Case 200500136: Argyll and Clyde NHS Board

Introduction

1. On 23 March 2005 the Ombudsman received a complaint from a man (referred to in this report as Mr C) that Argyll and Clyde NHS Board (the Board) failed to provide the proper care and treatment for his mother (Mrs A) from November 2003 to August 2004 while she was a patient at the Royal Alexandra Hospital (RAH), Paisley. Mr C was supported in this complaint by his sister (Mrs C).

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

(a) Mrs A should not have been admitted to hospital in November 2003 but given the option of being nursed at home instead;

(b) Mrs A contracted several infections because of poor hospital infection control procedures and failure to adhere to policies;

(c) insufficient staff were available on the ward to respond to patients' needs;

(d) communication with Mrs A's family was very poor and often contradictory;

(e) staff did not always respond to Mr C's complaints promptly or accurately.

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

(a) partially upheld, see paragraphs 10 to 16;

(b) partially upheld, see paragraphs 17 to 42;

(c) partially upheld, see paragraphs 43 to 52;

(d) upheld, see paragraph 53 to 66;

(e) upheld, see paragraphs 67 to 74.

4. In summary the investigation has identified concerns about the overall care planning for Mrs A and communication with her family. In the light of these findings, the Ombudsman recommends that the Board make a number of apologies to Mr C and consider a number of revisions to their current policies and practices.

5. Specific recommendations the Ombudsman is making resulting from this investigation are that the Board should:

iii. apologise to Mr C for the failure to adequately communicate with Mrs A's family regarding the reasons for her hospital admission;

iv. apologise to Mr C and Mrs C for the failure to communicate and adequately assess Mrs A's changing needs;

v. undertake an audit of compliance with the clostridium difficile guidelines;

vi. consider how the risks inherent in staff shortages are accounted for and managed in their clinical governance management;

vii. apologise to Mr C and Mrs C for the failure to act proactively in communicating information to the family;

viii. consider how to ensure important information is adequately and promptly communicated to patients and/or relatives in the future;

ix. consider the use of a Communication Sheet to reflect discussions with patients and relatives;

x. apologise to Mr C for the delay in responding to his complaint and the factual errors contained in the response;

xi. review their procedures for responding to complaints to ensure that responses seek to resolve the broader issues identified in a complaint not simply provide factual responses.

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

Medical Background

7. Mrs A (then aged 82) was admitted to the RAH on 25 November 2003. She was admitted at the request of her GP with a diagnosis of cellulitis (skin infection) in her left leg. The GP was concerned that the extent of the swelling and pain might indicate Mrs A also had a deep vein thrombosis (DVT). Investigations on admission ruled out the DVT, but the extent and severity of her cellulitis required treatment with intravenous antibiotics. Because of her oedema (swelling) Mrs A was investigated for possible heart failure and given diuretic medication (to encourage fluid to move from the tissues, usually increasing urinary output). During her admission Mrs A developed urinary tract infections (UTIs), which required additional antibiotics. In December 2003 she developed diarrhoea caused by the clostridium difficile toxin. This required further antibiotic treatment. Mrs A became infected with clostridium difficile on more than one occasion and the infection proved difficult to eradicate, requiring referral to a specialist centre. This contributed to her long-term hospital stay. Mrs A also became infected with norovirus. During her admission, Mrs A developed a much greater degree of dependence on her caregivers, and was discharged to a nursing home with reduced physical and mental capacities. It was also identified during this admission that Mrs A had a condition which compromised her immune condition.

Investigation and Findings of Fact

8. The investigation of this complaint involved obtaining and reading all the relevant documentation, medical records and complaint files. I met with Mr C and Mrs C and sought the view of a medical adviser (referred to in this report as the adviser). A number of written enquires were made of Argyll and Clyde NHS Board who provided me with copies of several policies and documents referred to in this report. I have met with representatives of the Board. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board have been given an opportunity to comment on a draft of this report. The terms used to describe persons referred to in the report are explained in Annex 1 and medical terms are explained in Annex 2.

9. A number of the issues giving rise to Mr C's complaint concerned a debate over the exact nature of what was said by members of staff or Mrs A's family in numerous meetings and the accuracy of correspondence between the Board and Mrs A's family. Some of these issues are addressed as they arise in my findings. There were also a number of issues where the only evidence available was the

uncorroborated evidence of one or other party to the complaint. In these cases it would not be possible for me to reach any meaningful conclusion and I have, therefore, not pursued these issues any further.

(a) Mrs C should not have been admitted to hospital in November 2003 but given the option of being nursed at home instead.

10. Mr C and Mrs C told me that their mother had a profound fear of hospitals as a result of a very difficult appendix operation many years before. They informed staff of this several times during this admission. Mr C complained that it was his belief that his mother's initial symptoms could have been treated at home and that neither her GP nor her family had expected her to be kept in hospital. He said that when the family arrived at hospital on 26 November 2003 to bring Mrs C home they were surprised to find she had been transferred from the admissions ward to Ward 3. Mr C stated that the GP had expected his mother to return home that evening or after an overnight stay and had issued a prescription for antibiotics for her use on return home. Mr C complained that he had been told by a consultant (Consultant 1) on 20 February 2004 that had his mother been treated at home she would probably not have contracted the repeated clostridium difficile infections (and others – see (b)) that gave rise to her protracted stay in hospital and her debilitated condition. He complained that the option of home treatment was never offered to his mother.

11. In response to Mr C's complaint the Board stated that Mrs A was admitted with severe cellulitis and was started on intravenous antibiotics which could not be administered at home.

12. The adviser stated that it is possible to treat some cases of cellulitis at home with oral antibiotics but that in his view Mrs A's cellulitis required hospital admission for intravenous antibiotics (which cannot be given at home) and investigation of the underlying cause. He notes that cellulitis had caused blistering of Mrs A's leg, an indication of its severity.

13. In her written responses to this complaint Consultant 1 denied that she said that cellulitis was treatable at home or that Mrs A would not have contracted infections if treated at home. Instead she told Mr C that his mother could have acquired the infections even if treated at home.

14. In her written responses to this complaint Consultant 1 expressed surprise that Mr C was not aware of his mother's transfer to Ward 3. She referred to an entry in

Mrs A's nursing records for 26 November 2003 which indicated that 'patient and family' had been informed of the transfer to Ward 3. The entry did not indicate which member of the family was called. This entry was not timed. The signature and handwriting do not correspond to any others in the nursing record so I have been unable to ascertain who the member of staff was and who they spoke with. Mr C and Mrs C had no recollection of being contacted. I note that no contact numbers and details for next-of-kin were recorded on Mrs A's admission documents from Accident and Emergency or Ward 12 so it is not obvious what contact details the member of staff used.

(a) Mrs A should not have been admitted to hospital in November 2003 but given the option of being nursed at home instead
Conclusion
15. The medical evidence I have seen indicates that Mrs A was suffering from a severe episode of cellulitis which required hospitalisation and could not have been properly treated at home. Nursing records are incomplete and there is no clear evidence that there was adequate communication with the family about the reasons for her remaining in hospital on her initial admission which might have allowed for a discussion of the limited options. I partially uphold this aspect of the complaint.

16. In light of this conclusion the Ombudsman recommends that the Board apologise to Mr C for the failure to adequately communicate with Mrs A's family regarding the reasons for her hospital admission.

(b) Mrs C contracted several infections because of poor hospital infection control procedures and failure to adhere to policies
17. Mr C and Mrs C complained that a lack of infection control procedures and failure to adhere to policies led to their mother suffering a number of repeated Healthcare Associated Infections (HAIs) all of which caused her protracted stay in hospital and contributed to her overall mental and physical decline. They also complained about the lack of information provided to them about these infections and inadequate communication between hospital staff and the family.

18. Mrs A contracted UTIs, clostridium difficile infections and the Noro Virus (also known as Norwalk) during her stay. I will deal with each of these separately as they give rise to different issues.

19. *Urinary Tract Infections:* Mrs A's nursing notes first noted her to be incontinent

in 1 December 2003. Her admission notes from her GP made no reference to continence problems and she was noted to be continent in the nursing records for 28 November 2003 and 30 November 2003. An entry on 26 November (the day after admission) noted that 'urine foul smelling, MSSU (mid-stream urine sample) obtained'. This sample was reported as being positive for an infection sensitive to flucloxacillin on 27 November 2003. Mrs A had already been prescribed this antibiotic to treat her cellulitis and, therefore, no further prescription was required. Mrs A subsequently tested positive for a different UTI on 5 December 2003 and was prescribed a further antibiotic, trimethoprim. The adviser noted that the timing of these events and results indicated that Mrs A contracted this first urinary tract infection prior to admission to hospital.

20. The adviser noted that Mrs A was prescribed frusemide (a diuretic) on 2 December 2003. At this time the antibiotics prescribed for cellulitis had partially reduced the swelling but Consultant 1 prescribed the diuretic to further treat the swollen leg. The adviser noted this was wholly appropriate but that the action of the diuretic would also increase urine output. The adviser told me that it is very common for elderly women who often have reduced mobility and weakened pelvic floor muscles to experience incontinence as a consequence of being prescribed a diuretic. The adviser also noted that Mrs A's urine infection would cause bladder irritation which would add to continence problems and expressed concern that the records do not indicate any reassessment of Mrs A's care plan to minimise the impact of this developing problem.

21. Mr C and Mrs C complained that they had not been made aware of the infections at the time they occurred. Mrs A's hospital records indicated her family were first informed of the UTIs by a nurse on 11 December 2003 and discussed the problem with Consultant 1 on 12 December 2003. Prior to this they had discussed the continence problems with a Senior House Officer (SHO 2) but he had only referred to the possible effects of the frusimide and Mrs A's difficulties in attracting the nurses' attention when she wished to be taken to the toilet.

22. When Mr C and Mrs C raised the questions of their mother's continence problems with the Board as part of their complaint much of the response and counter response was taken up with a discussion of exactly when Mrs A became incontinent and whether the staff attended to Mrs A's requests to go to the toilet in a timely manner. It was Mr C's belief that the incontinence problem was caused by the inactions of hospital staff. The Board response of 6 May 2004 from the Divisional Director stated that Mrs A complained of dysuria (pain on passing urine)

on admission on 25 November 2003 and that she was incontinent on 28 November 2003. Mr C took issue with both these statements.

23. I can find no entry in the nursing or medical record which referred to dysuria on or around 25 November 2003 although as stated in paragraph 19 the record referred to 'foul smelling urine' and a midstream urine sample being obtained. I also note that the nursing record for 28 November 2003 specifically stated Mrs A was 'continent – requesting for toilet'. I deal with the issue of staff responding to Mrs A's requests to be taken to the toilet in paragraphs 43 to 46.

24. *Clostridium Difficile: Mr C* and Mrs C complained that their mother acquired this infection on a number of occasions while in hospital. They considered that this was due to poor infection control practice within the hospital and pointed to the fact that she acquired one infection while being barrier nursed for another. They also complained that they were not promptly informed of their mother's first infection in December 2003. Mr C complained that he was only provided with information about infection control in April 2004 when he specifically asked for it and after he himself had acquired an infection. Mr C also complained about a specific incident on 20 February 2004 when Consultant 1 did not follow proper infection control procedures.

25. Clostridium difficile is a spore forming bacterium which is present as one of the normal bacteria of the gut of up to 3% of healthy adults and up to 66% of infants under 2 years old. It is generally only problematic for the elderly or others susceptible to contracting infection. The most common cause of the infection is when certain antibiotics alter the balance of the normal bacteria in the gut and most cases will resolve when the antibiotic treatment is stopped. It is also possible for clostridium difficile to spread from person to person as the spores can survive for some time and can be passed on by contact.

26. The adviser said that clostridium difficile infection is often acquired in hospital, usually as a result of antibiotic therapy. The adviser stated that this is just as likely to occur at home and can only ever possibly be partially blamed on staff practices and the ward environment. The adviser said that Mrs A was exposed to prolonged periods of antibiotics to treat her cellulitis and urinary tract infections. He further noted that she had known additional risk factors namely advanced age and an immunocompromising condition which could contribute in a small way to her vulnerability to infections.

27. Again a dispute arose during the course of this complaint about when Mrs A contracted her first clostridium difficile infection. In his response of 6 May 2004, the Divisional Director stated that:

> 'When Mrs (A) became faecally incontinent on 6th December 2003 of loose stools it was diagnosed that she had developed Clostridium Difficile infection'.

Mr C disputed this date and complained that the family were not informed about the specific nature of her infection until a meeting with Consultant 1 on 12 January 2004 and even then were given inadequate information. Prior to this they had been told only that Mrs A had a 'bowel infection'.

28. The nursing record first noted that Mrs A was 'incontinent of faeces' on 6 December 2003. This was noted again on 11 December and in entries for several days following. A sample was taken on 21 December 2003 and reported positive for clostridium difficile on 22 December 2003. The nursing record for 22 December 2003 recorded that Mr C was 'informed' but did not give any detail.

29. The adviser commented that while Mrs A might have contracted clostridium difficile by 6 December 2003, the mere fact of noting that she was incontinent of faeces on this date is not conclusive of such an infection. The infection was not confirmed until 22 December 2003. In this respect the Divisional Director was incorrect in his response.

30. The adviser reviewed the RAH guidelines on management of clostridium difficile and commented that they were clear and robust, being well supported by the Infection Control team. The adviser noted that the issue here was one of compliance by staff and auditing of such compliance. The adviser stated that there is little evidence to establish that staff were aware of the guidelines but this is mainly because of a lack of relevant recording. The adviser also commented on the general lack of documentation such as co-ordinated Nursing Care Plans. In particular there was a lack of care planning in relation to infection control and clostridium difficile and no evidence of Mrs A's care plan being amended to cope with the changes in her underlying conditions brought on by such infections.

31. The adviser also noted that the guidelines require all members of staff to wash their hands as soon as possible following contact with an infected patient. The Board advised me that on 20 February 2004 Mrs A's room contained a wash-hand

basin. Consultant 1 acknowledged that she did not wash her hands while in the room with Mrs A on this date but did so soon after she left the room. Mr C told me that this was not the case as Consultant 1 had returned to a side room with him immediately after this incident.

32. In response to my enquiries the Board told me that since these events a new system of nursing documentation had been introduced along with a specific care plan for clostridium difficile. The adviser reviewed these and stated that they would help ensure more consistent care planning overall and a clear care pathway for treating clostridium difficile infections. The adviser expressed concern that no specific audit of the clostridium difficile guidelines seemed to be in place. Such an audit would be beneficial in ensuring compliance and avoiding the lapses identified by this complaint.

33. In response to Mr C's complaint about the lack of information, the Divisional Director in his response of 6 May 2004 told Mr C that the Infection Control department had a number of information leaflets, including one on clostridium difficile, which would be made available to families on request. Mr C said that he could not have requested the leaflet as he was not told by ward staff of the nature of his mother's infection or the existence of the Infection Control team or their leaflets - only finding out about this through contact with another hospital. He told me that the meeting arranged with the Infection Control Team was useful but that it was too late.

34. In response to Mr C's complaint and my enquires the Board commented that there had been problems in the past when staff had provided patients or relatives with the wrong infection leaflet. They provided me with a copy of a guideline issued to all staff which requires that staff should provide copies of the relevant leaflet to patients or relatives when a patient is noted to be colonised or infected with a particular organism. The guidelines also require that staff inform the Infection Control team and advise relatives that they can contact Infection Control directly for further information. The Board also provided details of audit procedures and results of a number of recent audits relating to infection control.

35. The adviser commented that the new guidelines should help ensure patients and relatives are aware at the earliest stage of the nature of the infections and basic infection control procedures and of the availability of the Infection Control team. I note that such early input would have been of considerable benefit in avoiding several of the issues of this complaint.

36. *Norovirus*: Mrs A tested positive for norovirus on 22 December 2003, and reported on 6 January 2004. A further positive test was noted on 8 April 2004. Mr C complained that Mrs A's family were never told about the first infection and that it was while being barrier nursed for the second norovirus infection that Mrs A became infected with clostridium difficile again.

37. Norovirus is the most common cause of infectious gastroenteritis in the UK. The syndrome is commonly referred to as "winter vomiting disease".

38. I can find no entry in either the nursing or the medical record on or around 6 January 2004 which refers to the norovirus infection or any discussion between staff or with the patient or relatives regarding such an infection.

(b) Mrs A contracted several infections because of poor hospital infection control procedures

Conclusion

39. Given that Mrs A tested positive for a UTI from a urine sample obtained the day after her admission it is probable that the first UTI was contracted prior to her admission. This UTI combined with the effects of the diuretic would have given rise, at least in part, to her incontinence problem. The medical evidence I have seen indicates that it is most probable that Mrs A would have become infected with clostridium difficile wherever she was nursed. While it is possible that some or all of these infections were contracted because of poor hospital practice the likelihood is that these infections would have occurred spontaneously because of Mrs A's antibiotic treatments, immunocompromising condition and age but it is not possible to state conclusively how these infections were acquired. The same cannot be said for the norovirus which can only be spread through contact with an infected person.

40. The nursing and medical records do not provide sufficient evidence of staff awareness of all Mrs A's infections or of staff reacting to Mrs A's changing needs. Consultant 1 did not follow the guidelines when she met with Mrs A on 20 February 2004. There is a lack of evidence of early information provided to the family or timely discussion with them about Mrs A's infections. I deal with communication with the family in (d).

41. I partially uphold this complaint. I note the changes that the Board have undertaken since the time of these events both in nursing documentation and

infection control information management. I believe these would have been of considerable assistance to Mrs A's family but note that staff compliance with guidelines was a problem in this complaint.

42. In light of these conclusions and recognising the changes in procedure that have already occurred the Ombudsman recommends that the Board apologise to Mr C and Mrs C for the failure in communication and failure to adequately assess Mrs A's changing needs. The Ombudsman recommends that the Board undertake an audit of compliance with the clostridium difficile guidelines.

(c) Insufficient staff available on the ward to respond to patients' needs.

43. Mr C complained that his mother's initial continence problems were in part caused by a lack of nursing staff available to assist her to go to the toilet – even though it was hospital policy that she must be accompanied to the toilet. He stated that on a number of occasions his mother pressed the buzzer but no-one responded, or a nurse arrived but said she would return later and did not, or the buzzer was left beyond his mother's reach. He commented that he observed the same problem several times for other patients and that in his view Ward 3 of the RAH was understaffed. He also complained that staff did not make sufficient efforts to assist his mother with eating and she often missed out meals because of this. Mr C raised a concern that his mother's long term isolation because of infections and a lack of physiotherapy input caused her physical and mental capacity to diminish.

44. In response to Mr C, the Divisional Director wrote in his letter of 6 May 2004 that it was noted there had been only one incident where Mrs A was without her buzzer. This had been corrected by the Ward Sister and an apology given at the time. This incident is referred to in the nursing notes on 11 January 2004. The Board told me that the physiotherapist had assessed Mrs A as needing assistance and supervision in toileting and for this reason she needed to be accompanied to the toilet, not because it was a hospital policy.

45. The clinical records contain a reference by SHO 2 on 9 December 2003 to the fact that Mrs A would not always get a nurse's attention in time to go to the toilet. Mr C's note to Consultant 1 on 8 January 2003 referred to the same problem. The nursing records for 8 January 2003 referred to Mr C discussing this issue with the nursing staff that day. All of these occurred prior to the one incident referred to by the Divisional Director on 11 January 2004.

46. The adviser repeated the view expressed in paragraph 20 that despite being aware of Mrs A's difficulties in getting to the toilet there was no reassessment of her care plan to manage the continence problem.

47. The nursing records indicate that 'poor fluid and nutritional intake' was an identified problem although the adviser noted that there are only eight days' nutrition score forms completed. The Board told me that nutrition scores are completed only weekly unless there is a reason to do so more often. A referral was made to a dietician who noted on 29 December 2003 that the food chart requested had not been filled in. The adviser again considered this a failure in care planning.

48. In response to my enquiries the Board commented that there were members of staff on sick leave in Ward 3 between December 2003 and February 2004 and while efforts were made to ensure staffing levels remained at an acceptable level this was not always possible.

49. The adviser noted that in a situation of unresolved staff shortages senior staff and hospital management should discuss the impact of shortages on the ability of staff to deliver adequate care and ensure that there is appropriate prioritisation of care on that ward. The Board have not indicated that there were any such discussions.

50. The adviser commented that the records do demonstrate a good degree of input from both physiotherapy and occupational therapy staff. He noted that while infections caused her to be severely ill it was simply not possible for physiotherapy to work with Mrs A, but they did attend wherever possible. He noted further that this was also true of mental stimulation which cannot always be provided to acutely ill patients. The adviser stated that in such situations it is helpful to proactively discuss with the family how best to provide mental stimulation for the patient. Mr C told me that the family offered to assist with their mother's care on several occasions but felt they were actively discouraged from doing so. The Board have told me that it is hospital policy to involve carers as much as possible but there are practical limits to when and how this can happen.

(c) *Insufficient staff available on the ward to respond to patients' needs*

Conclusion

51. The clinical records indicate that Mr C raised the issue of the lack of available staff to assist Mrs A with toileting on a number of occasions all prior to the episode

of 11 January 2004 noted in the Divisional Director's response. There is a lack of evidence in the nursing records of how Mrs A’s nutritional and feeding difficulties were being addressed. I note the new nursing documentation referred to in paragraph 32 will help ensure a better co-ordinated approach to nutritional needs. Such new documentation is never fool-proof. The adviser suggested that the Board should also consider auditing staff compliance with the new procedures as a matter of routine. The Board acknowledged that there were staff shortages on occasion. The unremedied shortage of staff in this case diminished the ability of staff to deliver all aspects of care. The adviser’s view was that the physiotherapy and occupational therapy input was reasonable in the circumstances. However, input from family members would have been desirable. I partially uphold this aspect of the complaint.

52. In light of these conclusions (and recognising the changes already introduced by the Board with respect to nursing documentation) the Ombudsman recommends that the Board consider how the risks inherent in staff shortages are accounted for and managed in their clinical governance management. The Ombudsman asks that the Board provide this office with details of the outcome of their consideration.

(d) Communication with Mrs C family was very poor and often contradictory.

53. Mr C complained that he was not given sufficient information at an early stage about the nature of his mother’s medical problems on admission or at crucial points when she acquired infections. He complained that he was given different information by different members of staff and frequently told by nursing staff that he would need to refer his questions to medical staff but that medical staff would refer him back to the nursing staff.

54. Mr C also complained of three specific communication problems. Firstly, that shortly after her admission, SHO 2 advised him that his mother had no underlying heart problem but Consultant 1 later told him that his mother did have an irregular heartbeat. Secondly, nursing staff seemed unaware of any problem. Mr C also referred to his mother’s mini-mental state exams (MMSE). A test in January 2004 gave a result of only 10/30. He had been told by SHO 2 that the result shortly after her admission was 26/30 but was advised by the doctor who conducted the January test that this was not the case. Finally, Mr C complained that he was repeatedly told by staff in December 2003 that the plan was to discharge his mother home very soon (within a week) but that on 8 January 2004 he was told by

a doctor his mother would always need to be cared for in a nursing home and would not be returning home.

55. In response to Mr C’s complaint and my enquiries the Board referred to a substantial number of discussions and meetings between Mr C, Mrs C and numerous members of staff throughout Mrs A’s stay in hospital.

56. I have referred to the delays in communicating information to Mr C about his mother's underlying condition on admission and her infections in (a), (b) and (c).

57. With respect to Mrs A’s heart condition Consultant 1 commented in her response to Mr C’s complaint that SHO 2 had stated her heart function was satisfactory. Consultant 1 had told Mr C that his mother had an irregular heart beat. Both were correct as function refers to the ability of the heart to pump blood, while heart rate refers to the rhythm and speed at which the heart pumps.

58. With respect to Mrs A’s MMSEs, the medical record for 3 December 2003 by SHO 1 stated ‘recheck MMSE’. The record did not indicate when the original test was done, the result of this or whether it was subsequently retested. There was no MMSE on file before that performed in January 2004.

59. With respect to Mrs A’s planned discharge the nursing and medical records for December 2003 noted several times that Mrs A’s discharge was being considered in the near future and that this was discussed with the family.

60. I note that the ward manager stated in her comments to the Complaints Officer on 25 February 2004 that ‘I have no idea why he (Mr C) tries to ask medical questions of nursing staff.’ The Board told me that members of staff did find Mr C to be confrontational and difficult to deal with.

61. I am concerned to note that there are a number of references within Mrs A's medical records to the actions of Mr C in raising a complaint. While recognising the need for adequate recording of communication with families, this office recommends that patient's medical records should not contain specific references to complaints and the utilisation of the complaints procedure. Such recording can be considered to be prejudicial to any future treatment and should be avoided for this reason.

62. The adviser noted that despite Mrs A's many and changing needs and

problems there was no evidence in the medical records of any multi-disciplinary review of Mrs A's care during her stay on Ward 3. The Board told me that the records do indicate the input of several members of staff during ward rounds but accepted that this was not necessarily clear in the records. The adviser commented that such meetings are also useful in agreeing lines of communication with the patient and family. The adviser considered that it would have been beneficial if it had been agreed who would be the principal point of communication and if communication, where possible, had been proactive rather than reactive.

(d) Communication with Mrs C family was very poor and often contradictory

Conclusion

63. I conclude in (a) and (b) that Mr C and Mrs C were not initially given sufficient information regarding their mother's underlying medical condition or her infections. The evidence I have seen also supports Mr C's view that staff did not communicate clearly with him regarding his mother's heart condition or the impact of her infections on her potential discharge. Additionally the medical record is deficient in its recording of MMSE performed soon after Mrs A's admission.

64. I note that a considerable amount of the confusion and difficulty that arose in this complaint would have been addressed by a unified approach to Mrs A's medical and nursing problems which were complex and changing. Staff did take considerable steps to address Mr C's concerns but in the earlier weeks of Mrs A's admission this contact was not co-ordinated and reflected the lack of underlying overall planning both of care and communication. By the time staff addressed his concerns Mr C was wary of the seemingly contradictory views being expressed by staff and suspicious of the lack of information being provided about infections which he considered to be due to errors by hospital staff. It was then too late to restore an effective partnership between hospital staff and relatives as the lack of clear, early communication gave rise to distrust and suspicion on the part of the family and defensiveness from some members of staff. That Mr C, an ordinary member of the public, did not understand the difference between good heart function and irregular heart beat or the respective roles of nursing and medical staff, is a fault of communication not of understanding.

65. I uphold this aspect of the complaint. I recognise that the co-ordinated care plan introduced by the Board would have a limited role in assisting staff to address Mr C's many concerns. I am concerned that there was insufficient early communication with relatives on a number of occasions and no apparent co-ordinated approach to communication with relatives. I do not think this matter

would be addressed by the new documentation.

66. In light of this conclusion the Ombudsman recommends that the Board apologise to Mr C and Mrs C for the failure to act proactively in communicating information to the family. The Ombudsman recommends that the Board consider how to ensure important information is adequately and promptly communicated to patients and/or relatives in the future. The Ombudsman also recommends that Board consider the use of a Communication Sheet to reflect discussions with patients and relatives. This document would form an integral part of the overall care plan. The Board should advise the Ombudsman of the outcome of these considerations.

(e) Staff did not always respond to Mr C's complaints promptly or accurately

67. Mr C and Mrs C first complained in writing to Consultant 1 on 19 February 2004. This was copied to the Complaints Officer. Consultant 1 met with Mr C on 20 February 2004 to discuss a number of the issues he raised. The Complaints Officer wrote to Mr C on 24 February 2004, acknowledging his letter and stating she would investigate the matters he raised. Mr C raised further issues in a letter dated 1 March 2004. As he had not received a substantive response or an indication of when he might expect such a response he referred the matter to this office. The Complaints Officer advised this office on 21 April that a response had been drafted and was due to be sent out in 7 to 10 days. Mr C's response was ready to be sent on 6 May 2004 but due to an administrative error by staff outwith the Complaints Department it was not sent until this office notified complaints staff on 14 May 2004 that Mr C had still not received a response. The response was sent out on 15 May 2004 dated 6 May 2004.

68. The NHS complaints procedure requires that all complaints should be responded to within 20 working days or, if not, that the complainant be advised of the delay and the reasons for this delay.

69. I have referred in paragraphs 22, 27, and 44 to errors in the letter of 6 May 2004. In addition the letter refers to an incident where Mrs A was taken out on a day pass by Mr C. The date in the letter is 31 December 2003. In fact the incident occurred on 31 January 2004 and Mr C complained that this factual inaccuracy alongside the others in this letter demonstrate poor attention to detail.

70. My reading of the complaint file and the clinical records illustrate that a number

of the errors in the letter of 6 May 2004 occurred because errors in the staff reports used to compile the letter were not picked up by complaints staff or the Divisional Director who signed the letter. While none of the errors was indicative of poor medical practice they understandably served to increase Mr C's suspicions that there had been medical inefficiency or even an attempt to cover up malpractice.

71. The adviser commented that the response of 6 May 2004 was a description of the care provided to Mrs A during her admission rather than a robust attempt to answer the questions raised in the complaint and to clarify matters for Mr C.

(e) Staff did not always respond to Mr C's complaints promptly or accurately
Conclusion
72. I acknowledge that this was a difficult complaint to manage. Many of the issues raised were on-going ones which can be difficult to respond to in a comprehensive manner. The failures in early communication with Mrs A's family meant Mr C and Mrs C had lost faith with the medical and nursing staff and discussions were often confrontational. Responses from staff became defensive. Errors and delays in responses made matters worse. Where a complaint becomes entrenched or embittered it can be helpful to bring in a third party to conciliate. NHS complaints guidance makes reference to this possibility. I consider such action may have been helpful in this instance.

73. There was a delay in providing Mr C with a written response and there were a number of errors in the response Mr C received. I uphold this aspect of the complaint.

74. In light of this conclusion the Ombudsman recommends that the Board apologise to Mr C for the delay in responding to his complaint and for the factual errors contained in the response. The Ombudsman also recommends that the Board review their procedures for responding to complaints to ensure that responses seek to resolve the broader issues identified in a complaint not simply provide factual responses.

Summary Conclusion
75. While I have upheld the majority of this complaint, I have not identified any significant failing in the medical treatment or care provided to Mrs C. There were shortfalls in nursing care. However, I have not concluded that these were clinically significant. The problems that gave rise to this complaint are almost entirely due to

a lack of overall care planning for Mrs C and her complex needs and the inability of staff to provide her anxious family with the information they needed. As such these problems were avoidable. Once the family started to complain there were several useful meetings with key members of staff but these were too late to counteract the lack of trust that had already occurred. The complaints process was slow to react and unhelpful.

Further Action

76. The Board have accepted all the recommendations and will provide this office with an action plan for there implementation on receipt of the published report. The Board will also notify this office as and when each recommendation is completed.

28 March 2006

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	The co-complainant, Mr C's sister
Mrs A	The aggrieved. Mr C and Mrs C's mother
The RAH	The Royal Alexandra Hospital, Paisley
The Board	Argyll and Clyde NHS Board
Consultant 1	The consultant in charge of Mrs A's care from November 2003 to March 2004
SHO 1	The SHO who assessed Mrs A on her admission in November 2003
SHO 2	The SHO who first discussed several aspects of Mrs A's care with Mr and Mrs C in 2003

Annex 2

Glossary of medical terms

Clostridium Difficile	A spore forming bacterium which is present as one of the normal bacteria of the gut
Cellulitis	Skin infection
DVT	Deep Vein Thrombosis
HAI	Healthcare Associated Infection
Intravenous	By injection into the vein
MSSU	Mid-stream urine sample
Norovirus	Infectious gastroenteritis
Oedema	Swelling
UTI	Urinary Tract Infection