Scottish Parliament Region: Lothian

Case 200901774: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C), a Senior Project Worker for an advocacy service, complained about the care and treatment of a member of the public (Mrs A) during an admission to St John's Hospital (the Hospital).

Specific complaints and conclusions

The complaints which have been investigated are that Lothian NHS Board (the Board):

(a) failed to prevent a male patient from entering Mrs A's room on a number of occasions (*not upheld*);

(b) failed to explain what action they had taken to prevent a recurrence, when responding to the complaint (*upheld*);

(c) inappropriately continued to barrier nurse Mrs A, despite a negative stool specimen being provided on 26 May 2009 (*not upheld*); and

(d) stated, in response to Mrs A's complaint, that she was moved to Ward 17 for further assessment, whereas Mrs A had understood that she was simply being moved there because it was a safer environment (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) ensure that, in future complaint responses, they provide complainants with information regarding the action they intend to take to prevent recurrence of any problems identified; and

(ii) consider Adviser 1 and Adviser 2's comments at paragraph 18 and revise their action plan in order to ensure that it is comprehensive.

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

Main Investigation Report

Introduction

1. On 30 July 2009, the Ombudsman received a complaint from Mrs C, a Senior Project Worker for an advocacy service, on behalf of a member of the public, Mrs A, about her care and treatment during an admission to St John's Hospital (the Hospital) between 13 May 2009 and 2 June 2009.

2. Mrs A was admitted to Ward 9 of the Hospital with diarrhoea and vomiting on 13 May 2009. An analysis of a stool specimen provided by Mrs A showed evidence of campylobacter (a bacterium which causes infectious intestinal disease). As a result, on 14 May 2009, Mrs A was moved to a side room and barrier nursed. On the night of 26 May 2009, an incident occurred where a male patient, suffering from dementia, entered Mrs A's room. Shortly after, on the morning of 27 May 2009, Mrs A was moved to a room on an observation ward. On the same day, following an assessment by a psychiatrist, Mrs A was moved to Ward 17, where she stayed until her discharge on 2 June 2009.

3. The complaints from Mrs C which I have investigated are that Lothian NHS Board (the Board):

(a) failed to prevent a male patient from entering Mrs A's room on a number of occasions;
(b) failed to explain what action they had taken to prevent a recurrence, when responding to the complaint;
(c) inappropriately continued to barrier nurse Mrs A, despite a negative stool specimen being provided on 26 May 2009; and
(d) stated, in response to Mrs A's complaint, that she was moved to Ward 17 for further assessment, whereas Mrs A had understood that she was simply being moved there because it was a safer environment.

Investigation

4. As part of the investigation of this complaint, my investigator read all the complaints correspondence between Mrs C and the Board. My investigator also examined Mrs A's clinical records and asked the Board to provide comments on the complaint. My investigator sought advice from the Ombudsman's professional nursing adviser (Adviser 1) and the Ombudsman's professional adviser on mental health issues (Adviser 2). Adviser 2 provided specific advice on dealing with incidents involving patients with dementia.

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to prevent a male patient from entering Mrs A's room on a number of occasions

6. In her complaint to the Board, Mrs C stated that, shortly after Mrs A was admitted to the Hospital, a male patient started entering her room. She stated that Mrs A raised this issue with staff on a number of occasions but effective action was not taken to prevent this from happening. She stated that, on the night of 26 May 2009, the male patient entered Mrs A's room and got into bed with her. Mrs A was very distressed by the incident and called her husband, who reported the matter to the police.

7. In their response to the complaint, the Board only made reference to the incident on the night of 26 May 2009. They stated that a bed table was placed in front of Mrs A's door to attempt to deter the male patient from entering and that Mrs A was transferred to a different room. They noted that later, on the morning of 27 May 2009, Mrs A was visited by the charge nurse and two police officers but that the police took no further action given the male patient's condition (he suffered from dementia).

8. In responding to my enquiries, the Board said Mrs A's clinical records only recorded the incident on 26 May 2009 and that no other incidents of a male patient entering Mrs A's room were noted in the records. With regard to the incident on 26 May 2009, the Board explained that it occurred at 23:30 and left Mrs A in a state of distress. They said that Mrs A requested to be moved to a different room and that an alternative room was found for her on the observation ward. They explained that the incident was reported to the police and the senior manager on call at the time of the incident. They considered that staff were proactive and endeavoured to prevent a recurrence of the incident.

9. My investigator asked Adviser 1 to comment on the complaint. She noted that:

- she could find no evidence in the records of any incidents occurring prior to the 26 May 2009;
- the clinical records provided a detailed account of the incident on 26 May 2009;

- the nurse on duty called the most senior staff on duty and a member of the Board's senior management team was called and informed;
- an incident form was completed and details of all the staff involved and the police were recorded; and
- Mrs A was transferred to another room and the male patient was transferred to another ward.

10. Adviser 1 concluded that the records indicated that the incident had been taken seriously by staff, as senior staff were involved in managing the situation and appropriate actions were taken.

(a) Conclusion

11. I note that Mrs C refers to several incidents occurring with regard to the male patient. However, the clinical records record only the incident on 26 May 2009. I also note that staff involved in Mrs A's care made no reference to other incidents when providing statements to help the Board respond to the complaint. In these circumstances – and in the absence of further objective evidence – I am unable to substantiate Mrs C's allegation that several incidents occurred.

12. Understandably, the incident on 26 May 2009 was very distressing for Mrs A. However, I note Adviser 1's view that the Board's response to the incident was reasonable and that appropriate actions were taken to address the situation.

13. In light of the fact that I have found no evidence to substantiate Mrs C's allegation that several incidents occurred, and given Adviser 1's advice regarding the incident on 26 May 2009, I do not uphold this complaint.

(b) The Board failed to explain what action they had taken to prevent a recurrence, when responding to the complaint

14. Mrs C stated that, when they responded to Mrs A's complaint, the Board had not provided information about what they intended to do to prevent a recurrence of the incident. She noted that the 'Making a Complaint about the NHS' leaflet (the Leaflet) advised that complaint responses should 'explain what action may be taken to stop what you complained about happening again'.

15. The Board's complaint response letter stated that the issues raised by Mrs C about Mrs A's care and treatment 'will be used positively to improve the

service we provide'. However, the letter provided no details about what improvements were envisaged.

16. When responding to my enquiries, the Board said that staff had recognised that the incident could potentially occur for other patients in future and, consequently, an action plan was developed and implemented. The action plan considered the management of patients with dementia.

17. My investigator asked Adviser 1 and Adviser 2 to comment on the complaint and their advice centred on the action plan drawn up by the Board and whether it ensured sufficient learning from Mrs C's complaint.

18. Adviser 1 said that the action plan was brief and that she would have expected a more comprehensive plan, with specific reference to national policy on dementia. She said that there was room for the Board to demonstrate learning from the complaint at a more strategic level. Adviser 2 agreed and considered that the Board should have reviewed the general service response to the challenges presented by dementia in a wider context than that provided by Mrs A's unfortunate experience.

(b) Conclusion

19. I note that, although the Board's response to Mrs C's complaint referred to the outcome being used to improve their service, no details were provided of the action they intended to take. In my view, it would have been helpful for further information to be provided in this respect and I note that the Leaflet advises that this should be provided in complaint responses. Consequently, I uphold this complaint.

20. In providing me with their advice, Adviser 1 and Adviser 2 noted that the Board's action plan could be more comprehensive. Consequently, the Ombudsman's recommendations below include consideration of this issue.

(b) Recommendations

21. I recommend that the Board:

(i) ensure that, in future complaint responses, they provide complainants with information regarding the action they intend to take to prevent recurrence of any problems identified; and

(ii) consider Adviser 1 and Adviser 2's comments at paragraph 18 and revise their action plan in order to ensure that it is comprehensive.

(c) The Board inappropriately continued to barrier nurse Mrs A, despite a negative stool specimen being provided on 26 May 2009

22. Mrs A was concerned that, despite providing a stool specimen that showed no sign of infection on 26 May 2009, she continued to be barrier nursed by the Board's staff. She considered that this was inappropriate.

23. In responding to my enquiries, the Board noted that the stool specimen referred to showed no evidence of campylobacter. They said that, as a result, a single room and barrier nursing would not normally be required. However, Mrs A continued to pass watery stools and the health records noted that she frequently passed large volumes of category 7 stools, as classified on the Bristol Stool Chart (this is a medical aid which divides stools into seven categories, with category 7 being 'watery, no solid pieces'). The Board said that, for infection control purposes, patient dignity and to ensure Mrs A was able to access a toilet quickly, she remained in a single room. The Board apologised if this was not adequately explained to Mrs A.

24. My investigator asked Adviser 1 to comment on the complaint. She told me that, although the stool sample was negative, advice from Health Protection Scotland was that a negative result does not exclude infection. Therefore, she considered that it was reasonable for Mrs A to continue to be barrier nursed.

(c) Conclusion

25. I note that the Board continued to barrier nurse Mrs A as she was continuing to pass watery stools and to ensure infection control and patient dignity. I also note the Adviser's view that it was reasonable for Mrs A to continue to be barrier nursed, even after her stool specimen was found to be negative. Consequently, I do not uphold this complaint.

(d) The Board stated, in response to Mrs A's complaint, that she was moved to Ward 17 for further assessment, whereas Mrs A had understood that she was simply being moved there because it was a safer environment

26. Mrs A was concerned that the Board's response to her complaint had referred to her being moved to Ward 17 for further assessment. She had understood that she was being moved – following the incident on 26 May 2009 – so that she was in a safer environment.

27. I note, from the clinical records, that Mrs A was moved to the observation ward on 27 May 2009 and that, later the same day, she was moved to Ward 17. An entry in the clinical records at 15:00 on 27 May 2009 stated: '[Mrs A] is pleased that she will be able to speak to [psychiatry], who she feels will have a better understanding of her anxieties.'

28. Another entry, on the same day, recorded a detailed assessment of Mrs A's mental health which noted, amongst other things, that Mrs A reported feeling anxious as a result of the incident referred to above. The records noted the following:

> 'Offered options - go home …
> - go to [Ward] 17 …
>
> I asked [a doctor] to see [Mrs A] with me and he also felt the above were the only two options and informed [Mrs A] of this as I had.
>
> [Mrs A] opted for admission to [Ward 17] who are able to take her for short admission.'

29. In response to my enquiries, the Board said that, at Mrs A's request, she was moved to the observation ward on 27 May 2009. They noted that, whilst on this ward, she was reviewed by medical staff and assessed as medically fit for discharge. However, Mrs A was also noted to be distressed and anxious. The Board noted that the documented plan recommended a discussion and review by a psychiatrist.

30. The Board explained that, following assessment by a psychiatrist, Mrs A was admitted to Ward 17 on the same day. The Board explained that the move to the observation ward was for patient safety, while the move to Ward 17 was for assessment and possible treatment of her mental wellbeing. The Board said they thought they had explained this to Mrs A but apologised if this had not been done adequately.

31. My investigator asked Adviser 1 to comment on the complaint. She noted that the clinical records noted that Mrs A was pleased that she would be able to speak to a psychiatrist. In these circumstances, Adviser 1 considered that referral to Ward 17 was reasonable.

(d) Conclusion

32. I note that Mrs A was medically fit for discharge on 27 May 2009 and that the move to Ward 17 was for assessment of her mental well-being. The notes record Mrs A as feeling anxious and welcoming the opportunity to engage with a psychiatrist. The notes also clearly record that options for admission to Ward 17 were discussed with Mrs A at the time. I am, therefore, satisfied that the Board's complaint response letter was accurate in stating that Mrs A was referred to Ward 17 for further assessment. In light of these points and Adviser 1's view that the referral to Ward 17 was reasonable, I do not uphold this complaint.

33. 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, a Senior Project Worker for an advocacy service
Mrs A	The aggrieved
The Hospital	St John's Hospital
The Board	Lothian NHS Board
Adviser 1	One of the Ombudsman's clinical advisers
Adviser 2	Another of the Ombudsman's clinical advisers
The Leaflet	The 'Making a Complaint about the NHS' leaflet

Annex 2

Glossary of terms

Campylobacter	A bacterium which causes infectious intestinal disease
Bristol Stool Chart	A medical aid, which categorises stools into seven categories