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: South of Scotland

Case ref: 201404767, Borders NHS Board
Sector: Health
Subject: Hospitals; clinical treatment; diagnosis

Summary
Mrs A, who had dementia, was admitted to Borders General Hospital with sepsis (blood infection). She was discharged to her care home after a few weeks but was re-admitted two months later for end of life care. She died in hospital two days later. Her daughter (Mrs C) complained about several aspects of the care and treatment received by Mrs A during her admissions to the hospital. She said that, before her first admission to the hospital, Mrs A had been able to walk with the help of a walking stick and could feed herself. However, by the time of her discharge, she could neither stand nor eat without assistance. Mrs C said that Mrs A was not helped with personal care, her skin care was not attended to, and she was not helped with eating or drinking. She said that staff did not consider the needs of Mrs A as a person, despite the care home providing 'Getting to Know Me' documentation when she was admitted.

As part of my investigation I obtained independent advice from a nursing adviser. The adviser noted that the record-keeping, and particularly the nursing notes, about Mrs A's care was poor. Documents such as her care plan were not completed properly and other documents that my adviser expected to see (such as a wound chart, and food and fluid charts) were missing entirely. This meant that there was no evidence to show that reasonable nursing care was provided to Mrs A. The adviser said it was very poor that relevant personal information about Mrs A was lacking from her notes as this information was vital to ensure her care plan was person-centred. I was advised that Mrs A's care lacked any knowledge of dementia, and I am concerned that her needs and preferences were not taken into account. I concluded that Mrs A did not receive adequate care during this admission.

Mrs C also complained about communication from staff during Mrs A's first hospital admission. Despite the family holding welfare power of attorney for Mrs A, she said staff never approached them to discuss treatment or the care plan. She said the family, who made daily enquiries, were often given misleading information, and she complained that the staff discussed Mrs A with them in the corridor. The adviser said that they would have expected more

information in Mrs A's notes about communication with her family, and that the standard of communication was generally poor. They considered confidential discussions taking place in hospital corridors to be totally unacceptable practice. I found that the welfare power of attorney should have been identified and reflected in Mrs A's care plan, and the family should have been updated regularly. An inspection in 2012 by Healthcare Improvement Scotland (HIS) alerted the board to instances where staff failed to satisfy themselves that a welfare power of attorney was in place, and also instances where staff discussed confidential patient information in corridors. I was concerned that this was still occurring.

Mrs C was also unhappy about the care Mrs A received when she was re-admitted to Borders General Hospital for end of life care, and about the attitude and communication of nursing staff at that time. She said that Mrs A, who was close to death, and her grieving family were left alone for two and a half hours. She said the staff showed no care or compassion and seemed uninterested. The adviser said the nursing role is to care and support both the patient and their relatives, and that they would have expected staff to assess and provide care to a dying patient at least every two hours. However, there were long gaps between entries in the nursing records, which I found concerning. The family's needs were clearly not met and I conclude that the level of support provided was unreasonable.

Mrs C complained about the board's handling of her complaints, one of which did not acknowledge within the correct timescale or automatically treat as an official complaint. The board also failed to send Mrs C a written follow-up or apology after their meeting with members of the family. Mrs C considered that the board's investigation missed serious failings and, in particular, a breach in procedures that were put in place after the HIS inspection. I found that Mrs C's letter was clearly a complaint and should automatically have been dealt with as such, and that it would have been good practice to summarise the key points of the meeting for Mrs C. I considered that the board's learning from the complaints was vague, and I agreed with Mrs C that the board's action plan was insufficient. I upheld all of the complaints and made several recommendations.

Redress and recommendations

The Ombudsman recommends that the board:	*Completion date*
(i) carry out a review of nursing care and leadership	9 March 2016

	on the relevant wards, taking account of the failings highlighted in this report;	
(ii)	further develop their action plan to take account of the criticisms in this report and, in particular, ensure that specific and robust action is taken to address the identified record-keeping failings and the failure to provide appropriate, person-centred dementia care to Mrs A;	9 March 2016
(iii)	carry out a review of their consent to treatment policy and patient documentation to ensure that the existence of any formal adults with incapacity arrangement is promptly identified, reflected in the care plan, and that appropriate communication with the relevant appointed person(s) takes place;	9 March 2016
(iv)	take urgent action to address the issue of confidential patient information being discussed by staff in hospital corridors and inform the Ombudsman of the steps taken;	9 March 2016
(v)	provide us with a copy of their action plan / strategy for end of life care;	9 March 2016
(vi)	ensure they have a policy in place to guide staff in what they should do when a patient dies;	9 March 2016
(vii)	review their handling of this complaint and identify areas for improvement, taking account of their statutory responsibilities as set out in the CIHY guidance; and	9 March 2016
(viii)	apologise to Mrs C and her family for the failings this investigation has identified.	13 January 2016

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 Mrs C and the aggrieved as Mrs A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained to the Ombudsman about Borders NHS Board (the Board)'s actions in relation to her late mother (Mrs A)'s two separate admissions to Borders General Hospital (the Hospital) prior to her death. The complaints from Mrs C I have investigated are that:

(a) the Board provided inadequate care and treatment to Mrs A in the Hospital in March and April 2014 (*upheld*);

(b) communication from Board staff with Mrs C and her family in March and April 2014 was inadequate (*upheld*);

(c) the Board provided inadequate care to Mrs A in the Hospital on 15 June 2014 (*upheld*);

(d) the attitude of, and communication from, nursing staff with Mrs C and her family on 15 and 16 June 2014 was unreasonable (*upheld*); and

(e) the Board's handling of Mrs C's complaints was inadequate (*upheld*).

Investigation

1. In order to investigate Mrs C's complaint, my complaints reviewer considered all the information received from Mrs C and the Board. Independent advice was obtained from a nursing adviser (the Adviser). In this case, we have decided to issue a public report on Mrs C's complaint due to the significant personal injustice suffered by Mrs A and her family.

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

Background

3. Mrs A was admitted to the Hospital from a care home on 9 March 2014 with sepsis (blood infection). She was 91 years old and suffered from dementia. She was discharged back to the care home on 5 April 2014 but was subsequently re-admitted to the Hospital on 13 June 2014 for end of life care and she died on 15 June 2014.

4. Mrs C complained to the Board about various aspects of care and treatment, as well as communication, during Mrs A's first admission. She was unhappy with the Board's response and subsequently met with them to discuss her ongoing concerns. Meanwhile, Mrs C raised a further complaint with the Board about the care and communication during the second admission, particularly around the time of Mrs A's death. As she remained unhappy

following her meeting with the Board, and with their written response to her further complaint, she brought her complaints to the SPSO.

(a) The Board provided inadequate care and treatment to Mrs A in the Hospital in March and April 2014

Concerns raised by Mrs C

5. In her complaint to the Board, Mrs C said the family were shocked at the standard of care Mrs A received during this admission. She indicated that Mrs A had been independently mobile with the use of a walking stick prior to admission and that, although she required a little assistance with dressing and washing, she was able to feed independently. However, she complained that, following discharge, Mrs A was unable to stand or feed without assistance. She said there did not appear to be any procedures in place to safeguard dementia patients and that the Hospital failed to provide a safe and caring environment. She raised concerns that staff had failed to consider the needs of Mrs A as a person, stating that they did not take steps to find out about her fears and anxieties, her likes and dislikes, what calmed her distress etc.

6. Mrs C noted that Mrs A was put in isolation on the ward and, despite the family informing staff that she had a fear of being on her own, and asking them to pop in on a regular basis to comfort and reassure her, they arrived most days to find her alone with the door closed, distressed and shouting. She said nursing staff commented that 'she shouts like that all the time'.

7. Mrs C explained that Mrs A's left wrist was in plaster at the time of her admission, having sustained a fracture three weeks earlier. During her admission, she was reviewed in the fracture clinic and her plaster was replaced with a splint, which had to be worn until the next review. She complained that ward staff were unaware of this and Mrs A was often not wearing the splint.

8. Mrs C also noted that fluids were persistently left out of Mrs A's reach. She explained that Mrs A could not lift a cup by herself and could not see the food and drinks put in front of her, yet she said she was given no assistance to eat or drink. She also raised concerns that Mrs A was not assisted with her personal care, noting that she remained in dirty clothes, despite the family delivering clean clothing when requested, and that her hair remained unbrushed and her nails dirty.

9. In addition, Mrs C complained that Mrs A was kept in bed for a protracted period. She said the family were told that she would have to been seen by a physiotherapist before she could get out of bed to sit. She advised that there was a delay of a week between the consultant requesting physiotherapy and the physiotherapist attending and that, thereafter, physiotherapy visits were sparse and treatment time was short.

10. Mrs C also considered that Mrs A was catheterised for longer than necessary. She said they were told it was in case she was incontinent, despite her not having been incontinent prior to admission. Further, she said that emollient cream prescribed by Mrs A's GP for dry skin on her legs was not administered and the family had to point this out to staff. She also complained that Mrs A's legs were never elevated when she was sitting, which led to increased oedema and leaking fluid. She noted that Mrs A also had unexplained bruising and noticeable weight loss when she was discharged.

The Board's response

11. In responding, the Board stated that ward staff had contacted Mrs A's care home to establish her usual level of function with regard to washing, dressing and other activities. However, they acknowledged that the family should have been given 'Getting to Know Me'[1] documentation to complete following Mrs A's arrival on the ward and they said they were sorry they were not given this until 1 April 2014. They said that the ward sister would remind staff of the importance of ensuring that this documentation is completed as soon as possible after a patient's admission to the ward.

12. The Board confirmed that, in line with their infection control policies, Mrs A was nursed in a single room with the door closed as she was a carrier of methicillin-resistant staphylococcus aureus (MRSA). They noted that staff were sensitive to the fact that this could be distressing for some patients and said they generally provide regular reassurance to reduce anxiety. They said they were sorry that Mrs A was distressed when the family visited her and advised that the ward sister would ask her staff to reflect on this so they could ensure it does not happen again.

[1] 'Getting to Know Me' is a dementia resource developed by Alzheimer Scotland and the Scottish Government to assist staff in supporting patients and understanding their specific needs and preferences

13. The Board acknowledged that the outcome of Mrs A's fracture clinic review was poorly documented in her health record prior to a typed letter being received from the fracture clinic at a later date, explaining the purpose of the wrist splint. They apologised for this and accepted that nursing and physiotherapy staff should have been much more questioning of the outcome of the fracture clinic appointment. They noted that staff would be working within their teams to learn from this situation.

14. The Board noted that Mrs A's weight had increased from 71.4 kilograms to 73.5 kilograms during her admission. They said this suggested that she had been eating and drinking well on the ward.

15. The Board observed that Mrs A was quite unwell when she was admitted, with a number of ongoing medical issues, resulting in her only tolerating being out of bed for short periods at a time. They advised that there is no requirement for a physiotherapy assessment before getting a patient out of bed. They explained that this is determined by the patient's clinical condition and that nursing staff would have been able to help Mrs A to sit out of bed when she was able. They noted that physiotherapy is provided when the patient's clinical condition allows. They advised that Mrs A was assessed daily on the ward but she was not able to engage with treatment until 20 March 2014, after which she was seen by a physiotherapist on ten occasions prior to her discharge back to the care home.

16. With regards to Mrs A being catheterised, the Board said her acute illness resulted in the need for this on a temporary basis, even though she had not required a catheter prior to her admission. They explained that Mrs A had a rash and inflamed area across her buttocks and the catheter was, therefore, left in place to allow the skin to heal. They apologised that the need for catheterisation, and also the reasons for Mrs A remaining in bed and the provision of physiotherapy, were not fully explained at the time. They said that the ward sister would remind staff of the importance of communicating effectively with patients and their relatives.

17. The Board acknowledged that it was not acceptable for Mrs A to be wearing dirty clothes and they apologised for this. They advised that the ward sister had discussed the matter with the nursing team to prevent this happening again.

18. In relation to Mrs A's dry skin, the Board noted that this was being treated with an emollient cream. They said the ward doctor should have been asked to review this and prescribe an alternative if it was not effective and they apologised that this did not happen.

19. The Board noted that Mrs A found it uncomfortable having her legs elevated when sitting out of bed but they said that, when necessary, she was helped to rest on her bed to relieve the swelling in her legs. They explained that she was on blood-thinning injections to prevent blood clots. They said bruising is a common side effect of this and they suggested that this could have been the cause of the bruises Mrs C described. They noted that any bruising should have been documented but that there were no references to this in Mrs A's health record. They said that the ward sister would ensure staff were aware of their responsibilities in relation to appropriate record-keeping.

20. The Board's action plan flowing from the complaint included actions to draw up guidelines on dignity and respect and provide them to staff at a ward meeting; for staff dementia training to be extended (along with an acknowledgment that a further dementia champion was needed); and for the use of 'Getting to Know Me' documentation to be embedded into the ward and increased across the organisation.

Complaint to the SPSO

21. In complaining to this office, Mrs C said that the Board's recorded weights for Mrs A on admission and discharge did not match those recorded by the care home and were not in keeping with Mrs A's physical appearance on discharge. She said the Board agreed when the family met with them that Mrs A's nutritional needs had not been cared for properly, admitting that they were unaware she had macular degeneration and, therefore, could not see food placed in front of her.

22. With regards to Mrs A remaining in bed, Mrs C maintained that the family were told every day that this was due to her not having been assessed by the physiotherapist. She said this would suggest that she was not assessed daily by physiotherapy, as noted by the Board. She said the family observed the physiotherapist attending to Mrs A on two occasions and she described the treatment provided on those occasions as lacking encouragement and motivation. Mrs C also suggested that Mrs A being 'seen' by a physiotherapist on ten occasions over a period of 11 days, as indicated by the Board, did not

constitute treatment being provided. She said it was acknowledged at her meeting with the Board that Mrs A was not on bed rest and should have been out of bed.

23. Mrs C said the family did not feel their concerns had been taken seriously regarding the communication errors following Mrs A's attendance at the fracture clinic. She said that procedures should have been put in place to avoid this happening again and she did not consider that raising staff awareness was sufficient. She considered that communication pathways needed to be addressed and documentation improved.

24. Mrs C said that it had also been acknowledged when she met with the Board that Mrs A had not been assessed appropriately for catheterisation and that emollient cream had not been applied to her legs. She said she highlighted that there were no stools or chairs in Mrs A's room upon which to elevate her legs and that the Board agreed this should not have been the case. She said it was accepted by the Board that the family should have been informed they could have visited to assist at meal times or at other times to help with Mrs A's personal care. She confirmed that the family were unaware of this and had never been given this information.

25. Mrs C said the Board also accepted at the meeting that there was no dementia support available during Mrs A's admission due to staff with relevant experience having been away on secondment. She noted that the family had asked to speak to a dementia champion and staff had been unaware of any such person and they did not access any dementia advice. She highlighted that 'Getting to Know Me' documentation had been sent from Mrs A's care home to the Hospital when she was admitted. She said staff were, therefore, in receipt of information which would have made some difference to Mrs A's care.

26. Mrs C complained that the Board's investigation failed to identify a breach of procedures to safeguard elderly patients with cognitive impairment, despite this being an area highlighted in an inspection by Healthcare Improvement Scotland (HIS) in 2012.

The HIS Inspection

27. In July 2012, HIS carried out an announced inspection of the Hospital's care of older people, focussing on dementia and cognitive impairment; and nutritional care and hydration.

28. The HIS Inspection did not find any personalised care plans to address the needs of patients identified as having a cognitive impairment. They highlighted this as an area for improvement and noted that care plans should identify the specific needs of the patient and how staff will meet these needs.

29. The HIS Inspection also observed an absence of personalised nutritional care plans and limited and inconsistent use of food and fluid charts. An identified area for improvement was for staff to accurately and consistently record findings of assessment to ensure all patients have a personalised care plan, documenting their nutritional needs and how these needs will be met.

30. In light of similarities with some of the findings of this investigation to that found in the HIS inspection, a copy of the final investigation report will be shared with HIS.

Advice

31. The Adviser said that the nursing records were poor overall. They considered that the nursing assessment, which should be able to indicate personal and relevant information, was sadly lacking. They noted that there was no information about Mrs A's activities of living, what she was like at the care home, her likes and dislikes or how staff should communicate with her. They said this was very poor as this information is vital to ensure care is person centred, particularly in a woman of Mrs A's age who had dementia.

32. The Adviser considered that the inability to assess Mrs A and have a useful plan of care was unreasonable. They noted that the care home provided a summary for the Board and said the Board could have expanded upon this. They explained that 'Getting to Know Me' is now used throughout Scotland but said it is only part of an overall approach to the care and treatment of older people and those with dementia. They considered that Mrs A's care lacked any knowledge of dementia and the specific care that can be used to optimise the care of people living with dementia. They said the Board's action plan did not address the issues appropriately.

33. With regards to Mrs A's fracture, the Adviser observed that she attended the fracture clinic on the morning of 11 March 2014. They noted that there was no record of anyone accompanying Mrs A to the clinic or any record of what happened there. They considered this to be poor practice. They said they

would have expected a staff member to have accompanied Mrs A to provide clinic staff with information and ensure she was not distressed in an unfamiliar environment. They noted that the accompanying staff member could then have passed on the relevant information about wearing a splint to ward staff.

34. The Adviser confirmed that it is appropriate for patients with infection to be isolated in a single room with the door closed. They acknowledged that this can be distressing. They said staff should have taken Mrs A's concerns and dementia into account and taken steps to ensure she was seen regularly and her distress alleviated if possible. They were critical that the care plan had no record of any of these concerns and, therefore, no actions to alleviate the concerns.

35. With regards to Mrs A remaining in bed, the Adviser agreed with the Board that clinical judgement is needed to assess when patients can get out of bed. They said there did appear to have been an element of this happening. They were unable to find evidence of the family being advised that physiotherapy were required to assess Mrs A before she could get out of bed. They said there was evidence that the charge nurse listened to the family's concerns, however, they considered that the overall communication surrounding mobility appeared poor.

36. The Adviser noted that physiotherapists require patients to cooperate and they observed that this was problematic at times with Mrs A. They explained that some of the physiotherapy input was bed exercises and/or transfer from chair to bed. They noted that there was a delay in Mrs A initially being seen by physiotherapy but following this, taking account of the fact it was not always possible for Mrs A to consent and cooperate, the Adviser considered that the physiotherapy input was reasonable.

37. The Adviser informed my complaints reviewer that it would be acceptable practice to insert a catheter during an acute illness even if the patient did not require one before admission. They noted that Mrs A had incontinence resulting in skin breakdown and acute illness (infection) and they advised that these were relevant clinical reasons for inserting a catheter. They said there was evidence in the nursing and medical notes of regular assessment of the need for a catheter and a plan to remove it. They expressed their view that this complaint related to poor communication overall.

38. In relation to skin care, the Adviser said there was scant reference to the application of emollient cream to Mrs A's legs. They said the lack of a detailed care plan with information about skin care meant this aspect of care could easily have been missed. They also noted that there was nothing in the care plan to indicate that Mrs A's legs should have been raised on a footstool. They said this would have been good nursing care, however, they noted that many patients find having their legs raised uncomfortable. Given Mrs A's cognitive impairment, the Adviser considered that she was unlikely to have understood and cooperated with this aspect of care.

39. The Adviser observed that the nursing notes stated Mrs A's sacrum (bone located at the base of the spine) was red and they said they would have expected a wound chart to have been completed and regular assessments carried out. They noted that the tissue viability care bundle was part of the nursing care rounds but said it was completed in an ad hoc and often incomplete manner. They considered that this aspect of care was poor.

40. With regards to the concerns that Mrs A was not given any assistance with eating and drinking, and that she lost weight, the Adviser considered that the nutritional care was poor. They said there were few entries about Mrs A's intake except very general entries such as 'eating and drinking'. They said they would have expected a food and fluid chart to have been completed for Mrs A to allow staff to assess her input and output. They noted that the Malnutrition Universal Screening Tool (MUST) was done but no actions were taken forward.

41. The Adviser said there was nothing in the records to help them make a judgement on Mrs A's personal care. They said this was again an issue of poor record-keeping and suggested that staff did not take the care they should have in the personal care of Mrs A, which may well have led to the distress caused. They questioned whether there was an issue with the nursing leadership when so many issues have been described and where the nursing notes are so poor. They suggested that the Board could have an independent peer review of the nursing care carried out.

42. The fact that the family appear to have been unaware that they could have visited to assist at meal times was, in the Adviser's view, indicative of the poor relationship/attitudes of the nursing staff. They said they would want to see a detailed review and for actions to be taken to address the leadership, culture and ethos in the Hospital.

(a) Decision

43. The poor standard of record-keeping in this case means that there is no evidence to demonstrate that reasonable nursing care was provided to Mrs A. There were various omissions and deficiencies in her care plan. It lacked information on Mrs A's skin care and nutrition, with no wound chart or food and fluid charts completed. The tissue viability care bundle was not completed fully and consistently and the actions from the MUST were not taken forward. The care plan also failed to include specific actions to address Mrs A's noted fear of isolation and her requirement to have her legs elevated. Further, it is not possible to evidence that Mrs A's personal care was appropriately attended to.

44. Overall, I am advised that Mrs A's care appears to have lacked any knowledge of dementia and there is no evidence that her specific needs and preferences were taken into account. This is concerning. The Board acknowledged that 'Getting to Know Me' documentation should have been completed earlier. However, I note that relevant information appears to have been provided by the care home at the time of Mrs A's admission. This should have been used as a basis for a full and considered assessment by nursing staff, allowing Mrs A's care plan to be tailored to her particular needs. The HIS Inspection highlighted an issue with personalised care plans not being completed and it is unfortunate that, on the evidence of this case, this appears to remain an issue. I conclude that Mrs A did not receive adequate care during this admission and I uphold the complaint.

(a) Recommendations

45. I recommend that the Board:	*Completion date*
(i) carry out a review of nursing care and leadership on the relevant wards, taking account of the failings highlighted in this report; and	9 March 2016
(ii) further develop their action plan to take account of the criticisms in this report and, in particular, ensure that specific and robust action is taken to address the identified record-keeping failings and the failure to provide appropriate, person-centred dementia care to Mrs A.	9 March 2016

(b) Communication from Board staff with Mrs C and her family in March and April 2014 was inadequate

Concerns raised by Mrs C

46. In her complaint to the Board, Mrs C said that the family visited daily and witnessed poor communication practices. She noted that they held welfare power of attorney but were never contacted or approached to discuss Mrs A's treatment or care plan. She said that they enquired on a daily basis and were often given misleading information. She also complained that staff discussed Mrs A with them in the corridor.

The Board's response

47. In responding, the Board said they expect staff to keep relatives informed and to provide them with accurate information about their family member. They said they were sorry that the family were given misleading information and confirmed that the ward sister had reminded staff of the importance of providing relatives with accurate and up-to-date information. In addition, they said it was regrettable that staff discussed Mrs A's condition with the family in the corridor and they noted that the ward sister had also addressed this with the nursing team to ensure that their experience is not repeated.

48. The Board's action plan included actions for whiteboards to be introduced to support the flow of information, supported by 'Getting to Know Me' documentation; and for the senior charge nurse to increase their profile and speak to relatives regularly.

Complaint to the SPSO

49. In complaining to this office, Mrs C said it was accepted at her meeting with the Board that they had failed to complete an adults with incapacity form to assess Mrs A's capacity on admission or identify welfare power of attorney, as a result of which the family were not involved in decisions regarding Mrs A's care.

The Board's response to the SPSO

50. The Board told us that they recognised communication is different in relation to decision making and care planning when speaking to a relative with welfare power of attorney, in comparison with sharing information about an individual who has capacity and is, therefore, able to make decisions and understand and share information themselves. They said they were continuing to review existing documentation for patient records and planned to release updated versions imminently. They said this would include identification of

situations where adults with incapacity are identified, as well as who holds any form of power of attorney. They noted that there would also be a specific section for recording communication with relatives and carers.

The HIS Inspection

51. The HIS Inspection noted that the Board's consent to treatment policy required the medical practitioner to take steps to ascertain if there are any current formal arrangements in place, such as welfare attorney or guardianship. They found health records with no evidence of staff having satisfied themselves that a welfare power of attorney was in place. They highlighted the need to fully implement the local policy as an area for improvement and they recommended that the Board should provide training on their policy to all medical and nursing staff.

52. The HIS Inspection also found occasions where patient care was being discussed in ward corridors and they highlighted the need to maintain patient confidentiality as an area for improvement.

Advice

53. The Adviser said they would have expected more regular and detailed information about dialogue with the family to have been recorded. They considered that the overall standard of communication was poor. They noted that Mrs A was unable to consent, deemed incapable of making her own decisions, and the family held power of attorney. Yet, despite this, the Adviser said there was very little discussion with the family and communication seems to have only been about concerns. They said there should have been a clear account in the care plan about power of attorney and that both medical and nursing staff should have provided the family with regular updates on Mrs A's care and treatment. They advised that this was a vital part of the care given and not an add on.

54. With regards to the concerns raised that staff discussed Mrs A with the family in the corridor, the Adviser said it was very poor to hear that this was happening. They said there must be a room that could be used to speak to relatives. They considered this totally unacceptable practice and said that the Board should address this as a matter of urgency.

(b) Decision

55. The available evidence does not demonstrate an adequate level of communication with Mrs A's family. The family held welfare power of attorney and should, therefore, have been updated routinely and regularly but this does not appear to have happened. Again, this is a specific requirement that was not reflected in Mrs A's care plan. The existence of the welfare power of attorney should have been identified and specifically reflected in the care plan. The HIS Inspection identified instances of staff failing to satisfy themselves that a welfare power of attorney was in place and it is concerning that this still appears to be happening. The HIS Inspection also highlighted instances where staff discussed confidential patient information in corridors and, equally, it is concerning that this is still an issue within the Hospital. In the circumstances, I uphold this complaint.

(b) Recommendations

56. I recommend that the Board:	*Completion date*
(i) carry out a review of their consent to treatment policy and patient documentation to ensure that the existence of any formal adults with incapacity arrangement is promptly identified, reflected in the care plan, and that appropriate communication with the relevant appointed person(s) takes place; and	9 March 2016
(ii) take urgent action to address the issue of confidential patient information being discussed by staff in hospital corridors and inform the Ombudsman of the steps taken.	9 March 2016

(c) The Board provided inadequate care to Mrs A in the Hospital on 15 June 2014; and (d) The attitude of, and communication from, nursing staff with Mrs C and her family on 15 and 16 June 2014 was unreasonable

Concerns raised by Mrs C

57. Mrs C noted that Mrs A received excellent nursing care for the first 48 hours following her admission for end of life care on 13 June 2014. However, she said there was a change in staff on the ward on 15 June 2014 and also a drastic change in the care provided. She advised that Mrs A's breathing pattern altered around 22:30 that evening and, when she asked for her to be reviewed, the nurse-in-charge came into the room and said she was arranging for Mrs A to be transferred to a palliative care ward. Mrs C said this distressed the family as they had been told Mrs A's death was imminent. When

they informed the nurse that her breathing had changed recently, she told them she would not transfer her as death was close and left the room, but did not return.

58. Mrs C advised that Mrs A died at 23:10 and she informed another nurse. The nurse came into the room and Mrs A made a gasping sound, which the nurse said meant she was not dead and that she was gasping for breath. The family found this very upsetting. Mrs A then stopped breathing and the nurse said they would need to get a doctor to verify the death. The nurse left the room and, shortly after, Mrs C's sister went to the nurse's station to ask if the family could have some tea. Mrs C said the nursing staff appeared annoyed at being disturbed and that the nurse who agreed to deliver the tea did so grudgingly. When the tea was served, she said the nurse failed to notice Mrs A's body and the grieving family. She complained that the staff showed no compassion.

59. Mrs C said her sister approached the nurse-in-charge just before 01:00 and asked what they should do before leaving. She said the nurse-in-charge had not been informed that Mrs A had died and no doctor had been called. Mrs C raised concerns that, despite knowing Mrs A was close to death at 22:30, the nurse-in-charge never returned to review the situation or support the family until she was asked for help around 01:00. She complained that a dying patient and grieving family were left alone for two and a half hours. She noted that no one had attended to Mrs A by the time the family left at 02:00 and she was in the same resting position as when she died. She said that no one apologised, offered any comfort or spoke to them when they left. She considered that staff were not interested and did not care.

60. Mrs C noted that Mrs A had wished to die at home surrounded by her loved ones, and this had been discussed and agreed with her GP. Mrs C had, therefore, initially requested that she be transferred back to the care home. However, she said this request was refused due to fear that Mrs A would die on the journey. She lived for another three days and Mrs C said she wished they had taken her home. She said they were lulled into thinking that dying in the Hospital would be a peaceful experience, surrounded by the comfort and support of dedicated and caring professionals. Instead she felt they were abandoned. She said Mrs A's death was marred by the fact that nurses were negligent and failed to provide appropriate end of life care for Mrs A or support for her family.

61. Mrs C noted that the family returned to collect Mrs A's death certificate on the morning of 16 June 2014. She said they were attended to by the ward sister who she described as abrupt, dismissive and disinterested. She noted that the envelope containing the death certificate had the wrong name on it and was only identifiable by Mrs A's date of birth. She also noted that the death certificate had the wrong date and time on it.

The Board's response

62. The Board apologised unreservedly that the care provided to Mrs A and her family in the final hours of her life did not meet the standards they strive to achieve. They noted that the intention had been to move Mrs A to a quieter area following her admission as the ward she was admitted to was very busy, with multiple admissions and discharges each day. However, they said this regrettably could not take place as all single rooms in alternative wards were occupied. They said the senior charge nurse would address the concerns about their experience on the evening of 15 June 2014, and in the immediate aftermath of Mrs A's death, with the nursing staff involved and her wider team to ensure that standards of care and respect are paramount.

63. The Board passed on the ward sister's apologies for the errors around Mrs A's death certificate and for her appearing abrupt and disinterested. They said her own exasperation at the error may have come across as abruptness and they assured Mrs C that it was not her intention to give this impression. They said they were very sorry for the distress she was caused at such a sensitive time.

Complaint to the SPSO

64. In complaining to this office, Mrs C said that the nurse-in-charge had obviously been unaware of Mrs A's condition, as she told the family at 22:30 that she would be transferred to another ward, before changing her mind and advising that Mrs A was close to death. Mrs C reiterated that Mrs A died at 23:10 and the family were left with no support until 01:00, when the nurse-in-charge claimed not to have known Mrs A had died. She said they were then given some written information and left alone and that no one had attended to Mrs A's body by the time they left.

65. Mrs C complained that, when the family left the ward following Mrs A's death, the staff did not speak to them and showed no care or compassion. She

reiterated that the ward sister was abrupt with them the following morning when they came to collect the death certificate. She expressed doubt over the accuracy of the Board's explanation for this, noting that the error with the name on the envelope had not become apparent until after they left. She said that the ward sister had not appeared exasperated at any time.

The Board's response to the SPSO

66. The Board assured us that they continue to take the issues raised about staff attitude and manner seriously. They said that, as part of the actions following their response, staff have discussed and reflected upon how they can be perceived by others and on the need to be aware of how to respond to patients, relatives and carers in their ward. They said that staff attitude and behaviour continues to be a daily focus for nurse managers and senior charge nurses.

Advice

67. The Adviser said they were saddened by the experience described by the family. They said it was apparent that Mrs A was dying yet little action appeared to have been taken. They noted that the nursing records indicate that Mrs A was seen on 15 June 2014 at 04:40 and then again at 19:30, with the drug sheet indicating that sedation and pain control drugs were given at 05:50 and 15:45. The next entry was at 00:45 on 16 June 2014, following Mrs A's death, and the death was verified at 01:50. They said they would have expected nursing staff to have been assessing and providing at least two hourly care to a dying patient, and potentially hourly as Mrs A's condition deteriorated.

68. In addition, the Adviser noted that nursing staff should support relatives in attendance, checking whether they need anything and offering cups of tea at the same time as assessing the patient. They said the records do not indicate the level of intervention they would expect for a patient and their relatives at the end of life. They noted it likely that Mrs A and her family would have been feeling very vulnerable and said the nursing role is to care and support the patient and their relatives. With particular reference to supporting the family following Mrs A's death, the Adviser said the Board should have a policy in place for what to do when a person dies. They advised that this would normally include staff providing basic information for relatives about what should be done.

69. The Adviser considered the Board's response to this complaint to be poor and defensive and they said any learning was vague and non-specific. They suggested that the Board should be asked to provide us with their action plan / strategy for end of life care. They noted that health boards require implementation plans to meet the Scottish Government's 'Living and Dying Well' policy, which summarises its educational aims as follows:

> 'To ensure that all health and social care professionals are equipped with the knowledge, skills, competence and confidence to care for the diversity of patients and families living with and dying from any advanced, progressive or incurable condition.'

70. With regards to when the family returned to collect the death certificate, the Adviser noted that the ward sister said in her statement that this 'was very difficult to deal with as the family were very aggressive' (due to the inaccuracies on the death certificate) and that 'the family were finding the death of their mother very difficult'. The Adviser considered that this statement showed little insight, failed to see the incident from the family's perspective and, therefore, failed to demonstrate any compassion as to why they might have been upset and aggressive. They noted that anger is often the default emotion when families are distressed and that skilled and empathetic dialogue is often required. They said they would have expected the ward sister to understand that relatives react differently to death and dying. They considered that she should have asked for support from elsewhere, such as a manager or consultant, if she was finding this difficult.

(c) & (d) Conclusion

71. It has not been possible to reconcile Mrs C's specific account of events with the available records. I have no way of establishing what nursing staff said to the family or what attitude they displayed. In particular, there are no entries around 22:30 on 15 June 2014 when Mrs C said the family spoke with the nurse-in-charge, and there are no entries around 23:10, the time of death. The entry from 00:45 on 16 June 2014 indicates that the doctors were informed of Mrs A's death at this point, which may accord with Mrs C's account of no doctor having yet been informed when her sister spoke with the nurse-in-charge before 01:00. Mrs C said no one had attended to Mrs A by the time the family left at 02:00 and the records indicate that the death was verified just prior to this, at 01:50. This entry stated that the death was reported by nursing staff at 00:50. I understand that the death certificate was initially issued with the wrong time of

death and a further entry from 16 June 2014 confirmed that this was corrected and reissued.

72. The lack of nursing entries around what was obviously a very difficult time for the family is concerning and fails to demonstrate an adequate level of nursing care and support. I am advised that nursing input should have been at least two hourly yet there was a gap of more than five hours between entries on either side of Mrs A's death. I appreciate that there is a fine balance to be struck between providing care and support during a patient's final hours and giving a family space and privacy with their dying relative. However, the family's needs were clearly not met in this instance and I conclude that the level of support given to them was unreasonable. The Board indicated that this was due to a lack of available beds on less busy wards and they said the issues raised would be fed back to nursing staff. I am not assured that this is sufficient to prevent a repeat occurrence. The Board also apologised for any distress caused by the ward sister's manner when the family collected the death certificate and they said staff had discussed and reflected on how they can be perceived by others.

(c) Decision

73. In view of my findings in paragraphs 72 and 73, I conclude that the Board failed to provide an adequate level of care to Mrs A on 15 June 2014. Therefore, I uphold this complaint.

(d) Decision

74. In view of my findings in paragraphs 72 and 73, I conclude that nursing staff failed to communicate reasonably with Mrs A and her family on 15 and 16 June 2014. Therefore, I uphold this complaint.

(c) and (d) Recommendations

75. I recommend that the Board:	*Completion date*
(i) provide us with a copy of their action plan / strategy for end of life care; and	9 March 2016
(ii) ensure they have a policy in place to guide staff in what they should do when a patient dies.	9 March 2016

(e) The Board's handling of Mrs C's complaints was inadequate

Complaints process

76. Mrs C and her sister first complained to the Board in a letter dated 15 April 2014, which the Board received on 21 April 2014. The Board contacted Mrs C by telephone to request a copy of the power of attorney on 22 April 2014 and wrote to acknowledge receipt of the complaint on 24 April 2014. They stated that they would aim to respond within 20 working days of receiving the power of attorney. They wrote to acknowledge receipt of this on 29 April 2014 and, when doing so, they offered the family the opportunity of meeting with them once their investigation was complete. They noted that they would aim to respond by 28 May 2014 and their response letter was subsequently issued on 26 May 2014. In the interim, Mrs C and her sister had replied expressing their willingness to attend a meeting.

77. The meeting was held on 6 August 2014. No written follow-up was sent to the family and no meeting note is held within the Board's complaint file. The only record of the outcome of the meeting is a handwritten note stating 'family will consider today's discussion and responses and will be in touch if they wish anything further'. Mrs C and her sister wrote to the Board on 9 September 2014 confirming that they had taken up the offer to meet as they remained unhappy following receipt of the Board's response and did not feel that their complaints had been taken seriously or investigated properly. They noted that they had been offered the opportunity at the meeting to present their case to Board members at the end of one of their meetings and they said they had decided to also take up this offer.

78. Mrs C wrote separately on 9 September 2014 to complain about the end of life care Mrs A received in June 2014. The Board received this complaint on 12 September 2014 and wrote to acknowledge receipt on 19 September 2014. Although they indicated that an investigation would be carried out, they asked Mrs C to let them know if she wished her concerns to be dealt with through their formal complaints process. They also said they would be in touch to discuss the family having their story heard at a Board meeting.

79. Mrs C emailed the Board on 30 September 2014 noting that recalling the events leading up to Mrs A's death was distressing and not something she would have chosen to do unless to make a formal complaint. She said she fully expected her complaint to go through the Board's formal complaints process and expressed disappointment that procedures had not been followed and her

complaint had not been taken seriously. She noted that the Board had not acknowledged receipt of her complaint within three working days and she invited them to proceed and deal with it through their formal complaints process.

80. The Board replied on 2 October 2014 advising that it was their normal practice to ask those who raise concerns whether or not they wish them to be dealt with through the formal complaints process. They apologised that this had caused Mrs C further distress and confirmed that they would deal with the issues raised as a formal complaint. They indicated that they would aim to respond by 14 October 2014 and they subsequently responded on that date.

Complaint to the SPSO

81. In bringing her complaint to the SPSO, Mrs C complained that the issues raised by the family had not been fully read or investigated in any depth. She noted that the Board's investigation had failed to identify major flaws in Mrs A's care and, in particular, a breach in procedures implemented following the HIS Inspection. She considered that the process of investigation had been poorly conducted and she did not feel that the outcome would prevent a similar situation arising again. She felt that the staff involved in Mrs A's care should have been questioned rather than senior staff who had no direct involvement in the care and whose names she did not, therefore, recognise. Mrs C noted that the family had received no written follow-up after their meeting with the Board and, in particular, no written apology.

The Board's response to the SPSO

82. The Board told us that the complaints raised by Mrs C were managed in line with the NHS Can I Help You? (CIHY) guidance and responded to within the 20 working day deadline. They noted that senior staff met with the family following the initial complaint and, at the meeting, an offer was made for the family to give their story to a Board meeting.

CIHY guidance

83. The Patient Rights (Scotland) Act 2011 and associated Regulations and Directions came into effect in 2012 and introduced the CIHY guidance. The aim of this guidance is to help support NHS bodies and their health service providers in handling feedback, comments, concerns and complaints about health care services. This is statutory guidance which NHS service providers are required to comply with.

84. Part 3 of the CIHY guidance refers to the SPSO Model Complaints Handling Procedure's definition of a complaint as 'an expression of dissatisfaction about an action or lack of action or standard of care provided'. The guidance states that NHS staff 'will need to use their judgement and in the case of concerns should give individuals the opportunity to consider whether they want the issue to be considered under the complaints procedure'.

85. Section 3.9.1 states that complaints 'should be acknowledged within 3 working days of receipt' and section 3.13.1 states that investigations should 'be completed and a response issued, wherever possible, within 20 working days following the date of receipt of the complaint'.

86. Section 3.10.1 states that the goal of staff investigating a complaint 'is to establish all of the facts relevant to the points raised and provide a full, objective and proportionate response that represents the definitive position'. Section 3.12.2 states that, in terms of best practice, the complaint response should 'address all issues raised and demonstrate that each element has been fully and fairly investigated'.

(e) Decision

87. The Board failed to acknowledge Mrs C's second complaint, of 9 September 2014, within three working days of receipt. When they did acknowledge it, although they indicated that it would be investigated, they asked Mrs C whether she wished it to be dealt with as a formal complaint. When Mrs C queried this, they said it was their normal practice to ask this. However, they do not appear to have asked this when she submitted her first complaint. This was acknowledged within three days of receipt and appears to have been automatically dealt with as a formal complaint. The CIHY guidance indicates that staff can exercise their judgement, and liaise with the complainant, to determine whether concerns raised should be treated as a formal complaint. In this instance, Mrs C had already complained formally and met with the Board. Her subsequent letter was addressed to a complaints officer and raised serious concerns about care and communication around the time of Mrs A's death. Mrs C's concluding paragraph stated that 'nurses were negligent and failed to provide appropriate end of life care for [Mrs A] nor support for her family'. It appears clear to me that this was a complaint and should automatically have been dealt with as such. The Board responded within two weeks of clarifying that Mrs C indeed wished her letter to be treated as a formal complaint.

88. The Board had previously met with the family following their response to the initial complaint. However, there was no note from that meeting, other than a very brief handwritten summary and the only written follow-up was in relation to the family accepting the offer that was made to them to tell their story at a future Board meeting. Mrs C indicated that further failings were acknowledged at the meeting that had not been acknowledged in the prior written response and she, therefore, expected a written follow-up and apology. I consider that it would have been good practice for the Board to have captured details of the discussion to avoid any areas of dispute and to feed into their action plan going forward.

89. I consider that the Board's response to the complaints was unreasonably defensive in parts and, where failings were acknowledged, the learning was vague and the action plan was not sufficiently robust. I count several occasions where an apology was offered but the extent of the noted action was for staff to be reminded of their duties. Mrs C raised concerns this was not sufficient and it is understandable that she did not feel assured that the action taken would prevent a similar future occurrence. I also agree with her that the Board's investigation failed to identify some serious deficiencies, particularly surrounding the inadequacy of the nursing records and their failure to demonstrate appropriate care and communication. In the circumstances, I uphold this complaint. The Board have offered various apologies to Mrs C and her family for the acknowledged failings, however, in light of the additional failings this investigation has identified, my recommendations include a further, overall apology.

(e) Recommendations

90. I recommend that the Board:	*Completion date*
(i) review their handling of this complaint and identify areas for improvement, taking account of their statutory responsibilities as set out in the CIHY guidance; and	9 March 2016
(ii) apologise to Mrs C and her family for the failings this investigation has identified.	13 January 2016

91. 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 dates 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

Mrs C	the complainant
Mrs A	the aggrieved
the Board	Borders NHS Board
the Hospital	Borders General Hospital
the Adviser	the Ombudsman's nursing adviser
MRSA	methicillin-resistant staphylococcus aureus
HIS	Healthcare Improvement Scotland
MUST	Malnutrition Universal Screening Tool
CIHY	NHS Can I Help You? guidance

Annex 2

Glossary of terms

emollient cream	moisturising treatment applied directly to the skin to reduce water loss and cover it with a protective film
oedema	fluid retention in the body
methicillin-resistant staphylococcus aureus (MRSA)	a bacterial infection that is resistant to a number of widely used antibiotics
macular degeneration	an eye condition that leads to the gradual loss of vision
sacrum	bone located at the base of the spine
sepsis	blood infection

Annex 3

List of legislation and policies considered

'Getting to Know Me' – dementia resource developed by Alzheimer Scotland and the Scottish Government, May 2013

Healthcare Improvement Scotland Announced Inspection Report – care for older people in acute hospitals. Borders General Hospital, 17 – 19 July 2012

Living and Dying Well: A national action plan for palliative and end of life care in Scotland, October 2008

The Patient Rights (Scotland) Act 2011 and associated NHS Can I Help You? guidance, April 2012