SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Glasgow

Case ref: 201608430, Greater Glasgow and Clyde NHS Board - Acute Services Division
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mrs C complained about the care and treatment she received from Queen Elizabeth University Hospital Glasgow (the hospital). Mrs C was concerned about delays in the time taken for her to receive spinal surgery to address her medical condition (incomplete cauda equina syndrome). In addition, Mrs C complained about the level of care provided during her two admissions by physiotherapy and nursing staff. Mrs C also raised concerns about the aftercare arrangements made at the time of her discharge from the hospital.

We took independent advice from three clinical specialists: a consultant neurosurgeon, a physiotherapist and a nurse.

We found that the board failed to provide neurosurgery to Mrs C within a reasonable time. We noted that there had been unexpected repair works at the hospital that impacted on theatre availability; however, there is clear guidance on the need for surgery to be performed on an emergency basis in cases of incomplete cauda equina syndrome to minimise the risks associated with this condition. In these circumstances, we considered it was unreasonable for the board not to have provided the surgery, or arranged for this to take place at an alternative hospital site. We considered that it was likely that the delay would have impacted on Mrs C's poor outcome following the surgery. Our investigation also highlighted that there was no evidence of communication with Mrs C about the risks of the delays while she was on the neurosurgery ward, and that documentation in the relevant medical records was of a very poor standard.

Our investigation identified failings in the care and treatment provided to Mrs C during her admissions. We found that Mrs C's care while in hospital and on discharge did not appear to have been planned in a co-ordinated and multi-disciplinary way. We found that Mrs C did not receive an adequate level of physiotherapy care. We also had concerns about the level of continence care

provided to Mrs C, the management of her pain and wound care based on the evidence in the nursing records.

We found that there were failings in discharge planning and aftercare arrangements for Mrs C. We considered this was not planned in a co-ordinated and multi-disciplinary way. Our investigation also found there was inadequate patient information provided to Mrs C on discharge, and referrals for aftercare were not made. We noted that this likely contributed to Mrs C's difficult and distressing experience returning to her home.

We upheld Mrs C's three complaints and made a number of recommendations to address the issues identified. The board have accepted these recommendations and we will follow-up on these recommendations. The board are asked to inform us of the steps that have been taken to implement these recommendations by the dates specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm the recommendations have been implemented

Redress and Recommendations

The Ombudsman's recommendations are set out below:

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

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a), (b) and (c)	There was an unreasonable delay in providing neurosurgery to Mrs C. There were also failings in the physiotherapy and nursing care offered to Mrs C and failings in the multi-disciplinary and discharge planning processes	Apologise to Mrs C for the delay in providing neurosurgery; the failings in physiotherapy and nursing care and in the multi-disciplinary and discharge planning processes. The apology should meet the standards set out in the SPSO guidelines on apology available at: https://www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology By: 24 February 2018

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

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	There was an unreasonable delay in providing surgery to Mrs C, who was suffering incomplete cauda equina syndrome	Surgery for cauda equina should be performed within recommended timescales (in this case 24 to 48 hours), or the patient considered for transfer to an alternative hospital site	The Board should demonstrate that they have systems in place to ensure patients with incomplete cauda equina are operated on as an emergency, or transferred to an alternative hospital site for surgery By: 24 April 2018
(a) and (b)	There were significant failings in record-keeping. The ward review documentation was very poor in this case. There were gaps in nursing records (including assessments and fluid balance charts)	The Board should ensure staff complete adequate and contemporaneous medical documentation	The Board should demonstrate how this issue has been raised with relevant staff in a supportive way for reflection and learning and that learning has taken place and/ or relevant future training and development identified By: 24 April 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a), (b) and (c)	There were unacceptable failings in communication. There is no evidence that information was given about the risks of delays to the surgery. Mrs C was not given an appropriate level of information on discharge	Patients should receive relevant and understandable information about cauda equina syndrome	The Board should demonstrate how they will provide patients presenting with cauda equina syndrome with such information and in what way: for example, through discussions and an information leaflet By: 24 April 2018
(b)	There were failings in the physiotherapy care. Despite the record of Mrs C's anxiety, only one pre-discharge supervised trial of stairs was undertaken by physiotherapy	The Board should ensure an adequate level of physiotherapy assistance for patients in Mrs C's position	The steps the Board will take to ensure adequate physiotherapy support is provided to patients following surgery for cauda equina syndrome. By: 24 April 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	Mrs C's nursing assessment, both on admission to and during her stay in hospital, did not include sufficient detail on her symptoms of both pain and incontinence and wound management. Neither did it include the psychosocial impact of her diagnosis and symptoms on her health	Registered nurses should have the knowledge to carry out comprehensive assessments and to develop clear care plans which facilitate consistent and person-centred care. The Board should ensure that registered nurses can assess the psychosocial impact of illness for patients admitted to hospital and can plan care to ameliorate its effects as much as possible	The Board should demonstrate that they have: • reviewed their approach to both incontinence and pain management in in-patient settings; • that learning has taken place; and • put in place steps to implement any actions identified within definitive timescales By: 24 April 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b) and (c)	Mrs C's care while in hospital and on discharge does not appear to have been planned in a co-ordinated and multi-disciplinary way. Her nursing and physiotherapy records have little evidence of input from other professionals. The records did not suggest Mrs C was involved in discharge planning, or her perception of needs or anxieties considered	A supportive multi-disciplinary approach should be in place for patients with cauda equina syndrome	The Board should demonstrate they have reviewed their approach to multi-disciplinary working in in-patient settings to ensure that care is person centred and co-ordinated to optimise recovery for patients while in hospital. Consideration should be given to the use of multi-disciplinary records which facilitate better person-centred assessment and care planning By: 24 April 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(c)	There were failings in the discharge planning and arrangements made for Mrs C	Discharge should be planned in a co-ordinated way. A personalised aftercare plan should be undertaken prior to discharge in cases of this type and include prompt referral to appropriate services. The Board should ensure that patients returning home from hospital have the appropriate referrals made to community based services to support their care on discharge from hospital. This should include the transfer of care plans with the patient, where appropriate, to ensure continuity and consistency of care	An explanation with supporting documentation of the steps the Board will take to ensure appropriate discharge planning By: 24 April 2018

Feedback

Complaints handling

I agree with Adviser 3's comment about the Board's handling of this complaint. The Board did not investigate this complaint in a sufficiently detailed and analytical manner. They appeared defensive of, and failed to take account of the gaps in, nursing practice as evidenced in the nursing notes. While printed nursing records are lengthy, and consideration has been given to how they might facilitate assessment and care planning, it was nonetheless difficult (on the basis of this investigation) to understand the priorities for Mrs C's care. This must cause difficulty in personalising the care to meet individual patient need and for nurses, working different shifts, to be clear about the care plan.

Points to note on best practice

In line with the views of Adviser 2, I would ask the Board to consider the following points about delivering best practice in the care of patients presenting with cauda equina syndrome:

- patient representation on the Cauda Equina Forum;
- patient information developed for people who are at risk of developing cauda equina syndrome and for those with incomplete cauda equina syndrome for issue at the time of diagnosis;
- to ensure that the diagnosis of cauda equina syndrome is recorded, explained to the patient and communicated clearly across the multi-disciplinary team;
- training arranged for all members of the clinical team to ensure that; the diagnosis of cauda equina syndrome, the prognosis and the importance of personalised co-ordinated postoperative management are understood;
- a clear pathway to urology;
- a clear pathway to pain services; and
- a governance reporting system for cases who have poor post-operative outcomes related to cauda equina syndrome.

Points to note on the development of the information leaflet

The Board is asked to consider the following suggestions from Adviser 2 for further improvement:

- page 2: It is important to treat cauda equina syndrome as an emergency not urgently;
- page 3: the symptoms of cauda equina syndrome can also occur gradually, often related to spinal stenosis;
- page 4: women may also have sexual dysfunction related to vaginal numbness;
- page 7: links to patient support groups such as; www.caudaequina.org, www.ihavecaudaequina.com or www.caudaequinauk.com might be included; and
- the inclusion of guidance on when and where to seek help should symptoms deteriorate.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils,

housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

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

Introduction

1. Mrs C complained to the Ombudsman about the care and treatment Greater Glasgow and Clyde NHS Board - Acute Services Division (the Board) provided to her in relation to two admissions to Queen Elizabeth University Hospital (the Hospital). The complaints from Mrs C that I have investigated are that the Board:

(a) failed to provide neurosurgery within a reasonable timeframe (*upheld*);

(b) failed to provide appropriate care and treatment during Mrs C's admissions (*upheld*); and

(c) failed to provide appropriate aftercare following Mrs C's discharge (*upheld*).

2. Mrs C's concerns relate to the care and treatment provided by the Board when she presented with incomplete cauda equina syndrome (a rare and serious neurological condition that affects the bundle of nerves (cauda equina) at the base of the spine). Mrs C stated that, after attending a hospital out with the Board and being diagnosed with incomplete cauda equina syndrome, she was transferred to the Hospital for surgery on 26 March 2016. She complained that she should have received emergency surgery following transfer. Instead she was discharged home after being admitted for several days, with a plan to return for surgery a few days later. Surgery subsequently took place 12 days after her initial transfer to the Hospital on 7 April 2016. Mrs C complained that following surgery she was discharged home without an aftercare plan or information to assist her. Since then, Mrs C has continued to experience pain and significant mobility problems.

Investigation

3. In order to investigate Mrs C's complaint, my complaints reviewer considered all of the information provided by Mrs C and the Board and sought independent clinical advice from a consultant neurosurgeon (Adviser 1), a physiotherapist (Adviser 2) and a nurse (Adviser 3). In this case, I have decided to issue a public report on Mr C's complaint because of the significant failings identified.

4. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered. My complaints reviewer has reviewed all of the information provided during the course of the investigation. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Background

5. Mrs C had been suffering from spinal stenosis (an abnormal narrowing of the spinal canal), urinary incontinence, and lack of sensation. She called NHS 24, and attended a hospital out with the Board. Tests were performed, and incomplete cauda equina syndrome was diagnosed. Mrs C was transferred early in the morning of 26 March 2016 to Queen Elizabeth University Hospital to receive surgery and understood from medical staff at the previous hospital that surgery would need to be provided as soon as possible to avoid irreversible damage to her spine.

6. On admission to the neurosurgery ward (the Ward), an examination was taken and a magnetic resonance imaging (MRI) scan was performed (a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body). Emergency surgery was planned for Mrs C. Unfortunately, there was reduced theatre availability at the time, due to the impact of previous sewage ingress. Mrs C described being taken to the theatre, but the operation was cancelled. She said she raised concerns about the timescale. Mrs C was discharged home after being admitted for seven days without receiving surgery, but with a plan to return in five days' time for the surgery.

7. Mrs C was subsequently re-admitted to the Ward. Mrs C considered her symptoms had worsened by this time. The surgery took place on 7 April 2016, 12 days after her initial attendance.

8. On 8 April 2016 Mrs C was reviewed by physiotherapy. She was seen by physiotherapy again on 11 April 2016, the day of her discharge. Mrs C said that she was anxious about returning home, due to the stairs at her property, and raised this at the time. Mrs C also said she was discharged without an aftercare plan, or information to assist her to return home.

9. Mrs C told my office that she had a very difficult experience returning home, including experiencing severe pain and difficulties with the stairs to her apartment, and using the bathroom. Mrs C said this was traumatic for her family, including her young daughter. Over the following days, Mrs C said she had difficulty obtaining support in these circumstances. Mrs C has continued to experience pain and significant mobility problems, despite the surgery.

(a) The Board failed to provide neurosurgery within a reasonable timeframe

Concerns raised by Mrs C

10. Mrs C raised a number of concerns about the time taken to provide her with neurosurgery. She said she received advice when she first attended hospital out with the Board that the surgery needed to be carried out urgently. Mrs C accepted the Board's explanation for the reduced number of theatres; however, she questioned why arrangements were not made for her to attend another hospital, given the problems with the neurosurgery theatres. She also raised concerns about not receiving full honest information about the risks of delays, and the distress she felt at being repeatedly prepared for surgery. Mrs C attributed the pain and mobility problems she has continued to experience to delays in the surgery.

The Board's response

11. By way of background, the Board explained that theatre availability was impacted at this time by a sewage ingress and subsequent works to remedy the situation. The Board advised that this meant only emergency/urgent theatre capacity was available. The Board indicated that at the time of Mrs C's admissions (March to April 2016) they were in communication with the National Managed Service Network for Neurosurgery, and that some patients were transferred to other neurosurgery services where this was clinically indicated as needed.

12. The Board's view was that although Mrs C required surgery, this was not an absolute emergency. The Board acknowledged that the usual timescale for surgery of this kind would have been within 24 hours of admission. However, they considered that Mrs C's neurological condition remained stable during the time, and that Mrs C had compression of her cauda equina, but did not have complete cauda equina syndrome (a rare and severe type of spinal stenosis where all of the nerves in the lower back suddenly become severely compressed). The Board accepted that delaying Mrs C's surgery was unacceptable practice, but that this was due to exceptional circumstances.

13. The Board considered that the delay did not substantially contribute to Mrs C's eventual outcome. They noted that the calcification of tissues made Mrs C's surgery more difficult than usual. The Board stated that Mrs C's condition deteriorated following her surgery, not because of the delay in having surgery.

Neurosurgery advice

14. My complaints reviewer sought the advice of Adviser 1 (a neurosurgeon), on Mrs C's complaint that the Board failed to provide neurosurgery within a reasonable timeframe.

15. As a preliminary point, Adviser 1 noted there are no specific Scottish Intercollegiate Guidelines Network (SIGN) guidance on cauda equina. However they were mindful of the following guidance in providing advice on Mrs C's complaint:

- Society of British Neurological Surgeons (SBNS) guidance on Standards of Care for Established and Suspected Cauda Equina Syndrome (October 2009); and
- the SBNS and British Association of Spine Surgeons (BASS) guidance on Standards of Care for Suspected and Confirmed Compressive Cauda Equina Syndrome.

16. Adviser 1 said whilst timing of surgery can be debated in patients with complete cauda equina, it is generally understood and widely accepted in the neurosurgical and spinal community that decompression of incomplete cauda equina should be performed as an emergency (within the 24 to 48 hour timescale). This is in order to prevent possible progression to a complete cauda equina syndrome, which is associated with a very high incidence of permanent neurological deficit, bladder and/or anal sphincter, and sexual dysfunction. Adviser 1 noted the Board had acknowledged the above timescale.

17. Adviser 1 noted that Mrs C's clinical diagnosis was incomplete cauda equina syndrome secondary to compressive L3-4 stenosis (the L3-L4 spinal segment is positioned in the middle of the lower back). The MRI scan when Mrs C was admitted to the Hospital showed the disc prolapse (a prolapsed disc is where one of the discs of cartilage in the spine is damaged and pressing on the nerves) to be slightly larger than was previously known – but with near total obliteration of the cerebrospinal fluid (CSF) spaces around the cauda equina nerve roots. Adviser 1 said neurosurgical intervention to decompress was appropriately scheduled in accordance with the guidance – but the unfortunate and unforeseen circumstances relating to theatre unavailability prevented this from happening.

18. Adviser 1 considered the initial clinical decision to provide surgery for Mrs C within a 24 hour timescale was appropriate, given available literature suggested a timeframe within 24 to 48 hours. However, Mrs C was not taken to theatre until 12 days later. Adviser 1's view was that the Board failed to provide neurosurgery within a reasonable timeframe.

19. Adviser 1 noted the Board's response was that, as Mrs C had compression of cauda equina (not complete cauda equina syndrome), and her neurological situation remained stable, she was not an absolute emergency. Adviser 1 also noted Mrs C had questioned that she was clinically stable in light incontinence and increasing pain. Adviser 1 agreed that the available evidence suggested that Mrs C's neurological condition was stable since her admission. However, Adviser 1 noted it was also similarly documented in various places that she had incomplete cauda equina syndrome – the management of which involves decompressive surgery at the earliest (or at least within the 24 to 48 hour timeframe). Adviser 1 noted the Board's comments that neurosurgical theatre capacity was reduced from three (or four on certain days) to one or two theatres, but also that out-of-hours emergency provision was unaffected and one theatre was allocated to neurosurgical emergencies. In that context, Adviser 1 considered there was no reasonable basis to delay Mrs C's surgery.

20. Adviser 1 noted Mrs C had questioned why she was not transferred to another hospital site for surgery. Adviser 1 noted Mrs C had clinically documented incomplete cauda equina syndrome and a decision had been made to operate as an emergency. Despite provision for out-of-hours operating, in addition to a dedicated theatre for neurosurgical emergencies, Mrs C's surgery did not go ahead. Adviser 1 said they did not seek to question the Board's prioritisation of other cases during the time, as from their experience there could have been have been life threatening neurosurgical emergencies that had overridden Mrs C's surgical prioritisation. However, under such circumstances, Adviser 1 said the Board should have considered transferring Mrs C to another appropriate hospital site. In the professional opinion of Adviser 1, there was no reasonable basis for the Board to deny Mrs C a surgical decompression at another appropriate hospital site.

21. Adviser 1 commented that while the medical / nursing documentation in relation to this case ran to several hundreds of pages, only eight sheets related to contemporaneous ward based clinical documentation. The majority of the

rest was nursing related. The operation note, anaesthetic charts and clinic letters were separate.

22. Having considered the Ward review documentation, Adviser 1 was concerned that there was no specific documentation relating to discussions/counselling regarding risks of delay to surgery in any of the entries for Mrs C's admission. Adviser 1 did not find any clinical entries in the records for a number of days when Mrs C was an in-patient during both admissions. In addition, Adviser 1 considered that some ward round entries did not satisfy the accepted minimum standards (regarding the inclusion of such things as date, time, legibility, job title, and General Medical Council (GMC) registration number). Adviser 1 observed that, in some cases, it appeared that labelling stickers were used as ward round entries by the clinicians. Overall, Adviser 1 was of the opinion that the medical documentation was very poor.

23. Adviser 1 noted Mrs C was concerned about the impact the delay in surgery may have had on her outcome. Adviser 1 observed that neurological deterioration is a recognised effect of continued cauda equina compression and delay to decompress. The aim, therefore, is to minimise progression to a complete cauda equina syndrome. Adviser 1 considered that all the available recommendations in the guidance noted above highlight the same. Although true for the majority of the population, some patients may not experience neurological deterioration. Adviser 1 observed the social, psychological, financial and clinical effects of permanent or severely impaired lumbar and sacral nerve function (mobility; chronic pain; bladder, bowel and sexual dysfunction especially in the reproductive age group) are a severe burden to the patient, their family and the Healthcare System. Adviser 1 considered there was nothing to be gained by delaying surgery, and potentially a lot to be lost. Adviser 1 also noted that neurological deterioration can also be precipitated by the act of decompressive surgery itself ie manipulation of the lumbar and sacral nerves within the spinal sac whilst trying to remove the bulging disc and other degenerative tissue.

24. While the Board had stated that the delay 'did not substantially contribute' to Mrs Cs outcome, Adviser 1 noted the Board did not; however, quantify the term 'substantially' in the context of the patient's social, psychological and neurological outcome.

25. In the professional opinion of Adviser 1, although it was not entirely possible to prove that the delay to surgery did not contribute to the patient's eventual outcome, it was likely that it did.

(a) Decision

26. The basis on we which we reach decisions is reasonableness. Our investigations consider whether the actions taken, or not taken, were reasonable in view of the information available to those involved at the time in question.

27. Mrs C's complaint was that the Board failed to provide neurosurgery within a reasonable timeframe. The Board have acknowledged there was an unacceptable timescale in offering surgery, but explained that this was due to works at the Hospital. Given these circumstances and their assessment of Mrs C's condition, they considered it was reasonable not to offer emergency surgery, or transfer Mrs C to another hospital site.

28. In making my decision on this complaint, I have considered, taken into account and accepted the advice and views of Adviser 1.

29. I have found that there was unreasonable delay in this case. Adviser 1 noted there is clear guidance on the need for surgery to be performed as an emergency in cases where a patient, like Mrs C, is suffering from incomplete cauda equina syndrome. It is clear that the works at the Hospital were unforeseen and presented a challenging situation for the Board and their staff. However, I consider the Board should have taken further steps to ensure Mrs C received surgery given that the serious risks that the incomplete cauda equina syndrome posed to her.

30. I am unable to comment definitively on whether the surgery should have been performed at the Hospital, given the circumstances of the works, and the need for the Board to prioritise cases including life-threatening emergencies. However, should the surgery not been able to go ahead as an emergency within the Hospital, the Board should have considered transferring Mrs C to another hospital site. Given the known risks of delaying surgery for this condition I am critical that there is no evidence in the medical records that this was considered.

31. Mrs C also raised concerns about not receiving full honest information about the risks of delays to the surgery, and the distress of being repeatedly

prepared for surgery. The Board have acknowledged, in retrospect, risks could have been explained in more detail for Mrs C.

32. Noting the views of Adviser 1, I have found that there was inadequate documentation relating to discussions and counselling regarding risks of delay to surgery in any of the entries for Mrs C's admission. I have also found that the documentation in the medical records in this case was of a very poor standard. Given Mrs C's difficulties, it was important for her to be given a full explanation of the risks and delays, and I am concerned this did not happen.

33. Mrs C had attributed her subsequent pain and mobility problems to the delays in the surgery. In contrast, the Board considered the delay did not substantially contribute to her outcome, and that neurological deterioration was a recognised complication.

34. I have noted Adviser 1's comments that it is difficult to ascertain whether there was a causal link between the delays in surgery and Mrs C's subsequent difficulties. However, Adviser 1 also stated in their professional opinion, an impact on Mrs C's outcome was likely in this case. While I am unable to reach definitive conclusions as to the impact of the delay on Mrs C's outcome, I recognise this was an extremely distressing time for Mrs C and her family, and the delays would have added to this distress.

35. Based on the information the Board and Mrs C have provided, and the advice I have received and accepted, I uphold this complaint.

36. I have made recommendations to address all the failings identified at the end of this report.

(b) The Board failed to provide appropriate care and treatment during Mrs C's admission, and (c) The Board failed to provide appropriate aftercare following Mrs C's discharge

37. As complaint (b) and (c) are closely connected, I have considered them together.

Mrs C's concerns

38. Mrs C raised concerns about the level of care and treatment she received during her two admissions and in relation to her discharge and included:

- in relation to physiotherapy, Mrs C described having told physiotherapy staff she was worried about having to climb the stairs to her flat. She raised concerns about the level of physiotherapy support she received, noting when she returned home, she suffered severe pain and mobility difficulties, including difficulties climbing the stairs to her apartment, and using the bathroom;
- the level of nursing care the Board provided during her admissions to the Hospital; and
- discharge arrangements, including the information that was provided about aftercare, treating wounds and dealing with incontinence.

The Board's response

39. The Board acknowledged that limited information was offered to Mrs C upon her discharge. They said they now offer a leaflet to patients who have received an operation for cauda equina syndrome, and have also reviewed discharge arrangements.

Physiotherapy advice

40. My complaints reviewer sought the advice of Adviser 2 (a physiotherapist) in relation to the concerns raised by Mrs C.

41. As a preliminary point, Adviser 2 noted that in advising on Mrs C's complaint they had made reference to the Chartered Society of Physiotherapy: Quality Assurance Standards (August 2012) (the Guidance).

Post-operative physiotherapy care

42. Adviser 2 noted that Mrs C was reviewed by physiotherapy the day after surgery (8 April 2016) and again, three days later, on the day of her discharge (11 April 2016).

43. Adviser 2 noted the Guidance states that physiotherapists should communicate effectively with other health professionals and relevant outside agencies to ensure effective and efficient services (Quality Standard (QS) 7.3).

44. Adviser 2 found there was no record of any multi-disciplinary meetings or discussions related to Mrs C's case. Adviser 2 observed that the pre-operative diagnosis of incomplete cauda equina syndrome and the post-operative diagnosis of cauda equina syndrome were not clear in the clinical notes. Although it would be reasonable for the medical team to lead on this, had the

diagnosis been clearly recognised and communicated to physiotherapy staff caring for Mrs C, this may have informed the post-operative physiotherapy management.

45. Adviser 2 noted that although the physiotherapist who saw Mrs C recorded urinary disturbance there is no recorded liaison with the nursing staff (who normally lead on continence) with regard to post-discharge arrangements or the need for urology referral. Adviser 2 observed that there was no record of the physiotherapist liaising with the occupational therapist regarding the home environment prior to discharge, and there was no record of the physiotherapist referring Mrs C to social services. Although a referral was made to the community physiotherapy service there is no record of any verbal dialogue between the in-patient physiotherapy service and the community based service. Adviser 2 considered this was likely to reflect usual practice, but where there are specific concerns, verbal dialogue between organisations is best practice.

46. Adviser 2 noted the Guidance states that appropriate information relating to the service user and the presenting problem should be collected to inform the physiotherapeutic process (QS 8.3).

47. On reviewing the clinical records, Adviser 2 considered there was no documentation of Mrs C's perception of needs by way of planning her discharge. In addition, there was no documentation related to stairs at home (such matters as the number of stairs, hand rails, and frequency of use). Adviser 2 considered that, given the pre-operative report of right leg weakness and the history of falls (the records documented Mrs C had fallen on the fourth day of her admission) this was an important consideration for discharge planning. Adviser 2 also found there was no documentation related to access to the bathroom in Mrs C's home. Adviser 2 was of the opinion that, given the recorded urinary disturbance, it was important that the home environment was considered.

48. Adviser 2 noted Mrs C raised particular concerns about the physiotherapy support, given she said she told staff she was worried about having to climb the stairs to her flat. Adviser 2 observed that at the initial physiotherapy appointment (8 April 2016), the physiotherapist identified and recorded that Mrs C was anxious because she had previously fallen. On the second appointment, the physiotherapist recorded that Mrs C was anxious about going home (11 April 2016). Adviser 2 also observed there was no record of a

discussion related to stairs at home in the physiotherapy record. Only one physiotherapy supervised trial on stairs was undertaken whilst Mrs C was an in-patient. There was no record that Mrs C's reported anxieties were communicated to other members of the clinical team.

49. Adviser 2 considered it would be normal practice for the physiotherapist to discuss the patient's home environment, including stairs. Should a more detailed assessment of the home be needed, normal practice would be for referral to occupational therapy, who would do a home visit if needed. Where a patient was not confident or anxious a repeat trial on stairs, under physiotherapy supervision, would normally be undertaken. Over time the level of supervision would be gradually reduced. The physiotherapist would normally be part of a multi-disciplinary team who together with the patient would agree on readiness for discharge.

Discharge arrangements

50. Adviser 2 noted the guidance states that, on completion of the treatment plan, arrangements should be made for discharge or transfer of care (QS 8.7).

51. Adviser 2 advised that no patient information was issued relating to: spinal decompression, cauda equina syndrome, post-discharge arrangements, a person to contact should support be needed or for patient support groups. Adviser 2 was critical of the level of information provided to Mrs C.

52. Adviser 2 noted the Board had acknowledged there was limited information offered to Mrs C at her discharge. Adviser 2 commented that the physiotherapy records indicated that Mrs C was aware that she had been referred to the local physiotherapy service. However, there was no record of any patient information being issued to Mrs C pre or post-decompression surgery related to spinal decompression or cauda equina syndrome.

53. Adviser 2 observed that spinal surgical services generally have pre and post-operative patient information leaflets for discectomy and decompression. These typically provide guidance on; the condition, the treatment options (non-surgical and surgical), the risks and benefits of surgery, the procedure, immediate post-operative care, return to activity including work, home exercises tailored to the individual, discharge arrangements, wound care, pain relief, who to contact should post-operative help be needed, post-operative follow up arrangements and useful contact numbers.

54. In addition, spinal surgical services generally have patient information leaflets about cauda equina syndrome. These typically provide information on a description of lumbar spine anatomy, typical signs and symptoms, clear advice to seek emergency help should the symptoms occur, an explanation of the operation, what to expect after surgery (timescale for recovery; weakness, pain, bladder bowel, sexual function), what to do after surgery, symptoms that are important to tell the medical team about, advice on returning home, follow up arrangements, useful contact numbers (the ward, physiotherapy, continence advice service), and links to patient support groups.

55. Adviser 2 also observed that most spinal services will provide surgical patients with a named contact number/person should they have any problems or concerns.

56. Adviser 2 noted Mrs C had described how she suffered severe pain and mobility difficulties returning home, including difficulties climbing the stairs to her apartment, and using the bathroom. Adviser 2 commented that for patients with cauda equina syndrome, a co-ordinated multi-disciplinary discharge plan is important. Adviser 2 found there was no record of any multi-disciplinary meetings related to Mrs C's case. As a minimum, it would have been reasonable to expect discharge arrangements for: pain control, urology referral, priority physiotherapy, and perhaps occupational therapy and social services. Adviser 2 commented that the difficulties Mrs C experienced with stairs and using the bathroom could have been minimised by optimised pain relief, an occupational therapy visit, and more stair practice pre-discharge.

Action taken by the Board

57. Adviser 2 noted that the Board advised Mrs C and our office that they now offer a leaflet to patients in Mrs C's position, and had taken steps to review discharge arrangements. Adviser 2 emphasised the importance of cauda equina syndrome being recognised, documented and communicated to the patient and all members of the clinical team. Without this step, Adviser 2 considered the pathways and patient information would not follow.

58. Adviser 2 acknowledged the Board's response indicated that a significant amount of work had been underway to improve the care for patients presenting with cauda equina syndrome. In particular, Adviser 2 commented that:

- it was encouraging to see that a multi-disciplinary forum has been set up;

- the Board's booklet was an important development as was the spinal surgery video developed; and
- the clearer pathway to occupational therapy was also progress.

59. Adviser 2 also provided some suggestions for improvement and best practice in relation to physiotherapy care and overall management of the condition and the patient info leaflet. I have included this as feedback at the end of this report.

Conclusions

60. For the reasons outlined, it was Adviser 2's professional opinion that the physiotherapy provided to Mrs C on the Ward and in relation to discharge planning fell below a reasonable standard for a patient with cauda equina syndrome.

61. Adviser 2 observed that it is well known that cauda equina syndrome may have devastating consequences for patients post-operatively, and that the prognosis is poorer if there is a delay in surgical decompression. Adviser 2 observed that even with exemplary care the outcome of cauda equina syndrome can be difficult to deal with.

62. Adviser 2 noted Mrs C was an in-patient for six days pre-operatively. There was no record of any physiotherapy contact during this time. Nor was there any record of patient information related to spinal surgery being issued. Adviser 2 explained that when cauda equina syndrome occurs, supportive post-operative multi-disciplinary management over many months is generally required. For this to happen, the diagnosis needed to be recognised and clearly communicated amongst the multi-disciplinary team. Adviser 2 commented that patients need a co-ordinated supportive multi-disciplinary approach to optimise recovery. From the perspective of Adviser 2, there was a lack of a multi-disciplinary approach to discharge planning. Adviser 2 observed that the physiotherapist would be a key member of the multi-disciplinary team.

63. Adviser 2 noted it is difficult based on the evidence to make any conclusions about the impact that the failings identified had. However, Adviser 2 considered the lack of post-discharge support may have contributed to the distress, escalation in pain and helplessness, reported by Mrs C. Subsequently, this distress may then have contributed to a cycle of chronic pain and a poorer prognosis, for return to a productive lifestyle.

Nursing advice

64. My complaints reviewer also sought the advice of Adviser 3 (a nurse) in relation to the concerns raised by Mrs C.

65. As a preliminary point, Adviser 3 noted that in advising on Mrs C's complaint they had made reference to

- NHS Quality Improvement Scotland (QIS), Best Practice Statement ~ November 2005 Continence - adults with urinary dysfunction;
- NHS Quality Improvement Scotland, Best Practice Statement ~ February 2006 Management of chronic pain in adults;
- NHS Healthcare Improvement Scotland, Care of Older People in Acute Hospitals (2015);
- Scottish Government, Admission, Transfer and Discharge Protocol (2009); and
- Nursing and Midwifery Council, Professional standards of practice and behaviour for nurses and midwives (2015).

66. Adviser 3 was of the view that the nursing notes suggested that nursing staff failed to provide appropriate care during Mrs C's admission. Adviser 3 took the following into account:

- continence care;
- pain management;
- wound care;
- liaison between staff; and
- discharge arrangements.

Continence care

67. Adviser 3 considered the continence care provided to Mrs C. Adviser 3 observed that Mrs C had already had some urinary incontinence prior to admission to the Ward. Within the nursing notes, there was no record of further assessment of incontinence, no treatment plan and no related discussion with Mrs C about her urinary function during her first admission assessment. Throughout her stay in the Ward, there was variation in how her urinary incontinence was documented in the nursing notes. However, there was no proper assessment of this problem and its impact on Mrs C. Adviser 3 noted Mrs C sustained a fall coming from the toilet during the night of 29 March 2016 during her first admission. The Falls Assessment and Care Plan were updated

as a result: this noted referral to physiotherapist on two occasions but there was no apparent follow up advice available in the records. The Care Plan suggested commencing a Continence Assessment as per local guidelines but there was no evidence that this was initiated.

68. During her second period of admission to the Ward, Mrs C was catheterised post-operatively as she had not passed urine. While there was a record of the type and size of catheter used, it was indicated in the catheter insertion and maintenance record that this catheter was for long term use. The catheter was, however, removed two days later. Adviser 3 noted fluid balance charts were in place during this time although they were incompletely recorded with very little information on fluid intake. Mrs C's catheter was removed the day before her discharge. There was no record of advice or treatment plan or of any discussion with Mrs C in relation to the urinary problems she was experiencing. There was no evidence of any referrals being made to either hospital based urology services or to community based Continence Advisory Services.

69. Adviser 3 explained that, on admission to the Ward, when the admitting nurse identified that there had been recent episodes of urinary incontinence, Mrs C should have had a full assessment using an evidence based approach/tool. This should have been documented in her nursing notes (NHS QIS, Best Practice Statement ~ November 2005 Continence - adults with urinary dysfunction). Adviser 3 said there should also have been a treatment plan, developed with Mrs C to help her to manage any urinary incontinence during her stay in hospital. This treatment plan should have been clearly documented, including any discussion with Mrs C, to ensure that all staff were able to support her appropriately. Adviser 3 considered fluid balance charts should be used appropriately and fully completed to enable accurate assessment of patient status. In addition, this treatment plan should have been amended, as required, during Mrs C's stay in hospital and should also have been transferred home with her following discharge, when referral should have been made, with Mrs C's consent, to either the Continence Advisory Service for her local NHS board or to the local district nursing service.

70. Taking the above into account, Adviser 3 was of the view that Mrs C was left without an appropriate continence assessment and care plan. Adviser 3 noted this may have caused her significant discomfort, embarrassment, anxiety and concern while in the Hospital. The lack of documented comprehensive

assessment and treatment plan could also lead to inconsistent care delivery by the nursing staff, with no clear direction as to the most appropriate treatment. The lack of appropriate planning for discharge could have caused an exacerbation of Mr C's incontinence through inaccessibility of the toilet and lack of advice as to how best manage her symptoms at home.

Pain management

71. Adviser 3 considered the pain management provided to Mrs C. From the nursing notes, it appeared Mrs C was experiencing pain in her back and right leg throughout her admissions at the Hospital. There was variation and inconsistency in how the pain was scored and reported within the nursing notes. It appeared Mrs C's pain relief was managed through regular analgesia with morphine for breakthrough pain. Mrs C's care plan did not include on-going assessment and management of actions to promote and maximise comfort and improve physiological and psychosocial function.

72. Adviser 3 considered there was little recognition throughout the nursing notes of the actual or potential psychosocial impact of Mrs C's diagnosis and of actions taken by the nursing staff to ameliorate this. She was seen by the pain nurse on 29 March 2016 (the fourth day of her initial admission) who 'advises to continue taking analgesia and reassured her regarding dependency worries'. There was no record within the nursing notes of more detailed pain assessment or any amendments to the care plan. There was no further record of further assessment, management plan or referrals prior to discharge regarding pain management although Mrs C was still experiencing pain scoring between 4 to 8 (out of 10) on the day prior to discharge.

73. Adviser 3 explained that Mrs C should have had a more comprehensive and documented assessment of her pain which might have included the following factors:

- clinical history;
- general personality traits and dispositions;
- current level of somatic concern, depression, anger;
- report of pain and functional limitations;
- preliminary behavioural analysis;
- pain coping strategies;
- beliefs about injury, pain and treatment outcome;

- social, economic and occupational influences on symptom presentation. (NHS QIS, Best Practice Statement - February 2006 Management of chronic pain in adults)

74. In addition, Adviser 3 remarked that Mrs C's care plan should have noted individualised care assessment and plan to help her to manage her pain effectively. There should have been better documented evidence within her care plan of the psychosocial impact for Mrs C of her diagnosis and condition and of the actions taken to support her and her family. Assessment and recommendations for treatment by the pain nurse should have been documented more clearly within the nursing care plan for Mrs C. Adviser 3 considered it was possible that the physiotherapist may also have advised on pain management and this should have been recorded and the treatment plan amended if required. Mrs C should have been given advice and possibly written information on pain management when discharged from hospital.

75. Taking the above into account, Adviser 3 considered the lack of documented pain assessment throughout Mrs C's admission may have led to lack of understanding for Mrs C and for staff as to the potential for better understanding of her pain and better management of her symptoms. Lack of a co-ordinated multi-disciplinary approach between the Ward based nursing staff, the pain nurse and the physiotherapist may have led to inconsistent advice and treatment for Mrs C and potential confusion as to how she could best manage her pain. Lack of appropriate information on discharge from hospital could have led to Mrs C feeling frightened and unconfident when she got home. Such psychological factors can have an impact of a person's experience of pain and may make the symptoms worse (noting the NHS QIS Best Practice Statement ~ February 2006 Management of chronic pain in adults (page xv).

Wound care

76. Adviser 3 considered the wound care provided to Mrs C. The day following Mrs C's surgery, her nursing notes stated the she experienced discomfort at the wound site. While the notes state that the wound is on the 'back' and is 'glued', there is no detail of the condition of the wound. There was no reference on the date of discharge to the condition of the wound or to any post-discharge management plan.

77. Adviser 3 explained there should have been clearer information in Mrs C's nursing notes as to the condition of wound following surgery, especially when it

was reported that she was experiencing discomfort at the wound site. There should also have been information given to Mrs C on discharge from hospital as to wound healing and self-care.

78. Taking this into account, Adviser 3 was of the view that there was a lack of documented on-going wound assessment while in hospital, and lack of documented information provided to Mrs C on discharge, could potentially have led to failure to recognise symptoms of infection and delayed healing.

Liaison between staff

79. Adviser 3 noted that Adviser 2 had some concerns about liaison between physiotherapy and nursing staff. Adviser 3 observed that there was no evidence in the nursing notes related to Mrs C's stay in the Ward that there was any discussion with the physiotherapist, or occupational therapist, service in relation to Mrs C's care. While the Falls Care Plan and the Discharge checklist both refer to physiotherapy input, there was no evidence of this input, and any associated advice or treatment, in the nursing notes. There was no evidence in the nursing notes of a multi-disciplinary approach to planning Mrs C's discharge from hospital.

80. Adviser 3 explained that Mrs C should have been seen as soon as possible after admission by both a physiotherapist and occupational therapist. The findings of the physiotherapy and occupational therapy assessments, and recommended treatment plans, should have been communicated through multi-disciplinary meetings with nursing staff. Any changes to Mrs C's care plan should have been clearly documented within her nursing notes to ensure that there was a clear and consistent approach to her care while in hospital. Planning for her discharge from hospital should have been undertaken by the multi-disciplinary team, as soon after admission as possible, and should have clearly outlined the details of her pain management, continence care, home environment and any adaptations required support needs (Scottish Government, Admission, Transfer and Discharge Protocol). It would have been appropriate, prior to discharge, for referral to community based services, including occupational therapy, physiotherapy, district nursing and/or continence services.

81. Taking this into account, Adviser 3 was of the view that Mrs C's hospital based care did not meet the standards expected in relation to multi-disciplinary assessment and care planning. Her nursing notes did not document advice or

treatment recommendations from physiotherapy and occupational therapy and this lack of input may have adversely affected the in-patient care that she received in the Ward. The lack of multi-disciplinary planning for discharge may have led to the problems that arose for Mrs C when she returned home, in relation to her pain management, incontinence and subsequent stress and anxiety.

Discharge arrangements

82. Adviser 3 noted Mrs C had raised concerns about the discharge arrangements, including the information that was provided about aftercare, treating wounds and dealing with incontinence. Adviser 3 observed there was no reference throughout Mrs C's stay in hospital about planning for discharge for Mrs C in the nursing notes until the day prior to discharge. The nursing notes here stated that she was for possible discharge home the next day, and was to be seen by a physiotherapist. The following day, Mrs C was deemed fit for discharge as she has 'passed stairs i/c physio'. The discharge checklist was completed in her nursing notes. It was a series of tick boxes with no further information as to what has been considered. There was no evident record of multi-disciplinary discussion or planning for discharge. There was no record of further discussion with Mrs C and/or her family in preparation for discharge. There was no information available on additional information/leaflets/factsheets given prior to discharge.

83. Adviser 3 explained, as stated earlier there should have been clear planning for discharge by the multi-disciplinary team. This should have been started as soon as possible after admission, taking account of the actual and potential problems, which Mrs C may have faced following her illness and surgery. Plans should have been discussed and agreed with Mrs C and, where appropriate, her family. Their concerns and queries should have been dealt with and documented appropriately. Referrals to the appropriate services should have been made and documented appropriately. Information regarding Mrs C's care and treatment in hospital should have been communicated to community based services. Written information should have been provided to Mrs C on her condition and treatment and this should have been documented in the discharge plan.

84. Adviser 3 explained that poor discharge planning, and lack of person centred care co-ordination, could have led to the subsequent problems that Mrs C faced, especially in relation to her urinary incontinence, her anxiety and

her subsequent poor health. The lack of multi-disciplinary focus while in hospital could have caused Mrs C to feel confused and anxious about her care and treatment. The poor co-ordination and lack of clear planning could also have caused inconsistent and sub-optimal care.

85. Adviser 3 was of the view that nursing assessment and care planning was sub optimal with lack of appropriate assessment, analysis and personalised care planning. There was no documented evidence of discussion with Mrs C about her condition and her treatment plan. There was little evidence of robust discharge planning that was multi-disciplinary and that involved the patient and her family. There was no documented account of the referrals that were made to community services to support Mrs C after her discharge home. There was no evidence that Mrs C was given further information on her pain management and on her bladder function.

86. Adviser 3 considered there should have been more comprehensive assessment and care planning that was clearly documented and personalised to Mrs C's care. In this context, Adviser 3 highlighted the requirement in the Nursing and Midwifery Council (NMC) Code to 'assess need and deliver or advise on treatment', and in relation to 'keeping clear and accurate records'.

87. Adviser 3 considered there should have been evidence of Mrs C's involvement, through discussion, in her care planning and, again, this should have been documented. There should have been multi-disciplinary approach throughout her admission and in planning for her discharge and this should have been documented. Mrs C should have been given written information to support her care at home and information should have been shared with the community services to which she should have been referred.

88. Adviser 3 observed that it was difficult to state whether the initial impact of the gaps in her nursing care have contributed to the longer-term outcome for Mrs C. Adviser 3 was of the view that it was very possible that: first, the inconsistent and uncoordinated approach to her care; second, the lack of multi-disciplinary care planning; and third, the absence of appropriate discharge planning and community follow up may have led to Mrs C feeling anxious, upset, frightened and embarrassed on returning home. This could in turn potentially lead to feelings of helplessness, relationship stress and depression which could impact on Mrs C's longer-term outcomes.

89. Adviser 3 was of the view the Board should consider the following as learning points:

- patients who are admitted with, or develop incontinence while in hospital should have a full assessment and treatment plan, which should accompany the patient on discharge from hospital with referrals to the appropriate services as required;
- patients who are admitted with, or develop pain while in hospital should have a full assessment and treatment plan, which should accompany the patient on discharge from hospital with referrals to the appropriate services as required;
- ward based nursing assessment and care plans should include personalised care in relation to the individual patient, and also include assessment findings by other professionals which have an impact on the patient's on-going care;
- the psychosocial impact of illness should be assessed for each patient during their admission to hospital and actions taken to address should be documented within the care plan;
- fluid balance charts, when their use is indicated, should be completed accurately to enable proper assessment of both fluid intake and fluid output;
- multi-disciplinary team meetings to support discharge planning should take place and the decisions made should be clearly communicated with the patient (and where appropriate the family); and
- written information should be provided to the patient where appropriate and ongoing referrals made to community based services. These actions should be documented within the discharge plan.

90. In conclusion, Adviser 3 considered the nursing care provided to Mrs C did not meet the required standards as laid down by the NMC and by NHS QIS. The gaps in assessment and care planning while in hospital, as well as in discharge planning to support Mrs C's return home, may have led to her feelings of stress and anxiety, as well as exacerbating her experience of pain and incontinence.

(b) Decision

91. Mrs C's complaint was that the Board failed to provide appropriate care and treatment during her admission. Mrs C raised particular concerns about the physiotherapy support, given she said she told staff she was worried about

having to climb the stairs to her flat. She also raised concerns about the level of nursing care and treatment she received on the Ward.

92. In making my decision on this complaint, I have considered, taken into account and accepted the advice and views of Advisers 2 and 3.

93. Noting the advice of Adviser 2, I have found that Mrs C received inadequate physiotherapy care during her admission. Adviser 2 noted that the diagnosis of incomplete cauda equina syndrome was not recognised/communicated amongst the multi-disciplinary team. They considered that prior to Mrs C's surgery no physiotherapy or patient information was given. Adviser 2 also noted there was no documentation related to the home environment, including stairs, in the physiotherapy notes. Despite the record of Mrs C's anxiety about returning home, only one pre-discharge supervised trial of stairs was undertaken by staff.

94. Adviser 2 acknowledged that the Board has since this case been proactive in developing patient information and pathways for patients diagnosed with cauda equina syndrome. I consider these are positive steps and I have also drawn Adviser 2's suggestions for further improvements in cauda equina care to the Board's attention.

95. Noting the advice of Adviser 3, I have also found that the nursing care provided to Mrs C did not meet a reasonable standard. I share Adviser 3's concerns about the level of continence care provided to Mrs C, the management of her pain and wound care based on the evidence in the clinical records.

96. Based on the information the Board and Mrs C have provided, and the advice I have received and accepted, I uphold this complaint.

97. I have made recommendations to address all the failings identified at the end of this report.

(c) Decision

98. Mrs C's complaint was that the Board failed to provide appropriate aftercare following her discharge. Mrs C raised concerns about her care and treatment regarding the discharge, including the physiotherapy decision that she was fit to return home. She also raised concerns about the discharge

arrangements, including the information that was provided about aftercare, treating wounds and dealing with incontinence.

99. Noting the advice of Adviser 2 and Adviser 3, I have found there were failings in the discharge arrangements made for Mrs C which in turn meant there was a lack of aftercare following discharge.

100. Regarding the physiotherapy care provided in relation to Mrs C's discharge, Adviser 2 observed there was no record of any multi-disciplinary meetings or a multi-disciplinary approach to discharge planning. There was no record that Mrs C was involved in the discharge planning, or that her perception of her need or anxieties had been considered. Adviser 2 was critical of the level of information provided to Mrs C on discharge.

101. In relation to nursing care, Adviser 3 considered Mrs C's discharge does not appear to have been planned in a co-ordinated and multi-disciplinary way. Adviser 3 considered her nursing records have little evidence of input from other professionals. Adviser 3 also considered it would have been appropriate, prior to discharge, for referral to community based services, including occupational therapy, physiotherapy, district nursing and/or continence services to ensure aftercare was in place following discharge.

102. Mrs C described in her complaint the distressing and difficult time she experienced returning to her home, and the impact on her family. Following the significant surgery she had recently had, it was important that arrangements were put in place to ensure recovery, and I am concerned that this did not happen.

103. I am particularly struck by the similarity of the concerns expressed by Advisers 2 and 3 in relation to the lack of a multi-disciplinary approach to Mrs C's care and the lack of appropriate discharge planning. Both processes are fundamental to ensuring patient centred care and the omissions identified in relation to both processes in this case are of very real and genuine concern to me. Had there been more patient centred, multi-disciplinary involvement and better discharge planning I consider a number of the problems encountered by Mrs C following discharge could have been avoided and this in turn could have greatly reduced her level of suffering and distress.

104. I am also struck by the consistency of views (of all three advisers) about the poor standard of documentation and record-keeping.

105. Based on the information the Board and Mrs C have provided, and the advice I have received and accepted, I uphold this complaint.

106. I have made recommendations to address all the failings identified at the end of this report.

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

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 Mrs C:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a), (b) and (c)	There was an unreasonable delay in providing neurosurgery to Mrs C. There were also failings in the physiotherapy and nursing care offered to Mrs C and failings in the multi-disciplinary and discharge planning processes	Apologise to Mrs C for the delay in providing neurosurgery; the failings in physiotherapy and nursing care and in the multi-disciplinary and discharge planning processes. The apology should meet the standards set out in the SPSO guidelines on apology available at: https://www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology By: 24 February 2018

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

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	There was an unreasonable delay in providing surgery to Mrs C, who was suffering incomplete cauda equina syndrome	Surgery for cauda equina should be performed within recommended timescales (in this case 24 to 48 hours), or the patient considered for transfer to an alternative hospital site	The Board should demonstrate that they have systems in place to ensure patients with incomplete cauda equina are operated on as an emergency, or transferred to an alternative hospital site for surgery By: 24 April 2018
(a) and (b)	There were significant failings in record-keeping. The ward review documentation was very poor in this case. There were gaps in nursing records (including assessments and fluid balance charts)	The Board should ensure staff complete adequate and contemporaneous medical documentation	The Board should demonstrate how this issue has been raised with relevant staff in a supportive way for reflection and learning and that learning has taken place and/ or relevant future training and development identified By: 24 April 2018
(a), (b) and (c)	There were unacceptable failings in communication. There is no evidence that information was given about the risks of delays to the surgery. Mrs C was not given an appropriate level of information on discharge	Patients should receive relevant and understandable information about cauda equina syndrome	The Board should demonstrate how they will provide patients presenting with cauda equina syndrome with such information and in what way: for example, through discussions and an information leaflet By: 24 April 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b)	There were failings in the physiotherapy care. Despite the record of Mrs C's anxiety, only one pre-discharge supervised trial of stairs was undertaken by physiotherapy	The Board should ensure an adequate level of physiotherapy assistance for patients in Mrs C's position	The steps the Board will take to ensure adequate physiotherapy support is provided to patients following surgery for cauda equina syndrome. By: 24 April 2018
(b)	Mrs C's nursing assessment, both on admission to and during her stay in hospital, did not include sufficient detail on her symptoms of both pain and incontinence and wound management. Neither did it include the psychosocial impact of her diagnosis and symptoms on her health	Registered nurses should have the knowledge to carry out comprehensive assessments and to develop clear care plans which facilitate consistent and person-centred care. The Board should ensure that registered nurses can assess the psychosocial impact of illness for patients admitted to hospital and can plan care to ameliorate its effects as much as possible	The Board should demonstrate that they have: • reviewed their approach to both incontinence and pain management in in-patient settings; • that learning has taken place; and • put in place steps to implement any actions identified within definitive timescales By: 24 April 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(b) and (c)	Mrs C's care while in hospital and on discharge does not appear to have been planned in a co-ordinated and multi-disciplinary way. Her nursing and physiotherapy records have little evidence of input from other professionals. The records did not suggest Mrs C was involved in discharge planning, or her perception of needs or anxieties considered	A supportive multi-disciplinary approach should be in place for patients with cauda equina syndrome	The Board should demonstrate they have reviewed their approach to multi-disciplinary working in in-patient settings to ensure that care is person centred and co-ordinated to optimise recovery for patients while in hospital. Consideration should be given to the use of multi-disciplinary records which facilitate better person-centred assessment and care planning By: 24 April 2018
(c)	There were failings in the discharge planning and arrangements made for Mrs C	Discharge should be planned in a co-ordinated way. A personalised aftercare plan should be undertaken prior to discharge in cases of this type and include prompt referral to appropriate services. The Board should ensure that patients returning home from hospital have the appropriate referrals made to community based services to support their care on discharge from hospital. This should include the transfer of care plans with the patient, where appropriate, to ensure continuity and consistency of care	An explanation with supporting documentation of the steps the Board will take to ensure appropriate discharge planning By: 24 April 2018

Feedback

Complaints handling

I agree with Adviser 3's comment about the Board's handling of this complaint. The Board did not investigate this complaint in a sufficiently detailed and analytical manner. They appeared defensive of, and failed to take account of the gaps in, nursing practice as evidenced in the nursing notes. While printed nursing records are lengthy, and consideration has been given to how they might facilitate assessment and care planning, it was nonetheless difficult (on the basis of this investigation) to understand the priorities for Mrs C's care. This must cause difficulty in personalising the care to meet individual patient need and for nurses, working different shifts, to be clear about the care plan.

Points to note on best practice

In line with the views of Adviser 2, I would ask the Board to consider the following points about delivering best practice in the care of patients presenting with cauda equina syndrome:

- patient representation on the Cauda Equina Forum;
- patient information developed for people who are at risk of developing cauda equina syndrome and for those with incomplete cauda equina syndrome for issue at the time of diagnosis;
- to ensure that the diagnosis of cauda equina syndrome is recorded, explained to the patient and communicated clearly across the multi-disciplinary team;
- training arranged for all members of the clinical team to ensure that; the diagnosis of cauda equina syndrome, the prognosis and the importance of personalised co-ordinated postoperative management are understood;
- a clear pathway to urology;
- a clear pathway to pain services; and
- a governance reporting system for cases who have poor post-operative outcomes related to cauda equina syndrome.

Points to note on the development of the information leaflet

The Board is asked to consider the following suggestions from Adviser 2 for further improvement:

- page 2: It is important to treat cauda equina syndrome as an emergency not urgently;
- page 3: the symptoms of cauda equina syndrome can also occur gradually, often related to spinal stenosis;

- page 4: women may also have sexual dysfunction related to vaginal numbness;
- page 7: links to patient support groups such as; www.caudaequina.org, www.ihavecaudaequina.com or www.caudaequinauk.com might be included; and
- the inclusion of guidance on when and where to seek help should symptoms deteriorate.

Terms used in the report **Annex 1**

Adviser 1	a consultant neurosurgeon
Adviser 2	a physiotherapist
Adviser 3	a nurse
BASS	British Association of Spine Surgeons
Cauda equina syndrome	a rare and serious neurological condition that affects the bundle of nerves (cauda equina) at the base of the spine
CSF	cerebrospinal fluid, a clear colourless liquid that fills and surrounds the brain and spinal cord, and provides a barrier against shock
decompressive surgery	a type of surgery used to treat compressed nerves in the lower (lumbar) spine
GMC	General Medical Council
magnetic resonance imaging (MRI)	a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body
Mrs C	the complainant
NMC	Nursing and Midwifery Council
Overflow incontinence	involuntary release of the bladder

QIS	Quality Improvement Scotland
SBNS	Society of British Neurological Surgeons
SIGN	Scottish Intercollegiate Guidelines Network
stenosis	abnormal narrowing of the spinal canal
the Board	Greater Glasgow and Clyde NHS Board
the Guidance	Chartered Society of Physiotherapy: Quality Assurance Standards (August 2012)
the Hospital	Queen Elizabeth University Hospital
the Ward	neurosurgery ward

List of legislation and policies considered **Annex 2**

Chartered Society of Physiotherapy: Quality Assurance Standards (August 2012).

National Institute for Health and Care Excellence, Low Back pain and Sciatica in over 16s: assessment and management (NG59, November 2016)

NHS Healthcare Improvement Scotland, Care of Older People in Acute Hospitals (2015)

NHS Quality Improvement Scotland, Best Practice Statement ~ November 2005 Continence - adults with urinary dysfunction

NHS Quality Improvement Scotland, Best Practice Statement ~ February 2006 Management of chronic pain in adults

Nursing and Midwifery Council, Professional standards of practice and behaviour for nurses and midwives (2015)

Scottish Government, Admission, Transfer and Discharge Protocol (2009)

Scottish Government, Health and Social Care Standards My support, my life (2017)

Society of British Neurological Surgeons, Standards of Care for Established and Suspected Cauda Equina Syndrome (October 2009)

Society of British Neurological Surgeons and British Association of Spine Surgeons, Standards of Care for Suspected and Confirmed Compressive Cauda Equina Syndrome.