Scottish Parliament Region: Glasgow

Case 201201570: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category

Health: Hospital – General Medical; clinical treatment; communication

Overview

The complainant (Mrs C) complained about the care and treatment provided to her husband (Mr C) following his admission to the Royal Alexandra Vale of Leven Hospital (the Hospital). Mr C was 90 years old and was admitted because he was suffering pains in his legs; prior to his hospital admission he was living independently with no other immediate health concerns. Mr C developed pneumonia in hospital and while being treated for this developed diarrhoea, kidney failure, a pressure ulcer and severe oral thrush. Mr C subsequently died. Mrs C felt the Hospital staff's lack of timely action had contributed to Mr C's death.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) staff did not diagnose the cause of pain in Mr C's legs (*not upheld*);
(b) staff did not reasonably respond to Mr C's dehydration (*upheld*);
(c) there was an unreasonable delay in carrying out an x-ray or scan following the diagnosis of a chest infection on 25 March 2012 (*not upheld*);
(d) staff did not reasonably respond to Mr C's complaints of pain in his back on 1 April 2012 (*not upheld*); and
(e) staff did not reasonably respond to the development of thrush in Mr C's mouth (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) remind staff at the Hospital of the need to communicate with patients and their relatives and carers to ensure they are kept fully informed about their care and treatment, and of the importance of	5 June 2013

	a proactive approach in this regard;	
(ii)	conduct an audit to ensure the timely assessment of all acute admissions by consultant medical staff;	21 August 2013
(iii)	review the implementation of the fluid balance chart policy, with an emphasis on the identification of the appropriate point for staff to escalate concerns to clinical staff;	21 August 2013
(iv)	ensure junior medical staff at the Hospital receive full training on the management of elderly and acutely ill patients with the aim of preventing kidney failure;	21 August 2013
(v)	conduct a significant incident review with regards to the period of care from 27 March to 3 April 2012;	18 June 2013
(vi)	issue a reminder to all medical staff at the Hospital to ensure that nursing staff are given timely notice of changes to patients' medication;	5 June 2013
(vii)	advise staff at the Hospital that, where possible, patients and their families and carers must be able to discuss care and treatment with a named point of contact within the medical team; and	18 June 2013
(viii)	give a formal apology to Mrs C for the shortcomings identified in this report and for the distress she has suffered.	5 June 2013

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

Main Investigation Report

Introduction

1. Mr C was admitted to the Vale of Leven Hospital (the Hospital) on 20 March 2012 complaining of pain in both his legs and worsening mobility. He was initially given painkillers and physiotherapy but on 25 March 2012 he developed pneumonia. On 29 March 2012 he developed diarrhoea and his renal function deteriorated.

2. Mr C's condition worsened over the ensuing days; he developed oral thrush and a pressure ulcer on his back. Mr C began to receive palliative care, and died on 15 April 2012.

3. Mr C's wife (Mrs C) complained to Greater Glasgow and Clyde NHS Board (the Board) on 4 May 2012. She said she believed that Mr C's death was caused by very slow action to the continuous illness he contracted at the Hospital. She said she deeply regretted taking Mr C to the Hospital.

4. The Board responded on 3 July 2012, outlining the care Mr C had received. Mrs C was not satisfied by the Board's response and brought her complaints to my office on 17 July 2012. She felt that Mr C's leg pain had never been properly diagnosed, asked why he was not given fluid earlier, why the pressure ulcer on Mr C's back was not detected earlier, and why the oral thrush had been allowed to develop to such a severe state. Mrs C said that since Mr C had died, she had suffered constant nightmares about all of the pain he had suffered. She said she felt the fact that Mr C saw a different consultant every week meant there was no continuity of care, and assumptions had been made that given Mr C's age, he was a sick and frail old man, despite the fact he had entered the Hospital relatively fit and well for his age.

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

(a) staff did not diagnose the cause of pain in Mr C's legs;
(b) staff did not reasonably respond to Mr C's dehydration;
(c) there was an unreasonable delay in carrying out an x-ray or scan following the diagnosis of a chest infection on 25 March 2012;
(d) staff did not reasonably respond to Mr C's complaints of pain in his back on 1 April 2012; and
(e) staff did not reasonably respond to the development of thrush in Mr C's mouth.

Investigation

6. My complaints reviewer looked in detail at all the available correspondence within the complaint file. In addition Mr C's medical records were scrutinised. My complaints reviewer also sought independent advice from two of the Ombudsman's clinical advisers, a consultant in geriatric medicine (Adviser 1), and a general hospital adviser (Adviser 2) about the clinical care Mr C received, and advice from one of the Ombudsman's nursing advisers (Adviser 3) about the nursing care he received.

7. 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 in Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) Staff did not diagnose the cause of pain in Mr C's legs

8. Mrs C complained that the cause of the pain in Mr C's legs was never properly diagnosed. Mr C was admitted suffering from pain in both legs which was adversely affecting his mobility.

9. Mr C's clinical records show that this was treated with a combination of physiotherapy and analgesic medicine. The Board's response to our enquiries included a statement by the Clinical Director, in which Mr C was described as having a 'working diagnosis' of sciatica, which corresponded to the information provided to Mrs C in the Board's response to her complaint.

Advice obtained

10. I asked Adviser 1 if they considered that the evidence showed that this diagnosis was communicated to Mr and Mrs C and if the treatment had been appropriate. Adviser 1 said that the diagnosis of sciatica was made appropriately, and that the treatment initiated for it (analgesia and physiotherapy) was appropriate. However, he said that there was no documented evidence that this diagnosis was communicated to or discussed with either Mr or Mrs C.

(a) Conclusion

11. The medical records my complaints reviewer scrutinised show that the diagnosis of sciatica was made within days of Mr C being admitted to the

Hospital. I take into account the advice received that this was appropriate and was treated appropriately. For this reason, I do not uphold this complaint. However, there is no evidence to show that this diagnosis was communicated to either Mr C or Mrs C. This is not reasonable, and I would expect, as a fundamental part of the care and treatment process, for patients to be kept fully informed about the diagnoses made for them. I have made one recommendation to the Board in this regard.

(a) Recommendation

12. I recommend that the Board:

	Completion date
(i) remind staff at the Hospital of the need to communicate with patients and their relatives and carers to ensure they are kept fully informed about their care and treatment, and of the importance of a proactive approach in this regard.	5 June 2013

(b) Staff did not reasonably respond to Mr C's dehydration

13. Mrs C stated in her complaint that she had been concerned about Mr C's fluid intake from 22 March 2012 and that she had mentioned it again to staff on 28 March 2012. At this point Mr C had developed a chest infection and diarrhoea. Mr C was diagnosed with kidney failure on 3 April 2012 caused by dehydration.

14. The Senior Charge Nurse (SCN) made a statement as part of the Board's investigation into Mrs C's complaint. She said that a fluid balance chart was not commenced until the patient was started on intravenous fluids on 3 April 2012. She said that this was not acceptable practice. The SCN also said she fully reviewed the documentation on 3 April 2012 when it was brought to her attention on that day that Mr C had not had a senior medical review on 2 April 2012. At this point the SCN said she discussed with nursing staff individually and via a Safety Action Brief the importance of maintaining fluid balance and the need for nursing to be proactive with medical staff when intravenous fluids would be beneficial. She said blood results clearly showed a daily deterioration in hydration and renal function. The SCN also said in her statement that the situation was not helped by 'delayed decision making' on the part of the medical staff.

15. The Board's response to Mrs C on 3 July 2012 referenced part of the statement by the SCN. It failed to mention, however, that she considered

Mr C's care to demonstrate unacceptable practice, nor did it mention that the SCN had identified the lack of a senior medical review of Mr C's condition prior to acute renal impairment developing. The Board said that staff had given oral fluid frequently and that the SCN had discussed with nursing staff the importance of maintaining fluid balance and the need for nursing to be proactive with medical staff when intravenous fluids would be beneficial.

Advice obtained

16. My complaints reviewer asked Adviser 1 if Mr C's fluid intake was managed properly or not and whether kidney failure could have been prevented. Adviser 1 said that had Mr C's fluid management been good and intravenous infusion not delayed, acute renal impairment could have been avoided. He said that in his opinion, this aspect of Mr C's treatment was suboptimal and may have contributed to the eventual death of Mr C. He noted in particular that Mr C's blood tests on admission had shown no indication of kidney impairment. In addition, Adviser 2 noted that a junior doctor had recorded some concerning blood test results in Mr C's records on 27 March 2012, but that these had not been addressed by the consultant who subsequently reviewed Mr C on 29 March 2012.

17. Adviser 1 highlighted the statement from the SCN. He stated that good medical practice would have been to commence intravenous fluids early, as the chest infection set in, and certainly once Mr C started to suffer from both diarrhoea and vomiting. Adviser 1 also noted that the anti-inflammatory analgesic drug (Diclofenac), antihypertensive drugs (Ramipril) and diuretics (Bendrofumethiazide) prescribed to Mr C all had adverse effects on kidney function. Adviser 1 said that they were belatedly stopped following a review by the consultant responsible for Mr C on 3 April 2012.

18. My complaints reviewer also asked Adviser 1 about a statement within Mr C's medical notes that he was not seen for four days by a senior doctor. I asked if this was acceptable or normal practice and if not whether this would have had a detrimental effect on Mr C's condition. Adviser 1 said that the written notes were hard to decipher, which made it difficult to tell if Mr C had been assessed by a consultant within 24 hours of admission. He said that it appeared that Mr C was first seen by a consultant on 3 April 2012, when appropriate action was taken to treat his renal impairment. Adviser 1 considered the delay in hydration measures was a significant omission considering Mr C's clinical circumstances. He said that the delay of the

consultant's assessment and intervention was likely to have contributed to the onset of kidney failure. Adviser 1 noted that the SCN had reported the matter as a critical clinical incident in the Datix system.

19. My complaints reviewer asked Adviser 1 what he considered to be meant by the SCN's comment that indicated that there had been delays in decision making on the part of medical staff referred to. Adviser 1 said that in his view, this referred to the delayed decisions to discontinue medication which had an adverse effect on kidney function, commence intravenous hydration and chose a more appropriate antibiotic.

20. Adviser 3 provided comment on Mr C's care in this regard from a nursing perspective. She said that one of the key duties of the registered nurse caring for a patient is to ensure that adequate monitoring is in place to ensure patient care is well managed and any problems are promptly reported to medical staff to provide appropriate interventions.

21. My complaints reviewer asked the Board and Adviser 2 for further clarification of the review of Mr C by senior medical staff. The Board provided further clarification regarding the doctors who had seen Mr C, and this clarified that Mr C had been regularly reviewed by consultants during his admission, with the exception of the four day period already identified between 29 March 2012 and 3 April 2012. Adviser 2 confirmed this from the notes and the further information provided by the Board. The Board further explained this had been reported as a moderate incident on the Datix system, and had been drawn to the attention of both the Clinical Service Manager and the Clinical Director at the Hospital. They explained that, although Mr C had deteriorated over the weekend, he did not reach a 'trigger point' on any of the Hospital's early warning scoring systems, including the Modified Early Warning Score (MEWS) and the Pre-Empt Score. They considered that, although it had not been optimum for Mr C not to be reviewed for a period of four days, it was not considered to be a significant clinical incident and, therefore, they had not conducted a significant incident review.

(b) Conclusion

22. Mrs C has complained that staff did not reasonably respond to Mr C's dehydration. She said that she had been concerned about Mr C's fluid intake and that she had raised the matter with staff, however, she believed that insufficient action was taken, resulting in Mr C suffering from kidney failure.

23. I have received advice that the treatment Mr C received was not in line with good medical practice, in that kidney failure was not inevitable and could have been avoided. During the Board's investigation it was highlighted by a member of staff that his care was not in line with acceptable practice. In addition, Mr C was not reviewed by a senior doctor for a period of at least four days and possibly longer, during which time his condition deteriorated rapidly, as recorded in the clinical and nursing notes. As a result of this delay, Mr C continued to receive medicine which adversely affected his kidney function. The Board's response to Mrs C's complaint did not acknowledge this, nor did it indicate that actions had been taken to avoid a recurrence of the situation.

24. Although I take into account the Board's explanation about why they did not conduct a significant incident review, I am of the opinion given the advice I have received, in particular that concerning blood tests recorded on 27 March 2012 were not addressed by the consultant who reviewed Mr C on 29 March 2012, and that the four days was a period of serious deterioration for Mr C, that a significant incident review is warranted.

25. The impact upon Mr and Mrs C cannot be underestimated. Mrs C was making her concerns known to staff yet these were not acted upon, and this was naturally a very distressing experience for her. I note the comments of Adviser 1 that Mr C's kidney failure could have been avoided with better fluid management, and in particular his comment that the kidney failure may have been a contributing factor in Mr C's death. I am very critical of the Board that Mr C did not receive timely senior medical assessment. I uphold this complaint.

(b) Recommendations

26. I recommend that the Board:	*Completion date*
(i) conduct an audit to ensure the timely assessment of all acute admissions by consultant medical staff;	21 August 2013
(ii) review the implementation of the fluid balance chart policy, with an emphasis on the identification of the appropriate point for staff to escalate concerns to clinical staff;	21 August 2013
(iii) ensure junior medical staff at the Hospital receive full training on the management of elderly and acutely ill patients with the aim of preventing kidney	21 August 2013

failure; and

(iv)	conduct a significant incident review with regards to the period of care from 27 March to 3 April 2012.	18 June 2013

(c) There was an unreasonable delay in carrying out an x-ray or scan following the diagnosis of a chest infection on 25 March 2012

27. Mrs C complained that Mr C did not receive an x-ray or scan until 3 April 2012 despite being diagnosed with a chest infection on 25 March 2012. The computerised tomography (CT) scan on 3 April 2012 revealed bilateral pneumonia.

28. The clinical records show that following the diagnosis of a chest infection on 25 March 2012, Mr C was prescribed antibiotics at this stage and given oxygen. The records also show that Mr C was initially scheduled for a CT scan on 29 March 2012, but that this proved impossible due to the diarrhoea that he was suffering from.

Advice obtained

29. My complaints reviewer asked Adviser 1 whether the care given following the diagnosis of a chest infection was reasonable and whether a CT scan or x-ray should have been carried out immediately following the diagnosis of a chest infection. Adviser 1 said that from the moment a chest infection was diagnosed, treatment should have been instituted without delay. He noted Mr C was immediately prescribed antibiotics and that this was proportionate treatment. Adviser 1 said that in his opinion, a CT scan was not necessary as a first test, but he understood why the medical team had considered this, particularly given Mr C's age and the fact he had suffered significant weight loss in the preceding months. Adviser 1 said that a CT scan would indicate whether there was an underlying malignant disease affecting Mr C. Adviser 1 stated that in his opinion, aside from the previously mentioned issues around fluid management, the care provided for Mr C's chest infection was reasonable.

(c) Conclusion

30. Mrs C has complained that Mr C's chest infection was not treated appropriately, in that he was not immediately given a CT scan or x-ray upon diagnosis of a chest infection. I have received advice that the care Mr C received, in the form of the immediate prescription of antibiotics, was reasonable, and further investigative tests were not necessary at this stage. For that reason, I do not uphold this complaint.

(d) Staff did not reasonably respond to Mr C's complaints of pain in his back on 1 April 2012

31. Mrs C has complained that Mr C had complained of a sore back on 1 April 2012, although she offered to apply cream to it, he told her that nursing staff had been informed and they had said they would attend to him. On 2 April 2012, when he continued to complain, Mrs C said she insisted on seeing his back, and discovered a pressure ulcer, which she reported to staff. She said Mr C was quickly moved to an air bed, and this appeared to make Mr C much more comfortable.

32. In their response, the Board said the SCN was made aware of the pressure ulcer on 2 April 2012, and following this she reviewed Mr C's care plan and found that all pressure areas were being monitored and were recorded as intact. They said the pressure area was clearly caused by friction and was new as there was no evidence of slough, and the wound bed itself was moist and pink. They said the SCN was confident frequent skin inspection had been carried out as Mr C had required full nursing intervention for washing, mobilisation, and help with eating and drinking. They then detailed the care plan put into action following the discovery of the pressure ulcer.

Advice obtained

33. My complaints reviewer asked Adviser 3 to comment on the records for Mr C in terms of pressure area management prior to the discovery of the pressure ulcer on 2 April 2012, and whether the care given to Mr C had been reasonable. My complaints reviewer also asked if the staff's actions following the discovery of the pressure ulcer were reasonable.

34. Adviser 3 said that the nursing records suggested that the care provided was reasonable; the charts and records were generally of good quality and provided evidence of regular care and well documented treatment. Adviser 3 commented the pressure ulcer may have been caused by some kind of trauma, such as Mr C brushing against the bed rails. Adviser 3 said following the identification of the pressure ulcer, the nursing staff had taken all reasonable steps to ensure it healed and to prevent further skin deterioration. This included the implementation of a skin bundle care plan and a Waterlow assessment chart. In addition a wound chart had been completed, indicating that nursing staff were providing adequate care to the wound.

(d) Conclusion

35. Mrs C's complaint was that staff did not reasonably respond to Mr C's complaints of pain in his back on 1 April 2012. She stated that on that date, Mr C told her that staff were aware of the pain in his back and that he would be examined by a nurse. Mrs C was, therefore, understandably upset to discover a pressure ulcer on his back on 2 April 2012.

36. I have received advice that the nursing records show an adequate programme of care and treatment prior to the discovery of the pressure ulcer. Whilst I accept that Mr C told his wife that he had reported the pain in his back to a nurse and Mrs C's account of this, there is no record of this within the nursing notes, and I must take this into account when considering the reasonableness of the actions of the nursing staff.

37. Once the pressure ulcer was discovered, I have been advised that the actions of the nursing staff were reasonable and in line with good practice. They put in place the appropriate care plans, including the Waterlow assessment chart and a wound chart, and took action to ensure that Mr C's skin did not deteriorate further, including moving him on to an air bed. For these reasons, whilst I acknowledge the distress caused to Mrs C by this particular issue, I do not uphold this complaint.

(e) Staff did not reasonably respond to the development of thrush in Mr C's mouth

38. Mrs C complained that on 4 April 2012 she had advised the consultant treating Mr C of her concerns about the prescription of stronger antibiotics, as Mr C had developed oral thrush following a previous course of strong antibiotics. On 5 April 2012 Mrs C stated that Mr C was unable to swallow, and was barely able to talk. By 9 April 2012, Mrs C said that Mr C was finding even swallowing his saliva extremely painful and he was prescribed a 'patch' to be placed behind his ear to help with this, however, on 10 April 2012 it was no longer present, and was only re-applied following questioning of the nursing staff from Mrs C.

39. Mrs C asked why she had had to query and follow up on every aspect of Mr C's treatment.

40. The Board said they noted the condition of Mr C's mouth due to oral thrush to become of concern on 6 April 2012. They said a nursing management plan was commenced with Nystatin and intravenous Fluconazole. They said Mr C could only tolerate minimal intervention due to his mouth being so painful, and staff were carrying out two hourly care at this time. They apologised that the Hyoscine patch had not been present behind Mr C's ear on 10 April 2012, explaining that the kardex had been changed that day and the nursing staff on shift had not been immediately informed of the change to Mr C's medication.

Advice obtained

41. My complaints reviewer asked Adviser 1 whether Mr C was treated timeously and appropriately following the development of oral thrush. The Adviser said that Mr C's clinical records indicated that the oral thrush was identified on 6 April 2012, that a consultant saw Mr C later that day and anti-fungal therapy was commenced as detailed by the Board. He said oral thrush was an expected complication in a case such as Mr C's; he said it was not possible to speculate how long the infection was present before detection, but that appropriate treatment was commenced as soon as it was identified.

42. My complaints reviewer asked Adviser 3 to comment on the nursing treatment provided to Mr C in relation to the development of oral thrush. Adviser 2 said that nursing staff had noted the condition of Mr C's mouth on admission and regular oral checks are recorded on the notes. On 6 April 2012 Mr C was noted as having difficulty swallowing and medical staff were alerted, who prescribed appropriate medication. Nursing staff had then carried out regular mouth care, within the limits of what Mr C could tolerate. Adviser 3 stated that in their opinion, the oral care offered to Mr C had been reasonable.

43. Mr C's clinical records do not note Mrs C's position that she raised her concerns about oral thrush with the consultant treating Mr C on 4 April 2012.

(e) Conclusion

44. Mrs C has complained that the staff at the Hospital did not reasonably respond to Mr C's development of oral thrush. I note the descriptions of pain he suffered in this regard in her complaint. I have carefully considered that Mrs C had experience of a previous episode of Mr C suffering oral thrush and her position that she advised a consultant of her concerns on 4 April 2012; I note that although this is not referred to in Mr C's clinical notes, that the notes did say that Mr C was generally 'in pain and agitated' on 5 April 2012, was unable to

take anything by mouth on that date, and in the early hours of the morning of 6 April 2012 was unable to swallow fluids. It is not possible for me to reach definitive conclusions on this aspect of the complaint; this is not because I do not accept Mrs C's position, but rather because it cannot be substantiated by the documented evidence available. I must consider, therefore, the advice I have received about the reasonableness of the treatment once instigated.

45. The advice received suggests that the care offered to Mr C from 6 April 2012 was reasonable, and managed the oral thrush appropriately. On the balance of the evidence available, I do not uphold this complaint.

46. Despite this, there is one matter I wish to draw to the attention of the Board. In their response to Mrs C's complaint, the Board said that the failure to apply Mr C's Hyoscine patch on 10 April 2012 was due to nursing staff being unaware that alterations had been made to Mr C's kardex by medical staff. The Board apologised for the delay in applying the patch, but I consider that a further recommendation is appropriate to ensure nursing staff are timeously made aware of medication changes to prevent patients from suffering unnecessarily.

(e) Recommendation

47. I recommend that the Board:	*Completion date*
(i) issue a reminder to all medical staff at the Hospital to ensure that nursing staff are given timely notice of changes to patients' medication.	5 June 2013

General Comments

48. Although Mrs C did not make a specific complaint about this to my office, I noted her comments in her correspondence that she felt Mr C was dismissed as a frail old man due to his age during the latter part of her admission, given the fact he was seen by a number of different doctors and consultants. My complaints reviewer asked Adviser 1 to comment on Mrs C's perception of a lack of continuity of care and the impact upon Mr C as a result. Adviser 1 said that according to Mr C's clinical records, apart from two consultants who had seen Mr C on three separate days, there appeared to have been at least five other doctors, some GPs, who reviewed Mr C during his admission. Adviser 1 said he empathised with Mrs C that she perceived a lack of continuity in the medical care Mr C was receiving. Adviser 1 emphasised, however, that, apart from the lack of timely intervention in relation to Mr C's fluid management, he

found no evidence of a lack of appropriate medical care. Nonetheless, he said that having to relate to many different doctors, particularly those who had not seen Mr C earlier in his stay, must have been disconcerting for both an elderly patient and their elderly spouse.

49. I recognise of course that it will not be possible or practical for patients in hospitals to receive continual care from the same doctor or consultant. I also recognise from further information provided by the Board that the Hospital receives consultant cover via a rota model from consultants based at the Royal Alexandra Hospital, one week at a time. The Board advise that during this week, the consultant will be responsible for acute medical receiving and alternate day review of all in-patients in the ward. They said that, in order to ensure continuity of care for patients in for over week and, therefore, under the care of more than one consultant, there was a weekly multi-disciplinary team meeting held to discuss all long-term and complex patients.

50. I consider that, wherever possible and particularly in the case of care of the elderly during admissions of more than a few days, it would be beneficial and of reassurance to both the patient and their family to be able to discuss the care and treatment being provided with the responsible consultant. I have one recommendation in this regard, as well as a further general recommendation relating to this report as a whole.

General Recommendations

51. I recommend that the Board:	*Completion date*
(i) advise staff at the Hospital that, where possible, patients and their families and carers must be able to discuss care and treatment with a named point of contact within the medical team; and	18 June 2013
(ii) give a formal apology to Mrs C for the shortcomings identified in this report and for the distress she has suffered.	5 June 2013

52. 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 aggrieved, husband of the complainant
The Hospital	The Royal Alexandra vale of Leven Hospital
Mrs C	The complainant, Mr C's wife
The Board	Greater Glasgow and Clyde NHS Board
Adviser 1	The Ombudsman's clinical adviser, a Consultant in Geriatric Medicine
Adviser 2	Another of the Ombudsman's clinical advisers, a general hospital adviser
Adviser 3	The Ombudsman's nursing adviser
The SCN	The Senior Charge Nurse at the Hospital
The Clinical Director	The Clinical Director at the Hospital

Annex 2

Glossary of terms

Bendrofumethiazide	diuretic, used to treat high blood pressure
Computerised tomography (CT) scan	an x-ray which takes a series of pictures of particular parts of the body
Datix	a critical incident reporting system
Diclofenac	an anti-inflammatory painkiller
Flucanozole	an anti-fungal medication
Hyoscine	a medication to help prevent excess salivation
Kardex	a card filing system which records details of a patient's medication and dosages
Nystatin	an anti-fungal medication
Palliative care	end of life care
Ramipril	an anti-hypertensive medication
Sciatica	a nerve condition which affects a large nerve extending from the lower back down each leg
Skin bundle care plan	a tool used for best practice skin inspection and care
Waterlow assessment chart	a chart used to assess and prevent pressure ulcers