SPSO decision report

Case: **201304621, Borders NHS Board**
Sector: health
Subject: nurses / nursing care
Outcome: upheld, recommendations

Summary

Ms C was admitted to Borders General Hospital (hospital 1), then Knoll Hospital (hospital 2) after being involved in an accident. She was given pain relief at the scene of the accident and taken to hospital 1. On arrival, there was a mix-up over patient details and Ms C told us that on that day and the following day, staff tried to give her medication meant for another patient. Ms C told us that this took some time to resolve and, as a result, she said she was not given pain medication in a timely manner or when requested. She also believed she was given an overdose of morphine, which affected her ability to pass urine. She alerted nursing staff who then identified a urine retention issue. Ms C was transferred to hospital 2 the following month. She said that nursing staff there were institutionalised in their attitudes and treated her as if she was an elderly patient. Ms C discharged herself five days later.

We took independent advice on this case from our nursing adviser, who said that pain charts were not fully utilised at hospital 1 to manage Ms C's pain. Although pain was recorded there was no record of any action taken. In addition, Ms C was known to the pain team but they were not alerted until four days after her admission. We also found that although Ms C was already known to have chronic pain, she was not assessed for this in a proactive manner, and that in this instance care was not reasonable. Moreover, we were concerned that her patient details were incorrect. This was rectified and did not result in any medication errors, but could potentially have had more serious consequences. We were satisfied that the nursing care in relation to urine monitoring and that provided by staff at hospital 2 including their attitude was reasonable, and were satisfied Ms C was not given an overdose of morphine. However, in light of the failings identified, we upheld the complaint.

Recommendations

We recommended that the board:

- review how pain is assessed and monitored in Borders General Hospital and how instruments such as early warning system charts are used;
- inform us of the steps taken to ensure patient details are correct; and
- apologise for the failures this investigation identified.