SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Lothian

Case ref: 201401793, Lothian NHS Board
Sector: Health
Subject: Hospitals; clinical treatment; diagnosis

Summary
Miss C was suffering from a severe headache with associated flashing lights that was not relieved by painkillers. Following referrals from her GP she twice attended an out-patient clinic at St John's Hospital where on both occasions she was reviewed by staff and sent home with medication. She had a computerised tomography scan two days after the second appointment which showed that she had a brain abscess. She was transferred to another hospital for emergency surgery, followed by another operation to further drain the abscess. Miss C raised a number of concerns about the care and treatment she received while attending St John's Hospital, in particular, that the delay in undertaking investigations necessary to diagnose her condition may have led to a more serious outcome and unnecessary prolonged pain and distress.

When Miss C was transferred back to St John's Hospital, she was unhappy with the care she received, in particular the attitude of staff on the ward. Miss C also complained to us about the delay in diagnosing her condition and the way the board handled her complaint.

I took independent advice from a general medical adviser and a senior nursing adviser. On the initial diagnosis of Miss C's condition, my medical adviser said that there were sufficient red flag symptoms for Miss C's condition, which was deteriorating over time, to prompt clinicians to investigate further. Although it is not possible to know if an earlier operation would have improved the outcome for Miss C, I found that the board failed to give her the care and treatment she could have reasonably expected. I found that in terms of infection control on the ward, there was an unreasonable level of uncertainty from medical staff. I also found that there was inadequate communication with Miss C and her family. There had also been errors in relation to one of Miss C's prescriptions and her discharge medication which, whilst my medical adviser said would not have caused any harm, further reduced the confidence of Miss C in the ability of the ward to care for her. I am also critical that whilst the board apologised, they did not explain how these errors occurred in the first place. During my investigation, the board also failed to send copies of information sent by them to

Miss C's GP. I was also critical of this, as this was relevant information given that Miss C also complained about poor communication between the board and her GP following her discharge from hospital.

In terms of the nursing care she received, my nursing adviser said that whilst there are notes documenting regular interaction between nursing staff and Miss C, some of the notes were poorly completed, so I have concerns about record-keeping. There was also a breach in nursing protocol in relation to the disposal of a used syringe. The board has accepted that this protocol had been breached and has assured us that action will be taken to address this.

Although there were some aspects of the board's complaints handling that could have been better, on balance I considered that Miss C received a reasonable level of service in this regard so did not uphold her complaint about the way her complaint was dealt with.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Miss C for the failings identified in this complaint;	19 August 2015
(ii) report back to the Ombudsman on the outcome of the review of the discharge prescribing and drug ordering procedures at ward level and on any action taken to prevent similar errors occurring in the future;	16 September 2015
(iii) remind nursing staff of the need to maintain full and accurate nursing records in line with NMC guidance;	16 September 2015
(iv) explain how they will monitor compliance to protocols and ongoing improvements in relation to the safe disposal of clinical waste;	16 September 2015
(v) report back on the outcome of the review of infection control procedures to evidence that learning and improvement has occurred; and	16 September 2015
(vi) report back to the Ombudsman on the action taken as a result of this case in relation to communication to improve the service provided.	16 September 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Miss C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. The complaint relates to the care and treatment the complainant (Miss C) received at several consultations at St John's Hospital (Hospital 1) between 11 and 19 September 2013, during an admission between 24 October 2013 and 4 November 2013 and at an appointment in November 2013 after Miss C was discharged.

2. Miss C attended the Medical Assessment Unit (MAU) at Hospital 1 on 11 September 2013 having been referred by her GP with ongoing headache, associated flashing lights and little relief from analgesia. Miss C was seen by a doctor (Doctor 1) and was reviewed by another doctor (Doctor 2). She was unhappy that a computerised tomography (CT) scan was not carried out and she was sent home with Ibuprofen. Miss C next attended Hospital 1 on 17 September 2013 again having been referred by her GP. During this visit Miss C was seen by a doctor (Doctor 3) at the Primary Assessment Unit Area (PAA). Doctor 3 carried out a number of tests and Miss C was sent home with co-codamol and an anti-depressant to relax her muscles. Miss C is aggrieved that Doctor 3 failed to investigate the potential of a more serious condition at this time.

3. On 19 September 2013 Miss C again attended Hospital 1 where a CT scan was carried out, which confirmed the presence of a brain abscess. She was transferred to the Western General Hospital (Hospital 2) where an emergency operation was carried out to drain the abscess. This was followed by a second operation on 24 September 2013 to further drain the abscess.

4. On 24 October 2013 Miss C was transferred from Hospital 2 to Hospital 1. She was unhappy with elements of the care she then received at Hospital 1 and complained about unprofessional comments made by some medical staff. She also complained that poor coordination and communication between staff led to missed medication, an error in sending specimens and, therefore, unnecessary delays in Hospital 1. Miss C further complained about poor communication and the poor attitude of nurses with regard to infection control and information.

5. Miss C was also unhappy with the comments made by medical staff during an out-patient appointment on 8 November 2013 and complained that there appeared to be confusion about whether a blood test was required when she attended the Planned Investigation Unit (PIU) on 22 November 2013. Finally,

she complained that her GP had not received her discharge letter from Hospital 1 timeously.

6. Miss C was concerned that the delay in diagnosis and treatment may have led to a more serious outcome and unnecessary prolonged pain and distress than may otherwise have been the case if earlier investigation and treatment had been provided. She also complained about the lack of respect given to her as a patient and the manner in which she was treated.

7. Miss C complained to Lothian NHS Board (the Board) on 5 February 2014 and received their response on 1 April 2014. As Miss C remained dissatisfied with the response, she complained to this office.

8. The complaints from Miss C which I have investigated are that:

(a) the Board provided inadequate medical care and treatment to Miss C between September and November 2013 (*upheld*);
(b) the Board provided inadequate nursing care and treatment to Miss C between September and November 2013 (*upheld*);
(c) infection prevention and control in relation to Miss C's case was inadequate (*upheld*);
(d) the Board staff's communication with Miss C and her family was inadequate (*upheld*); and
(e) the Board's handling of, and response to, Miss C's complaint was inadequate (*not upheld*).

Investigation

9. The investigation of this complaint involved obtaining and reading all the relevant documentation, including the complaints correspondence and Miss C's health records. Independent advice has been obtained from a general medical adviser (Adviser 1) and a senior nursing adviser (Adviser 2). In this case, we have decided to issue a public report because of the significant personal injustice to Miss C.

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

(a) The Board provided inadequate medical care and treatment to Miss C between September and November 2013

11. Miss C raised a number of concerns about the medical care and treatment she received between September and November 2013. In particular, that the delay in undertaking investigations necessary to diagnose her condition may have led to a more serious outcome and unnecessary prolonged pain and distress.

Board's response to Miss C's complaint

12. In response to Miss C's complaint the Board addressed the issues raised by her on 1 April 2014 as follows:

Visit on 11 September 2013

13. The Board stated that, on arrival at the MAU, Miss C was seen by Doctor 1 and was also reviewed by Doctor 2. Her examination did not show any obvious sign suggestive of severe infection. Her physical examination showed normal neurology and she had no temperature. Doctor 2 felt Miss C had a bad migraine and possible underlying viral illness and suggested some analgesia medication. The Board stated that, although not documented clearly in the health records, Doctor 2 would normally ask patients to see their GP if symptoms persist. They went on to say that Doctor 2 did not feel a CT scan was indicated at that time.

Visit on 17 September 2013

14. The Board outlined the care and treatment given to Miss C when she attended the PAA. They explained that Miss C's history and findings obtained by Doctor 3 were recorded and, at the time of this review, her observations and temperature were normal. Miss C's GP had suggested a raised temperature. Doctor 3 performed and documented a full neurological examination and he referred to a potential visual field defect, which had not been documented previously by other medical practitioners. Miss C's GP's correspondence stated there was no visual defect. The Board indicated that, despite repeated attempts at assessment of Miss C's visual fields, Doctor 3 could not determine a consistent pattern of visual field loss. Doctor 3's impression at the time was that there was clinical evidence of musculoskeletal pain and tenderness, and a possible visual field defect, which may require to have further investigation if symptoms persisted. Doctor 3 wrote to Miss C's GP with his findings.

Visit on 19 September 2013

15. The Board stated that, during a telephone call from Miss C's GP on 19 September 2013, Doctor 3 arranged an urgent CT brain scan. When Miss C attended Hospital 1 she was seen by another doctor who was in PAA at the time and then some ten minutes later by Doctor 3. An initial assessment by Doctor 3 confirmed that there had been a change in Miss C's physical condition and she had features consistent with delirium and a very high temperature. Immediate resuscitation was implemented and CT imaging performed which confirmed the presence of a brain abscess. Doctor 3 made direct contact with the on-call neurosurgical registrar and transfer for ongoing specialist intervention was arranged and actioned. Miss C was transferred to Hospital 2 The care and treatment Miss C received while in Hospital 2 does not form part of this investigation.

Admittance to Hospital on 24 October 2013

16. Miss C was admitted to Ward 21 following her transfer from Hospital 2 on 24 October 2013 and was initially reviewed by Doctor 3's medical colleague. Doctor 3 had contacted the consultant neurosurgeon at Hospital 2 on 16 October 2013 prior to Miss C's transfer to clarify the nature of her ongoing treatment and care. The Board stated that this communication, as well as the transfer letter, allowed Doctor 3 and medical colleagues at Hospital 1 to put in place an ongoing plan from the time of Miss C's arrival, which related to her antibiotic therapy and ongoing monitoring and imaging. They went on to say that, when Doctor 3 saw Miss C on 28 October 2013, he confirmed the presence of a modest hemianopia and her otherwise good health. Doctor 3 had been aware of the diagnosis of a sinus venosus ASD (rare cardiac abnormality) but did not, and still did not, attribute this finding to the cause of Miss C's brain abscess.

17. The Board explained when Miss C was transferred from Hospital 2 a four day supply of the antibiotic meropenam had been sent with her. They indicated that normal protocol would mean a further supply would be ordered in advance of her needing it. While in this case further supplies were ordered on 25 October 2013, Miss C missed a dose at 14:00 on 28 October 2013 because the supply was not available. The Board indicated they were very sorry for this error and accepted this had added to Miss C's concerns about the interruption to her treatment. However, Doctor 3 indicated that, having reviewed the properties of this drug, a single missed dose would have had no effect on the course of her treatment.

18. The Board also explained that, while Miss C had been incorrectly discharged home on 4 November 2013 with 1 x 500 milligram of amoxicillin, a further prescription was written on 5 November 2013 for the correct dose of antibiotic (2 x 500 milligram of amoxicillin). The Board apologised for this mix-up.

19. The Board further explained that Miss C's cerebral abscess was a rare condition, which had not been suspected by any of the medical practitioners who saw her prior to the diagnosis made on 19 September 2013. The Board went on to say that the appearances documented on the CT scan suggested the cerebral abscess had been present for many weeks prior to Miss C initially seeking medical attention on 11 September 2013. Therefore, the time period from Doctor 3 seeing Miss C to the initiation of treatment and appropriate diagnostic imaging did not, in Doctor 3's opinion, have any effect on the outcome of Miss C's management or progress.

20. In her complaint to this office Miss C detailed why she remained dissatisfied with the response received from the Board: in particular, her continuing concern that a CT scan was not ordered as a precaution when she first attended Hospital 1 on 11 September 2013; and that no investigation was arranged to rule out a potentially serious illness. Miss C also remained dissatisfied that investigations were not undertaken during her second visit on 17 September 2013 to exclude something serious or to assist diagnosis. Miss C indicated that she felt her life and health were endangered by the treatment she received. She also indicated that, while the Board stated it appeared she had made a full recovery she had, at the time of her complaint to this office, no peripheral vision in her left eye. When commenting on a draft of this report, the Board stated that this did not reflect the recording made by clinicians dealing with Miss C's care. However, Miss C's account of her recovery related to the time of her complaint to this office, not the assessment.

The Board's response to SPSO

21. The Board confirmed their position that Miss C had a rare condition, namely a brain abscess. In addition, she was found to have a cardiac malformation which had been present, undiagnosed, from birth. The Board indicated that, while Miss C attended Hospital 1 on three occasions, it was only on the third visit (19 September 2013) that the diagnosis of a brain abscess was made. On this visit, a diagnostic procedure was ordered prior to her attendance

following a telephone conversation with her GP. This alerted the clinical team to the likely underlying diagnosis and allowed immediate treatment to begin. In addition, immediate contact was made with regional specialist services and transfer initiated to Hospital 2.

22. The Board further explained that delayed diagnosis of rare conditions is neither rare nor unexpected. On Miss C's two previous visits to Hospital 1 (11 and 17 September 2013) she was seen by consultant staff and a number of relevant investigations were undertaken, which excluded a number of potential diagnoses. On both occasions a CT of her head was not undertaken based on a combination of her symptoms, investigations at that point and physical findings. The Board indicated that, at the first indication of a change in her condition (following telephone contact from her GP on 19 September 2013), Miss C had prompt diagnostic evaluation and treatment undertaken.

23. The Board further stated that, on her return to Hospital 1 on 24 October 2013 from Hospital 2, she received treatment for her brain abscess after surgical therapy. Doctor 3 contacted the consultant neurosurgeon in charge of her care at Hospital 2 to clarify the intended treatment plan. This was prior to Miss C arriving in Hospital 1, to ensure the correct information was obtained to allow treatment to be given in a seamless fashion.

24. The Board accepted there was an issue regarding the supply of meropenem and a single dose of this was omitted due to non-availability on 28 October 2013. Whilst regretted, the Board explained that it was Doctor 3's view that this did not have any impact on the overall outcome of Miss C's care.

25. With regard to Miss C discharge medication (amoxicillin), the Board explained that it appeared a dispensing error within the pharmacy had led to her being given amoxicillin 500 milligram three times daily, rather than 1000 milligram three times daily. The Board stated this was remedied the following day (5 November 2013).

26. The Board explained that all available learning points had been discussed in this case, including a review of the case in the medical unit morbidity meeting, inclusion in Doctor 3's appraisal process and a review of the discharge prescribing and drug ordering procedures at ward level.

Advice obtained

27. My complaints reviewer asked Adviser 1 if he considered that the care and treatment Miss C received during her various attendances at Hospital 1 was reasonable and appropriate. Adviser 1 said it was clear from Miss C's GP referral note on 11 September 2013 that they were concerned she had a serious illness and documented that she had a raised temperature and photophobia. He said that the assessment of Miss C in Hospital 1 on 11 September 2013 noted her photophobia, vomiting and that she had felt feverish with neck stiffness. Miss C also had a slightly raised temperature of 37.4^{0}C. The presence of small lymph glands in her neck was also noted. Adviser 1 said that the diagnosis reached was a 'viral infection on top of migraine' and Miss C was discharged.

28. When Miss C attended Hospital 1 on 17 September 2013 she was reassessed by Doctor 3. Some visual loss, neck stiffness and that she had vomited nine times over the last 24 hours was noted. Pain at the back of her neck was also noted. Adviser 1 indicated that the pain was thought to be musculoskeletal and Miss C was discharged.

29. Adviser 1 said that the Scottish Intercollegiate Guidelines Network (SIGN) guideline for the assessment of headache includes:

> 'Patients who present with headache and red flag features for potential secondary headache should be referred to a specialist appropriate to their symptoms for further assessment.'

30. He went on to say that these red flag (warning) features listed in the SIGN guideline are used to distinguish between headache due to benign causes and more serious ones. He said that, overall, he found there were red flag features of Miss C's condition (change in headache frequency, characteristics or associated symptoms, abnormal neurological examination, neck stiffness and fever) which should have prompted further thought and investigation by the clinicians caring for her. In particular, the presence of a severe persistent headache of over a week's duration combined with the presence of a temperature, neck pain, vomiting, photophobia and visual loss, should have prompted more investigation. Adviser 1 indicated that he would have expected the clinicians to consider a CT scan of Miss C as essential in her care.

31. Adviser 1 indicated that the clinicians caring for Miss C chose viral infection as part of the diagnosis in the first presentation on

11 September 2013, which is understandable. However, he went on to say, even allowing for the benefit of hindsight, the clinicians should have given more credence to the warning signs and the assessment at this time could have prompted an earlier diagnosis. Adviser 1 indicated it is important to note that the red flag signs are also not specific for some of these: for example, it is true that someone with a severe viral illness could have a headache and a temperature. Adviser 1 said that Miss C's photophobia was the only symptom not explained by a viral illness, but this is seen in migraine. Adviser 1 said that the diagnosis of the clinicians was superficially attractive, but in his view also failed to explain all her symptoms adequately enough to justify the diagnosis. He said that they failed to see the single unifying diagnosis which would explain all of Miss C's symptoms, but chose to attribute these to two separate but simultaneous diagnoses instead. Adviser 1 indicated he did not consider there was any missed information, as the clinicians caring for Miss C had all the information needed to make a diagnosis. Adviser 1 was critical of the failure to undertake further investigations at this time (11 September 2013) and the reassurance given to Miss C and her GP, which delayed the eventual diagnosis as a result.

32. Adviser 1 said that he was more critical of Miss C's care at the time of her second presentation to Hospital 1 on 17 September 2013. Adviser 1 indicated that by Miss C's second presentation it was clear that a typical viral infection would not last this long. However, at this point the clinicians caring for Miss C changed from the diagnosis of migraine and viral illness and made an alternative diagnosis of musculoskeletal pain instead. However, Adviser 1 explained that it would be very unusual for pain arising from the muscles and soft tissues of the neck to cause the symptoms and signs of visual loss which she was demonstrating at the time and were not explained by the diagnosis of musculoskeletal pain that was made.

33. Adviser 1 concluded that overall, he was critical of the assessment of Miss C, particularly during the second presentation on 17 September 2013. In his view, this fell below a level of care Miss C could expect and was unreasonable.

34. As indicated above, the Board, when responding to Miss C's complaint, explained that delayed diagnosis of rare conditions is neither rare nor unexpected. My complaints reviewer raised this point with Adviser 1, who indicated that he did not accept that the diagnosis of a rare underlying condition

such as this is so difficult it cannot be made, is a reasonable position. He said that medical staff should be able to diagnose rare conditions, where the symptoms of this are typical. He did not agree that a brain abscess was unduly rare. It is a condition discussed at all stages of medical training, and the doctors would have been aware of this condition, but did not diagnose it in this case. Adviser 1 went on to explain that the persistent symptoms and signs were clearly indicative of significant disease in Miss C's brain. Clinically, it was more likely that Miss C had meningitis than a brain abscess, partly as meningitis is more common than a brain abscess, but both can present in a similar way. Adviser 1 went on to explain there were sufficient red flag symptoms for Miss C's condition, which was deteriorating over time, that clinicians should have investigated Miss C further. This would have led to the diagnosis of the underlying condition, even if the exact nature of this (an abscess in the brain) had not been suspected clinically.

35. Adviser 1 considered there had been an unreasonable delay in diagnosing Miss C's brain abscess. Although brain infection with an abscess was probably a difficult diagnosis to make at the first visit to Hospital 1 on 11 September 2013, something of this significance had already been suspected by Miss C's GP. He said there were missed opportunities to make this diagnosis.

36. Adviser 1 indicated that, if Miss C had been diagnosed earlier, say on 11 September 2013, then she probably would have been operated on that day and avoided her continuing symptoms between 11 and 19 September 2013. Adviser 1 considered Miss C suffered several days of severe symptoms which would not have occurred if her operation had been performed earlier. However, Adviser 1 said that it was not currently possible at this stage to judge if an earlier operation would have improved her outcome more generally, as Miss C's clinical records did not contain details of her clinical condition afterwards in sufficient detail and, at the time of the complaint, it was likely that Miss C was still recovering after this significant illness.

37. Miss C had also raised her concern that she had missed a dose of her medication while in Hospital 1 on 28 October 2013. While the Board indicated that this had not had any impact on the overall outcome of Miss C's care, my complaints reviewer raised this matter with Adviser 1. Adviser 1 indicated that, in his view, the Board's response to Miss C's concerns was vague and described the lack of harm from missing a dose, but did not explore why this

had occurred. He said he was critical that the medication was allowed to 'run out' when it was clear that it would be needed for several days to come. While Adviser 1 agreed that a single missed dose was unlikely to have had a significant risk of harm after so many previous doses, it would have reduced the confidence of Miss C in the ability of the ward to care for her.

38. Adviser 1 felt that this could have been resolved by discussion with Miss C at the time this occurred, rather than in their complaint response of 1 April 2014. In addition, Adviser 1 was critical that there was no specific entry in the health records relating to this, or any communication with Miss C at the time. When responding to a draft of this report the Board stated that they had discussed with Miss C at the time the reason for the missed dose of medication, although they accepted that this discussion was not detailed in the medical notes. As such, there is no evidence that such a discussion took place.

39. My complaints reviewer also asked Adviser 1 if the dispensing error in relation to Miss C's discharge medication would have had any adverse effect on her care. In response Adviser 1 said that, as above, he found there was very little in the way of analysis of why this error occurred. He said that the dose appeared to have been prescribed correctly by the ward doctor on the discharge medication sheet. There appeared to have been an error after this, at the pharmacy stage, which meant that the dose Miss C went home with, was less than the dose planned.

40. Adviser 1 said that the Board's response to Miss C's complaint stated 'several changes were made over the course of the day to your prescription' but it did not explain how this occurred or how similar errors may be prevented in the future. Adviser 1 indicated that it was unlikely this error would have caused any harm, as the duration of antibiotics had been so long, but it would have further reduced the confidence of Miss C in the ability of the ward to care for her.

(a) Decision

41. I recognise that this would have been an extremely distressing and difficult experience for Miss C and her family. The Board explained that a number of relevant investigations were undertaken when Miss C attended Hospital 1 on 11 and 17 September 2013 which excluded a number of potential diagnoses. However, the advice I have received and accept is that there were red flag symptoms which should have been investigated further by the clinicians caring

for Miss C. I consider that the failure to undertake further investigations, including a CT scan, led to an unreasonable delay in the diagnosis of Miss C's brain abscess which in turn led to a delay in the operation being carried out to drain the abscess. I am concerned that, as a result, Miss C suffered several days of severe symptoms which may have been avoided if an earlier operation had been carried out.

42. While I am critical of the failure to undertake further investigations prior to 19 September 2013, especially when Miss C attended Hospital 1 on 17 September 2013, I am mindful of the advice I have received from Adviser 1 that it is not currently possible at this stage, based on the evidence available at the time of Miss C's complaint to the Board, to judge if an earlier operation would have improved her outcome more generally.

43. I am also critical that there were errors in relation to Miss C's medication which resulted in a missed dose while she was in Hospital 1 and then being discharged on the wrong dosage. While the advice I have received and accept is that this did not have any impact on the overall outcome of Miss C's care, I consider that these errors would have added to Miss C's distress during what was a worrying time. I am also concerned that, while the Board apologised for these errors and indicated that a review had been carried out, they failed to explain how these errors occurred.

44. In view of the failings identified I uphold the complaint.

(a) Recommendations

45. I recommend that the Board:	*Completion date*
(i) apologise to Miss C for the failings identified in this complaint; and	19 August 2015
(ii) report back to the Ombudsman on the outcome of the review of the discharge prescribing and drug ordering procedures at ward level and on any action taken to prevent similar errors occurring in the future.	16 September 2015

(b) The Board provided inadequate nursing care and treatment to Miss C between September and November 2013

46. Miss C raised her concern about the nursing care afforded to her during her admission to Ward 21 at Hospital 1 and during her attendance at the PIU.

In particular, Miss C was concerned that a ward nurse had walked out of her room at Hospital 1 on 25 October 2013 with a used syringe in her hand and that there appeared to be confusion about her attendance at the PIU.

The Board's response to Miss C's complaint

47. When responding to Miss C's complaint on 1 April 2014, the Board explained they were disappointed to learn that a ward nurse had walked out of Miss C's room with a used syringe in her hand and that this had happened on several occasions. The Board explained that, given the lapse in time since this incident, it had been difficult to identify the nurse concerned. However, the Board apologised for this breach in nursing protocol and explained that, as a result of Miss C's complaint, the senior charge nurse for the ward had and continues to strongly raise this issue with staff at the daily ward safety brief.

48. The Board also responded to Miss C's concern about her experience at the PIU on 22 November 2013. They stated that, having spoken to the nurse practitioner (the Nurse), it was her impression that Miss C had been extremely happy with the level of care she had received. They stated that Miss C's Hickmanline had been removed whilst at Hospital 2 and the Nurse had offered to take bloods at the PIU to alleviate any stress, aware that Miss C had problems getting blood taken at her GP surgery. The Board went on to explain that the Nurse had not been sure why, after Miss C had been discharged, she had returned to Hospital 1 but discussed this with Doctor 3. It appeared that Doctor 3 had reviewed Miss C at the PIU on 8 November 2013, when blood tests were performed as part of the agreed clinical monitoring. The Nurse explained that Miss C should contact her directly if repeat bloods were needed to be done in a few days' time. The Nurse then contacted Miss C as she had not heard from her to ask if she had been contacted by Hospital 2 or her GP. The Board stated that the Nurse was sorry if Miss C had perceived her behaviour to be unprofessional and had indicated that her actions were done out of courtesy and care for Miss C.

49. In her complaint to this office, Miss C stated that she disagreed with the response given by the Board about what had happened while at the PIU on 22 November 2013 and maintained there had been confusion on the Nurse's part about why she had attended and that she disagreed she had indicated there was any problem about getting blood taken at her GP surgery.

Advice received

50. Adviser 2 commented on the nursing care and treatment Miss C received from 24 October 2013 onwards. Adviser 2 said that she believed the plan of care for Miss C was to continue her intravenous therapy, following the care she received in the very acute phase of her illness, and the nursing assessments reflected that Miss C was recovering and was generally independent, managing her own daily activities. She said that the pro-forma 'care rounding' documents indicated that overall, there were regular interactions between nursing staff and Miss C. However, Adviser 2 went on to say that it is usual practice to see some evidence of assessment of the patient needs, care planning and evaluation of care. She said that nursing staff will document daily evaluation of the care that they have given, briefly noting their input and any relevant information which will inform other staff of the care given and progress of the patient.

51. Adviser 2 indicated that, in this case, nurses were to attend to Miss C at least four hourly, and check aspects of care, including pressure area care, elimination, food fluid and nutrition, falls, pain, and general aspects such as checking a cannula site or that the buzzer was within reach. Adviser 2 said that, as the care rounding documents are relied upon as the evidence of the care given, it would be reasonable to expect staff to be robust in their completion. However, Adviser 2 indicated that four of the pro forma forms were poorly completed and offered no or little evidence of care.

52. Adviser 2 said that these care rounding documents have to be taken as the records of communication between staff and Miss C, and there would have been medicine rounds and the recording of physiological observations. Adviser 2 indicated that, unfortunately, they were insufficient for her to offer advice on whether communication went beyond these very specific rounding instances. Adviser 2 went on to say that there was no evidence of communication with Miss C's family. I address this point at paragraph 84.

53. Adviser 2 said that Nursing and Midwifery (NMC) Guidance on record keeping for nurses and midwifes 2009 (the Guidance) details the importance of record-keeping stating:

> 'Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow.'

54. Adviser 2 stated that, while the Board indicated the care rounding documentation was the equivalent of nursing notes, these did not, in her view, meet the Guidance on record-keeping. Adviser 2 was also concerned that there were significant gaps in the rounding of care and, as a result, no evidence of the care given.

55. In relation to Miss C's concern that a nurse had left her room with a syringe in her hand, when responding to Miss C's complaint, the Board explained that, given the passage of time, they had been unable to identify the nurse involved. As Miss C had in her complaint to this office raised her continuing concern that the member of staff could not be identified from the health records, my complaints reviewer raised this matter with Adviser 2. In response Adviser 2 indicated that, in this case, it would not be proportionate for investigating staff to examine all the health records to identify the nurse and that the Board had offered an assurance there would be overall monitoring of compliance with the nursing protocols. However, Adviser 2 suggested that the Board should explain how they will monitor compliance to protocols and ongoing improvements.

56. My complaints reviewer also raised with Adviser 2 the care and treatment Miss C had received at the PIU on 22 November 2013. Adviser 2 said that Miss C attended the PIU for repeat bloods and for a change of dressing. The area where the dressing had been was inflamed and the Nurse advised Miss C to leave the wound site exposed and not to use toiletries. Adviser 2 said that, based on the available evidence, she was satisfied that the Nurse who was seeking to assist a patient had taken reasonable action when Miss C attended the PIU.

(b) Decision

57. Before I address the specific issues raised by Miss C in her complaint, I want to comment on the general nursing care and treatment Miss C received from 24 October 2013 onwards. The advice I have received and accept is that, while the care rounding documents demonstrate that, overall, there were regular interactions between nursing staff and Miss C, some of the care rounding forms were poorly completed and offered little or no evidence of care. I am also concerned that the standard of record-keeping in this case does not meet the Guidance.

58. Turning to the specific issues raised by Miss C, it is of concern to me that there was a breach in nursing protocol in relation to the disposal of a used syringe. I recognise Miss C's concern that the Board had been unable to identify the nurse involved. However, the advice I have received and accept is that it would not be proportionate for investigating staff to examine all the health records to identify the nurse. In accepting this advice, I am mindful that the Board accepted there had been a breach of protocol and they had offered an assurance that there would be overall monitoring of compliance with nursing protocols.

59. I also recognise that Miss C gained the impression there was confusion on the Nurse's part about why she had attended the PIU. However, I am satisfied that the Board when responding to Miss C's complaint, outlined the action taken by the Nurse and indicated that the Nurse was sorry if Miss C had perceived her behaviour to be unprofessional. While Miss C clearly disagrees with the explanation provided by the Board, the advice I have received and accept is that, based on the available evidence, Adviser 2 was satisfied that the Nurse had taken reasonable action and was seeking to assist Miss C.

60. In view of the failings I have identified above, I uphold the complaint.

(b) Recommendations

61. I recommend that the Board:	*Completion date*
(i) remind nursing staff of the need to maintain full and accurate nursing records in line with NMC guidance; and	16 September 2015
(ii) explain how they will monitor compliance to protocols and ongoing improvements in relation to the safe disposal of clinical waste.	16 September 2015

(c) Infection prevention and control in relation to Miss C's case was inadequate

62. Miss C stated that, on 30 October 2013, she was moved to a side room at Hospital 1 because she had vancomycin resistant enterococcus (VRE) but complained she received no other explanation. Miss C indicated that a nurse noticed she was upset and asked a doctor to speak to her. Miss C stated the doctor gave her a good explanation and reassurance, which included advice that she was being isolated to prevent other patients being exposed to the bacteria.

63. On 31 October 2013 Miss C explained she was advised that Hospital 1 had discovered carbapenemase-producing enterobacteriaceae (CPE) in her bowels and she was given an information sheet to read about this infection. She complained that when she advised the registrar (Doctor 4) she did not understand the information sheet she was advised to speak to the nurses. Miss C felt the response from Doctor 4 was disappointing and questioned how much time it would have taken for Doctor 4 to provide her with an explanation. Miss C further stated that, when she did speak to the nurses, they advised her they had never heard of CPE but they would read the sheet and try to provide an explanation.

64. When responding to a draft of this report the Board stated that Miss C did not have CPE in her stool samples on any occasion. They accepted that, in error, they had referred to Miss C developing CPE when responding to her complaint. They clarified that Miss C had been in contact with a possible CPE case while at Hospital 2, but a negative CPE sample was reported. The Board explained that their CPE screening protocol had been in the process of being changed to require three negative screens and it had been agreed that two further samples should be obtained for CPE testing. The two further samples obtained were also negative.

65. Miss C stated she was also given conflicting information in relation Hospital 1's management of infection prevention and control. She stated that, while she had initially been informed she could be allowed out of Hospital 1, she was then advised to keep away from children and elderly vulnerable people and was then advised that she could visit the café in Hospital 1.

66. On 1 November 2013 Miss C stated she was advised that infection prevention and control IPC staff had advised the ward nurses that they needed three negative stool samples before she could leave the ward. On 2 November 2013, while a third stool sample was taken, Miss C was then advised by nurses that a sample had been sent away for the wrong thing so they required another sample. On 4 November 2013, while there was discussion about Miss C being discharged, she was then advised that another sample was required. Miss C complained about the apparent confusion surrounding the requirement for testing. When responding to a draft of this report the Board clarified that no stool samples were ordered or sent to the microbiology laboratory on 2 November 2013. However, they explained that

Miss C also had an invasive device, a central venous catheter (CVC) and, as part of the screening process, the CVC site should also have been swabbed. They went on to explain that the IPC staff had gone to the ward to speak to Miss C with her ward nurse present as there appeared to be some confusion regarding CPE. At this meeting Miss C's questions were answered.

The Board's response to Miss C's complaint

67. The Board explained to Miss C that Doctor 3 had reviewed her on 29 October 2013 and recorded in her health records her ongoing management, namely continued antibiotic therapy and encouraging passes outwith the ward. However, later it was recorded by IPC staff regarding the finding of a VRE from a stool sample obtained at Hospital 2 on 21 October 2013. The Board further explained that, while it was unclear if Miss C was spoken to directly about this by IPC staff at the time (21 October 2013), her health records indicated that two junior doctors discussed the VRE result with Miss C and its importance to her.

68. The Board went on to explain that, on 30 October 2013, Miss C was moved to a side room and they indicated they were sorry if no other explanation was given to her at this time for this action. They stated that there was input from the consultant microbiologist (Doctor 5) in relation to stopping intravenous drugs for Miss C. The Board indicated that this is not a common infection encountered within Ward 21 and it was correct that the nursing staff asked their medical and infection control colleagues to discuss this with Miss C.

69. The Board stated they were sorry to learn that Miss C had developed CPE infection on 31 October 2013 (see paragraph 64) and, although it was recorded in her health records that further discussions between Miss C and junior medical staff took place, they were disappointed that Miss C had felt the response from Doctor 4 was not helpful. They went on to say that a further visit was carried out by IPC on 1 November 2013 when matters surrounding VRE were re-discussed. Later that day, following his discussion with Doctor 5, Doctor 3 informed the ward doctor to commence oral amoxicillin in place of meropenem and if tolerated, to anticipate discharge home, with a clear plan for such recorded in Miss C's health records of 4 November 2013. A further visit from IPC staff to Miss C was recorded on 4 November 2013 and further advice recorded as given (although I am aware Miss C stated that IPC had only spoken to her on 1 November 2013). Despite this, the Board explained they were sorry to learn about Miss C's poor experience and that confusion remained about her isolation.

The Board's response to SPSO

70. The Board stated that Miss C was noted to be a carrier of VRE in her stools, whilst an in-patient in Hospital 2. On her return to Hospital 1 she was informed of her VRE carrier status and the specific infection control procedures related to this on two occasions noted by medical staff and also by IPC staff. Further advice was sought from Doctor 5 with regard to this issue and the matters pertaining to ongoing antibiotic therapy. The Board stated that all measures taken were in direct accordance with their policies at that time. However, they explained that a review of infection control procedures at ward level had been carried out.

Advice obtained

71. My complaints reviewer raised with Adviser 1 the actions taken by the Board in relation to infection prevention and control. Adviser 1 said the health records from Hospital 2 did not show any evidence that the VRE infection was diagnosed prior to Miss C's transfer to Hospital 1 and, on balance, he was satisfied that VRE was probably not diagnosed until after Miss C transferred back to Hospital 1, so there was no reason for Miss C to be put in a side room when she was initially transferred to Hospital 1 (although when responding to a draft of this report Miss C indicated that she had been put in a side room for a few days before moving to the ward area).

72. Adviser 1 went on to say that an IPC staff member saw Miss C on 1 November 2013 and wrote 'we would advise her to be isolated until she had 3 clear CPE screens, stool, wounds'. The health records record that, on 4 November 2013, Doctor 3 wrote 'awaiting further stool for CPEv – 2 negatives. Allow home'. An IPC staff member wrote 'Please may I request another CPE screen to be taken so that hopefully she will be clear'. Adviser 1 said the ward nursing note after this highlights that a sample was sent on 4 November 2013.

73. Adviser 1 indicated that there does seem to have been uncertainty about the rationale for testing, and the implications of the test results, between the medical, ward nursing and IPC staff.

74. In response to Miss C's concerns that, as the nurses on the ward could not tell her what CPE or VRE were, how could they manage infection control properly, Adviser 2 said that it was reasonable that nursing and medical staff do

not have knowledge of every condition, and they will refer to those more knowledgeable and expert for advice - IPC staff in this instance. Adviser 2 said that this complied with the NMC code which states at paragraphs 29 and 32:

> 'You must consult and take advice from colleagues when appropriate' and 'you must make a referral to another practitioner when it is in the best interests of someone in your care'.

(c) Decision

75. The advice I have received and accept is that there was no reason for Miss C to be put in a side room when she was transferred to Hospital 1 on 24 October 2013. However, having been moved to isolation on 30 October 2013, the advice I have also received is that it appears there was uncertainty about the rationale for testing and the implications of the test results between medical, nursing and IPC staff. I consider that this was an unreasonable level of care.

76. While I recognise that Miss C was unhappy with the level of explanation given to her by Doctor 4, I note that a number of discussions were held between Miss C and junior doctors. I also recognise Miss C's concern that the nurses did not appear to have knowledge about the CPE infection; however, the advice I have received and accept is that it is reasonable that nursing staff do not have knowledge of every condition and that, in line with the NMC code, they will refer to those more knowledgeable. I am also mindful that the nurses advised Miss C that they would read the leaflet and try to provide an explanation. I consider that this was reasonable action to take.

77. While I am satisfied that reasonable action was taken to discuss the infections with Miss C given the uncertainty about the rationale for testing and the implications of tests results, on balance, I uphold the complaint.

(c) Recommendation

78. I recommend that the Board:

	Completion date
(i) report back on the outcome of the review of infection control procedures to evidence that learning and improvement has occurred.	16 September 2015

(d) The Board staff's communication with Miss C and her family was inadequate

79. Miss C raised her concern that there was a lax attitude by some medical staff in recording and communicating with her as a patient and with her parents. In particular, Miss C raised her concern about comments made to her by medical staff which she found distressing and felt were unprofessional, also the apparent confusion about the continued need for isolation. In addition, Miss C raised her concern about the delay in her discharge letter from Hospital 1 being received by her GP, which meant that they did not know whether she needed blood tests once or twice a week. Miss C also raised her concern that poor communication had led to missed medication, and an error in sending specimens. I have addressed these matters at paragraph 43.

The Board's response to SPSO

80. The Board explained that Miss C was spoken to on numerous occasions by many members of the medical and nursing staff and these were documented in the health records. They stated that, at all stages, there were no concerns raised by Miss C or her family regarding the content or frequency of communication. However, the Board stated they had acknowledged Miss C's concerns about the communication involved during her care and had apologised for the short-comings in these areas. These related to missed medication and incorrect dosage on discharge which I have addressed (see paragraphs 17 and 18).

81. The Board, when responding to Miss C's complaint, had also indicated they were sorry Miss C felt comments made to her by medical staff had been inappropriate and that she perceived there had been a lack of respect shown to her. They stated this was not acceptable and an apology was offered for any further distress caused to her. The Board went on to explain that Doctor 3 had apologised if he said anything to Miss C which was felt to convey anything other than relief that she had recovered from a serious illness. The Board indicated that Miss C's feedback would be used to improve the service they provided and that lessons had been learned.

Advice obtained

82. My complaints reviewer raised with Adviser 1 Miss C's concern about the level of communication with her and her family. Adviser 1 said this seems to have been about the degree of isolation Miss C required to try to prevent the spread of infection to other patients. Adviser 1 indicated that he found infection

control advice confusing. He said that it read 'please isolate patient asap'; but then concluded with 'please encourage patient to perform hand hygiene especially if going out and about in hospital'. From the Board's VRE policy Adviser 1 understood that isolation was needed, except where other tests were needed in other departments etc. Adviser 1 was critical that this uncertainty was allowed to remain unresolved, and was, in his view, an unreasonable level of care.

83. My complaints reviewer also raised with Adviser 1 Miss C's concern that there had been an unreasonable delay in her discharge letter being sent to her GP. Adviser 1 said that on 8 November 2013 there was a letter from Doctor 3 to the consultant at Hospital 2 but this was not copied to Miss C's GP to inform them of the consultation and plan. Adviser 1 also indicated that he could not find within the health records a letter from the Nurse who saw Miss C on 22 November 2013. He said that if no letter was sent it was not surprising if Miss C's GP did not know the plan of care for her. He went on to say that overall, the responsibility of this aspect of care seems to have been shared between Hospital 1, Hospital 2 and Miss C's GP. While Adviser 1 went on to say that he could not see any poor clinical care of Miss C's infection directly as a result of this, there was no evidence of good communication between them, which was a poor level of this aspect of care and fell below a level Miss C could reasonably expect. When responding to a draft of this report the Board explained that a letter had been sent to Miss C's GP. While the Board have now provided a copy of this letter, it was not provided during our investigation of the complaint.

(d) Decision

84. The Board indicated that it was not acceptable that Miss C felt that comments made to her by medical staff had been inappropriate and that she had perceived there had been a lack of respect. They explained that Doctor 3 had apologised for Miss C's concern about this matter. It is clear that aspects of communication with Miss C and her family were inadequate. I also consider that the uncertainty about the degree of isolation required which was allowed to continue was an unreasonable level of care. I am also concerned that a copy of the letter to Miss C's GP was not initially provided by the Board. In all the circumstances, I uphold the complaint.

(d) Recommendation

85.	I recommend that the Board:	*Completion date*
(i)	report back to the Ombudsman on the action taken as a result of this case in relation to communication to improve the service provided.	16 September 2015

(e) The Board's handling of, and response to, Miss C's complaint was inadequate

86. Miss C stated that, while she had received a response to her complaint from the Board, she remained dissatisfied. She felt that the investigation carried out by the Board was inadequate and she was not satisfied that lessons had been learned from her case.

87. Miss C complained to the Board on 5 February 2014. This was received by the Board on 11 February and was acknowledged on 13 February 2014. Written statements were obtained from relevant medical and nursing staff. A holding letter was sent to Miss C on 5 March 2014 apologising for the delay in providing a full response and indicating that a full response would be sent to her as soon as possible. A response letter was then issued on 1 April 2014, about which Miss C raised several points of concern.

88. The national guidance on handling NHS complaints states that letters of complaint should be acknowledged within three working days and where possible full responses should be sent within 20 working days. Where it is not possible to meet this deadline, the guidance states that the complainant should be kept informed of the reason(s) for any delay and they should be given an idea of when to expect the full response.

The Board's response to SPSO

89. The Board stated that the investigation was conducted in accordance with standard procedures and sought evidence from all named or relevant parties. They went on to say that all available learning points had been discussed in this case, including a review of the case in the medical unit morbidity meeting, a Serious Event Analysis in Miss C's GP Practice, inclusion in Doctor 3's appraisal process and a review of the infection control, discharge prescribing and drug ordering procedures at ward level.

(e) Decision

90. I recognise that Miss C disagreed with aspects of the Board's response to her representations, and while I am concerned that the Board failed to provide an explanation for why the errors in relation to Miss C's medication occurred (see paragraph 43), taking everything into account, on balance, I am satisfied that the Board conducted a reasonable investigation into the issues raised by Miss C.

91. The guidance makes it clear that, although a full response within 20 working days is desirable, this is a merely a guideline and there will be times when it is not possible to meet this. However, complainants should be kept informed of the reasons for the delay and given an expectation of when they will receive a response. In this case, the Board explained the reason for the delay in their letter of 5 March 2014. I consider that it would have been helpful had the Board given an estimated time for a written reply, however, the response was provided within 20 working days of the holding letter, which I consider was a reasonable level of service.

92. In the circumstances, on balance, I do not uphold the complaint.

93. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Miss C	the complainant
Hospital 1	St John's Hospital
MAU	Medical Assessment Unit
Doctor 1	a doctor
Doctor 2	a doctor
CT scan	Computerised tomography scan
Doctor 3	a doctor
PAA	Primary Assessment Area
Hospital 2	Western General Hospital
PIU	Planned Investigation Unit
the Board	Lothian NHS Board
Adviser 1	a general medical adviser
Adviser 2	a senior nursing adviser
SIGN	Scottish Intercollegiate Guidelines Network
the Nurse	a nurse practitioner
NMC	Nursing and Midwifery Council
the Guidance	Nursing and Midwifery Guidance on record keeping for nurses and midwifes 2009

VRE	Vancomycin enterococcus
CPE	carbapenemase-producing enterobacteriaceae
Doctor 4	a registrar
IPC	Infection prevention and control
CVC	central venous catheter
Doctor 5	a consultant microbiologist

Annex 2

Glossary of terms

abscess	focal area of infection, often an area of 'pus'
amoxicillin	antibiotic useful for the treatment of a number of bacterial infections
analgesia	Medication that acts to relieve pain
carbapenemase-producing enterobacteriaceae (CPE)	the name given to a group of bacteria which have become very resistant to antibiotics, including those called carbapenems
hemanopia	where part of the visual field is 'missing', as the brain does not process the information from the eyes correctly
hickmanline	A central venous catheter
meropenam	an antibiotic drug for intravenous injection
photophobia	where light causes irritation and is a sign of raised pressure in the brain
vancomycin enterococcus (VRE)	bacteria which cause an infection that is hard to cure