

SPSO decision report

Case: 201800508, Highland NHS Board
Sector: health
Subject: nurses / nursing care
Decision: upheld, recommendations

Summary

Mrs C complained about the nursing care that her late mother (Mrs A) received at Broadford Hospital. Mrs C had a number of concerns about the board's record-keeping and also complained about the communication from the nursing staff. Mrs A was admitted to the hospital where a provisional diagnosis of urinary sepsis (blood infection) was made. Mrs A also developed a pressure ulcer while at the hospital.

We took independent advice from a nursing adviser. We found that:

- daily checks on Mrs A's Peripheral Vascular Catheter were not recorded.
- a "Getting to Know Me" document was not in place for Mrs A.
- a Short Term Care Plan was in place for Mrs A for more than 48 hours.
- Mrs A's urine output was not recorded on the Feed/Fluid Balance Chart when she was being treated for sepsis.
- no Active Care or Care Rounding Charts were in place for Mrs A.
- the board failed to provide reasonable pressure ulcer care to Mrs A and there was no evidence that the family were informed of Mrs A's pressure ulcer.

The board also identified some record-keeping failures during their own investigation of Mrs C's complaint and said that they had taken steps to address these. We asked the board to provide evidence of the action they had already taken.

In light of the above, we upheld Mrs C's complaints that the board failed to provide Mrs A with reasonable nursing care and that the board failed to communicate reasonably with Mrs A's family.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to provide Mrs A with reasonable nursing care during her admission to hospital. The apology should meet the standard set out in the SPSO guidelines on apology available at www.spsa.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Daily checks on Peripheral Vascular Catheters should be carried out and recorded in accordance with relevant standards.

- The appropriate care plan should be in place in accordance with relevant guidance.
- Patient Feed/Fluid Balance Charts should be completed in line with policy and guidance.
- There should be appropriate assessment, monitoring, recording and communication regarding patients at risk of developing pressure ulcers in accordance with relevant policies and guidance.
- A “Getting to Know Me” document should be used to support person centred care for older people in hospital, especially if they are frail.
- Active Care or Care Rounding Charts should be used to evidence that patients have been asked about their care and comfort needs.