Scottish Parliament Region: Glasgow

Case 200800634: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospitals; care of the elderly; treatment and diagnosis

Overview

The complainant (Mrs C) was unhappy with the care provided to her late father (Mr A) by Greater Glasgow and Clyde NHS Board (the Board). Mr A was admitted to the Western Infirmary (Hospital 1) on 5 January 2008, as he had been diagnosed with bladder and prostate cancer and his condition was deteriorating. On the following day, it was recorded that he had two pressure sores[1] and that his heel was red and soft. Mr A was transferred to Ward 3A in Gartnavel General Hospital (Hospital 2) on 7 January 2008. He was then transferred to the Beatson West of Scotland Cancer Centre (Hospital 3) on 15 January 2008 and discharged on 24 January 2008. During this time, he contracted Noro virus (more commonly known as winter vomiting virus). On 28 January 2008, he was readmitted to Hospital 1 and was transferred to Hospital 2 on the following day. He was discharged again on 5 February 2008. He was then readmitted to Hospital 1 on 9 February 2008, but was transferred to Hospital 2 on the following day. Tests completed showed that Mr A had contracted MRSA and Clostridium difficile. Mr A was referred to the palliative care team on 20 February 2008. Sadly, he died later that day.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board failed to effectively manage Mr A's pressure sores (*upheld*);

(b) Mr A contracted MRSA and other infections because the infection control measures were inadequate (*not upheld*);

(c) there was a delay in referring Mr A to the palliative care team (*upheld*); and

[1] In a clinical context, pressure ulcer is the correct term. However, pressure sore remains more widely understood and, outside of the technical recommendations, is the term used throughout this report.

(d) there was a lack of continuity in the nursing care provided to Mr A (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) undertake a root cause analysis or similar improvement tool to examine the reason why Mr A received inadequate treatment for his pressure ulcers;

(ii) ensure that the policies in place reflect current national best practice standards for pressure ulcer assessment, prevention and treatment and that robust systems are in place to review, monitor and report adherence;

(iii) confirm that the learning from report 200702913, published by the Ombudsman in June 2009, is being transferred across the Board region;

(iv) ensure that there are steps in place to verify that staff are able to diagnose patients who might benefit from palliative care and then make timely referrals to palliative care teams;

(v) take immediate steps to implement the Liverpool Care Pathway or similar end of life care planning system;

(vi) continue to review and monitor the nursing care in Ward 3A in Hospital 2. This should include an examination of the clinical leadership and management; the patient experience; and the quality of care. In undertaking the review, consideration should be given to Improvement Methodology and the implementation of the Scottish Government policy for Senior Charge Nurses – Leading Better Care;

(vii) ask the Director of Nursing to verify that appropriate education and development is in place to ensure that nursing staff throughout the Board are aware of and adhere to national standards in relation to pressure ulcers, control of infection and end of life care[2];

(viii) ensure that systems are in place to review and monitor standards of all aspects of nursing documentation in line with professional standards;

(ix) ensure that patient transfer policies exist and are used in the best interests of patients, ensuring that communication and continuity of care is paramount; and

(x) make a full and detailed apology to Mrs C for the failings identified in this report.

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[2] A number of national initiatives are in place to support standards of nursing care such as the Clinical Quality Indicators for pressure ulcers and the new End of Life Strategy – Living and Dying Well.

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

Main Investigation Report

Introduction

1. The complainant (Mrs C) was unhappy with the care provided to her late father (Mr A) by Greater Glasgow and Clyde NHS Board (the Board). Mr A, then 84-years-old, was admitted to the Western Infirmary (Hospital 1) on 5 January 2008, as he had been diagnosed with bladder and prostate cancer and his condition was deteriorating. On admission, Mr A was noted to have significant weight loss and poor appetite. He was also nauseous. On the following day, it was recorded that he had two sores and that his heel was red and soft. Mr A was transferred to Ward 3A in Gartnavel General Hospital (Hospital 2) on 7 January 2008. He was then transferred to the Beatson West of Scotland Cancer Centre (Hospital 3) on 15 January 2008 and discharged on 24 January 2008. During this time, he contracted Noro virus (more commonly known as winter vomiting virus).

2. On 28 January 2008, Mr A was readmitted to Hospital 1 and was transferred to Hospital 2 on the following day. He was discharged again on 5 February 2008. He was then readmitted to Hospital 1 on 9 February 2008, but was transferred to Hospital 2 on the following day. Tests completed showed that Mr A had contracted MRSA and Clostridium difficile. Mr A was referred to the palliative care team on 20 February 2008. Sadly, he died later that day.

3. The complaints from Mrs C which I have investigated are that:

(a) the Board failed to effectively manage Mr A's pressure sores;
(b) Mr A contracted MRSA and other infections because the infection control measures were inadequate;
(c) there was a delay in referring Mr A to the palliative care team; and
(d) there was a lack of continuity in the nursing care provided to Mr A.

4. Mrs C also complained about the delay in diagnosing Mr A's condition and about the clinical treatment he received. I sought the views of a specialist medical adviser (Adviser 1) on these aspects of her complaint. He commented that the clinical management of Mr A was of a high standard. He also said that Mr A was investigated in a timely and appropriate manner and the investigations performed were appropriate and compliant with the relevant guidance. In view of the advice received, I decided not to investigate these aspects of Mrs C's complaint.

Investigation

5. Investigation of Mrs C's complaint involved reviewing Mr A's clinical and nursing records relating to the events. I also sought the views of a specialist nursing adviser (Adviser 2). As a result of the advice received from Adviser 2, further enquiries were made of the Board.

6. 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 is contained in Annex 1. A glossary of the terms used in this report can be found at Annex 2 and a list of the legislation and policies considered at Annex 3. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to effectively manage Mr A's pressure sores

7. Mr A was admitted to Hospital 1 on 5 January 2008. A Pressure Sore Risk Assessment Documentation Form was completed on the same day. This shows that Mr A was assessed as having a very high risk of developing pressure sores. However, it is not clear if he had any sores on admission, as no record was made in relation to this until 6 January 2008. On that date, it was recorded that Mr A had a small sore on his right buttock and a larger one on his left buttock. It was also recorded that his heel was red and soft. The records for that date state that the sores were dressed and that cream was applied to all vulnerable areas. The notes also state that Mr A was assisted to change position regularly.

8. Mr A was transferred to Ward 3A in Hospital 2 on 7 January 2008. However, a pressure relieving mattress was not ordered until 13 January 2008. Although the evidence we have received shows that it was installed in the ward on the same day, the nursing notes do not state when Mr A started to use the mattress. Section 7 of the NHS Quality Improvement Scotland Best Practice Statement on the prevention and management of pressure sores states that '[P]atients/clients assessed as being at risk of pressure ulcer development are not cared for on a standard NHS mattress or on basic divan mattress. As a minimum they are provided with a pressure redistributing foam mattress or overlay'.

9. Mr A was transferred to Hospital 3 on 15 January 2008 and the pressure relieving mattress was put in place for him there on the following day. A wound chart was commenced on 16 January 2008, but the entry is blank. The chart

was not completed until 20 January 2008, after Mr A had developed an additional two pressure sores on his heels. Adviser 2 commented that there was no referral to a specialist Tissue Viability Nurse at this time. Mr A was discharged on 24 January 2008.

10. Adviser 2 commented that there was an unreasonable delay in providing a pressure relieving mattress for Mr A. He was admitted to Hospital 1 on 5 January 2008 and, in relation to pressure sores, he was assessed as very high risk. However, the pressure relieving mattress was not ordered until 13 January 2008. Adviser 2 also said that she would have expected the staff to have sought the advice of a Tissue Viability Nurse to ensure the plan of care was comprehensive. She said that this was important to ensure continuity of care between different wards and departments.

11. On 28 January 2008, Mr A was admitted to Hospital 1 and was transferred to Hospital 2 on the following day. Adviser 2 commented that she could find no evidence that a wound chart was completed for this admission. She also said an entry in the records for 29 January 2008 stated 'needs alpha relief mattress', but this was the only reference to a special mattress. Mr A was discharged again on 5 February 2008. Adviser 2 commented that the admission highlighted the lack of ongoing assessment and treatment of Mr A's pressure sores.

12. Mr A was then admitted to Hospital 1 on 9 February 2008, but was transferred to Hospital 2 on the following day. A new care plan and assessment charts were commenced, including a wound assessment and treatment plan. Adviser 2 commented that the information documented during this admission was of a reasonable standard: the nursing notes stated that Mr A had a pressure relieving mattress in place; his position was changed two-hourly; and the wound dressings were changed on a daily basis.

13. I asked the Board for their comments on this aspect of the complaint. In their response, they said that there was no evidence of review or updates in relation to tissue viability on Mr A's transfer to Ward 3A in Hospital 2 on 7 January 2008 or throughout the period he was in this ward. They said that Mr A was nursed on a soft form mattress, which has a dynamic surface that accommodates up to grade 2 pressure damage, but that it was unclear from the notes as to the level of pressure damage throughout the time from admission on 5 January 2008 to his transfer to Hospital 3 on 15 January 2008. The Board

also said that a cushion should have been in place. They have also told us that all wards now have their own therapeutic cushions and additional therapeutic cushions can be ordered alongside therapeutic mattresses.

14. The Board said that although it was possible that Mr A was being nursed appropriately on a soft form mattress with skin checks and positional changes overnight, the nursing documentation failed to evidence the nursing management. They said that it would have been appropriate to have ordered a pressure relieving cushion for Mr A to sit on a chair, but this was not actioned when he was in Ward 3A. They said that there was a complete lack of documented evidence to support the ongoing assessment and management of Mr A's sacral sores throughout his nine day stay on the ward. The Board told me that the blister on Mr A's heel was first documented on 13 January 2008 and this triggered the ordering of the pressure relieving mattress.

15. We asked the Board about their current policy on the assessment and treatment of pressure sores from admission, including the use of pressure relieving mattresses, dressings and referral to the Tissue Viability Nurse. In the Board's response, they stated that all patients admitted to wards have their pressure sore risk assessed using the Waterlow Assessment. They said that this assessment has ten components to it. Each component is scored individually and a total score is obtained at the end of the process. Patients with a score of 20 or more are considered to be very high risk. The Board said that staff use this information to help them make a decision as to whether a therapeutic mattress is required or not. The documents sent to us by the Board state that a therapeutic mattress should be obtained for patients considered to be very high risk. The Board told us that the assessment is carried out daily for patients at risk and less frequently for those not at risk.

16. The Board also said that the whole process of pressure sore risk assessment and prevention has been significantly improved recently with the introduction of the National Tissue Viability Project. They said that a new pressure sore grading tool, the European Pressure Ulcer Advisory Panel, is used in all wards throughout the Board. Wards also have flowcharts that incorporate the National Tissue Viability Project, and when to seek Tissue Viability Nurse advice and the suggested therapeutic mattress. The Board also said that the Tissue Viability Nurse is contacted by telephone or email to review patients. The Waterlow Assessment is now being documented within six hours of admission. The Board said that the current standard is that the Tissue

Viability Nurse will review the patient within 48 hours of the referral, although an audit of the service has shown that the majority of patients are being seen within 24 hours.

17. We also asked the Board for their comments on what lessons had been learned from this complaint and what changes had been introduced as a result. In response, they said that a review of the complaint and analysis of the issues raised for tissue viability in the Acute Services Division had led to significant actions being undertaken in relation to training, education and raising awareness. They said that an action plan had been specifically drawn up for Ward 3A to address the educational needs of nursing staff in relation to tissue viability assessment and documentation. They said that update sessions covering documentation, litigation, the National Tissue Viability Project, and dressings were to be delivered to all staff in the ward. The Board also said that the Tissue Viability Nurse would meet with the link nurses to provide specific link nurse education.

18. In their response to the draft report on this complaint, the Board said that there has been considerable focus on pressure sore prevention and assessment in the past year. They said that the major driver has been the implementation of the National Project. The Board also said that they used the change of contract for therapeutic beds to highlight the importance of accurate risk assessment of pressure sore development during the training sessions.

19. Adviser 2 considered the Board's response and commented that action had been taken and there was some evidence of learning from the complaint. She said that the Board had outlined their policy in relation to the assessment and treatment of pressure sores and a number of measures had been introduced to address the shortcomings in Mr A's case. She said that she welcomed the use of the flowcharts and the education and training that was to be carried out. However, she also commented that some of the actions were short term and that further action should be taken to ensure that robust systems were in place to continually monitor and measure standards of care.

(a) Conclusion

20. Mr A was assessed as very high risk when he was admitted to Hospital 1 on 5 January 2008 and was transferred to Hospital 2 on 7 January 2008. Although the Board have stated that Mr A was nursed on a soft form mattress, it was unclear from the notes as to the level of pressure damage throughout this

time, as there is insufficient information about pressure sores in the care plan and nursing notes. However, considering that he had been assessed as high risk on admission, I agree with Adviser 2 that there was an unreasonable delay in obtaining a pressure relieving mattress for Mr A. Staff should also have sought the advice of a Tissue Viability Nurse at that time.

21. Mr A was admitted to Hospital 1 on 28 January 2008 and was transferred to Hospital 2 on the following day. There is no evidence of ongoing assessment and treatment of Mr A's pressure sores during this admission. It was recorded that he needed a special mattress, but there is no evidence that action was taken to put this in place.

22. I accept it is the case that, in some circumstances, sores and even severe sores cannot be avoided, even with the highest level of care. However, the care provided to Mr A in relation to pressure sores was inadequate and it is likely this contributed to his distress and the deterioration in his condition. Taking all this into account, I uphold this complaint.

23. The Board have provided an action plan to address the omissions when Mr A was on Ward 3A. In report 200702913, published in June 2009, the Ombudsman made a number of recommendations to the Board in relation to the management of pressure sores. These recommendations, and the recommendations made to the Board in previous reports published by the Ombudsman's office, have been taken into account and reflected in the recommendations made below.

(a) Recommendations

24. The Ombudsman recommends that the Board:

(i) undertake a root cause analysis or similar improvement tool to examine the reason why Mr A received inadequate treatment for his pressure ulcers;

(ii) ensure that the policies in place reflect current national best practice standards for pressure ulcer assessment, prevention and treatment and that robust systems are in place to review, monitor and report adherence; and

(iii) confirm that the learning from report 200702913, published by the Ombudsman in June 2009, is being transferred across the Board region.

(b) Mr A contracted MRSA and other infections because the infection control measures were inadequate

25. During Mr A's first admission to Hospital 2, a stool specimen was sent for analysis on 11 January 2008, as he had vomited on the previous day. Mr A was then transferred to Hospital 3 on 15 January 2008. On 16 January 2008, it was recorded in the nursing notes that the stool samples were positive for Noro virus. The Infection Control Team visited the ward and Mr A was put into isolation. The nursing records also state that stools and vomit were to be sent for analysis. On 18 January 2008, the Infection Control Team said that Mr A did not need to be nursed in isolation, as he was no longer vomiting. Mr A was discharged from Hospital 3 on 24 January 2008. On 28 January 2008, he was admitted to Hospital 1 and was transferred to Hospital 2 on the following day. The nursing notes state that a stool sample was taken on 3 February 2008, as he had loose stools overnight, but Mr A was then discharged again on 5 February 2008.

26. Mr A was then readmitted to Hospital 1 on 9 February 2008, but was transferred to Ward 8A in Hospital 2 on the following day. The Board have told me that Mr A was admitted with very high inflammation markers, which indicated the presence of infection. They said that this was thought to be a chest infection along with a possible urinary tract infection. Chest examinations revealed a right-sided pneumonia, which was treated with appropriate antibiotic therapy. The Board have stated that this was likely to be the reason that Mr A then developed the Clostridium difficile infection[3], which was recorded in the nursing notes on 13 February 2008. Sadly, at this time, plans were in place to transfer Mr A to a hospice, however, they were unable to take him due to the positive result for Clostridium difficile. The nursing records show that the antibiotics were stopped and treatment for Clostridium difficile was commenced. The records also show that staff were awaiting a side room to move Mr A to at that time, but none were available.

27. The Board also said that MRSA was found in swabs taken on 11 February 2008. They said that given the short time span between Mr A's admission on the evening of 9 February 2008 and the swab taken on 11 February 2008, it was likely that MRSA was present prior to admission.

[3] Some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, Clostridium difficile bacteria can multiply and cause symptoms such as diarrhoea and fever.

They said that staff consider any infection isolated within 48 hours of admission as 'non-hospital acquired'. The Infection Control Team visited the ward on 14 February 2008 and provided advice on specific infection control measures. Mr A was reviewed on 16 February 2008 and it was recorded that his diarrhoea had settled. On 18 February 2008, a positive MRSA result was obtained from the sacral and heel wounds. A stool sample also showed the presence of Clostridium difficile. This was discussed with the family on 19 February 2008. It was agreed that he should finish a course of antibiotics.

28. I asked the Board for further information and evidence in relation to their infection control measures. They have provided the Safe Patient Environment Audit results for Ward 8A in Hospital 2 for 2007. They also provided their monthly statistical process charts for both MRSA and Clostridium difficile and these show that both were in control during the time that Mr A was a patient in the ward.

(b) Conclusion

29. Adviser 2 commented that Mr A was at high risk of developing infections, as he was in a poor nutritional state. He was also underweight and was receiving intravenous antibiotics. She said that he must have been distressed at contracting the infections and that, in addition, because he had contracted them, he was not transferred to the hospice. We upheld a complaint in report 200800720, published in July 2009, that staff took insufficient care in handling an outbreak of infection in another of the Board's hospitals. However, having carefully considered the matter, I have not seen any clear evidence in this case that Mr A contracted the infections because the hospitals' infection control measures were inadequate. In view of this, I do not uphold the complaint.

(c) There was a delay in referring Mr A to the palliative care team

30. Mr A had been diagnosed with a terminal illness. A doctor spoke to Mr A's family on 14 February 2008 and palliative care was discussed at that time. It was also noted that he had a respite place at a hospice, but they would not accept him because of his Clostridium difficile infection. A note in the nursing records for 15 February 2008 states 'pain control poor'. Mr A's medical notes for 18 February 2008 also state that palliative care was to be discussed, but there is no further record relating to this.

31. We asked the Board for comments on this aspect of the complaint. They said that Mr A's condition deteriorated after 18 February 2008 and, during

discussion with his family on 19 February 2008, a decision was made to continue active treatment for his bronchopneumonia, but not to resuscitate him in the event of a cardiac arrest. They said that Mr A appeared to be comfortable at that time, although his family reported that he was sometimes confused. They said that he became agitated overnight and a referral was made to the palliative care team.

32. However, there are a number of references in the records to Mr A being in pain or agitated in the days before his death, including on 15, 17 and 19 February 2008. Despite this, Mr A was not seen by the Palliative Care Nurse until 17:00 on 20 February 2008. She noted that Mr A was unsettled, agitated and 'appears to be dying'. An infusion was commenced and Mr A died within the next few hours.

33. Adviser 2 commented that there appeared to be a lack of knowledge and understanding from both nursing and medical staff about diagnosing the end of life. She said that as a result of this, Mr A was not referred to a specialist and did not receive the specialist input from staff experienced in end of life care prior to his death. We asked the Board for their comments on any lessons learned from this aspect of the complaint. They said that the Acute Services Division is implementing the Liverpool Care Pathway to identify and improve the care of people in the last few days of their life.

(c) Conclusion

34. Despite Mr A's diagnosis of a terminal illness and references in his notes that he was in pain from 15 February 2008, he was not referred to the palliative care team until 20 February 2008. There was a clear delay in referring Mr A to the team and I, therefore, uphold the complaint.

(c) Recommendations

35. The Ombudsman recommends that the Board:

(i) ensure that there are steps in place to verify that staff are able to diagnose patients who might benefit from palliative care and then make timely referrals to palliative care teams; and

(ii) take immediate steps to implement the Liverpool Care Pathway or similar end of life care planning system.

(d) There was a lack of continuity in the nursing care provided to Mr A

36. I asked the Board for further information on the systems in place to ensure patients with complex needs, who are transferred to a number of wards, have a continuous level of care provided appropriate to their individual needs. In their response, the Board said that this process starts on admission through comprehensive history taking of the patient's current and past condition. The Board said that a number of risk screening assessments are undertaken within 24 hours of admission to assess for risks related to nutrition, tissue viability, falls and continence. They said that if specific problems are identified, then a care plan is commenced and updated according to the risk identified and as the condition changes. In addition, they said that a number of specialists are available to provide in-depth assessment and further guidance on care planning. They told us that transfer to another ward involves careful co-ordination and communication to ensure a full picture of the patient's condition is captured and transferred.

37. The Board told me that when patients are transferred between clinical teams, there is a verbal handover between nursing teams to highlight particular issues of concern or risk. They said that key aspects of nursing documentation are continued in a new ward to ensure that staff are aware of the patient's condition in the preceding period.

38. Adviser 2 considered this aspect of the complaint and commented that although some of the problems highlighted earlier in this report indicated poor nursing care, she was also aware that Mr A was a very frail, elderly man who was at a very high risk of developing both pressure sores and infections. She said that she had reviewed the records and her impression was of inconsistent nursing care and a lack of an overall plan of care. She said that each ward admission was treated separately, and that care plans and other assessment documents appeared to have been written in isolation. She also stated that there was no evidence of robust communication or of effective handover arrangements between wards.

39. Adviser 2 also commented that the assessment records were, on the whole, scant and of a poor standard. She said that some of the writing was illegible and that signatures were not always provided. She said that her impression was that the care of Mr A was compromised, due to the number of admissions and transfers during the last two months of his life. She stated that

in each ward area there appeared to be a lack of continuity of care and this was particularly evident in the poor management of the pressure sores.

40. She said that the care Mr A and his family received at the end of his life was poor with little evidence of planned care, such as assessing his needs and preferences; co-ordinating care across all locations; managing the last days of his life; and support for carers both during the hospital admissions and afterwards. Adviser 2 stated that for people approaching the end of their life, the family have a vital role in the provision of care and should be involved in any decision making. She said that she could find no evidence that staff involved Mr A's family in any plans for the final months of his life. The Ombudsman has previously raised concerns about the Board's communication with relatives in reports 200501476 (published in December 2007); 200702258 (published in July 2008); and 200800720 (published in July 2009). Report 200600345 (published in May 2008) set out in detail how communication between clinical staff and patients and their carers should be recorded.

41. Adviser 2 stated that whilst she could not identify one single error of judgement or failing, Mr A's case demonstrated a lack of co-ordination, leadership and continuity in the hospitals' systems and processes. She commented that there were shortcomings in relation to continuity of care and communication during transition from one hospital to another and from hospital to home. She made a specific criticism of the poor record-keeping, nursing documentation and the resulting quality of care for Mr A and his family in Ward 3A in Hospital 2. Adviser 2 outlined the importance of effective clinical leadership by the Senior Charge Nurse, who is responsible for co-ordinating care, leading the team and advocating on behalf of patients. She also criticised the record-keeping in Hospital 2 during the admission for the period 29 January 2008 to 5 February 2008. She said that all of this resulted in a poor experience for Mr A and his family.

42. During my investigation of the complaint, I also noted that Mrs C had written to the Scottish Government on 5 December 2007 to complain about the clinical treatment that Mr A had received. The letter was referred to the Board for response. Mrs C then wrote to the Board on 20 February 2008 to complain about the nursing treatment Mr A had received. The Board wrote to Mrs C on 19 March 2008 and said that they were responding to the two letters. However, the Board's response failed to address the nursing issues that Mrs C had raised.

(d) Conclusion

43. I have carefully considered the evidence I have received from Mrs C and from the Board along with the comments I have received from Adviser 2. I agree with Adviser 2 that, on the whole, nursing staff failed to provide reasonable care to Mr A. Considering Mr A's frail and vulnerable condition, particular care should have been taken to ensure that care was effective and continuous. In addition, I have not seen any evidence that staff involved Mr A's family in the plans for the final months of his life. During my investigation of the complaint, I also noted that the Board failed to respond to the complaints that Mrs C made about the nursing care that Mr A had received in her letter of 20 February 2008. In view of all of the above, I uphold the complaint.

(d) Recommendations

44. The Ombudsman recommends that the Board:

(i) continue to review and monitor the nursing care in Ward 3A in Hospital 2. This should include an examination of the clinical leadership and management; the patient experience; and the quality of care. In undertaking the review, consideration should be given to Improvement Methodology and the implementation of the Scottish Government policy for Senior Charge Nurses – Leading Better Care;

(ii) ask the Director of Nursing to verify that appropriate education and development is in place to ensure that nursing staff throughout the Board are aware of and adhere to national standards in relation to pressure ulcers, control of infection and end of life care[4];

(iii) ensure that systems are in place to review and monitor standards of all aspects of nursing documentation in line with professional standards;

(iv) ensure that patient transfer policies exist and are used in the best interests of patients, ensuring that communication and continuity of care is paramount; and

(v) make a full and detailed apology to Mrs C for the failings identified in this report.

[4] A number of national initiatives are in place to support standards of nursing care such as the Clinical Quality Indicators for pressure ulcers and the new End of Life Strategy – Living and Dying Well.

45. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	The aggrieved, Mrs C's late father
The Board	Greater Glasgow and Clyde NHS Board
Hospital 1	The Western Infirmary
Hospital 2	Gartnavel General Hospital
Hospital 3	The Beatson West of Scotland Cancer Centre
Adviser 1	Specialist medical adviser
Adviser 2	Specialist nursing adviser

Annex 2

Glossary of terms

Clostridium difficile	A bacterium which is one of the most common causes of infection of the large bowel (colon); now recognised as the chief cause of hospital acquired diarrhoea in Europe
Infusion	The therapeutic introduction of a fluid other than blood as solution into a vein
Liverpool Care Pathway	This consists of a linked series of guidance, policies and documentation which was developed to transfer the hospice model of care into the hospital setting
MRSA	Methicillin-resistant Staphylococcus aureus. A bacterium from the Staphylococcus aureus family
Noro virus	A viral infection more commonly known as winter vomiting virus
Waterlow Assessment	A standard assessment tool which allows staff to assess the risk of pressure sores in an individual patient

Annex 3

List of legislation and policies considered

The NHS Quality Improvement Scotland Best Practice Statement on the prevention and management of pressure ulcers

Scottish Government: Leading Better Care: Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project