amended file note which incorporated Mrs C's comments and the results of the review by the tissue viability nurse.

(c) Conclusion

39. There are three aspects to Mrs C's complaint about the Board's complaint handling. They failed to respond in good time and produce an accurate note of the meeting or a copy of the tissue viability opinion. Turning first to whether the Board had responded in good time, the Board acknowledged that there had been delays, including delays in sending Mrs C a note of the meeting, and apologised for this. However, there were further shortcomings in the way the Board dealt with Mrs C's complaint.

40. When the Board's investigation exceeded 40 working days (mid-April 2010), Mrs C received their final response and agreed to meet them to discuss her complaint further. Following this meeting, though, they failed to make Mrs C aware of her right to approach my office when she raised her concerns about the length of time the Board were taking to deal with her complaint. This is of concern, particularly in view of Mrs C's emails from 27 August 2010 onwards asking if the complaints procedure had now been exhausted as Mrs C wanted to consider referring her complaint to my office. It

is also of concern that the Board did not respond to Mrs C's email of 27 August 2010 until Mrs C sent them a reminder on 13 September 2010, given its content.

41. Turning now to Mrs C's complaint that the Board failed to produce an accurate note of the meeting and the review from the tissue viability nurse, I note that these have now been produced and that the note has been amended to incorporate Mrs C's comments. The Board had taken appropriate steps to address Mrs C's complaint by meeting with Mrs C and requesting the review by tissue viability nurse. However, I am critical of the length of time it took to produce these documents. The Board have apologised for the delay, but did not explain clearly why there had been a delay. For example, it is not clear why the Board did not send Mrs C a copy of the review and action plan until 24 November 2010 when these had been drafted by 3 September and 11 October 2010 respectively.

42. In view of all the above, I uphold Mrs C's complaint that the Board did not deal reasonably with Mrs C's complaint in that there were delays and they failed to inform Mrs C of her right to approach my office.

(c) Recommendation

43. I recommend that the Board:	*Completion date*
(i) review their procedures to ensure they deal with complaints in accordance with the NHS complaints procedure.	20 July 2011

General recommendation

44. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for the failures identified in this report.	20 July 2011

45. 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

Miss A	Mrs C's aunt
Hospital 1	Glasgow Royal Infirmary
The Board	Greater Glasgow and Clyde NHS Board
Hospital 2	Stobhill Hospital
Mrs C	The complainant
The Adviser	One of the Ombudsman's professional advisers
The Consultant	A consultant physician at Greater Glasgow and Clyde NHS Board

Annex 2

Glossary of terms

Embolism	An obstruction in a blood vessel
Ischaemia	Insufficient blood supply
Pneumonia	A respiratory infection
Pressure ulcer	A area of tissue damage connected to issues of nutrition, mobility, continence, pain and infection control
Sacral	The sacrum is a large triangular bone at the base of the lower spine
Sepsis	A life-threatening illness caused by the body overreacting to an infection
Tissue viability	The maintenance of skin integrity and the management of patients with acute and chronic wounds, prevention and management of pressure damage