Scottish Parliament Region: Lothian

Case 201002030: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; general surgical; policy/administration

Overview

The Complainant (Miss C) complained on behalf of her friend (Mrs A) who underwent surgery for an inguinal hernia at the Western General Hospital in March 2010. Miss C raised concerns about delays to Mrs A's operation, which she felt could have been avoided. She also raised complaints about the service that Mrs A received from Lothian NHS Board (the Board) when she was in hospital.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs A's operation was unnecessarily delayed (*upheld*);
(b) Mrs A's special medical requirements were not made known to ward staff prior to her admission to Ward 23 (*upheld*);
(c) cleanliness and staff hygiene practices in Ward 23 were poor (*not upheld*);
(d) food service on the ward was poor (*upheld*);
(e) the Board discharged Mrs A without ensuring that she had access to adequate support outwith the hospital (*upheld*); and
(f) the Board's complaint handling was poor (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) share this report with the staff involved in Mrs A's care with a view to identifying any lessons that can be learned from her case;	30 November 2011
(ii) review their procedures for reporting CT scan results back to the referring clinician;	30 November 2011
(iii) review their procedures for tracking the progress of patients whose treatment has been referred to a different consultant;	30 November 2011

(iv)	take steps to ensure that nursing staff maintain patient records in line with the Nursing and Midwifery Council's Record Keeping and Guidance for Nurses and Midwives;	30 November 2011
(v)	take steps to satisfy themselves that the steady decline in the cleanliness monitoring score between September 2009 and March 2010 was not indicative of an endemic deterioration in cleanliness and hygiene standards on Ward 23; and	30 November 2011
(vi)	provide training to staff on Ward 23 regarding nutrition, communication and record-keeping.	30 November 2011

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

Main Investigation Report

Introduction

1. Mrs A had an inguinal hernia (a protrusion of the contents of the abdominal cavity through the inguinal canal – a tubular passage at the front of the abdomen). She was referred for inguinal hernia repair at the Western General Hospital (Hospital 1) and an appointment was made for her to undergo this surgery as a day patient. Mrs A attended a pre-operative assessment and arrived as scheduled for her operation. However, the surgeon felt that she was not a suitable candidate for surgery as a day patient. Surgery was deferred until she could be admitted as an in-patient. Mrs A encountered further delays to her treatment, as there were concerns about her heart when she presented for the rescheduled appointment. Mrs A's operation took place in March 2010, some 15 months after she was put on the waiting list.

2. Mrs A stayed in hospital after her surgery. She is deaf and is assisted by her friend, Miss C. Miss C raised a number of complaints on Mrs A's behalf regarding the service provided in Ward 23. In particular, she complained that staff did not demonstrate an awareness of Mrs A's special medical requirements. She also found food service and cleanliness to be poor on the ward.

3. Miss C raised her complaints with Lothian NHS Board (the Board) in December 2009. Dissatisfied with their response, she brought her concerns to the Ombudsman in September 2010.

4. The complaints from Miss C which I have investigated are that:

(a) Mrs A's operation was unnecessarily delayed;
(b) Mrs A's special medical requirements were not made known to ward staff prior to her admission to Ward 23;
(c) cleanliness and staff hygiene practices in Ward 23 were poor;
(d) food service on the ward was poor;
(e) the Board discharged Mrs A without ensuring that she had access to adequate support outwith the hospital; and
(f) the Board's complaint handling was poor.

Investigation

5. In order to investigate this complaint, my complaints reviewer reviewed Mrs A's clinical records and Miss C's correspondence with the Board. He obtained further comments from the Board regarding their actions and procedures and sought the opinions of two of my professional medical advisers. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Miss C and the Board were given an opportunity to comment on a draft of this report.

(a) Mrs A's operation was unnecessarily delayed

6. Mrs A, an 83-year-old deaf lady with severe osteoarthritis, was referred to Hospital 1 by her GP for consideration for surgery to repair a left inguinal hernia. She was referred to the clinic of a consultant colorectal surgeon (Consultant 1). She attended Consultant 1's clinic on 15 December 2008 and was seen by a Specialist Registrar (the Registrar). He confirmed her inguinal hernia and added her to the waiting list for day case surgery.

7. Mrs A attended a pre-operative assessment appointment on 6 May 2009. Miss C told me that, by the time of the pre-operative assessment, Mrs A's hernia had increased in size. However, she said that although this was explained to the examining nurse (the Nurse), Mrs A's hernia was not examined at that appointment. The clinical records for that examination include a standard pre-assessment pro forma which notes that abdominal and chest examination were omitted. My complaints reviewer was provided with a written statement from the Ward Manager regarding the Nurse's examination. She said that it is not routine for full examination of patients to take place for day surgery cases and noted that there was no record of Miss C or Mrs A notifying the Nurse of an increase in the hernia's size. The Ward Manager stated that Mrs A was 'assessed by a very experienced member of the pre op team and determined as suitable for day case surgery within guidelines'.

8. Mrs A was booked in for surgery at the Royal Infirmary of Edinburgh (Hospital 2) on 21 May 2009 under the care of another consultant colorectal surgeon (Consultant 2).

9. Upon attending Hospital 2 on 21 May 2009, Mrs A was seen by a doctor in Consultant 2's team (the Doctor). Miss C said that he became impatient and annoyed as Mrs A was unable to get up onto the examination table. Instead, he examined her in a standing position, which Mrs A found to be uncomfortable

and undignified. Consultant 2 was asked to attend and examined Mrs A's hernia. He found that it was too large to be operated on as a day case and reportedly expressed his concern that this had not been picked up at the pre-operative assessment. Consultant 2 told Mrs A that, before her operation could go ahead, she would require a CT scan. She would also have to be admitted to the hospital as an in-patient. Mrs A underwent a CT scan on 13 July 2009. In response to Miss C's complaint, the Board commented on the Doctor's examination. They apologised if he was rude to Mrs A (he had since left the Board) but explained that examinations in the standing position are an accepted method for investigating certain hernias.

10. Following Mrs A's scan, Miss C telephoned Consultant 2's secretary to obtain the results. She told me that, after several calls, she was told that Consultant 2 refused to look at the scan results as he had not ordered the scan. Consultant 2 reportedly considered Mrs A to be Consultant 1's patient and expected the scan results to be sent to him at Hospital 1. Consultant 1 was unaware of the scan, however, the results were eventually sent to him at Hospital 1.

11. Mrs A attended a further consultation with Consultant 1 on 7 September 2009. She was put on the waiting list again and marked as 'urgent'. She saw an anaesthetist (the Anaesthetist) on 30 September 2009 and it was decided that he and Consultant 1 would carry out the surgery.

12. After not hearing from Hospital 1, Miss C telephoned the Waiting List Office on 18 November 2009 to enquire when Mrs A's operation would be. She was told that the operation would be on 15 December 2009, with a pre-operative assessment on 7 December 2009. At the pre-operative assessment, an electrocardiogram was taken of her heart activity. This showed that Mrs A had a heart flutter and the Anaesthetist decided that her GP should refer her to a cardiologist for further investigations before the surgery went ahead. In the meantime, Mrs A was put back on the waiting list for surgery.

13. Following her cardiology appointment, Mrs A underwent surgery to repair her inguinal hernia on 2 March 2010.

14. Miss C complained about the length of time that it took for Mrs A to have her operation. She felt that had Mrs A been properly assessed at the outset, she could have been booked in as an in-patient and operated on far sooner.

15. The Board provided my complaints reviewer with comments from their Waiting List Office detailing the time that Mrs A spent on the waiting list for surgery. They confirmed that she was first put on the waiting list on 15 December 2008. Mrs A had requested that she be taken off the waiting list between 16 February and 15 April 2009, accounting for the extended period between her initial consultation and her pre-operative assessment on 6 May 2009.

16. Mrs A was next put on the waiting list following her consultation with Consultant 1 on 7 September 2009. The Board's records confirm that Miss C telephoned the Waiting List Office on 18 November 2009. When commenting in response to her complaint they acknowledged that there may have been a failure in communication, and they were not aware of the reason for Mrs A being back on the waiting list at that time. A new waiting list referral had been issued on 12 October 2009 when Mrs A was transferred back to Consultant 1's patient list rather than Consultant 2's. She effectively started again on the waiting list at that time.

17. Consultant 2 also commented in response to Miss C's complaint. He said that, upon examining Mrs A and reviewing her history on 21 May 2009, he formed the opinion that a CT scan should be arranged to check for any intra-abdominal or pelvic causes for the hernia. He also felt that given Mrs A's frailty and other medical conditions, surgery was a high risk so she was not suitable for treatment as a day-patient. Consultant 2 said that he had expected the CT scan results to come back to him at Hospital 2 but understood that they were sent to Hospital 1, resulting in some delay. He commented that, in retrospect, given the increased risks involved with Mrs A, it would have been better if her entire care had been in a single hospital and that she had been placed on the personal waiting list of the consultant looking after her.

18. When investigating this complaint, my complaints reviewer sought the advice of one of my professional medical advisers (Adviser 1). Adviser 1 noted that no examination was carried out of Mrs A's abdomen or hernia at the pre-assessment appointment on 6 May 2009. She commented, however, that this was a nurse pre-assessment and, as such, would not normally involve an abdominal examination. She said that a patient's clinical condition should be recorded by the clinician (in this case Consultant 1) at the initial out-patients appointment. Adviser 1 explained that, at a pre-operative assessment, accurate

records should be taken of the patient's history (medical and social), medication and any specific problems such as deafness. She was satisfied that the Nurse carried out a full examination within her remit. Adviser 1 added that the examining nurse should report any changes in the clinical condition reported by the patient at the pre-operative assessment. Adviser 1 noted that there is no record of Miss C or Mrs A advising the Nurse about the increase in size of Mrs A's hernia.

19. With regard to the examination carried out by the Doctor and Consultant 2 on 21 May 2009, Adviser 1 confirmed that examination in the standing position is a recognised technique and noted that this can be the only way to properly examine some hernias.

20. Adviser 1 considered that the CT scan results should have been returned to Consultant 2 as he requested the scan. She noted that the clinical records contain a hand-written note completed by Consultant 2 on 21 May 2009 stating the need for a CT scan and requesting that the results be returned to him for review. Adviser 1 said that Mrs A's pre-assessment documents would have been in a pack with identification labels detailing the consultant's name from the initial out-patient consultation (Consultant 1). Confusion may have been caused by Consultant 2 requesting the scan, but the labels with Consultant 1's name on it being stuck onto the request. She felt, however, that the secretaries of either consultant could have acknowledged receipt of the scan results.

21. Adviser 1 commented on the overall waiting time for Mrs A's surgery. Whilst she made reference to national waiting time targets, she felt that the key issue in this case was the fact that Mrs A was assessed by the Registrar as being suitable for surgery as a day case on 15 December 2008. She said that 83-year-old patients are not candidates for day case surgery. As I mentioned previously, Adviser 1 was satisfied with the Nurse's examination of Mrs A on 6 May 2009. However, she said that, as the Nurse documented all of Mrs A's existing medical conditions and her age, she would have expected the Nurse to alert Consultant 2 that Mrs A was not a suitable day case. Adviser 1 noted that Mrs A had an extensive past and current medical history and was on numerous medications. She lived alone and had poor mobility. Adviser 1, therefore, did not consider it likely that Mrs A could have discharged from hospital within 24 hours.

22. My complaints reviewer obtained a copy of the Board's staff guidance on pre-operative assessment of patients for day surgery (the Guidance). The Guidance sets out a range of criteria that staff should check at the pre-operative assessment. Social criteria such as the distance the patient lives from the hospital, how they will get home after surgery and whether they have someone at home to look after them are considered. In addition to this, medical criteria such as blood pressure, heart condition, and medical history are assessed.

23. At the time of Mrs A's surgery, the national waiting time target for surgery was 18 weeks from being placed on the waiting list.

(a) Conclusion

24. In terms of the national waiting time target for surgery, both of Mrs A's proposed operation dates on 21 May and 15 December 2009 were comfortably within the 18 week deadline when taking into account her self-imposed period off the list and other factors causing the 'clock' to be stopped. However, the overall waiting time that Mrs A encountered from GP referral to surgery was around 73 weeks, which I found to be excessive given the nature of her condition.

25. I accept Adviser 1's comments regarding Mrs A's age and medical history and agree that the key issue in this case was that Mrs A was initially treated as a candidate for surgery as an out-patient. The Guidance sets out social and physical criteria for assessing whether a patient is suitable for day surgery. I found these criteria to be reasonable and the guidance clear. However, whilst Mrs A 'passed' in terms of the criteria and was put forward as a day case, Consultant 2 evidently shared Adviser 1's view that her age and other medical conditions meant that she should be admitted as an in-patient. It would be inappropriate to set an age limit for day surgery, or a list of medical conditions that preclude patients from such surgery, as each individual is different. However, the Board should consider how they may take a more holistic view of a patient's suitability of a day case, even when they meet the criteria in the Guidance.

26. Had Mrs A been listed for admission as an in-patient from the outset in December 2008, I have no doubt that her operation would have been carried out far sooner. Instead, time was lost through the subsequent referral for a CT scan, confusion over where the scan results should be sent, and an apparent breakdown in communication within the Board when she was re-listed

on the waiting list. When Mrs A returned for her second pre-operative assessment in December 2009, almost 12 months after her initial assessment, she was found to have a heart condition that was not previously present. Whilst it was, of course, appropriate and necessary to investigate this heart condition, the additional time required for this contributed to the overall waiting time for Mrs A's surgery.

27. Consultant 2 commented that, in retrospect, it would have been better had Mrs A been treated under one consultant, suggesting that this would have avoided some of the confusion around reporting the CT scan results and re-listing on the waiting list. Whilst I agree that the communication between the two hospitals was poor and contributed to the delays that Mrs A encountered, I do not necessarily find it inappropriate or poor practice for patients to be referred to a different hospital/consultant if this is likely to expedite their treatment. In this case, rather than finding that Mrs A should have been treated solely under the care of Consultant 1, I found that had communication been better between the two hospitals, the CT scan results would have been reported sooner. Furthermore, Mrs A would have been put back on the waiting list sooner. A substantial part of the delays that she encountered would have been avoided.

28. Miss C's complaint emphasised her belief that Mrs A's hernia should have been examined at her pre-operative assessment on 6 May 2009. She felt that, had it been examined, Mrs A would not have been put forward for surgery as a day case and the subsequent delays could have been minimised. I accept the Board's and Adviser 1's comments regarding the Nurse's examination and am satisfied that this pre-operative assessment was carried out appropriately. That said, the evidence that I have seen suggests that Mrs A should have been identified as unsuitable for day surgery prior to this. I found that this oversight and the subsequent communication and administrative issues regarding the CT scan results and waiting list led to excessive delays to Mrs A's treatment. I, therefore, uphold this complaint.

(a) Recommendations

29. I recommend that the Board:	*Completion date*
(i) share this report with the staff involved in Mrs A's care with a view to identifying any lessons that can be learned from her case;	30 November 2011

(ii)	review their procedures for reporting CT scan results back to the referring clinician; and	30 November 2011
(iii)	review their procedures for tracking the progress of patients whose treatment has been referred to a different consultant.	30 November 2011

(b) Mrs A's special medical requirements were not made known to ward staff prior to her admission to Ward 23

30. Mrs A had specific needs as a result of her medical conditions. She attended a pre-operative assessment for her surgery on 24 February 2010. Miss C said that the nurse that conducted the pre-operative assessment was very helpful and took care to note down all of Mrs A's special needs in the documentation.

31. Mrs A was admitted to Ward 23 at Hospital 1 on 1 March 2010. Miss C accompanied her. She explained that she and Mrs A arrived at Ward 23 during visiting time at around 15:30. They were shown to a room and left to wait. At around 16:45, with no sign of any staff, Miss C went to the nurses' station to ask if someone would be joining them to talk Mrs A through what would be happening. She was joined by a staff nurse (Staff Nurse 1). Miss C explained that Mrs A had swelling in both legs due to severe leg ulcers and required her feet to be elevated. She asked how to raise the foot of the bed, however, Staff Nurse 1 was reportedly unable to show her how to do this. Miss C said that Staff Nurse 1 told her that a doctor would attend after their clinics were finished. She was allowed to stay with Mrs A after visiting time until the doctor arrived.

32. By evening visiting time no doctor had arrived. Miss C said that Mrs A was in a lot of pain as she had not been allowed to take any of her medication. She was told that Mrs A could not have the medication until a doctor had 'written it up'.

33. The noise of the evening visiting time caused Mrs A great distress as she suffered from tinnitus and auditory hallucinations. As a result she was shown to a quiet room. Once Mrs A was settled in the quiet room, Miss C returned to the nurses' station and explained Mrs A's particular problems to another staff nurse (Staff Nurse 2) and how staff could help her. She asked whether the doctors were still planning to visit Mrs A. Staff Nurse 2 reportedly checked Mrs A's records at this point and found that her medical requirements were detailed and that there was, in fact, no need for Mrs A to be seen by a doctor.

34. Miss C complained that the information that Mrs A had provided at the pre-operative assessment was not passed on to ward staff and that staff were, therefore, unprepared for Mrs A's arrival or to meet her needs.

35. The Board told my complaints reviewer that staff in the pre-admission service collate all patient requirements and communicate any special needs in writing to the admitting wards. However, it can be a challenge for ward staff to pick up this information as patients are not assigned to specific wards until the day of admission. The Board noted that special requirements should be picked up by ward staff when they complete the patient's admission documentation and told my complaints reviewer that they have reinforced with their staff the need to ensure that individual patient needs are appropriately documented.

36. In their response to Miss C's complaint, the Board acknowledged that it had been recorded at the pre-operative assessment that Mrs A had specific difficulties with her hearing and her mobility. They apologised for the fact that ward staff were unaware of Mrs A's needs until she arrived in the ward and said that the matter had been raised with the Charge Nurse in the pre-admission clinic in an attempt to improve communication in the future. The Board also apologised to Miss C for the fact that she had to seek out assistance from staff on the ward. They assured her that the Charge Nurse had reiterated to staff the importance of communicating effectively with patients and of being visibly present on the ward.

37. My complaints reviewer sought the opinion of another of my professional medical advisers (Adviser 2). Adviser 2 considered the pre-operative assessment documentation to have been completed well and that it included detailed information to support Mrs A's planned admission. She said that it is normal practice for ward staff to have access to patients' pre-assessment information prior to the patient arriving on the ward, providing them with the ability to refer to these records as part of their admission process. During admission, staff should then ensure that the information remains valid and add further information if required to inform the care plan. Adviser 2 said that she could find no evidence to suggest that staff on Ward 23 implemented a plan of care that had been informed by the information gathered at the pre-operative assessment.

38. Adviser 2 found that the care planning document, completed on 1 March 2010 was incomplete, lacking much of the relevant detail. For example, there was no record of Mrs A having leg ulcers or of the dressings that were in place at the time of her admission. The skin assessment form referred only to her surgical wound and cannula (small tube inserted into the veins) sites. Adviser 2 further commented that the nutritional screening tool paperwork and other care planning assessments often did not contain Mrs A's details and had minimal detail completed. She felt that the paperwork was inadequate to inform the care provided and did not provide any reassurance that the staff caring for Mrs A truly recognised her needs, beyond those directly related to her surgery. Adviser 2 found that the records maintained by staff on Ward 23 failed to meet the minimal standards for record-keeping as set out in the Nursing and Midwifery Council's Record Keeping and Guidance for Nurses and Midwives.

(b) Conclusion

39. I acknowledge that ward staff do not receive detailed information about incoming patients until the day of admission and that much of the patient's information is, therefore, gathered or implemented during the admissions process. However, as Adviser 2 noted, Mrs A's admission paperwork does not appear to carry on from, or build upon, the detailed information gathered at the pre-operative assessment.

40. Miss C's account of events suggests that there was minimal interaction between staff and Mrs A in terms of gathering information about her needs during the admission process. Her comments regarding the doctors' visit also suggest that information that was available to staff was not picked up until their attention was drawn to it.

41. I accept Miss C's account of events and Adviser 2's comments. I found both the record-keeping in Ward 23 and staff's communication with Mrs A upon her admission to the ward to be poor. Whilst I am satisfied that at least some of Mrs A's needs were addressed by, for example, finding her a quiet room, this only happened as a result of Miss C actively seeking out assistance from staff. Help relating to issues identified in the pre-operative assessment was not forthcoming from staff and I, therefore, uphold this complaint.

(b) Recommendation

42. I recommend that the Board:	*Completion date*
(i) take steps to ensure that nursing staff maintain patient records in line with the Nursing and Midwifery Council's Record Keeping and Guidance for Nurses and Midwives.	30 November 2011

(c) Cleanliness and staff hygiene practices in Ward 23 were poor

43. Miss C complained about what she felt was a lack of organisation on Ward 23. She was particularly concerned about the level of cleanliness and staff hygiene. She said that the ward was dirty and unhygienic and when she pointed out to one of the domestic staff that there was dirt left on the floor after one of the cleaning rounds, she was told not to worry as it would be picked up during the next round. Miss C said that she witnessed several members of staff not washing their hands or using the hand-cleaning gel provided.

44. In response to Miss C's complaint, the Board said that infection control was an issue that staff on Ward 23 took very seriously. They said that the ward had undertaken a significant amount of audit work on factors including hand hygiene, environment and waste management in order to provide evidence of good practice and to highlight any areas that may need to be improved. Ward 23 was noted to have consistently achieved favourable results in these audits and had a cleaning schedule which the Board felt provided a robust system for ensuring that cleaning tasks were undertaken. Furthermore, the ward's Charge Nurse reinforced to all staff members their shared responsibility for infection control and encouraged them to challenge any poor practice that they witnessed.

45. My complaints reviewer obtained copies of the Board's policies on hand hygiene and ward cleaning. He also obtained the results of cleanliness audits for Ward 23 during Mrs A's stay. The ward achieved 97 percent hand hygiene compliance in March 2010 and averaged 95.8 percent compliance between March 2009 and March 2010.

46. The ward cleaning policy sets out a list of cleaning tasks that are required to be completed and details which function has responsibility for the task (nursing staff or Domestic Services) and how frequently each task should be carried out. Cleanliness monitoring results for Ward 23 were as follows:

Month	*Percentage*
September 2009	99%
October 2009	97%
November 2009	95%
December 2009	96%
January 2010	95%
February 2010	95%
March 2010	94%

47. My complaints reviewer found no evidence within the records of Miss C or Mrs A raising concerns with ward staff about standard of cleanliness.

(c) Conclusion

48. In the absence of any objective evidence to support Miss C's comments regarding cleanliness and hand hygiene in Ward 23, it is impossible for me to confirm whether cleanliness levels were poor when she and Mrs A was there. The audit results and cleanliness monitoring tools provide a useful picture of the general standards on the ward, but do not record, for example, whether a particular staff member failed to clean their hands at a time when Miss C was visiting the ward.

49. The monitoring and auditing tools that my complaints reviewer obtained are fairly standard and I am satisfied that they are fit for purpose. I note that the ward monitoring score remained relatively high at 94 percent in March 2010, despite a steady decline from 99 percent in September 2009. There is insufficient evidence available to determine a particular cause of this decline and given that the percentage score covers a whole month rather than the specific times that Mrs A was in the ward, I am unable to conclude that there was a clear problem with cleanliness during her stay. As such, I do not uphold this complaint.

(c) Recommendation

	Completion date
50. Although I did not uphold this complaint, I recommend that the Board:	
(i) take steps to satisfy themselves that the steady decline in the cleanliness monitoring score between September 2009 and March 2010 was not indicative of an endemic deterioration in	30 November 2011

cleanliness and hygiene standards on Ward 23.

(d) Food service on the ward was poor

51. Mrs A was dissatisfied with the food service in Ward 23. Miss C said that on the first night of her stay Mrs A was given a plate of soup. Mrs A liked the soup's taste but it was served cold. Another patient in a nearby bed also complained that the soup was cold.

52. Following her operation on 2 March 2010, Mrs A was taken to the High Dependency Unit (HDU) where she stayed until the morning of 5 March 2010. Miss C said that the care that Mrs A received in the HDU was excellent and food was served piping hot. Upon returning to Ward 23 around 08:00 on 5 March 2010, Mrs A was given a bed in a single room. She was pleased to have a quiet room, however, staff failed to bring her any breakfast and she felt that she had been forgotten about.

53. Miss C said that, by lunchtime, Mrs A was very hungry. She was given soup and a fish dish, both of which were served cold. Mrs A was unable to eat the food provided and Miss C had to get her a sandwich from the hospital shop when she visited at 15:00.

54. In response to Miss C's complaint, the Board explained that it is their policy to serve food promptly so that it is at the correct temperature. Ward staff are also expected to respond to any issues raised regarding food and should seek a replacement meal if the patient is dissatisfied. The Board acknowledged the importance of nutrition when caring for patients and noted that they included Malnutrition Universal Screening Tool scores (MUST) in their care plans so that patients had appropriate support with their dietary intake. The Board were unable to comment as to why Mrs A was not provided with breakfast when she returned to Ward 23, as the ward staff could not recall this issue being raised at the time. They explained, however, that the food trolley visited the HDU later than Ward 23, which suggested that Mrs A may have left the HDU before breakfast was served and arrived at Ward 23 after service had ended.

55. The Board publish a patient information leaflet: Your Meals in Hospital (the Leaflet). The Leaflet provides patients with information about meal times and states 'There are always snacks and drinks available outwith these times. Please ask a member of staff if you would like a snack or drink'. It also states 'We try to ensure you are not interrupted during meal times. If you miss a meal

because you are receiving treatment, having tests or because you are admitted to the ward late in the day, we will provide one for you, or a suitable snack'.

56. My complaints reviewer asked the Board whether Mrs A should have been provided with a meal automatically upon arriving back into Ward 23 after breakfast had been served, or whether she would have had to request this. He also asked whether replacement meals would have been available for Mrs A had she notified staff that her food had been served cold. The Board said that patients would not automatically be asked on arrival on the ward if they had eaten, unless meals were being served at the time. It is expected that patients will let staff know if they have missed a meal. When staff are made aware of a missed meal, they will then telephone the kitchen to request a meal for the patient. The kitchen will then either provide a suitable meal from the dining room, or will cook something fresh if the request is made outwith the dining room opening hours.

57. Adviser 2 reviewed Mrs A's clinical records and commented on entries relating to nutrition. She found that, whilst the MUST assessment tool was being used during Mrs A's stay, it was not properly completed by staff. This was the case for Ward 23 and the HDU. There was no detailed entry in relation to Mrs A's nutritional intake or concerns relating to the lack of food provision or cold food. Adviser 2 found no specific care plan relating to nutrition and, as Mrs A was noted to be independent in this area (not requiring assistance with feeding), she felt that there may have been an assumption that all was well.

58. Adviser 2 stated that it is the responsibility of nursing staff to ensure that all patients receive adequate nutrition whilst in hospital and to seek feedback from patients regarding the standard of food provided. Nursing staff should also take action if it is observed that a patient has not eaten their food.

(d) Conclusion

59. I found no evidence of Mrs A having raised concerns about food being cold or meals being missed at the time of her stay. That said, I have no reason to doubt Miss C's comments.

60. The Board acknowledge the importance of nutrition as part of patients' care and I found that the information provided to patients in the Leaflet supported this. I was also satisfied with the Board's explanation regarding

different food service times between the two wards and felt that this accounted for Mrs A's missed breakfast.

61. I was generally satisfied that the Board have practical measures in place to provide food to patients with additional arrangements for patients to receive food outside of normal meal times, or to change meals if they are not satisfactory. Mrs A's experiences are, therefore, of particular concern as she was left feeling hungry on more than one occasion. It would appear that Mrs A did not, or did not feel able to, raise her concerns with ward staff or that ward staff failed to identify that there was an issue. I accept that some responsibility lies with the patient to voice their concerns with staff and to ask for food if they are dissatisfied with what has been served. However, it would appear that, on at least two occasions, Mrs A left meals uneaten due to their having been served cold. I found no evidence of enquiries being made by nursing staff as to why she had not eaten her meals.

62. Whilst I accept that Mrs A or Miss C could have raised their concerns regarding food service at the time of Mrs A's stay, I consider that more could have been done to ensure that meals were served hot and that Mrs A was eating enough. On balance, I uphold this complaint.

(d) Recommendation

63. I recommend that the Board:	*Completion date*
(i) provide training to staff on Ward 23 regarding nutrition, communication and record-keeping.	30 November 2011

(e) The Board discharged Mrs A without ensuring that she had access to adequate support outwith the hospital

64. Mrs A had leg ulcers which needed to be dressed regularly with pressure bandages. Miss C visited Mrs A in Ward 23 on 5 March 2010. She found Mrs A sitting on her bed with her leg ulcers undressed and leaking onto the sheets. Miss C raised this with a member of staff and was told that a member of the dermatology team had been asked to attend, as ward staff were not trained to apply the type of bandaging that Mrs A required.

65. Miss C was asked to wait for the doctor to attend, as he wanted to have a word with her. A doctor (Consultant 3) arrived and told Miss C that Mrs A could be discharged. Miss C pointed out to Consultant 3 that Mrs A lived alone and was not yet able to get into bed unaided. Consultant 3 reportedly told Miss C

that there was nothing more that the Board could do for Mrs A surgically. Miss C, however, was not able to take Mrs A home until her legs had been dressed and it was not yet clear when the dermatologist would attend. It was agreed that Mrs A should remain in hospital overnight and be discharged the following day. Miss C returned the following day to take Mrs A home, but remained concerned about her ability to mobilise at home alone. She felt that the Board should have done more to support Mrs A at home. Mrs A received assistance from the district nurse to change her dressings, but when the district nurse asked for further support to be provided to assist Mrs A to get into bed, she was told that it would take several days for this help to be provided.

66. The Board said that their records showed Mrs A and Miss C had been involved in discussions about Mrs A's discharge arrangements. There was no record of concerns having been raised at the time regarding Mrs A's ability to cope at home and her ability to cope at home was not seen to be worse than it had been prior to her admission to hospital. The Board acknowledged that Miss C's complaint did not reflect their records and apologised for the lack of communication between her and Mrs A and their staff.

67. My complaints reviewer asked Adviser 2 to comment on the Board's discharge arrangements for Mrs A. Adviser 2 was satisfied that the clinical records showed that some discussion had taken place with Mrs A and Miss C regarding discharge arrangements. References were made to wound dressing, mobility, and the fact that a consultant had reviewed Mrs A and found her to be fit for discharge. Essential factors for discharge such as transport arrangements, discharge letters and medication were also referred to. That said, Adviser 2 found no evidence of a multi-disciplinary assessment of Mrs A's ability to cope after discharge. She also found that the Patient Discharge Information Summary, whilst reasonably complete, did not contain important details such as arrangements for follow up at out-patient clinics.

68. Mrs A's clinical records for 6 March 2010 state:

> '04:50 - Observations stable … District Nurses are aware of how to redress. Mobilising independently with mobiliser (4 wheels). For home today at Midday, discharge letter done, Query transport, will check when wakes up … slept well overnight. No complaints

11:00 – Reviewed by [Consultant 3]. To inspect wound and discharge home … leg dressings done … discharge home with friend – own transport.'

(e) Conclusion

69. The evidence that I have seen indicates that the nursing staff and Consultant 3 considered Mrs A to be well enough to be discharged home on 6 March 2010. She is noted as being able to mobilise independently with a wheeled Zimmer and the district nurse was aware of her ongoing needs as regards her leg ulcers. I note Adviser 2's comments regarding the discharge paperwork. Miss C complained about the lack of support for Mrs A in her own home, specifically in terms of helping her get into bed. Whilst there is no record of this issue being raised with staff prior to Mrs A's discharge, I accept that this does not mean that the matter was not discussed. Consideration of Mrs A's ability to cope appears to have concentrated on her ability to cope with the physical affects of her surgery, rather than a multi-disciplinary look at the support available to her outside hospital and the practicalities of coping with daily life. I consider that more could have been done in this regard. As such, on balance, I uphold this complaint.

(e) Recommendations

70. I have no recommendations to make.

(f) The Board's complaint handling was poor

71. Miss C made two formal complaints to the Board. On 15 December 2009 she raised her concerns about the delays to Mrs A's surgery and on 20 April 2010 she complained about the treatment and service provided by Ward 23. The Board responded to her complaints on 29 January and 26 May 2010 respectively.

72. Miss C complained to the Ombudsman that the Board had not addressed all of the points raised in her correspondence. Specifically, they failed to respond to her complaints about the attitude of various members of staff. She also complained that she was not offered a meeting with the Board's management, an opportunity that she was aware is often presented to complainants to discuss their complaints face-to-face with staff.

73. In her first letter, Miss C complained about the Doctor's attitude. She found him to be rude and impatient toward Mrs A and that he treated her

roughly when examining her. The Board's response was informed by a statement provided by Consultant 2, in which he expressed his concern that one of his staff had been rude to a patient. The Doctor no longer worked for Consultant 2 at the time of Miss C's complaint, so no further action was taken.

74. In her complaint of 20 April 2010, in addition to her comments regarding the need to seek out staff, Miss C said that she found Ward 23 to be disorganised, with staff drifting around without any real leadership as to what they should be doing. She felt that staff were uncaring, especially those who were responsible for running the ward. She complained that when seeking help at the nurses' station, no help was forthcoming unless she 'spoke up', even when staff were not busy with other tasks. The Board responded to Miss C's concerns, noting that the ward's Charge Nurse had high expectations regarding the attitude and behaviour of her staff and had reinforced this expectation with them. The Charge Nurse aimed to set an example to her staff by maintaining a visible presence on the ward. It was noted that the General Surgery Charge Nurses were reviewing methods of obtaining constructive feedback from patients and visitors with a view to gathering auditable information about the service being provided by ward staff.

(f) Conclusion

75. Complaints about attitude and behaviour are very difficult to investigate, as they tend to relate to conversations or personal demeanour and are not recorded unless the issue is raised at the time. I was satisfied that the Board accepted Miss C's assertions about staff behaviour at face value and that they acknowledged the importance of attitude as part of the overall service being provided.

76. I found the Board's response to the complaint about the Doctor's examination to be reasonable.

77. Miss C's complaint about the attitude of staff on Ward 23 was quite general and, as such, I consider the general response provided to be appropriate. I also accept the Board's comments regarding the work that they are doing to actively seek feedback from patients and visitors and consider this to be a positive step. I do not uphold this complaint.

(f) Recommendations

78. I have no recommendations to make.

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

Annex 1

Explanation of abbreviations used

Mrs A	The complainant's friend
Hospital 1	The Western General Hospital
Miss C	The complainant
The Board	Lothian NHS Board
Consultant 1	A consultant colorectal surgeon for the Board
The Registrar	A specialist registrar in Consultant 1's clinic
The Nurse	A nurse for the Board
Hospital 2	The Royal Infirmary of Edinburgh
Consultant 2	A consultant colorectal surgeon for the Board
The Doctor	A doctor in Consultant 2's team
The Anaesthetist	An anaesthetist for the Board
Adviser 1	A professional medical adviser to the Ombudsman
The Guidance	The Board's guidance for pre-operative assessment of day surgery patients
Consultant 3	A consultant colorectal surgeon for the Board

Staff Nurse 1	A staff nurse at Hospital 1
Staff Nurse 2	A staff nurse at Hospital 1
Adviser 2	A professional medical adviser to the Ombudsman
HDU	High Dependency Unit
MUST	Malnutrition Universal Screening Tool
The Leaflet	The Board's Your Meals in Hospital information leaflet

Annex 2

Glossary of terms

Cannula	A small tube inserted in to the veins
Computer Tomography (CT) scan	A three dimensional scan of the body
Electrocardiogram	Measurement of the electrical activity of the heart
Inguinal hernia	A protrusion of the contents of the abdominal cavity through the inguinal canal – a tubular passage at the front of the abdomen

Annex 3

List of legislation and policies considered

The Nursing and Midwifery Council – Record keeping and guidance for nurses and midwives