What can we learn from the ombudsman?

In this article...
- Findings of the NHS ombudsman on care of older people
- Patient stories from the ombudsman report
- Expert views on lessons for nursing

Expecting dignified, pain-free care, in clean surroundings in hospital should be the right of all older people. However, a report by the health service ombudsman (see her comment, right) that addresses serious complaints against the NHS, has highlighted cases where older patients have suffered unnecessary pain, neglect and distress.

The report, Care and Compassion? (Health Service Ombudsman, 2011) is based on the findings of in-depth reviews of 10 independent investigations, concluded in 2009-10, into complaints about NHS care for older people across England. Nine of the 10 patients died during the events described in the case studies or soon afterwards. A selection of the cases are summarised in Boxes 1-3.

Of nearly 9,000 complaints made to the ombudsman about the NHS last year, 18% were about the care of older people. In total, it accepted 226 cases for investigation – twice as many as for all the other age groups combined. In a further 51 cases, the ombudsman resolved complaints directly without the need for a full investigation.

The issues highlighted in these cases – dignity, healthcare-associated infection, nutrition and hydration, discharge from hospital and personal care – featured significantly more often in complaints about the care of older people.

In the wake of these stories, the health service ombudsman Ann Abraham is demanding an urgent change in the health service’s attitudes towards the over 65s. Nursing Times asked a range of expert nurses and commentators to analyse what this report means for nursing and what the profession can learn from its findings.

Jonathan Webster: A challenge to ways of working

This report highlights a number of failings in care that cannot be condoned or excused. The cases should act as a wake-up call for nurses, our managers, employing organisations and policy makers.

The report also brings to the fore the need to challenge and question values, beliefs and ways of working that diminish dignity and the essentials of skilled compassionate nursing care.

Leadership in older people’s nursing – at all levels – along with effective work-based cultures are fundamental to quality. Leaders set the scene – they enable and support while challenging unsatisfactory practice. The culture reflects the values underpinning care and skilled therapeutic working.

Meeting the needs of older people with multiple needs can be complex. Understanding the interplay of physical, psychological, social and spiritual needs, at a time when the person and family may be highly vulnerable, requires skill and knowledge. Frequently, the term “basic care” is used to describe meeting such needs – but there is nothing basic about essential, skilled care.

We need to understand what leads to poor care and to address these failings. Day-to-day practice can bring immense challenges, but fundamental to our role as nurses working with older people is the need to ensure they are central to care, irrespective of where that care is delivered.

Jonathan Webster, assistant director, quality and clinical performance, Bexley Care Trust; honorary senior research fellow, Christ Church Canterbury University, and honorary nurse clinical director for older people, NHS London.

Jocelyn Cornwell: Why not say sorry?

Nurses and doctors often say they are not allowed to say sorry because their employers or their insurers won’t let them. This is actually not true: NHS policy changed some time ago, as have the insurers, but people still believe it.

No one likes being judged or being in the wrong. They like it even less if they are unhappy about the thing in the first place, or feel guilty and ashamed.
Our first instincts are always defensive and people really hate criticism if they feel it’s unfair: perhaps others were involved; it was not their fault; or they feel the circumstances prevented them from doing anything about it. Nurses may find it hard to say sorry when they feel they have been left carrying the can for other people and feel powerless to do anything differently.

The same simple psychology plays out in organisations: corporate bodies are instinctively defensive.

For decades, governments and ombudsmen have urged NHS organisations to respond differently to complaints, to apologise when things go wrong, and to take complaints seriously and learn from them.

But they continue not to do so. Most NHS trust boards will receive reports on numbers of complaints received and how long it took to respond to them, but very few examine what caused them. Every trust has an established process for investigating complaints and punishing wrongdoers, but hardly any have established processes for learning from complaints and supporting staff when things go wrong.

Unless and until that changes, I don’t expect to see nurses or anyone else lining up to say sorry.

Jocelyn Cornwell, director, The Point of Care, The King’s Fund

---

**“A PICTURE OF NHS PROVISION THAT IS FAILING TO MEET EVEN THE MOST BASIC STANDARDS OF CARE”**

*Care and Compassion?* tells the stories of 10 people over the age of 65, from all walks of life and from across England.

Many of them were people with energy, creativity and vitality, active in their retirement and well-known and liked within their communities. They wanted to be cared for properly and, at the end of their lives, to die peacefully and with dignity. What they have in common is their experience of suffering unnecessary pain, indignity and distress while in the care of the NHS.

Their stories, the results of investigations concluded by my office in 2009-10, illuminate the gulf between the principles and values of the NHS Constitution and the felt reality of being an older person in the care of the NHS in England. These are not exceptional or isolated cases and the issues highlighted – dignity, healthcare-associated infection, nutrition, discharge from hospital and personal care – feature significantly more in complaints I receive about the care of older people.

---

**“Each of my investigations led to change... [but] I have yet to see convincing evidence of a shift in attitude towards older people across the NHS”**

The opening words of the NHS Constitution say: “The NHS touches our lives at times of basic human need, when care and compassion are what matter most.”

Yet my investigations reveal an attitude – both personal and institutional – that fails to recognise the humanity and individuality of the people concerned and to respond to them with sensitivity, compassion and professionalism. They present a picture of NHS provision that is failing to meet even the most basic standards of care.

There are very many skilled nurses in the NHS who provide a compassionate and considerate service to patients. Yet the cases I see confirm that this is not universal. Instead, the actions of individual staff add up to an ignominious failure to look beyond a patient’s clinical condition and respond to the social and emotional needs of the individual and their family. The difficulties featured in *Care and Compassion?* were not solely a result of illness, but arose from the dismissive attitude of staff, a disregard for process and procedure and an apparent indifference to deplorable standards of care.

Each of my investigations led to real change at the hospitals or GP surgeries concerned, including staff training, new systems to ensure better information provided to families and improved record-keeping. I have yet to see convincing evidence of a widespread shift in attitude towards older people across the NHS that will turn the commitments in the NHS Constitution into tangible reality. An impetus towards real and urgent change is needed.

Every member of NHS staff should pause and ask themselves if any of their patients could suffer in the same way. I know from my caseload that in many cases the answer must be “yes”. The NHS must close the gap between the promise of care and compassion outlined in its constitution and the injustice that many older people experience.

Every member of staff – no matter what their job – has a role to play in making the commitments of the Constitution a felt reality for patients.

Ann Abraham, health service ombudsman

---

**“We respond with humanity and kindness to each person’s pain”**

*NHS Constitution*
Older people

CASE STUDY 1: MR W

Mr W was 79 years old. He suffered from dementia and depression, was frail and had not long been widowed.

He was admitted to St Peter’s Hospital (part of Ashford and St Peter’s Hospitals Foundation Trust) with recurrent dehydration and pneumonia. The hospital treated Mr W with intravenous fluids and antibiotics, which were stopped when his chest infection cleared up.

A week later, his daughter, herself a former nurse, told a doctor caring for Mr W she was concerned that his general condition had deteriorated during his admission and that he would be better off receiving IV fluids. The doctor said he could not do this as it would “prevent his leaving hospital” and that “he can meet his needs orally”.

Mr W’s daughter disagreed as he frequently refused to eat and drink more than small amounts. The doctor said that Mr W was medically fit for discharge, but that he was frail and prone to further infection and any further treatment should be palliative.

Over the next few days, Mr W ate and drank very little. He refused most meals and drank about one cup of fluids each day. Feeding him through a percutaneous endoscopic gastrostomy tube was considered but ruled out because of the high risk of death associated with PEG feeding of patients with advanced dementia.

Despite his daughter’s concerns, the hospital discharged Mr W to a care home on Christmas Eve. He weighed just 6st 7lb. They did not tell his family who therefore “could do nothing to stop it”.

Three days later, Mr W was admitted to a different hospital with breathing difficulties. He was severely dehydrated and had pneumonia. This hospital treated Mr W’s pneumonia and fed him through a PEG tube. His daughter told the ombudsman that, once the tube had been inserted and Mr W received adequate nutrition and fluid, he had been “transformed”. She said that, after this treatment, Mr W had not needed to be hospitalised since, enjoyed life and participated in activities in the care home.

After complaining first to the trust and then to the Healthcare Commission, Mr W’s daughter came to the ombudsman that, once the tube had been inserted and Mr W received adequate nutrition and fluid, he had been “transformed”. She said that, after this treatment, Mr W had not needed to be hospitalised since, enjoyed life and participated in activities in the care home.

“Whenever the media reports poor nursing care, you do not have to look far to find a continence issue”

Gaye Kyle: Continence care is essential for dignity

Whenever the media reports poor nursing care, you do not have to look far to find a continence issue – soiled linen left unchanged, slow response to calls for help with going to the toilet, dirty toilets, and verbal abuse because a patient has had an incontinent episode.

Loss of patients’ dignity comes about by diminished control of their bodily functions and loss of privacy, particularly during intimate care such as washing, toileting and bowel interventions. Do older people receive such poor care on grounds of age discrimination, because nurses lack the basic skills and compassion, or both?

Incontinence is often a consequence for older people with long-term conditions and complex healthcare needs, particularly when mobility is compromised. The continence care they receive depends on the competence of those providing it. Indeed, effective assessment and care can reduce the embarrassment and lack of self-respect associated with continence problems.

CASE STUDY 2: MR AND MRS J

Mrs J was 82 years old. She had Alzheimer’s disease and lived in a nursing home. Her husband visited her daily and they enjoyed each other’s company. Mr J told the ombudsman that: “She had been like that for nine years. And I was happy being with her”.

One evening, Mr J arrived at the home and found that his wife had breathing difficulties. An ambulance was called and she was taken to Ealing Hospital Trust at about 10.30pm, accompanied by her husband. She was admitted to accident and emergency and assessed on arrival by a senior house officer who asked Mr J to wait in a waiting room.

Mrs J was very ill. She was taken to the resuscitation area, but was moved later when two patients arrived who required emergency treatment.

She was then seen by a specialist registrar as she was vomiting and had become unresponsive. It was decided not to resuscitate her. She died shortly after 1.00am. At around 1.40am, the nursing staff telephoned the nursing home and were told that Mr J had accompanied his wife to hospital. The

Continence care is an essential aspect of nursing and should be taught throughout all pre-registration programmes, yet sadly nurses appear to lack the relevant skills.

Where does the blame lie? In part, it must be with nurse training and the Nursing and Midwifery Council, but it also lies with the style of ward management. When I trained to be a nurse, the ward sister/charge nurse was totally in command, knew every patient and what care that patient should receive – and woe betide any nurse who failed to give that care.

What should be done? Better education, particularly in the field of continence, and a rethink on the style of ward management.

Naomi Campbell: Dehydration is not a simple issue

The ombudsman highlights yet again the problem of dehydration, leaving nurses struggling to defend their public image as the “caring profession” and at risk of losing the nation’s trust and respect. But
Cat Study 3: Mrs R

Mrs R lived with her husband in a warden-assisted flat. She had limited mobility and was dependent on him for support to walk. In March 2007, she was admitted to Southampton University Hospitals Trust with deteriorating mobility, recurrent falling and confusion. She was diagnosed with dementia the following month. Her health deteriorated and she was given palliative care. She died in July 2007.

Her daughter complained to the trust and then to the ombudsman about various failings in nursing care during her mother’s time in hospital.

She said staff had not offered Mrs R a bath or shower during her 13-week stay. When she and her sister tried to bathe her, they were left in a bathroom on another ward, without support from staff or instructions on how to use the hoist. They felt unable to risk using the equipment so Mrs R went without a bath. Her hair was unwashed and her scalp became so itchy that, at the family’s request, nurses checked her hair for lice.

Mrs R’s daughter complained that staff had to be asked on four consecutive days to dress an open wound on Mrs R’s leg, which she said was “weeping and sticky”. When she raised concerns about this with ward staff, she was told there was no complaints department.

Mrs R was not helped to eat, even though she was unable to do it herself. Her daughter said this had once happened when several nurses were “chatting” at the nurses’ station. Nurses left food trays and hot drinks out of patients’ reach and Mrs R’s family felt she would not receive food or drink unless they gave it to her. Her daughter felt the fact that staff did not give her mother food or drink was effectively “euthanasia”.

Her daughter said Mrs R had suffered four falls in hospital, including two in 24 hours – she was unaware that her mother had actually had nine falls – and that the family’s requests for bedrills had been declined on the grounds that their use might compromise her mother’s rights.

One fall led to Mrs R sustaining a large facial haematoma with bruising, which greatly distressed her family when they viewed her body before the funeral. Mrs R’s daughter described her father as a robust man but he was in tears seeing the bruises. He died shortly afterwards. His daughter felt he had “died of a broken heart”.

dehydration is not unique to patients in the UK; it is an international, persistent and escalating problem, facing all modern healthcare providers.

The sheer enormity of the problem in terms of human suffering and health economics is immeasurable and will only increase unless a sustainable cost-effective solution can be found. The very fact that dehydration is such a widespread problem surely suggests that there is as yet, an unidentified flaw or weakness in the process of providing adequate hydration.

In theory, the problem should not exist. It is universally acknowledged that dehydration can be easily prevented or treated by giving patients adequate fluids. This, combined with an unlimited supply of clean drinking water makes it all the more puzzling why this problem persists today.

Ironically, it appears that the problem lies with the assumption that giving a patient a drink is a “simple” task. Anyone who has cared for a vulnerable ill patient of any age, or indeed who has been such a patient themselves, will know that task is not all that it might seem. It is affected by an interplay of a combination of complex and holistic issues around the patient, clinical environment and staffing levels.

Until we acknowledge its complexity and that it cannot be left to others, we will not eradicate dehydration from our hospitals. Naomi Campbell, Cornwall Hydration Project for Vulnerable Infirm Patients, Cornwall and Isles of Scilly PCT

Graham Pink: Silence over bad practice is no longer an option

These revelations must force nurses, individually and as a body, to seriously consider how such despicable behaviour by colleagues is to be tackled. I accept that most nurses work to very high standards. But there is a problem with the minority and we now need to see action on many fronts. Two thoughts.

First, where care of older people is concerned, staff ought to be full time. Most of my fellow workers (trained and untrained) were part time – on duty usually two nights a week. Older people want to see familiar faces, like to get to know us as individuals and establish a close relationship.

Nurses must see that silence over bad practice is no longer an option. Basing my observations not just on what happened when I blew the whistle at Stepping Hill Hospital, but on the evidence of thousands of letters from nurses, doctors and members of the public, I concluded staff were far too submissive and powerless with national leadership. At all levels no one was prepared to accept responsibility, to say “the buck stops here”. As a body, nurses and midwives are two-thirds of a million strong but our mouse-like demeanour ensures we are often treated as easily pushed-around handmaidens, the tame gofers of the NHS. Graham Pink, retired nurse, who blew the whistle on poor standards of care at Stepping Hill Hospital in the 1980s and lost his job.

Reference