Scottish Parliament Region: North East Scotland

Case 200502887: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; Neurosurgery

Overview

The complainant (Mr C) raised a number of concerns about the treatment his wife (Mrs C) received at Aberdeen Royal Infirmary (Hospital 1) and Dr Gray's Hospital, Elgin (Hospital 2) in 2005.

Specific complaint and conclusions

The complaint which has been investigated is that Mrs C received inadequate care and treatment from Hospital 1 and Hospital 2 in 2005 *(not upheld)*.

Redress and recommendation

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 23 January 2006 the Ombudsman received a complaint from Mr C about numerous concerns relating to the care and treatment his wife (Mrs C), received while a patient in Aberdeen Royal Infirmary (Hospital 1) and Dr Gray's Hospital, Elgin (Hospital 2) in 2005. Mrs C was admitted to Hospital 1 on 18 August 2005 and had her operation on 19 August 2005. She was subsequently transferred to Hospital 2 for rehabilitation and was discharged home on 14 October 2005.

2. The complaint from Mr C which I have investigated is that Mrs C received inadequate care and treatment from Hospital 1 and Hospital 2 in 2005.

Investigation

3. In writing this report I have had access to Mrs C's clinical records and correspondence relating to the complaint. I made a written enquiry of Grampian NHS Board (the Board) regarding the maintenance of chair buckles which will be addressed later in this report. I also sought advice from one of the Ombudsman's professional nursing advisers (the Adviser) regarding the clinical aspects of the complaint. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report can be found in Annex 1. Mr C and the Board have had the opportunity to comment on the draft of this report.

Complaint: Mrs C received inadequate care and treatment from Hospital 1 and Hospital 2 in 2005

4. Mr C complained to the Board on 19 October 2005 about numerous issues relating to Mrs C's treatment while she was a patient. Included in his complaints were that during the eight week period his wife was a patient staff had lost samples; used faulty and malfunctioning equipment; gave incorrect information; lost personal belongings and caused personal injury to Mrs C. Mr and Mrs C attended a meeting at Hospital 2 on 25 October 2005 where they gave further clarification about their concerns. Mr C said that his concerns were that on 19 August 2005 he had telephoned the ward on five occasions to ask about Mrs C's condition. He was told on the fourth call that she was in recovery but on the fifth call that she was in surgery. This caused Mr C to believe there had been complications when in fact the operation had been a complete success.

Mr C was concerned that a urine sample or its result had been lost and as a result Mrs C was treated with general antibiotics rather than antibiotics specific to the infection. Mr C complained that Mrs C had been allowed to sit in a chair despite her confusion and that she suffered a fall and sustained an injury to her face. Mr C said that the chair buckles had been faulty and that his wife should not have been put in a chair. Mr C reported that staff at each hospital had lost a dressing gown belonging to Mrs C and that a walking stick was missing. He noted that when he reported these losses the staff's attitude was poor.

5. In response to Mrs C's complaints, the Board's Chief Executive said that an investigation had not established who had incorrectly told Mr C that his wife was in recovery when in fact she was still in surgery. An apology was given for the incorrect information and measures had been put in place to ensure that as accurate as possible information is given to relatives at all times. It was explained that the urine sample and the result were not lost and that an appropriate antibiotic had been prescribed for the infection. It was confirmed that the results of Mrs C's records showed that the infection was sensitive to the prescribed antibiotic. The Chief Executive explained that due to Mrs C's agitation and continual attempts to climb over the bed rails, night staffing levels on the ward had been increased. Staff decided it was appropriate to take Mrs C out of bed and nurse her on a chair with safety belt apparatus. However, despite being under scrutiny Mrs C managed to undo the buckles and sustain a fall. The chairs and buckles had been checked by Estates Management (Note: I have seen the maintenance report) and that no fault was found with them. Investigations had been carried out to establish the whereabouts of the dressing gown and walking stick without success. A claim form was subsequently sent to Mr C by the General Manager if he wished to pursue the matter although it was noted at a meeting that Mr C had indicated the loss of the dressing gown was not a major issue.

6. Mr C further complained that it was a nurse who told him the urine sample had been lost and that the urine infection lasted nine weeks. He had taken photographs of the chair straps which had no mechanism to buckle them and it looked like they could have been closed by tape.

7. The Adviser told me she was impressed with the standard of record-keeping by all healthcare disciplines involved in Mrs C's care and treatment. It was easy to follow Mrs C's hospital journey and to understand what happened to her and what progress was made. All changes in Mrs C's condition were

noted and responded to promptly. All incidents were reported in the progress notes. The staff identified risks appropriately and delivered care in response to these. The Adviser believed that Mrs C's fall was understandable given her level of confusion and mobility status. The Adviser said that overall the documented evidence supported the view that Mrs C received appropriate and good care; that she was treated as an individual; and that communication with the family was adequate.

(a) Conclusion

8. The advice which I have received, and accept, is that during the period Mrs C was a patient at Hospital 1 and Hospital 2 she received appropriate care and treatment. The Board have provided Mr C with an appropriate apology that he had been given incorrect information regarding whether Mrs C was in recovery or surgery. Mr C quite rightly had concerns when Mrs C fell from the chair and sustained an injury to her face. However, I have been assured that it was appropriate for Mrs C to have been nursed in a chair and that there is no evidence to substantiate Mr C's claim that Mrs C's fall was caused by a faulty buckle. I note that Mr C also complained that the staff's attitude was poor when he reported the missing belongings and without being present at the time of the report it is difficult to establish the position. However, from the clinical records and correspondence relating to the complaint I have not seen evidence to support this. In all the circumstances, I have decided not to uphold this complaint.

27 March 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	The complainant's wife
Hospital 1	Aberdeen Royal Infirmary
Hospital 2	Dr Gray's Hospital Elgin
The Board	Grampian NHS Board (who have responsibility for hospitals within the Grampian area)
The Adviser	The Ombudsman's professional nursing adviser
Chief Executive	The Chief Executive of the Board
General Manager	A Board General Manager