SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Complaints reviewers have conducted these investigations with the delegated authority of the Scottish Public Services Ombudsman.

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Scottish Parliament Region: Glasgow

Case ref: 201702337, Greater Glasgow and Clyde NHS Board - Acute Services Division

Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary

Ms C complained about the care and treatment provided to her late father, Mr A, by Greater Glasgow and Clyde NHS Board (the Board) in the Enhanced Recovery Area at Glasgow Royal Infirmary (the Hospital). Mr A was admitted to the Hospital with a history of recent weight loss and abdominal pain. He had a laparotomy (an incision in the abdomen), which showed a lump in his colon.

Mr A underwent a primary anastomosis (where sections of the intestine are reconnected following the removal of diseased tissue). After the operation, he was admitted to the High Dependency Unit (HDU). Ms C has stated that the nursing care Mr A received there was excellent and that the family were welcomed to actively participate in his recovery. She also told us that her father was improving and was mobile in the hours prior to his transfer out of the HDU. He was then transferred to the Enhanced Recovery Area in the Hospital. Ms C complained to us about both the medical treatment and the nursing care her father received in the Enhanced Recovery Area when his condition deteriorated. Following transfer back to HDU, Mr A had further surgery, however, he died there several days later.

We took independent advice from a consultant general surgeon (Adviser 1) and a general nursing adviser (Adviser 2). In relation to Ms C's complaint that the Board did not provide reasonable medical treatment to Mr A in the Enhanced Recovery Area, we found that there were a number of failings. In summary:

- communication with Ms C's family had been unreasonable and staff had failed to act on their concerns;
- had Mr A been assessed and examined proactively by an experienced doctor earlier, it was likely that they would have recognised his deterioration and escalated his care sooner. Had this happened, there would have been a greater chance of survival;
- a CT scan should also have been carried out sooner and this would have alerted staff to the anastomosis leaking and gross abdominal infection;

- there were case note entries from a variety of junior doctors, but little documented evidence of Consultant involvement;
- there was delay in providing a dietician assessment;
- the majority of medical interventions appeared to be reactive rather than proactive.

In view of these failings, we upheld Ms C's complaint that the Board did not provide reasonable medical treatment to Mr A.

Ms C also complained that the Board did not provide reasonable nursing care to Mr A in the Enhanced Recovery Area. We found that the actions of nursing staff in relation to Mr A's transfer to the Enhanced Recovery Area had been reasonable. This included their actions in relation to mobilising Mr A and in maintaining his fluid and nutritional intake. However, we also found that the monitoring and observation of Mr A had not been reasonable and was not carried out in line with the relevant guidance. In view of this, we upheld Ms C's complaint that the Board did not provide reasonable nursing care to Mr A in the Enhanced Recovery Area.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Ms C:

Complaint number	What we found	What the organisation should do	What we need to see
(a) and (b)	The Board did not provide Mr A with reasonable care and treatment in the Enhanced Recovery Area	Apologise to Ms C for failing to provide Mr A with reasonable care and treatment in the Enhanced Recovery Area. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology By: 19 October 2018

We are asking The Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	There was little documented evidence of Consultant involvement in Mr A's care in the Enhanced Recovery Area and the majority of medical interventions appeared to be reactive rather than proactive. The medical documentation was poor with limited notes of poor quality that were difficult to read	Patients in the Enhanced Recovery Area should receive appropriately regular senior review to ensure proactive care. This should be documented appropriately	Evidence that these matters: > consultant review/proactive patient care > record-keeping have been fed back to staff in a supportive way and, where appropriate, action has been taken and any changes disseminated By: 19 November 2018
(a)	There was a delay in carrying out a CT scan, which would have alerted staff to gross abdominal infection and breakdown in the anastomosis	All staff in the Enhanced Recovery Area should be aware of the potential for anastomotic leak in patients who have a primary anastomosis and that this may present with subtle deterioration. There should be a low threshold for senior review and CT scan in these cases	Evidence that this matter has been fed back to staff in a supportive way and that they now have the appropriate level of understanding By: 19 November 2018

Complaint number	What we found	Outcome needed	What we need to see
(a)	There was a delay in providing a dietician assessment for Mr A	Patients appropriately referred to dieticians should be assessed within a reasonable time	Evidence that this matter has been considered and, where appropriate, action has been taken and any changes disseminated By: 19 December 2018
(a)	Communication between medical staff and Ms C's family was unreasonable and staff failed to act on the concerns Ms C and her sister raised. On the few occasions where there was communication between medical staff and Ms C's family, this was with junior staff	Communication with patients and/or families should be proactive and when a consultation with the medical team is requested, this should be facilitated at a senior level	Evidence that this matter has been considered and, where appropriate, action has been taken and any changes disseminated By: 19 December 2018
(b)	The monitoring and observation of Mr A was unreasonable and was not carried out in line with the relevant guidance	Monitoring and observation of patients should be carried out in line with the relevant guidance	Evidence that this matter has been considered and, where appropriate, action has been taken and any changes disseminated By: 19 December 2018

Feedback

Points to note

The Board should note Adviser 2's comment in relation to the entry in the nursing records that the family were, 'to be encouraged not to visit at mealtimes.'

Complaints handling

The Board are encouraged to reflect on their own handling of the complaint and why their investigation did not identify the good and poor practice in the provision of care.

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

Introduction

1. Ms C complained to my office about the care and treatment her late father, Mr A, received when he was admitted to the Glasgow Royal Infirmary on 30 September 2016 with a history of recent weight loss and abdominal pain. He had a laparotomy (an incision in the abdomen), which showed a colonic mass. Ms C said that having discussed this with the surgeon, she made it known that Mr A feared a colostomy, but that the surgeon would be the best judge of how the operation should proceed.

2. On 5 October 2016, Mr A underwent a primary anastomosis (where sections of the intestine are reconnected following the removal of diseased tissue). After the operation, he was admitted to the High Dependency Unit (HDU). Ms C has stated that the nursing care Mr A received there was excellent and that the family were welcomed to actively participate in his recovery. She also told us that her father was improving and was mobile in the hours prior to his transfer out of the HDU.

3. On 12 October 2016, Mr A was transferred to the Enhanced Recovery Area in the Hospital. Ms C's complaint is about the care and treatment Mr A received there before he was transferred back to the HDU on 16 October 2016. Following transfer back to HDU, Mr A had further surgery, however, he died on 21 October 2016.

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

(a) the Board did not provide reasonable medical treatment to Mr A after he was admitted to the Enhanced Recovery Area in Glasgow Royal Infirmary in October 2016 (*upheld*); and

(b) the Board did not provide reasonable nursing care to Mr A in the Enhanced Recovery Area (*upheld*).

Investigation

5. I and my complaints reviewer considered the information provided by Ms C and the Board. This included Mr A's medical and nursing records and the Board's complaint file. We also obtained independent advice from two advisers: a consultant general surgeon (Adviser 1) and a general nursing adviser (Adviser 2).

6. In this case, I have decided to issue a public report on Ms C's complaint because of my concerns about the significant failings identified in Mr A's care and treatment and because I consider it is in the wider public interest.

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

(a) The Board did not provide reasonable medical treatment to Mr A after he was admitted to the Enhanced Recovery Area in Glasgow Royal Infirmary in October 2016

Concerns raised by Ms C

8. On 4 April 2017, Ms C wrote to the Board to complain about the care and treatment provided to Mr A in the Enhanced Recovery Area. Ms C asked the Board a number of questions and said that Mr A's condition had deteriorated rapidly there. Ms C said that Mr A became too weak to get out of bed and that, although he was not eating or drinking, there was no sign of the promised parenteral feeding (intravenous administration of nutrients). Mr A was subsequently moved back to the HDU.

The Board's response

9. The Board issued a response to Ms C's complaint on 23 May 2017. They stated that Mr A's death had been reviewed at a Colorectal Mortality and Morbidity meeting and it was concluded that his death might have been prevented if a colostomy had been performed at the initial operation. They said that the breakdown in the anastomosis was conclusively diagnosed at laparotomy on 17 October 2016. They also stated that the Consultant Surgeon had explained that an echocardiogram (a heart scan that uses sound waves to create images) was not undertaken for Mr A and there were no definite plans to perform one.

10. The Board said that a Medical Registrar had recommended a treatment plan to control Mr A's pulse rate with a beta blocker (which he had received) and an echocardiogram if he remained well. They said that it might be helpful to explain that at that point, the Medical Registrar believed Mr A's fast heart rate was most likely due to an underlying sepsis. They stated that on reviewing Mr A's notes, it was not clear why the echocardiogram was not conducted and they were sorry this was not explained to Ms C and her family at that time.

11. The Board went on to say that, there were a number of potential causes of reduced urine output, hypotension (low blood pressure) and oedema (fluid retention), including cardiac failure, malnutrition and sepsis. They added that the Consultant Surgeon had advised that, in hindsight, the severe abdominal infection related to the breakdown in the anastomosis would have contributed to the reduced urine output, hypotension and oedema Mr A experienced.

12. The Board said that the Consultant Surgeon had advised that the main lesson from Mr A's case was to review the balance of risks and benefits between undertaking an anastomosis in the emergency setting and performing a colostomy at the outset. They said that, nevertheless, this remained an informed choice for individual patients to make. Ms C has stated that she considers that her father neither made nor was given a choice.

Advice obtained

13. I asked Adviser 1 whether the continuity of care between the HDU and the Enhanced Recovery Area had been reasonable or unreasonable. In their response to me, Adviser 1 said that the nursing notes indicated that the handover and associated communication on 12 October 2016 when Mr A was moved from HDU to the Enhanced Recovery Area had been reasonable and appropriate.

14. However, they commented that Ms C had raised concerns in her correspondence about Mr A's management in the Enhanced Recovery Area and had cited examples of poor communication, perceived rudeness and, in particular, the failure of nursing and medical staff to listen to the concerns of the family. Adviser 1 said that continuity of care from the medical staff in the Enhanced Recovery Area was poor, with case note entries from a variety of junior doctors, but no documented evidence of Consultant involvement.

15. I also asked Adviser 1 whether Mr A should have had an abdominal ultrasound scan when he was admitted to the Enhanced Recovery Area and to comment on Ms C's concern that staff had unreasonably failed to identify Mr A had a 'bellyful of pus', as stated in Ms C's complaint. In response, Adviser 1 said that there was no indication for Mr A to have an abdominal scan when he was first admitted to the Enhanced Recovery Area, as his condition had improved. However, he soon deteriorated clinically with progressive drowsiness, low blood pressure, poor urine output and impaired kidney function.

16. Adviser 1 said that this deterioration should have alerted medical staff to the possibility of abdominal sepsis secondary to anastomotic leak. A CT scan was eventually performed on 17 October 2016 and showed signs of gross infection with gas and fluid. Anastomotic leakage was confirmed soon after. Adviser 1 stated that based on the clinical signs, a CT scan should have been done sooner. They considered that there had been an unreasonable delay in identifying that Mr A had an infection.

17. I also asked Adviser 1 if it had been reasonable or unreasonable that an echocardiogram was not carried out. In their response to me, Adviser 1 said that this had been reasonable. They commented that at 04.25 on 8 October 2016, Mr A had been reviewed by a medical doctor regarding high blood pressure, high pulse rate and pyrexia (fever). The blood pressure and heart rate settled after administration of a drug Metoprolol (medication used to treat angina and high blood pressure). An electrocardiogram (ECG) showed an abnormal heart rhythm (supraventricular tachycardia) and it was concluded that this was likely to have been caused by infection rather than primary heart disease. It was suggested, however, that if Mr A remained well he should have an echocardiogram, but this was not done as he subsequently deteriorated. Adviser 1 stated that there was nothing to suggest that performing an echocardiogram would have changed Mr A's management or outcome.

18. Next, I referred Adviser 1 to Ms C's comments about Mr A's hypotension, oedema and decreased urinary output and asked them whether they considered staff had failed to diagnose and act on septicaemia/sepsis. In response, Adviser 1 said that they considered there had been a delay in this. They commented that this had been caused by gross abdominal infection, which had resulted from anastomotic leak. The risk of mortality associated with emergency colonic surgery is significant with even higher rates in elderly and malnourished patients (such as in Mr A's case). Post-operative death is often associated with anastomotic leak, which is the most serious complication of this type of surgery. The risk of leak is higher in emergency cases with a primary anastomosis.

19. Adviser 1 commented that the clinical presentation of this complication can be subtle. If there are any signs of deterioration and disturbed physiology, the possibility of a leak should be considered by CT scan immediately. They stated that in Mr A's case, by the time the CT scan was done, his condition had deteriorated to an extent where further surgery and aggressive treatment were

unlikely to be successful. Ms C has stated that staff did not listen to the family about Mr A's deterioration.

20. I then asked Adviser 1 if they considered there had been a delay in requesting the initial dietician assessment and/or in starting parenteral feeding. In response, Adviser 1 said that there had been a delay in providing a dietician assessment. However, they stated that they agreed with the Board's response that there was no mention or plan for parenteral feeding. Adviser 1 said that when Mr A was admitted, it was recognised by medical and nursing staff that he was malnourished. A brief nutritional profile was completed, but there was no apparent input from dieticians until 10 October 2016, despite a referral on 2 October 2016. Enteral feeding (nutrition given into the gut) was recommended post-operatively and Adviser 1 said that in general terms, this is safer and preferable to parenteral feeding. They also commented that before the operation, there was a food diary, which confirmed minimal food intake. Adviser 1 said that this was not surprising as Mr A had a bowel obstruction.

21. I then asked Adviser 1 if the medical review carried out on the evening of 16 October 2016 had been reasonable or unreasonable. In response, Adviser 1 said that whilst the review had been reasonable and appropriate, it was important to note Ms C's comments that she had been 'begging' for medical help for Mr A for the preceding three days.

22. Adviser 1 commented that there is a record in the case notes of a discussion with the family and a junior doctor at 08:20 on 14 October 2016 (Ms C has stated that this meeting was with a member of the surgical staff who had operated on her father and that the junior doctor took the notes). Adviser 1 said that there was a brief and barely legible two-line entry in the notes on 15 October 2016. The next documentation of medical input was at 18:46 and then 19:30 on 16 October 2016, when other doctors were asked to review Mr A, who had deteriorated further and was difficult to rouse. Adviser 1 said that these doctors had made appropriate assessments and management plans and the second doctor arranged transfer to HDU. Mr A arrived there at 21.40. His care was then rapidly escalated to the Intensive Therapy Unit, where he had further surgery, but did not recover.

23. I referred Adviser 1 to Ms C's comments that she and her sister frequently voiced their concerns about Mr A's decreasing physical condition, but nothing was done. I asked Adviser 1 if they considered that staff had reasonably or

unreasonably responded to their concerns. In their response to me, Adviser 1 said that they considered that staff had unreasonably failed to act on their concerns.

24. I then asked Adviser 1 if they considered that staff should have called for assistance from HDU and whether or not they considered staff had unreasonably delayed in transferring Mr A back to HDU. In their response, Adviser 1 said that had Mr A been assessed and examined proactively by an experienced doctor on 15 October 2016, it was likely that they would have recognised his deterioration and escalated his care sooner than the evening of 16 October 2016.

25. I asked Adviser 1 to comment on the communication with the family from medical staff whilst Mr A was in the Enhanced Recovery Area. In their response to me, Adviser 1 said that there were records in the medical notes of two episodes of communication between the family and medical staff whilst Mr A was in the Enhanced Recovery Area. At 20:30 on 12 October 2016, a Foundation Year 1 (FY1 - most junior) doctor clearly and comprehensively documented what appears to have been a difficult discussion regarding the family's annoyance at the perceived poor care in the Enhanced Recovery Area. There is also documentation by another FY1 doctor of a discussion with the family at 08:20 on 14 October 2016 regarding Mr A's management plan.

26. Adviser 1 stated that from this evidence, communication with medical staff was neither reasonable nor appropriate. They said that whilst it is reasonable that in some situations, the FY1 may be the only available doctor to talk to relatives initially, it would be established good practice that if the family were concerned, they would be offered an appointment to talk to a senior doctor, preferably the Consultant, at a mutually convenient time.

27. I asked Adviser 1 what they considered the impact of any failings by the Board had been. In response, they said that in the case of malignant bowel obstruction in an elderly, malnourished man, the risks of death were always high. They commented that large bowel obstruction in the elderly is often due to colorectal cancer. This diagnosis was suspected in Mr A's case on the basis of the clinical presentation and CT scan that showed a narrowing in the descending colon. Surgery was planned to remove the tumour and relieve the obstruction. Often surgery in these situations will result in a temporary or permanent stoma, (colostomy or ileostomy), but Mr A wished to avoid a stoma

and a more risky procedure, namely a left hemicolectomy (an operation to remove part of the large bowel on the left side), with a primary anastomosis was carried out. Adviser 1 stated that by the time of Mr A's re-operation, he was very unlikely to recover. However, there would have been a greater chance of survival had the severe abdominal sepsis due to anastomotic leak been diagnosed and treated earlier. We sent a draft copy of this report to Ms C and the Board for comment. In her response to us, Ms C said that Mr A's last eight days were of suffering and she found this unacceptable.

28. Adviser 1 went on to say that the most serious and feared complication of a primary anastomosis is anastomotic leak where the joined ends of the bowel fail to heal. They said that the factors that increase the risk of leakage include older age, vascular disease and poor nutrition and that Mr A was, therefore, at high risk of a leak. Some leaks can be small and resolve with antibiotics and time, but major leaks are often fatal in the elderly. The signs of leakage can appear days or weeks after surgery. Sometimes the signs are obvious with sudden severe pain and signs of peritonitis (inflammation of the tissue lining the abdomen) but often the signs are more subtle with general deterioration, confusion, reduced urine output and low blood pressure (as in Mr A's case).

29. Adviser 1 stated that the diagnosis of a leak is made usually on a CT scan and the CT scan on 17 October 2016 showed free fluid and gas, which was almost certainly due to a leak. Although this was not mentioned in the report, a leak was confirmed at surgery.

30. In their response, Adviser 1 said that Ms C had stated that she had spoken to the surgeon pre-operatively, but they could find no record of this discussion in the case files and no consent form. I asked the Board for their comments on this. In response, they said that there was no consent form, as Mr A was unable to consent. They sent me a copy of a Certificate of Incapacity completed for him. They also sent me comments from the Consultant Surgeon stating that their recollection, of which there is no record, was that the family were very keen that Mr A did not get a stoma. Ms C has stated that it was not true that Mr A or the family had a strong view that he should not get a stoma and that they left the decision to surgical staff. Adviser 1 stated that any discussion about consent should include clear information on the potential risks and benefits of surgery.

31. Adviser 1 also stated that they considered that the Board should take steps to improve documentation, communication and continuity of care in the Enhanced Recovery Area. Adviser 1 stated that generally, medical documentation was poor with limited notes of poor quality, which were difficult to read. They also said that the majority of medical interventions appeared to be reactive rather than proactive. On the few occasions where there was communication with the family, this was with junior staff.

32. Adviser 1 said that they considered that the Board should look at ways to make sure that there are effective, well-documented handovers along with regular senior review of patients and support for junior doctors. They said that there was a recurrent theme throughout this complaint that the family 'were not listened to' in the Enhanced Recovery Area and commented that improving this culture is the responsibility of medical and nursing teams at all levels. They stated that when patients and/or families request consultation with the medical team, this should be facilitated at a senior level.

33. During our investigation, Adviser 1 suggested that stenting (putting in a stent) rather than anastomosis might have been an option for Mr A and we asked the Board if they had considered this. In response to this, the Board said that this had not been considered. They referred to the guidance from the Scottish Intercollegiate Guidelines Network (SIGN 126: Diagnosis and management of colorectal cancer) and said that Mr A was considered to be fit for surgery. They also said that the surgeon was not enrolled in a trial of stenting versus surgery. Having considered the Board's comments, Adviser 1 said that they considered that it had been reasonable for the Board not to have considered stenting.

Decision

34. The complaint I have considered is that the Board did not provide reasonable medical treatment to Mr A after he was admitted to the Enhanced Recovery Area in Glasgow Royal Infirmary in October 2016. I have considered the issues Ms C has raised and have considered all of these in reaching my conclusion. The medical advice I have received and accepted is that:

- it was reasonable not to carry out an echocardiogram when Mr A was in the unit; and
- the medical review carried out on the evening of 16 October 2016 had been reasonable and appropriate.

35. I have also received and accept advice that the continuity of care from the medical staff when Mr A was moved to the Enhanced Recovery Area was poor as set out from paragraph 13 above. In summary:

- communication with Ms C's family had been unreasonable and that staff had failed to act on their concerns;
- had Mr A been assessed and examined proactively by an experienced doctor on 15 October 2016, it was likely that they would have recognised his deterioration and escalated his care sooner. Had this happened, there would have been a greater chance of survival;
- a CT scan should also have been carried out sooner and this would have alerted staff to anastomotic leakage and gross abdominal infection;
- there were case note entries from a variety of junior doctors, but little documented evidence of Consultant involvement;
- there was delay in providing a dietician assessment;
- the majority of medical interventions appeared to be reactive rather than proactive.

36. In view of all of these failings, I uphold this aspect of Ms C's complaint. My recommendations in relation to this matter can be seen at the end of this decision letter.

(b) The Board did not provide reasonable nursing care to Mr A in the Enhanced Recovery Area

Concerns raised by Ms C

37. In Ms C's complaint to the Board, she said that Mr A's condition had deteriorated rapidly after his admission to the Enhanced Recovery Area. Ms C stated that he was not eating or drinking sufficiently and was pulling out his nasogastric tubes (tubes passed into the stomach through the nose) in his confusion. Ms C said that there was no continuity of care between the HDU and Enhanced Recovery Area and that Mr A did not have a named nurse. She commented that Mr A was not mobilised and had very little help or encouragement with his fluid intake. She said that the family had asked for Mr A to be moved to a single room, but this was refused.

The Board's response

38. In the Board's response to Ms C's complaint, they said that they were sorry that for the short period of time Mr A was in the Enhanced Recovery Area, the 'Getting to Know Me' document (a document that provides information about

the patient's likes, dislikes etc. to hospital staff) was unable to be used. They stated that they were committed to using this form and were in the process of establishing how best to implement this within their surgical wards. They also said that they had reconfigured the management and staffing module for the area and that the senior charge nurse (SCN) would like to reassure Ms C that any reported concerns about Mr A's health were escalated to medical staff and Mr A was reviewed. They also stated that there is a nurse allocated daily to each patient and it is their responsibility to make themselves known to the patient and their family.

39. The Board also said that Mr A was referred to the physiotherapist on 13 October 2016 and was reviewed by them on the same day. They said that he had been mobilised. They apologised that Mr A was not offered more assistance with fluid intake and said that this matter had been raised with staff. They added that a nutrition profile was undertaken for Mr A on admission and a further dietician review was undertaken on 13 October 2016. They stated that they would like to reassure Ms C that regular observations were undertaken for Mr A after his transfer to the Enhanced Recovery Area. In addition, the Board said that it is not always possible for patients to be moved to a single room, as there might be other patients who require to be nursed in isolation.

40. In Ms C's complaint to us, she complained about the delay in carrying out the initial dietician assessment and said that in her opinion, the lack of attention to Mr A's nutritional state was a contributing factor in delaying the post-operative healing process.

Advice obtained

41. I asked Adviser 2 for their comments on Ms C's complaint. They commented that the records showed that Mr A had been transferred to the Enhanced Recovery Area at 14:45 on 12 October 2016. It was noted that he required much assistance including help with eating and drinking. Later that day, it was noted that he had taken minimal food and that staff were awaiting instruction about artificial feeding. At 19:00, it was recorded that medical staff had been contacted, as nursing staff had concerns about Mr A.

42. Adviser 2 commented that on 13 October 2016, nursing staff recorded that Ms C's family were concerned about Mr A's deterioration. It was noted that staff were to assess cognitive impairment, due to concerns that his mood was low. On the following day, it was recorded that Mr A was receiving nasogastric food

(food carried to the stomach through a nasogastric tube), but had dislodged the tube and initially refused to allow it to be replaced. It was subsequently reinserted, but was then dislodged again. Nursing staff also made medical staff aware of Mr A's NEWS score (National Early Warning Score - a tool to support recognition of and response to acute physiological deterioration) at 18:45 that day.

43. Adviser 2 went on to comment that on 15 October 2016, it was noted that Mr A had taken a 'very small amount of diet' and that the family were now trying to assist with this. On 16 October 2016, it was recorded that Mr A's NEWS score were recorded and, at 21:00, it was noted that he was to be transferred to Surgical HDU.

44. I asked Adviser 2 if they considered that the continuity of care between the HDU and the Enhanced Recovery Area had been reasonable or unreasonable. I referred them to Ms C's comments that if Mr A's named nurse from the HDU had liaised with their colleagues in the Enhanced Recovery Area in the days immediately after Mr A's transfer, the change in his condition would have been detected at a far earlier stage. I also asked Adviser 2 if they considered that the communication between nursing staff in the HDU and nursing staff in the Enhanced Recovery Area had been reasonable.

45. In their response, Adviser 2 said that the records indicated that Mr A had arrived into the Enhanced Recovery Area on 12 October 2016. They said that the records showed that the nursing notes and charts continued seamlessly from one area to another. Adviser 2 commented that both units would be used to transferring patients between them when their conditions change and that the nursing notes in relation to the initial transfer conformed to the Nursing and Midwifery Council (NMC) standards for record-keeping and were comprehensive, legible and contemporaneous.

46. However, Adviser 2 referred to a comment in Mr A's records on 12 October 2016, when he was transferred to the Enhanced Recovery Area that the family were, 'to be encouraged not to visit at mealtimes.' Adviser 2 considered that this view is outdated in the current climate when many ward areas are encouraging open visiting or indeed encouraging family members to assist with mealtimes rather than exclude them. Adviser 2 said that the Board should take into account personal wishes and work with families and patients to accommodate them.

47. I also asked Adviser 2 if they considered that the action taken by nursing staff to try to mobilise Mr A had been reasonable and appropriate. In their response, Adviser 2 said that they would have expected Mr A to have been more mobile and that there was only one entry that suggested he was up. However, they added that this was not necessarily a failing, as it is a matter for clinical judgement about when to assist patients walking. They said that due to his age and major surgery, staff might have felt it was more appropriate to keep him in bed and this was reasonable.

48. Next, I asked Adviser 2 if they considered that the actions of staff in relation to providing Mr A with nutrition and fluid had been reasonable and appropriate. In their response to me, Adviser 2 said that staff had documented numerous times when the nasogastric tube had been pulled out by Mr A. Adviser 2 stated that this would have been distressing for all those involved. They stated that it was their view that staff were acting in Mr A's best interests by using nasogastric feeding along with offering him fluids and diet. They commented that the food assessment chart in Mr A's records indicated that his intake was very poor, however, this was not unexpected after major surgery and explained why the nasogastric feeding was commenced. Adviser 2 concluded that whilst Mr A's intake had been poor, staff had taken reasonable steps to maintain adequate fluid and nutritional intake.

49. I then asked Adviser 2 if they considered that the monitoring and observation levels for Mr A had been reasonable or unreasonable in the Enhanced Recovery Area. In response, Adviser 2 said that although there was evidence of reasonable personal care in the records, Mr A's NEWS scores should have been done at least every four hours in line with the guidance, particularly when his score had gone up to three. They added that there were occasions when there were more than six hours between observations and that there had been a gap of over seven hours on 14 October 2016, which was unreasonable. This was during the period Mr A was deteriorating.

50. Adviser 2 said that this was unreasonable in a patient who had just had major surgery. They stated that vital signs recording and NEWS scores are a key tool for nurses to assess, monitor and manage the care of a deteriorating patient and that the NEWS policy the Board have in place was not followed. They concluded that this had been unreasonable and said that the Board should have recognised this themselves.

51. I also asked Adviser 2 if they considered it was reasonable or unreasonable that Mr A was not moved into a single room. In their response, they said that this was always a difficult question, because nursing staff have to take account of many conflicting issues in the ward/department including the gender mix (as bays must be single sex); patients who are infectious or at risk of infection; and any patients who are at end of their life and require privacy. Adviser 2 stated that, in summary, whilst they recognised that the family considered that Mr A should have been in a single room, the Board's response on this matter was reasonable.

Decision

52. I know that in bringing her complaint to this office, Ms C wanted to help improve care and experiences for other patients and their families. I can see how distressing the loss of Mr A was for Ms C's family. It is also clear to me that many of Ms C's concerns relate to communication and the failure of nursing and medical staff to listen to the concerns of the family.

53. The advice I have received and accepted is that the actions of nursing staff in relation to Mr A's transfer to the Enhanced Recovery Area were reasonable. In summary I accept:

- whilst Adviser 2 would have expected Mr A to have been more mobile, the actions of nursing staff in relation to this had been reasonable;
- nursing staff had taken reasonable steps to maintain adequate fluid and nutritional intake and that it was reasonable that Mr A was not moved into a single room.

54. I also accept that the monitoring and observation of Mr A had not been reasonable and was not carried out in line with the relevant guidance.

55. In view of this, I uphold Ms C's complaint that the Board did not provide reasonable nursing care to Mr A in the Enhanced Recovery Area. I have made a recommendation in relation to this below.

56. I am pleased to note that the Board have accepted the recommendations and will act on them accordingly. The Board are asked to inform my office of the steps that have been taken to implement these recommendations by the dates specified. I expect evidence (including supporting documentation) that

appropriate action has been taken before I can confirm that the recommendations have been implemented to my satisfaction.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for Ms C:

Complaint number	What we found	What the organisation should do	What we need to see
(a) and (b)	The Board did not provide Mr A with reasonable care and treatment in the Enhanced Recovery Area	Apologise to Ms C for failing to provide Mr A with reasonable care and treatment in the Enhanced Recovery Area. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leafletsand-guidance	A copy or record of the apology By: 19 October 2018

We are asking The Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	There was little documented evidence of Consultant involvement in Mr A's care in the Enhanced Recovery Area and the majority of medical interventions appeared to be reactive rather than proactive. The medical documentation was poor with limited notes of poor quality that were difficult to read	Patients in the Enhanced Recovery Area should receive appropriately regular senior review to ensure proactive care. This should be documented appropriately	Evidence that these matters: > consultant review/proactive patient care > record-keeping have been fed back to staff in a supportive way and, where appropriate, action has been taken and any changes disseminated By: 19 November 2018
(a)	There was a delay in carrying out a CT scan, which would have alerted staff to gross abdominal infection and breakdown in the anastomosis	All staff in the Enhanced Recovery Area should be aware of the potential for anastomotic leak in patients who have a primary anastomosis and that this may present with subtle deterioration. There should be a low threshold for senior review and CT scan in these cases	Evidence that this matter has been fed back to staff in a supportive way and that they now have the appropriate level of understanding By: 19 November 2018
(a)	There was a delay in providing a dietician	Patients appropriately referred to dieticians	Evidence that this matter has been considered and,

Complaint number	What we found	Outcome needed	What we need to see
	assessment for Mr A	should be assessed within a reasonable time	where appropriate, action has been taken and any changes disseminated By: 19 December 2018
(a)	Communication between medical staff and Ms C's family was unreasonable and staff failed to act on the concerns Ms C and her sister raised. On the few occasions where there was communication between medical staff and Ms C's family, this was with junior staff	Communication with patients and/or families should be proactive and when a consultation with the medical team is requested, this should be facilitated at a senior level	Evidence that this matter has been considered and, where appropriate, action has been taken and any changes disseminated By: 19 December 2018
(b)	The monitoring and observation of Mr A was unreasonable and was not carried out in line with the relevant guidance	Monitoring and observation of patients should be carried out in line with the relevant guidance	Evidence that this matter has been considered and, where appropriate, action has been taken and any changes disseminated By: 19 December 2018

Feedback

Points to note

The Board should note Adviser 2's comment in relation to the entry in the nursing records that the family were, 'to be encouraged not to visit at mealtimes.'

Complaints handling

The Board are encouraged to reflect on their own handling of the complaint and why their investigation did not identify the good and poor practice in the provision of care.

Terms used in the report Annex 1

Adviser 1	a consultant general surgeon who provided advice on the treatment provided to Mr A
Adviser 2	a nursing adviser who provided advice on the care provided to Mr A
beta blocker	drug used to treat various conditions including those of heart, blood pressure and anxiety
colostomy	**an operation to divert part of the bowel through an opening in the tummy**
CT (computerised tomography) scan	a scan that uses x-rays and a computer to create detailed images of the inside of the body
echocardiogram	a heart scan that uses sound waves to create images
electrocardiogram	ECG - a test that records the electrical activity of the heart
enteral feeding	artificial feeding through a feeding tube
HDU	high dependency unit
hemicolectomy	an operation to remove part of the large bowel
hypotension	low blood pressure
ileostomy	surgical procedure carried out on the small intestine

laparotomy	an incision in the abdomen
Metoprolol	medicine used to treat angina and high blood pressure
Mr A	the late father of Ms C and the subject of this complaint
Ms C	the complainant
nasogastric food	food carried to the stomach through a nasogastric tube
nasogastric tubes	tubes passed into the stomach through the nose
NEWS	National Early Warning Score – a tool to support recognition of and response to acute physiological deterioration
NMC	Nursing and Midwifery Council
oedema	fluid retention
parenteral feeding	intravenous administration of nutrients
peritonitis	inflammation of the tissue lining the abdomen
primary anastomosis	where sections of the intestine are reconnected following the removal of diseased tissue
pyrexia	fever
SCN	senior charge nurse

sepsis	blood infection
SIGN	Scottish Intercollegiate Guidelines Network
stenting	putting in a stent
stoma	a surgically made pouch on the outside of the body
supraventricular tachycardia	abnormal heart rhythm
The Board	Greater Glasgow and Clyde NHS Board – Acute Services Division
The Hospital	Glasgow Royal Infirmary

List of legislation and policies considered   Annex 2

Nursing and Midwifery Council (NMC): Record keeping guidance

Scottish Intercollegiate Guidelines Network (SIGN) SIGN 126: Diagnosis and management of colorectal cancer