Scottish Parliament Region: Glasgow

Case 200400662: Greater Glasgow NHS Board

Introduction

1. On 15 July 2004 the Ombudsman received a complaint from a man (referred to in this report as Mr C). Mr C was admitted to Stobhill Hospital on 29 December 2003 for chemotherapy. He complained to Greater Glasgow NHS Board (the Board) about the care and treatment he received while he was there.

2. The complaints from Mr C which I have investigated concerned:

(a) when Mr C arrived at the hospital there was no bed for him;

(b) Mr C was not provided with assistance to wash prior to his chemotherapy;

(c) a staff nurse ridiculed Mr C;

(d) the use of Mr C's bed to examine another patient.

3. Following the investigation of all aspects of this complaint I came to the following conclusions:

(a) not upheld, see paragraphs 13 to 15;

(b) upheld, see paragraphs 16 to 19;

(c) upheld, see paragraphs 20 to 23;

(d) upheld, see paragraphs 24 to 25.

4. In the light of these findings, the Ombudsman recommends that that the Board give Mr C a specific apology in relation to one matter, improve their complaints procedure and remind staff about the importance of correctly completing the Nursing Assessment on Admission Form.

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

Investigation and findings of fact

6. On 13 January 2004 Mr C complained about the care and treatment he received at Stobhill Hospital. He said that when he arrived there was no bed for him and he was sent away to await a telephone call from the hospital which he received later that afternoon at about 14.30. On leaving the hospital to await the call he slipped on black ice and damaged his right wrist which required an x-ray when he was recalled that afternoon. Although the x-ray showed that his wrist was not broken, it was severely bruised, swollen, painful and immobile. Mr C suffers from Marfan syndrome, Reynaud's disease and neutropenia which leaves him debilitated in some areas including his left arm. Mr C asked for help to wash before his chemotherapy which was due to take place on the following day. He was told that there would be no problem. He says that he sat freezing in his pyjamas from 19:00 as he was unable to put on his dressing gown on. Despite his disabilities and his concern about hygiene he was not provided with assistance to wash prior to his chemotherapy which began about noon the following day. When the doctor came to insert the tube for his chemotherapy Mr C complained to him that he had not been washed. He says that when the doctor took the matter up with the staff nurse she said the nurses were busy and then ridiculed Mr C by making comments like 'sterile and now he wants washed' for the amusement of the staff. Mr C also complained about the use of his bed to examine another patient. Mr C later found out that the patient in question had been admitted into isolation with suspected meningitis which had later turned out to be pneumonia. Mr C considered that the staff had put his health at risk.

7. The Board investigated Mr C's complaints but he remained dissatisfied with their response. The next stage of the formal NHS complaints process in practice at that time allowed the complainant to request an independent review of the complaint. An Independent Review Panel Convener (the Convener) considers such requests. This would usually be a non-executive director of the NHS body concerned. The Convener declined to convene an Independent Review Panel in this case. I note that in his complaint to the Ombudsman Mr C said that he had nothing but praise about the treatment and courtesy he received from the staff at Haematology outpatients where all of his subsequent treatments were carried out

and he stated that the fact that he is alive is a testament to their dedication and expertise.

8. In his initial response to Mr C's complaint on 19 February 2004 the General Manager said that he was sorry that the hospital was unable to admit him until later in the day. This was mainly due to the pressures of receiving acute medical cases, a situation which could unfortunately arise at that time of the year. He said that the period Mr C was in the ward was an extremely busy one with many dependent patients. Nursing staff, therefore, had to prioritise their care delivery and unfortunately that meant that Mr C's care was not delivered until later that day. He said he was sorry Mr C was cold and it was unfortunate that he had not brought that to the attention of the staff who could easily have helped him to put on his dressing gown. The General Manager said that the Clinical Nurse Manager and the Sister had reviewed Mr C's notes and had a discussion with the Staff Nurse involved. That Staff Nurse had not been directly responsible for planning Mr C's care that day and could not recall personally dealing with him. However, she suggested that as Mr C was in a bed which is in close proximity to the nurses' station it may be possible that he overheard parts of a conversation in relation to other patients. The Staff Nurse denied ridiculing Mr C and such a complaint had never been made about her previously. She apologised for the upset caused by an inappropriate comment which may have been made by a member of staff. The General Manager said that all staff had been made aware that patients should be treated with dignity and respect at all times. He agreed that the use of a patient's bed to examine another patient was a practice which should not be encouraged specifically in relation to infection risks in vulnerable patients. The Clinical Nurse Manager had discussed Mr C's complaint with the consultants and the medical staff had been told that this practice must not be repeated.

9. When Mr C took issue with the General Manager's response the General Manager sent Mr C another letter. In that letter he said that he had spoken to two other Staff Nurses. One said that in response to a request from Mr C for assistance she told Mr C that if he was awake in the morning she would assist him before she left but as this was not the case she had passed on that duty at handover to the Staff Nurse responsible for Mr C's care during the day. That Staff Nurse said that she did ask the staff to assist Mr C but as the ward was very busy staff had to prioritise their care delivery. Mr C was told that he would be assisted

once the staff had looked after a few other patients first. She also recalled that during that day she had several conversations with Mr C in relation to his pending treatment but did not recall him saying that he was still waiting for a wash. Mr C did not inform her of this until after dinner when his chemotherapy was being administered. She had offered to assist Mr C after his treatment was finished but he declined at that point. The doctor who had been in the ward at the time no longer worked in the area so the General Manager had been unable to speak to him.

10. In his written request for Independent Review Mr C said that there were discrepancies between the two responses he had received. In the first letter it said that he had been attended to later that day which was not the case as he complained to the Staff Nurse the night after his treatment. She told him it would be attended to the next day which it had been. Mr C said it was not the case that he only mentioned that he had not been washed after his treatment had started. Mr C said he spoke to the night nurse who told him she had left a note for the Staff Nurse to ensure it was done. Mr C insisted that the Staff Nurse had ridiculed him to other members of staff when the doctor approached her regarding Mr C's concerns. Mr C said that he said to the doctor that he took exception to it and the doctor had replied that he knew how he felt. Mr C also repeated his complaint about the use of his bed.

11. In preparing this report I have had access to Mr C's complaint form and letter, his clinical notes covering the period of his hospital admission and the complaint correspondence. I also obtained further information from the Board. I have obtained advice from a professional adviser in connection with this complaint and my conclusions are based on the advice which I have received.

12. I issued my report to Mr C and to the Board on 8 November 2005 for comments by 6 December 2005. Mr C provided his comments on 28 November 2005. Mr C considered that the report was fair and balanced. The Medical Director of the Board sent his comments on 20 December 2005 and these are referred to in this report.

Conclusions

(a) When Mr C arrived at the hospital there was no bed for him

13. I accept what the General Manager said about the reason for the delay in Mr C's admission and do not uphold this complaint. There is, however, no indication that any action was taken to try to inform Mr C of the lack of beds before he attended the hospital. Had this been done, Mr C would have suffered less inconvenience. In my report I considered that it would have been appropriate for Mr C to have been given a more detailed explanation about the availability of a bed.

14. In his response to my report the Medical Director said that Mr C attended the Haematology Clinic at Stobhill Hospital on the morning of 29 December 2003 to have his bloods checked in preparation for his chemotherapy. He was told at the clinic by the Sister that unfortunately there was no bed available at that time but the hospital would contact him later that day or the next morning. He considered that Mr C did not have an unnecessary journey to the ward but went to the Haematology Clinic as part of his preparation for admission.

15. I agree that Mr C attended the Haematology Clinic with the expectation that he would be admitted after his appointment. He was not told prior to his attendance at the clinic that there was no bed available for him, neither were alternative arrangements made to check his bloods when a bed was available. This would have prevented Mr C having to make two trips to the hospital which was difficult for him given his physical problems and the weather conditions at that time of year. I remain critical of the lack of explanation provided to Mr C.

(b) Mr C was not provided with assistance to wash prior to his chemotherapy

16. There is little information in the nursing notes that the nursing staff were aware of Mr C's limited ability to care for himself during his admission. He had limited movement of his left arm, an injured right wrist and a venflon (a tube to deliver intravenous fluid) secured in his left hand. The nursing staff have acknowledged that movement would be difficult but no action to support him is documented. The Nursing Assessment on Admission stated that he was 'Independent with ADLs' (Activities of Daily Living). This was incorrect.

17. I note that there is some conflict about whether or not Mr C was offered a shower. In his complaint Mr C suggested that the shower was being used to store materials. I put this point to the Board and the reply I received was that the shower area was not used to store materials and that if the shower area had been out of use for any reason there are six showers within the ward area and an alternative would have been available. It would, therefore, appear that this was not the reason why Mr C could not have been assisted to shower.

18. There is no doubt in my mind that the nursing staff should have been more considerate and attentive to Mr C when he was admitted. He had several physical problems which caused him some distress while he was in hospital. The care provided by nursing staff was insufficient. Whilst it is understandable that some tasks may not be completed when the ward is busy and staff are under pressure, in my view Mr C should have been given a full explanation and an expression of apology for the failings in his care. I uphold this complaint.

19. In response to my report the Medical Director said that he absolutely accepted that Mr C should have had assistance earlier and had apologised to Mr C and upheld this aspect of his complaint when it was considered by the hospital. He apologised that the wording of the letters from the General Manager caused confusion; they should clearly have stated that they were referring to the day of Mr C's chemotherapy which was Tuesday 30 December 2003. That would have clarified that there was no discrepancy between the responses.

(c) A staff nurse ridiculed Mr C

20. Mr C noted that the doctor who had witnessed this incident had left the hospital and had not been asked for a statement about it. In response to my enquiries the Board said that as Mr C's complaint was about a member of the nursing staff and not the doctor that they did not pursue comments from the doctor. Mr C, however, was quite specific in his complaint that the remarks were designed to ridicule him rather than simply overheard by him and that they caused him a significant amount of distress, so much in fact that he told another doctor that he considered abandoning his treatment. It is difficult to accept without further explanation the circumstances in which a comment such as the one he heard could be a comment about another matter. I have tried to contact the doctor to see if he could

remember the incident but without success. It appears that he no longer works in Scotland. The Board should have had a forwarding address for him and it would have been appropriate for them to have contacted him at the time. In the absence of an acceptable explanation of the context in which this remark was made I uphold this complaint on a balance of probabilities. I note that in his letter to Mr C the General Manager said that all staff have been made aware that patients should be treated with dignity and respect at all times. I hope this action will prevent a similar situation arising in future.

21. In response to my report the Medical Director said that the nurse involved was interviewed by the Clinical Nurse Manager and Ward Sister who also spoke with other members of staff who were nearby, and no-one heard the nurse make these or any such comments. Nevertheless an apology was offered to Mr C by the nurse in the General Manager's letter of 19 February 2004.

22. The Medical Director said that the doctor Mr C said he spoke to had left the North Glasgow division by the time Mr C's complaint was being investigated and had not been pursued by the Patient Liaison Department as the complaint was about the nurse. The Patient Liaison Department informed me that due to training rotations it was likely that the doctor would have changed hospitals several times and given that he was unaware of the complaint it was unlikely that he would remember a conversation on the ward in December 2003.

23. I agree that the doctor may not recall the conversation and as my attempts to contact him failed we may never know. Among the documents which I recovered from the Board, however, there is a statement from the Clinical Nurse Manager following the interview which the Medical Director mentions and it refers to the discussion with the nurse. It states that the nurse said it is possible that Mr C overheard 'part of her conversation in relation to other patients' but it does not explain the context in which the remark was used. The nurse was presumably speaking to another member of the nursing staff when she made the remark and yet none of the staff nearby came forward to explain the context in which the remark was made. In my report I clearly stated that I did not consider that the explanation provided was acceptable. In his complaint to the hospital what Mr C said was both credible and consistent. In the absence of any further evidence

which would explain the context of such a remark I continue to uphold this complaint.

(d) The use of Mr C's bed to examine another patient

24. The Board acknowledged that this happened and that the practice was unacceptable but Mr C was not given a specific apology in relation to this complaint. I, therefore, uphold this complaint. In response to my further enquiries the Board said that the practice of using a patient's bed to examine another patient is not a regular occurrence and it was, therefore, felt more appropriate to speak with the medical staff rather than implement a protocol. I note that Mr C considers that the incident has simply been glossed over. However, I am satisfied that appropriate action has been taken to prevent this happening again. It is not good practice to allow beds to be used to treat two or more patients and the nursing staff as advocates for their patients must ensure this does not happen in future.

25. In response to my report the Medical Director reiterated that this was not a regular occurrence and stated that steps had been taken to avoid a recurrence. He said he was sorry that a more specific apology had not been given to Mr C. The Ombudsman recommends that the Board apologise to Mr C now.

Further action

26. In this report I have been critical of the way in which Mr C's complaints were handled by the Board in particular that the explanations given to Mr C were not adequate and the lack of a specific apology over the use of his bed. I have also found that Mr C's Nursing Assessment on Admission was incorrectly completed.

The Ombudsman recommends that:

(i) the Board instruct staff dealing with complaints to give full explanations to complainants;

(ii) the Board apologise to Mr C specifically for the fact that his bed was used to examine another patient;

(iii) nursing staff be reminded about the importance of correctly completing the Nursing Assessment on Admission, particularly in relation to any assistance which a patient may require.

27. As noted in paragraph 13, the Board have accepted the recommendations. The Ombudsman asks the Board to notify her when and how the recommendations are implemented.

28 February 2006

Annex 1

Glossary of medical terms

Marfan syndrome	A connective tissue disorder
Reynaud's disease	A condition affecting blood flow
Neutropenia	A reduction in white blood cells