Scottish Parliament Region: Glasgow

Case 201102521: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; care of the elderly; nursing care

Overview

The complainant (Mrs C) raised a number of concerns against Greater Glasgow and Clyde NHS Board (the Board) that her late father (Mr A) had been inappropriately cared for by nursing staff in Dunrod F Ravenscraig Hospital (the Hospital) from 2 February 2011 up to his death on 24 April 2011.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) nursing staff unreasonably failed to monitor and maintain Mr A's fluid levels (*not upheld*);

(b) nursing staff unreasonably failed to deal with incontinence issues (*not upheld*);

(c) nursing staff unreasonably failed to maintain a reasonable level of hygiene for Mr A (*upheld*);

(d) there were inadequate transfer systems and documentation in place (*upheld*);

(e) there was poor communication from staff (*not upheld*);

(f) nursing staff unreasonably failed to pass on information to the relevant Social Work team when Mr A was transferred and this delayed the process of establishing a suitable nursing home for him to go to (*not upheld*);

(g) inadequate attention was paid to Mr A's dignity by ensuring that his clothing was appropriately attended to (*upheld*); and

(h) the investigation of Mrs C's complaint to the Board was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) ensure that measures are taken to feed back the learning from this to nursing staff to avoid similar	27 February 2013

	situations recurring;	
(ii)	provide him with an update on the actions they have taken to ensure such an incident does not recur;	27 February 2013
(iii)	ensure that communication between family members and staff are appropriately recorded;	27 February 2013
(iv)	ensure that measures are taken to feed back the learning from this to complaints investigation staff to avoid similar situations recurring; and	27 February 2013
(v)	apologise to Mrs C for the failures identified in this report.	16 January 2013

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

Main Investigation Report

Introduction

1. The complainant Mrs C told us that her late father (Mr A) had fallen at home and was admitted to Inverclyde Hospital on Ward 'G' North on 19 December 2010. Thereafter, Mr A was transferred to Ward 3 Larkfield Unit before being transferred to Dunrod F Ravenscraig Hospital (the Hospital) on 2 February 2011. Due to dementia and other domestic factors, it was decided that Mr A was a candidate for a nursing home.

2. Mrs C stated that Mr A was badly let down by the hospital systems and the poor standard of nursing care that was delivered. She stated that while the Hospital had a duty of care to ensure that Mr A was being well looked after, his general condition had rapidly declined and he died suddenly, aged 82, on 24 April 2011.

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

(a) nursing staff unreasonably failed to monitor and maintain Mr A's fluid levels;
(b) nursing staff unreasonably failed to deal with incontinence issues;
(c) nursing staff unreasonably failed to maintain a reasonable level of hygiene for Mr A;
(d) there were inadequate transfer systems and documentation in place;
(e) there was poor communication from staff;
(f) nursing staff unreasonably failed to pass on information to the relevant Social Work team when Mr A was transferred and this delayed the process of establishing a suitable nursing home for him to go to;
(g) inadequate attention was paid to Mr A's dignity by ensuring that his clothing was appropriately attended to; and
(h) the investigation of Mrs C's complaint to the Board was inadequate.

Investigation

4. As part of my investigation, my complaints reviewer obtained copies of Mr A's clinical records and the complaints correspondence from Greater Glasgow and Clyde NHS Board (the Board). Advice was sought from one of my independent nursing advisers (the Adviser). My complaints reviewer also met and discussed this complaint with the Adviser. Relevant policies were reviewed, for example, NHS Greater Glasgow and Clyde Patient Escort Policy.

5. 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.

(a) Nursing staff unreasonably failed to monitor and maintain Mr A's fluid levels

6. In her letter of complaint to the Board, dated 30 July 2011, Mrs C stated that Mr A had a urinary catheter fitted, due to prostrate problems. She stated that this led to frequent urinary tract infections, however, she had seen from an account of a doctor's statement she had reviewed that they did not carry out fluid balance monitoring. Given this, Mrs C queried how the Hospital could ensure a patient was receiving adequate fluids. She stated that Mr A had experienced more urinary tract infections while a patient in the Hospital than he ever did at home. She said this could only be attributed to the lack of oral fluids being offered.

7. In the Board's response to Mrs C's complaint dated 30 August 2011, they stated no evidence was found to support Mrs C's concerns about this issue.

8. In the Board's response to our enquiry, the Head of Administration stated that the local Mental Health Services in Inverclyde (the MH Services) had provided comments on the 13 points Mrs C had raised in her complaint.

9. MH Services stated that Mr A was not on a fluid balance chart, as there were no concerns about his fluid intake or output which required this. There were also no laboratory results which indicated that Mr A was clinically dehydrated.

10. The Adviser stated that she has seen evidence in the records that Mr A was encouraged to eat and drink. The Malnutrition Universal Screening Tool (MUST) assessment was completed on 20 December 2010 and regularly thereafter. The assessment noted that the risk of malnutrition was low (score 0). The nursing notes contained entries most days about diet and fluids taken.

11. The Adviser said fluid balance charts are notoriously difficult to ensure accuracy and suggested they were probably not appropriate to use in Mr A's case, as his fluid output would have been difficult to measure.

12. The Adviser considered that repeated urinary tract infections cannot be associated solely with lack of fluids, but can be caused by hospital associated infections and, for example, by Mr A's handling of the catheter when, as she had noted, there were periods when he was confused and pulled it out.

(a) Conclusion

13. Mrs C complained that Mr A's fluid levels were inadequately maintained and monitored. Within my investigation, there is no evidence I have seen to support this view. For the reasons outlined above, I do not uphold this complaint.

(b) Nursing staff unreasonably failed to deal with incontinence issues

14. Mrs C complained that on one occasion when she visited the Hospital, Mr A was sitting in a chair and exposed a large incontinence pad. In Mrs C's opinion, this type of pad was inappropriate as Mr A only required a slip pad and incontinence pants.

15. Mrs C also said that there was an occasion when she told staff that Mr A had been incontinent with faeces and required assistance. Mrs C stated that after having waited 15 minutes for assistance she attended to Mr A herself.

16. Mrs C also stated that when she reviewed the post mortem report it stated that the catheter was in situ and she felt this should have been removed.

17. MH Services stated that Mr A had several instances of faecal incontinence and this was managed by use of 'Attends' pads. They said that in the Hospital, nursing staff used this type of incontinence garment for patients who required assistance for continence care and personal hygiene. They added that these pads were specifically designed to ensure the dignity of patients, as far as possible.

18. MH Services stated that as Mrs C had not provided details of the alleged delay in attending to Mr A's needs such as dates / names of staff they were unable to investigate this aspect of her complaint (see paragraph 14).

19. MH Services stated that the nurse attending to Mr A did not remove the catheter as her understanding was that equipment (for example catheters, infusion pumps) was required to be left in situ in all instances of sudden death

where a post mortem is requested. MH Services stated 'This was an intended act and not an omission or neglect of [Mr A's] dignity'.

20. The Adviser stated that the decision to use large incontinence pads should not be taken lightly, however, the decision taken by staff appeared reasonable. She also stated that staff would try to weigh up the indignity caused by faecal incontinence and the wearing of pads.

21. The Adviser said that waiting for a member of staff to provide assistance for personal hygiene needs should be provided as a matter of urgency and any wait was not acceptable. The Adviser acknowledged that this must have been distressing for Mrs C; however, she stated that a wait of 15 minutes is not wholly unreasonable in a busy ward area.

22. The Adviser stated that the Board have followed instructions by leaving the catheter in situ, as this was in line with their policy in the event of a sudden death and the involvement of the Procurator Fiscal.

(b) Conclusion

23. I have carefully considered all aspects of this complaint and taken account of the advice I have received. I have seen no evidence that nursing staff failed to address incontinence issues to a satisfactory standard. I have also not seen evidence to support Mrs C's view that by leaving the catheter in situ, the Hospital had failed to follow appropriate procedures by not removing it. For these reasons, I do not uphold this complaint.

(c) Nursing staff unreasonably failed to maintain a reasonable level of hygiene for Mr A

24. Mrs C complained that it appeared Mr A's bath night was a Monday; however, there was no additional bathing during his periods of faecal incontinence. She also stated that she often had to clean Mr A's teeth and dentures during her visits and raised concerns about the effects of poor oral hygiene. Mrs C also complained that Mr A had contracted an infection in his right eye socket (the eye was removed 11 years previously).

25. MH Services stated that there was documentary evidence that Mr A's personal hygiene needs were assessed and a care plan instituted. Furthermore, within a chronological record of care there are numerous entries that describe attendance to Mr A's personal hygiene needs which included care

(daily cleaning) of his eye socket. I noted MH Services stated that Mr A had not worn his prosthetic eye for several months and the family had explained this was due to his deteriorating ability to manage it.

26. MH Services stated that Mr A's oral hygiene needs were also assessed and a care plan instituted. They said that Mr A was examined by a dentist on 19 April 2011 and had outlined the report of the dentist's examinations and findings. The report identified that Mr A had 'sharp edges' to his lower teeth which were dressed with filling and had oral thrush which was treated with an oral suspension and mouthwash. MH Services stated the dentist had made no note or record of a dental abscess.

27. The Adviser stated that it was noted in the care plan that Mr A required assistance from one nurse for personal hygiene, however, there is no record of a weekly bath. She stated she would have expected that a patient with incontinence problems would be given assistance to have a shower as often as required. Also, there were problems with the urinary catheter being dislodged and episodes of urinary incontinence necessitated the need for frequent showers (see paragraph 12).

28. The Adviser added that the eye socket should have been cleaned regularly at the same time as bathing or washing occurred. She considered that the eye infection may have occurred for a number of reasons and was not necessarily due to a lack of hygiene.

29. The Adviser stated oral hygiene should have been carried out as part of Mr A's regular hygiene needs. However, from her reading of the notes, she said it would suggest that compliance from Mr A may have been an issue, due to his cognitive impairment. Therefore, Mrs C may have been well placed to provide mouth care due to her relationship with him - that is, he may have consented to her cleaning his mouth, however, refused the nursing staff to do so.

30. The Adviser criticised the lack of information recorded about the personal care given to Mr A. She stated that there was little documented about the frequency and type of personal care given to Mr A, as the notes focussed on Mr A's behaviour and mental health.

(c) Conclusion

31. Mrs C complained that aspects of Mr A's personal care (hygiene) were unreasonable. There is no evidence I have seen to support this view, with regard to his oral and eye care. However, I consider that one scheduled weekly bath was inadequate, given Mr A's personal needs. I am also critical that there is scant information recorded in the notes about the frequency and type of personal care given to Mr A. Taking these factors into account, I uphold this complaint.

(c) Recommendation

32. I recommend that the Board:	*Completion date*
(i) ensure that measures are taken to feed back the learning from this to nursing staff to avoid similar situations recurring.	27 February 2013

(d) There were inadequate transfer systems and documentation in place

33. Mrs C stated there was poor communications between wards on transfers and that each time Mr A was moved, no transport documentation accompanied him. For example, Mrs C stated that Mr A was put in a patient transport bus and arrived without an escort, with his belongings in a black plastic bag and no notes. Mrs C said that in her view, having no escort must be a serious breach of hospital protocol regarding the safety of patients and staff.

34. MH Services stated that it is normal practice to transfer patients from G North Medical Receiving Ward Inverclyde to Larkfield Medicine for the Elderly Unit Inverclyde for further assessment or rehabilitation.

35. They stated that a decision to transfer Mr A to the Hospital was agreed with Ward 3 Staff (Larkfield Unit) and they had arranged for Mr A's transfer by hospital transport. MH Services confirmed that Mr A was transferred by Scottish Ambulance Service patient transport, unaccompanied by a nurse. They added that Hospital nursing staff received written information as filed in Mr A's case notes.

36. MH Services stated that the 'Lead Nurse for Dunrod Unit contacted acting Lead Nurse for Ward 3 to raise concerns surrounding the transfer i.e. that [Mr A] was transferred unaccompanied by a Nurse'.

37. I have seen from one of the investigation interviews with a charge nurse she stated she was in Ward 3 the day Mr A tried to throw his zimmer through the window. The Charge Nurse said the Doctor came and assessed Mr A but did not mention Mr A would require to be escorted over to the Hospital.

38. I have seen from an interview with the Doctor she stated that 'Behaviour on Ward 3 difficult. Verbally and physically aggressive to staff. Smashed window with a zimmer. Problems with secondary dementia. Decision to transfer to [the Hospital].'

39. I have seen from the Board's letter dated 30 August 2011 that they had investigated this issue and acknowledged that the transfer of Mr A had not followed the Board's policy. They apologised to Mrs C and her family for any distress this had caused and stated 'I will ensure that the matter is raised with Ward Staff so that this is not repeated for others'.

40. The Adviser noted a discharge letter / transfer plan completed by a staff nurse on 2 February 2011, which she said contained relevant information, although not a great deal of details. The Adviser stated the Board have admitted that Mr A should not have been transferred without a nurse and that this was not following their own procedures. There was no evidence to clarify why this decision was taken, however, the Adviser stated it was unacceptable to transfer Mr A alone. This was not only compromising Mr A's safety, but also the safety of other patients due to Mr A's erratic and sometimes volatile behaviour. The Adviser concluded that there was no doubt Mr A should have been transferred by a member of staff who knew him and who could also have provided a handover at the Hospital.

(d) Conclusion

41. Mrs C complained that staff failed to ensure Mr A was correctly transferred between Larkfield and the Hospital. While I have seen that a transfer plan contained relevant information, it is clear that Mr A should have been accompanied by a member of staff on his transfer. Not only were procedures not followed but, Mr A, who was known to staff as vulnerable, had his safety and the safety of others compromised. Taking all these factors into account, I uphold this complaint.

(d) Recommendation

42. I recommend that the Board:	*Completion date*
(i) provide the Ombudsman with an update on the actions they have taken to ensure such an incident does not recur.	27 February 2013

(e) There was poor communication from staff

43. Mrs C raised several issues of concern, which included her view that staff appeared unwilling or unable to answer her questions or advise her of x-ray results. She also stated that staff demonstrated poor clinical knowledge and lacked compassion and sympathy for her loss.

44. I noted that Mrs C's allegations centred on her interactions with nursing staff specifically about the results of a neck x-ray in March 2011 and during a telephone discussion with a staff nurse on the day Mr A died.

45. MH Services stated there were records of discussions between staff and Mrs C which related to the care and treatment Mr A received. For example, outcomes of a review were discussed with the family and decisions about medication were communicated to them. They said it was not specifically recorded whether the x-ray results were discussed and this aspect could not be confirmed or otherwise.

46. The Adviser stated she would have expected to have seen a communication or family dialogue sheet (or something similar) to record the key aspects of communication between staff and Mrs C, who she noted was also Mr A's welfare guardian. She said:

> 'There is very little communication recorded and therefore I am critical of this. The behaviours and deterioration of [Mr A] must have been very distressing for [Mr A]'s family and their needs should have been taken into account. The Nursing and Midwifery Code explicitly states that you must: 'work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community' and 'provide a high standard of practice and care at all times'.'

(e) Conclusion

47. Mrs C complained about nursing staff not answering questions, or giving the results of x-rays and lacking clinical knowledge and compassion. I have carefully considered all the evidence outlined above and taken account of the

advice I have received. I acknowledge that Mrs C was dissatisfied with the verbal exchanges she had with nursing staff, however, these are impossible to prove when differing accounts are presented. For these reasons, I do not uphold this complaint. However, I am critical that there is little communication recorded and make the following recommendation.

(c) Recommendation

48. I recommend that the Board:	*Completion date*
(i) ensure that communication between family members and staff is appropriately recorded.	27 February 2013

(f) Nursing staff unreasonably failed to pass on information to the relevant Social Work team when Mr A was transferred and this delayed the process of establishing a suitable nursing home for him to go to

49. Mrs C complained that during Mr A's move from G North Larkfield Unit to the Hospital, Social Services had terminated their involvement as his classification had moved from 'Frail Elderly' to 'Mental Health'. Mrs C stated that the hospital who was dealing with Social Workers had not ensured that Mr A's case was handed over correctly (see complaint (d)). She stated that after a meeting with the Doctor and ward staff they had reaffirmed that Mr A was too good to be in hospital and that a nursing home would be more appropriate. However, when Mrs C and family had enquired with social work they were told that Mr A did not have a named social worker and his case was not progressed.

50. In their response to our enquiry, MH Services stated that this issue related in the main to the time when Mr A was being cared for in the Larkfield Unit. However, records demonstrated that from admission to the Hospital on 2 February 2011, staff took steps to ensure that there was Social Work involvement to facilitate Mr A's transfer to a nursing home. They stated that, in addition, consideration was given to making a referral to the Older Persons Community Mental Health Team to support the transfer. MH Services stated that during this time in the Hospital, the nursing staff did everything they reasonably could to pass on information to the relevant social work and community teams to facilitate the process of establishing a suitable nursing home for Mr A.

51. I have seen from the Board's investigation the Doctor stated that initially a nursing home was not discounted for Mr A, however, the initial aim was for Mr A

to stabilise, and, therefore, Social Work was not necessary until this point. The Doctor said that eventually Social Work input was not actively pursued because of ongoing behaviour issues and decline in Mr A's mental state (see complaint (d)).

52. I have reviewed Mr A's case notes and seen an entry within a Mental Health Care Plan that on 9 February 2011 Social Work had been contacted and that on 26 February 2011 Hospital Staff were contacting a named Social Worker to establish who Mr A's new Social Worker was. I have also seen that the Hospital Staff had considered the Older Persons Community Mental Health Team regarding Social Work referrals on 1 March and 11 March 2011 and also contacted the Doctor on these dates about this. In Mr A's case notes on 31 March 2011, I have seen that the Doctor's review indicated that a nursing home was no longer an option (see also paragraph 51), so referral to the Older Persons Community Mental Health Team was to be deferred.

53. The Adviser noted from the case notes an entry on 27 March 2011 that 'staff will contact [the Doctor] and social work to discuss [Mr A]'.

(f) Conclusion

54. I have seen from the Doctor's statement and entries in Mr A's case notes that Mr A's situation was being regularly monitored and there was a communication pathway with Social Work. I have also seen matters that involved Social Work and Older Persons Community Mental Health Team were being regularly considered by staff and the Doctor. I have also seen that the Doctor made a professional decision that Mr A's condition had not stabilised. Given these facts, I do not consider that nursing staff unreasonably failed to pass on information to social work and this delayed the process of establishing a nursing home for Mr A. For these reasons, I do not uphold this complaint.

(g) Inadequate attention was paid to Mr A's dignity by ensuring that his clothing was appropriately attended to

55. Mrs C complained that on several occasions when arriving at visiting times, Mr A's jumpers were soiled from meal time accidents and drooling. She stated this highlighted the lack of dignity provided to Mr A by staff. She also stated her disappointment in that the hospital laundry service did not iron patients' clothing. Mrs C said that she paid a private laundry firm to collect and launder Mr A's clothes, however, sometimes other patients' items were included and sometimes Mr A's clothes were sent to the Hospital laundry by mistake.

56. MH Services stated they were unable to determine any instances recorded in their nursing notes where Mrs C had indicated to staff she was unhappy or dissatisfied with the condition of Mr A's clothes at any of the times she visited him.

57. The Adviser said that details about clothing would not be recorded, therefore, this related to the observations made by Mrs C. The Adviser said that soiling of clothes from foodstuffs was undignified and unacceptable in a care setting. The mistakes about other people's clothing beings sent to the laundry was also unacceptable; however, it was a regular occurrence in the NHS laundry system. I noted that the Board paid Mrs C compensation to meet some costs.

(g) Conclusions

58. Mrs C complained that Mr A's dignity was affected by soiled clothing and inappropriate management of his laundry items.

59. I accept the advice I have received that the detail of patients clothing is not recorded. There is also no record that Mrs C had indicated to staff she was dissatisfied with Mr A's clothes when she visited him. For these reasons, I am unable to reach a conclusion on this issue. However, given that the Board have reimbursed the family for lost clothing, I uphold this complaint, but have no recommendations to make.

(h) The investigation of Mrs C's complaint to the Board was inadequate

60. In her letter to the Board dated 30 July 2011, Mrs C complained about the nursing care and treatment Mr A had received from his arrival at the Hospital up to his death. She outlined 13 points of concern and stated how strongly she felt about the inadequate care Mr A had endured.

61. In the Board's response to Mrs C dated 30 August 2011, the Head of Mental Health, Addictions and Homelessness (the MH Head) stated she had set up an investigation team to review each of the issues Mrs C had raised. She said the investigation had examined case notes and interviewed medical, nursing and social work staff.

62. The MH Head acknowledged that Mr A had been transferred from Ward 3 Larkfield Unit to the Hospital without an escort, contrary to Health Board policy,

and had apologised to Mrs C and her family for any distress this had caused and stated, 'I will ensure that the matter is raised with Ward Staff so that this is not repeated for others'. The MH Head outlined their policy on the catheter remaining in situ until a full medical assessment was completed by a doctor to confirm cause of death. The remaining complaints were addressed collectively and, in this regard, the Head stated that no evidence was found to support Mrs C's concerns.

63. The MH Head reiterated her apologies that no escort accompanied Mr A on his move between wards and advised Mrs C that she could refer her complaints to us if she wished to do so.

64. In MH Service's response to our enquiry they stated that they considered their investigation of Mrs C's complaint was adequate. They included a statement from the MH Head in which she clarified her response to Mrs C dated 30 August 2011 (see paragraph 60). She stated that consideration had been given to the fact that only one of Mrs C's 13 complaints was being upheld and it was felt this may have been distressing for Mrs C. Given this, they believed that a more sensitive approach should be taken in their response. As a result, her letter had followed the format as outlined in paragraphs 61 and 62. The MH Head stated she had reflected on this and acknowledged her response letter had been brief, as it had not provided a full account against the 13 points of complaint. The MH Head also reflected she should have offered to meet with Mrs C to discuss the investigation and outcomes 'which I regret and again apologise for not doing so'.

65. The MH Head stated that on 6 September 2011 she received an email and letter from Mrs C about her dissatisfaction with the complaint response. She emailed Mrs C on 7 September 2011 to apologise and offered to meet with her and followed this up with a letter dated 8 September 2011.

66. In my review of the complaints correspondence I have seen that Mrs C's complaint was acknowledged separately by In Patient Service Manager Lead Nurse in Mental Health on 3 August 2011 and by Lead Nurse Old Age Psychiatry on 3 August 2011. I also noted that plans for the format the investigation would take commenced on 4 August 2011.

67. I have seen that the Head of Occupational Therapy Services (Mental Health) commenced interviewing and investigation work with nursing staff by

11 August 2011 and also that a meeting was being arranged to discuss the complaint and investigations at that time. I have seen the transcripts of interviews with two staff nurses, two charge nurses and the Doctor. I have reviewed the investigation plan which encompassed the 13 points of Mrs C's complaints and a further plan which outlined the outcome of the investigations. I have reviewed the MH Head's email dated 7 September 2011 to Mrs C and also in letter format dated 8 September 2011.

(h) Conclusion

68. Given the response we received from MH Services and the documents from the Board which included the statements taken from the nursing staff and Doctor 1 that were closely involved with Mr A's care, I am satisfied that the investigation of Mrs C's complaint was adequate. However, I am critical that in the Board's reply to Mrs C's complaint, the details and outcome of their investigations were not adequately conveyed to Mrs C. This represents a failure of the investigative complaints process if, as a result of that process, Mrs C was not provided with the results of the investigation which addressed all the specific issues she had raised. For this reason, I uphold this complaint.

(h) Recommendation

69. I recommend that the Board:	*Completion date*
(i) ensure that measures are taken to feed back the learning from this to complaints investigation staff to avoid similar situations recurring.	27 February 2013

General Recommendation

70. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for the failures identified in this report.	16 January 2013

71. 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

Mrs C	The complainant
Mr A	The late father of Mrs C
The Hospital	Dunrod F Ravenscraig Hospital
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	The Ombudsman's nursing adviser
The MH Services	Mental Health Services in Inverclyde
The MH Head	The Head of Mental Health, Addictions and Homelessness
The Doctor	Ward Consultant Psychiatrist, Old Age Psychiatry

Annex 2

Glossary of terms

Attends pads	A garment for continence care
Cognitive	Mental process such as perception, memory, judgement, etc
Inverclyde Hospital G Ward	The first ward and hospital Mr A was admitted to – this is a medical receiving ward
Prostrate	A gland in the male reproductive system
Ward 3 Larkfield Unit	The second ward in Inverclyde Hospital Mr A was transferred to
Urinary Catheter	A tube inserted into a patient's bladder

Annex 3

List of legislation and policies considered

NHS Greater Glasgow and Clyde Patient Escort Policy