Scottish Parliament Region: Glasgow

Case 200502203: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Cardiology

Overview

The complainant (Mr C) raised a number of concerns about the treatment his wife (Mrs C) received at the Western Infirmary, Glasgow (the Hospital) in January 2005 including the failure of staff to take a wound swab and that his complaint was not dealt with through proper channels.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs C was given inappropriate care and treatment (*upheld*); and

(b) the Board's complaints handling was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) monitors compliance of the amended handover procedure to ensure that staff read patient documentation in addition to receiving a verbal report;

(ii) review their guidance on discharge procedures to ensure that planned care has been provided prior to discharge; and

(iii) reminds staff when receiving letters direct from patients to clarify and record whether they are making an enquiry or a formal complaint.

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

Main Investigation Report

Introduction

1. On 10 November 2005 the Ombudsman received a complaint from Mr C, via an advocate, about the treatment provided to his wife, Mrs C, at the Western Infirmary, Glasgow (the Hospital) in January 2005.

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

(a) Mrs C was given inappropriate care and treatment; and

(b) the Board's complaints handling was inadequate.

Investigation

3. In writing this report I have had access to Mrs C's clinical records and correspondence relating to the complaint. I sought clinical advice from one of the Ombudsman's professional medical advisers (Adviser 1) and a nursing adviser (Adviser 2). I have not included in this report every detail investigated but I am satisfied no matter of significance has been overlooked. An explanation of the abbreviations used in the report can be found at annex 1 with a glossary of medical terms at annex 2. Mr C and Greater Glasgow and Clyde NHS Board (the Board) have had the opportunity to comment on a draft of this report.

(a) Mrs C was given inappropriate care and treatment

4. Mr C said that Mrs C was admitted to the Hospital on 2 January 2005 for a blood transfusion. She was discharged on 3 January 2005 and when they arrived home there was a telephone message from the Hospital which said that Mrs C had to attend her GP to arrange a blood test to check her haemoglobin and platelet levels. Due to the holiday period, the GP attended on 5 January 2005. The GP said Mrs C had to be readmitted to hospital due to a swollen and painful left knee. She was referred for a rheumatology and orthopaedic opinion. Mrs C's left knee was aspirated on 7 and 9 January 2005. Mrs C's condition started to deteriorate and she subsequently suffered a cardiac arrest and died on 15 January 2005.

5. Mr C met with the consultant cardiologist (Consultant 1) and handed him a note as he had concerns about the treatment Mrs C received following the hospital admission on 2 January 2005. Mr C said Mrs C had told him staff had hurt her left leg when pulling her up the bed using a slide sheet and that staff had not assisted

them when he was taking Mrs C out of the ward to the car in a wheelchair. When Mr C arrived home he was shocked to see that the wound on Mrs C's knee had not been examined by staff and the bandage was soaked from the weeping sores. Mr C wanted to know why swabs were not taken and why the wound was not dressed. He also had concerns whether the blood test should have been taken prior to discharge and if the delay caused by the holiday period had affected the final outcome.

6. Consultant 1 responded to Mr C after he received comments from the charge nurse (Nurse 1). Nurse 1 said that a wound swab had been requested when Mrs C was admitted to the ward and this was written in both the nursing notes and care plan. However, this was not verbally passed on to the nurse who was directly in charge of Mrs C's care. An apology was made and Nurse 1 had re-emphasised to all staff the need for up-to-date, accurate communication both written and verbal on all issues pertaining to patient care. The nursing staff had said that Mrs C's leg dressing was not weeping and that if it had then it would have been changed immediately. Nurse 1 interviewed the senior nursing staff and none could recall that Mrs C was moved using a slide sheet, although it would have been an appropriate aid to use. Staff could not recall Mrs C complaining of a sore knee and there was no indication of this in the nursing or medical notes. Nurse 1 said that Mrs C had arrived on the ward in a porter's chair and that she had not been upset or crying on departure because if she had then staff would have intervened and also that staff were not asked to help Mrs C to her car.

7. Consultant 1 continued that there was no note of Mrs C reporting knee problems and that a doctor had spoken to her two hours before her discharge and she appeared in good humour. Consultant 1 could not say if an infection from Mrs C's leg ulcers had entered her bloodstream and infected her knee. The fact that the haemoglobin check was not made prior to discharge would not have affected the final outcome. Consultant 1 could not comment if Mrs C had had antibiotics on 3 January 2005 whether this again would have affected the final outcome as there was no way of knowing this.

Medical background

8. Adviser 1 reviewed Mrs C's clinical records and from the evidence provided it seemed that Mrs C had a multitude of medical problems which affected her heart,

her gastrointestinal tract, her musculo-skeletal system, her kidneys and very probably her liver. In the past she had suffered from Pyoderma Gangrenosum and at various times had had leg ulcers. Mrs C also had had total knee replacements bilaterally 25 years before her death. On her last admission Mrs C had a large left knee effusion which was aspirated. The knee was washed out on 7 January 2005 (Staph.aureus was isolated from the aspirate) and again on 9 January 2005.

9. Adviser 1 felt that although Mrs C had recurrent leg ulcers they were only one of a number of major issues involved in the generation of her ill health. Mrs C's immune system would have been diminished because of her rheumatoid arthritis (probable SLE) and drug therapy such as hydroxychloroquine. She was on a multiplicity of other drugs for high blood pressure, a duodenal ulcer, heart failure and her right Leg infection. Whilst leg ulcers can undoubtedly cause systemic infection if they become seriously infected themselves, infection tends to remain localised to the ulcers.

10. In this case, most importantly, Mrs C had an infected total knee replacement. Adviser 1 thought it was highly likely that Mrs C was admitted to hospital with septicaemia i.e. organisms had escaped from the knee joint into the blood due to a possibly long-standing infection in her total knee replacement. Adviser 1 explained if you leave an infected joint in place for a period of time without curing the infection, there is a real risk that a patient such as Mrs C suffering prolonged ill-health, may develop septicaemia and death. Leg ulcers may not have been a cause of her septicaemia. But for this to have happened the infected ulcers would have been so catastrophically obvious to clinical staff that it is very likely that they would have had to have taken very different action than just giving antibiotics alone i.e. she would have needed major surgery and very possibly amputation. For all these reasons Adviser 1 thought it more likely, organisms would have emanated from the infected total knee joint.

11. Adviser 2 said that there was no conclusive evidence on whether or not any action by nursing staff contributed to the condition of Mrs C's knee. There is a comment in the night report of 2/3 January 2005 that Mrs C had 'no specific complaints'. Adviser 2 said she was clear that there was failure by nursing staff to follow some aspects of the Care Plan. The need for a wound swab is quite clear and she would have expected that the Care Plan would have been checked prior to

discharge to ensure that all care had been delivered. Again there is a plan to observe leg wounds for signs of deterioration and to apply emollients daily yet there is no comment in the progress notes to indicate that any of this was done. The wound swab was ordered in writing in both the Care Plan and the Care Plan Evaluation Sheet but was not passed on verbally at the change of shift. Adviser 2 thought there was an issue here about the use of non-core staff, in this case a bank nurse. This matter has already been picked up and addressed by the Board. The handover procedure has been amended to include the need for bank nurses to read patient documentation as well as receiving a verbal report. This is ideal but maintenance of this practice could be challenging. Adviser 2 suggested that the Ombudsman emphasise to the Board the importance of monitoring compliance.

12. Adviser 2 said the Care Plan states clearly the need to observe wounds for sign of deterioration and to apply emollients daily. There is no evidence that happened. Adviser 2 would have expected the wound to be uncovered, observed, treated and redressed at least once during this short hospital stay. The Board accepted this, apologised and agreed to review practice at the meeting on 26 July 2005 (see paragraph 16). Adviser 2 thought it would be fair to ask the Board to review/develop guidance on discharge to include advice on the need to check that planned care has been given prior to discharge.

13. Adviser 2 said that on admission on 2 January 2005, Mrs C was assessed as fully independent/fully mobile. There is nothing in the evaluation and progress of care sheet to indicate that this status changed up to the time of discharge. Adviser 2 noted that Nurse 1 claimed that Mrs C arrived at the ward in a porter style wheelchair and that the same kind of chair was used for discharge although this is disputed by Mr C. She commented that it is good nursing practice to support a patient at discharge and good manners to ensure that the patient gets safely into the car. Adviser 2 considered that this was even more relevant in this case given that the nursing notes indicate that Mrs C had been upset and agitated during the night and required constant reassurance. In addition her blood transfusion was only completed shortly before discharge.

(a) Conclusion

14. Mr C had concerns that the care afforded to Mrs C following the admission on 2 January 2005 was deficient and that if staff had taken appropriate action then the

final outcome may have been different. The advice which I have received and accept is that there were failures in the nursing care but that it was unlikely to have caused Mrs C's deterioration and subsequent death. Nursing staff failed to take a wound swab although it was clearly documented that one should have been taken. In addition, there was no recording in the records that nursing staff had observed Mrs C's wounds for signs of deterioration or had applied emollients. Mr C maintained that on arriving home, Mrs C's wound was soaked from weeping sores yet staff said there was no evidence of this on discharge. Given that the nursing documentation was incomplete I am minded to accept that Mr C's interpretation was more accurate than that of the staff.

15. The issues regarding Mrs C being hurt when staff turned her using a slide sheet and the circumstances surrounding her discharge from the ward to her car cannot be resolved due to the lack of corroboration and further investigation of these issues would unlikely uncover additional information which would progress matters. However, I agree with Adviser 2 that it would have been good nursing practice if staff had provided support to Mrs C in taking her to her car as she had displayed signs of upset and agitation the previous evening and required constant reassurance. Accordingly, in view of the failings which have been identified I uphold this aspect of the complaint.

(a) Recommendation

16. The Ombudsman recommends that the Board monitors compliance of the amended handover procedure to ensure that staff read patient documentation in addition to receiving a verbal report. The Ombudsman also recommends that the Board review their guidance on discharge procedures to ensure that planned care has been provided prior to discharge.

(b) The Board's complaints handling was inadequate

17. After two meetings with Consultant 1, Mr C asked that his complaint be formally dealt with by the Board as the matter had not been resolved. Mr C attended a meeting at the Board on 26 July 2005 and was told that his complaint had come into the Board in a different route from the usual way. It was explained that normally a complaint is received in writing and is processed formally through the Patient Liaison Office and sent to the Service Manager and Clinical Nurse Manager. They would receive any staff comments and check these to ensure any

inconsistencies are challenged and investigate further to avoid contradictory information being provided to the complainant. Mr C wanted the Ombudsman to consider why his original complaint did not go through official channels.

(b) Conclusion

18. There is a requirement for all NHS Boards in Scotland to comply with the NHS Complaints Procedure and I have not seen evidence to suggest that the Board are not acting in accordance with the published guidelines. However, where the matter becomes clouded is when complainants raise their concerns directly with the clinicians involved rather than through the formal complaints procedure. The clinicians themselves might not realise that an actual complaint has been made and could deem the matters raised are an enquiry for additional information or explanations rather than a formal complaint. In this instance Mr C met with Consultant 1 at the outset and handed him a letter outlining his concerns and Consultant 1 then responded after seeking comments from Nurse 1.

19. I have no doubt that Consultant 1, by meeting with Mr C and noting his concerns, was trying to be helpful and to address the concerns which had been raised. However, in cases where it is not clear whether the complainant is making an enquiry or a formal complaint, the matter should be clarified at the outset in order that recognised procedures are followed. When responding to the draft report the Board have commented that when Consultant 1 met with Mr C he asked him if he wanted to make a complaint to which Mr C replied he did not. However, I am unable to reconcile this with Mr C's concern at why his initial submission to the Hospital did not proceed through the original complaints procedure. In this instance I am persuaded given the extent and significance of the issues raised that Mr C's letter should have been forwarded to the Patient Liaison Office at the outset and this would have allowed it to be considered in accordance with recognised procedures. I have, therefore, decided to uphold this aspect of the complaint.

(b) Recommendation

20. The Ombudsman recommends the Board remind staff that if they receive correspondence from a patient that they clarify and record whether it is a formal complaint and if so, forward it to the Patient Liaison Office.

27 February 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	The complainant's wife
The Hospital	Western Infirmary, Glasgow
The Board	Greater Glasgow and Clyde NHS Board who are responsible for the administration of the Hospital
Adviser 1	The Ombudsman's professional medical adviser
Adviser 2	The Ombudsman's professional nursing adviser
The GP	GP who visited Mrs C on 5 January 2005
Consultant 1	Consultant Cardiologist who treated Mrs C
Nurse 1	Charge Nurse from the ward which Mrs C was admitted to on 2 January 2005

Annex 2

Glossary of terms

Emollients	Creams/ointments that soothe, smooth and hydrate skin
Hydroxychloroquine	Medication to treat SLE
Pyoderma gangrenosum	A chronic skin disease which is characterised by large spreading ulcers
Septicaemia	Blood poisoning
SLE	Systemic Lupus Erythematosus – chronic autoimmune disease
Staff.aureus	Infection which is resistant to antibiotics