Scottish Parliament Region: Glasgow

Case 200501357: Greater Glasgow and Clyde NHS Board

Summary of investigation

Category:

Health: Hospitals; Paediatrics; Clinical treatment/diagnosis

Overview

The complaint concerned the way a nurse carried out a feeding procedure on the complainant's young child (Baby C) and the nurse's attitude towards the complainant (Ms C).

Specific complaints and conclusions:

Complaints which have been investigated are:

(a) a staff nurse (nurse 1) delayed changing Baby C's NG tube and, when she did, she carried out the procedure in an inappropriate manner *(not upheld); and*

(b) nurse 1 displayed an inappropriate attitude towards Ms C *(no finding).*

Redress and Recommendations:

The Ombudsman recommends that the Board:

(i) should ensure that there is a method of ensuring that all relevant information pertaining to the care of a baby is accurately entered into the clinical notes;

(ii) should ensure that any discussion with a staff member relating to a complaint made is documented and that additional support to the staff member through education and training is offered; and

(iii) should ensure that each newly qualified staff member in a specialised unit such as the neonatal unit, as well as having clinical competencies to achieve, should be assessed on their skills in managing stress and difficulties within the family unit to ensure full support is available from the unit team.

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

Main Investigation Report

Introduction

1. On 22 August 2005 the Ombudsman received a complaint from a woman (referred to in this report as Ms C) that Greater Glasgow NHS Board (the Board) failed to provide proper care for her baby (Baby C) at the Queen Mother's Hospital, Glasgow, in June 2005.

2. Baby C was born on 9 May 2005 with complex health problems, many of which will require long-term management. These included orthopaedic problems which were being managed with plaster casts on both legs. He also suffered from microcephaly and poor head growth, hypertonia and irritability. In addition, he had difficulty in feeding and gaining weight. Part of his nursing care included naso-gastric feeding through a naso-gastric tube (NG tube) to manage and maintain his nutritional needs.

3. The complaints from Ms C which I have investigated are:

(a) a staff nurse (nurse 1) delayed changing Baby C's NG tube and, when she did, she carried out the procedure in an inappropriate manner; and

(b) nurse 1 displayed an inappropriate attitude towards Ms C.

Investigation

4. The investigation of this complaint has involved reading all the documentation supplied by Ms C; Baby C's clinical records and the complaints file. A professional nursing adviser (the adviser) was appointed to advise me on the clinical issues of the complaint. Interviews were conducted with nurse 1, a neonatal midwife educator (the educator) and a clinical midwife specialist (the specialist). I set out my findings of fact and my conclusions for each of the heads of Ms C's complaint. Where appropriate, the Ombudsman's recommendations are set out at the end of the sections dealing with individual heads of complaint.

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. A glossary of medical terms used appears at Annex 2. Ms C and the Board have had the opportunity to comment on the draft investigation report.

(a) Nurse 1 delayed changing Baby C's NG tube and, when she did so, she carried out the procedure in an inappropriate manner; and (b) nurse 1 displayed an inappropriate attitude towards Ms C

6. Ms C complained to the Board, in a letter dated July 2005, that there had been an occasion in the previous three weeks when Baby C pulled out his NG tube a while before his feed was due and she asked nurse 1 to insert a new NG tube. She had to ask the nurse again after ten minutes. Ms C said that nurse 1 sighed and said she hated passing NG tubes. It appeared to Ms C that she was taking her time obtaining the equipment in the hope that another member of staff would take over. Ms C stated that nurse 1 took a long time to pass the NG tube, that Baby C was becoming very distressed and Ms C thought nurse 1 had handled Baby C roughly. Baby C started going bright red and was coughing and spluttering but nurse 1 did not seem bothered and said it was because Baby C did not like having the NG tube changed. Nurse 1 then sat down on a chair and wrote in the nursing notes although it was clear to Ms C that Baby C was choking. Ms C then noticed a piece of the NG tube coming out of Baby C's mouth which she stated proved that nurse 1 had not inserted it correctly. Ms C was concerned that had she not noticed the NG tube coming out, it could have been dangerous if she had started feeding Baby C. Ms C advised that she was disgusted that nurse 1 had not checked that the NG tube was in the correct position and at her attitude that it was not her fault.

7. The Board responded in a letter to Ms C dated 9 August 2005 that the reason there was an initial delay in changing Baby C's tube could have been caused by workload pressures at the time and the delay would not normally cause problems. Nurse 1 could not recall sighing at Ms C or saying that she hated passing NG tubes. Nurse 1 had gathered the necessary equipment to enable her to pass the NG tube and the procedure did take some time as Baby C typically became very distressed when the procedure was carried out. Nurse 1 swaddled Baby C in a blanket for his comfort and safety prior to starting the procedure and spoke gently to him for comfort and reassurance. After the NG tube had been passed, nurse 1 checked Baby C's mouth was clear; she injected air into the end of the NG tube and used a stethoscope to listen to the area over his stomach. The Board advised that this is usually sufficient evidence that the tip of the NG tube is in the baby's stomach. Nurse 1 then asked a second member of staff to confirm her findings, which she did, and Nurse 1 then proceeded to update the nursing notes. Nurse 1

did not recall Baby C choking or Ms C telling her about the NG tube coming out of Baby C's mouth although he was distressed at the times when his NG tube was replaced.

8. The adviser commented that Ms C had maintained nurse 1 was lacking the skill and confidence to undertake the fairly routine task (within the neonatal unit) of passing a NG tube for the purpose of administering liquid nourishment or medication to the baby. This was a task regularly undertaken by nurses on the neonatal unit and normally, once inserted, the NG tube was left in place for a period of time. Regular testing by aspirating a tiny amount of stomach content using a syringe and viewing its reaction on litmus paper (blue litmus paper turning pink indicates stomach contents) would take place prior to each feed to ensure that the NG tube was properly positioned. The traditional practice in this area of the Board, used to test whether the tube was in place or not, was injecting air down the NG tube via a syringe, at the same time listening via a stethoscope placed on the stomach for air entry. The task of passing a NG tube did, however, become more complex when the baby was born with problems such as those suffered by Baby C. Baby C was frequently distressed and unsettled much of the time but even more so when the NG tube had to be passed; he would have required a nurse who had gained experience in this field. The nursing records identified that Baby C frequently managed to dislodge or remove the NG tube (on 19 occasions over a four day period). The adviser said that, whilst the nursing records for the period of Baby C's admission were generally of an acceptable standard, those notes relating to his feeding regime were less complete and did not identify the actions taken when Baby C was distressed or unsettled. There was also an absence of the recording of the details when injecting air into the stomach was used and why.

9. The adviser noted that nurse 1 could not recall the incident complained of, but she felt that she was competent in the practice of passing NG tubes on newborn infants. She had been involved in NG tube feeding of babies before she commenced training (working as a carer in the community); during her child branch training; and since qualifying. She had been assessed by her preceptor as being competent in this practice, along with a range of other skills she had to develop since qualifying. The specialist advised us at interview that the practice of injecting air into a baby's stomach as a method of determining the accuracy of

placement of NG tubes had been suspended, pending the issue of a new policy in NG tube feeding for neonates. She went on to advise that a Glasgow wide audit was currently underway to assess the validity of using pH indicator paper in the newborn. The current practice in the unit was to use pH paper and litmus paper for testing aspirate. The West of Scotland Clinical Guidelines group (of which the specialist is chair) had produced a draft guideline advising that, where there is difficulty withdrawing aspirate for testing, 1-2 millilitres of air may be injected to aid pushing the end of the tube away from the stomach wall; a further attempt should then be made to aspirate the tube and test with pH indicator paper or litmus paper. This practice followed the guidance set out in the National Patient Safety Agency alert (NPSA) dated August 2005.

10. We were told at interview that the Board ensured that alerts such as NPSA alerts were cascaded to staff via a communications book, advice from the educator, the intranet and the hospital information system and staff meetings. The Board had also carried out a local audit (albeit it was not signed or dated) into testing the accuracy of placement of NG feeding tubes using pH indicator paper and litmus paper, the results of which appeared to contradict information provided in the NPSA alert.

11. The adviser noted that the Board were involved with a large geographical area that was undertaking an audit to assess the validity of using pH indicator paper in the newborn. The educator was continuing to work closely with staff on the unit and senior staff were encouraged to become preceptors supporting newly qualified staff undertaking a preceptorship programme. The programme enabled the member of staff to achieve competencies required to deliver safe care to the neonate and their family. This included 'care of the baby requiring tube feeds'. At interview, nurse 1 recognised that the documentation relating to difficulties in feeding Baby C should have been more detailed and robust in the quantity and quality of information provided.

12. The adviser recommended that the Board should ensure that there was a method of ensuring that all relevant information pertaining to the care of a baby was accurately entered into the clinical notes.

13. The adviser commented that Ms C also complained that nurse 1 displayed an inappropriate attitude, which was less than caring towards her and Baby C during the procedure. As a result, Ms C felt Baby C was exposed to considerably more distress than was necessary. Following Ms C making the complaint, nurse 1 attended a meeting with her preceptor to discuss the issues raised and subsequently a meeting with the specialist, who offered further support in helping her to recognise how a carer's perception of care delivered can be interpreted. Nurse 1 had completed all assessments required of her during her first year post qualifying but to date had not had an appraisal with a written personal development plan or objectives. The specialist advised us at interview that she was in the process of appraising her senior team and, following this, the appraisal process would be cascaded throughout the ward teams.

14. The adviser noted that neither of the two discussions held with nurse 1 by senior colleagues following the complaint were recorded. An assumption was made by staff that Ms C was extremely stressed and anxious because of the difficulties she had to cope with in accepting Baby C's condition and a previous traumatic experience in another hospital. This contributed to her stress and for staff it occasionally made looking after the baby more difficult. The induction process for new staff covered issues such as communication, handling conflict and aggression and interpersonal and people skills management, however the adviser commented it would have been beneficial to nurse 1 had she been supported by attending an update on these particular skills and had this documented in her personal folder.

15. The adviser recommended that the Board should ensure that any discussion with a staff member relating to a complaint made was documented and that additional support to the staff member through education and training is offered. She also recommended that the Board should ensure that each newly qualified staff member in a specialised unit such as the neonatal unit, as well as having clinical competencies to achieve, should be assessed on their skills in managing stress and difficulties within the family unit to ensure full support was available from the unit team.

16. The adviser concluded that the Board had recognised the need to provide robust audit results in relation to NG feeding if they were to depart from guidelines

issued by the NPSA, and were working as part of a wider team to ensure this happens. The preceptorship programme for newly qualified staff within the neonatal unit appeared to work well and should be commended. The Board did have to recognise that complaints made towards a member of staff should be followed through with a written report, which includes any supporting action taken.

(a) Conclusion

17. Ms C believed that nurse 1 had problems carrying out the procedure where Baby C's NG tube had to be replaced and took her time gathering the equipment in the hope that another member of staff would take over. She also had concerns that nurse 1 handled Baby C roughly; was not competent to carry out the task in an appropriate manner; and caused Baby C to be distressed. Ms C did not make a formal complaint at the time and it was some two to three weeks before she did so. Nurse 1 could not recall the incident and, in her opinion, she had no concerns about the way she normally carried out the procedure. Nurse 1's preceptor had assessed her as being competent in this regard. The adviser has explained that such a procedure would be a regular occurrence for nurses on the neonatal unit and that it can cause a baby some distress, especially one with Baby C's medical condition. Baby C was frequently distressed and unsettled and this increased when the NG tube had to be replaced. However, the nursing records did not identify the actions taken when Baby C was in distress.

18. While there is no doubt the procedure caused Baby C some distress, this could have been attributed to his medical condition and does not necessarily mean that nurse 1 was not carrying out the procedure in an appropriate manner. In light of the information I have obtained during this investigation, I have not seen evidence which would throw doubt on nurse 1's ability to perform the procedure and I have decided not to uphold this aspect of the complaint.

(a) Recommendation

19. The Ombudsman recommends that the Board need to ensure that there is a method of ensuring that all relevant information pertaining to the care of a baby is accurately entered into the clinical notes.

(b) Conclusion

20. Ms C complained that nurse 1 sighed when she was asked to change the

NG tube and acted as though Baby C's distress was not caused by her actions. Nurse 1 does not recall the incident but did discuss the complaint with her preceptor and the specialist who offered her support in helping her to recognise how a carer's perception of care delivered can be interpreted. Issues concerning attitudes can be open to different interpretation by both parties and, in the absence of independent corroboration, I make no finding on this aspect of the complaint. Nevertheless, I am pleased to note that nurse 1 subsequently received support about how a carer could perceive how care is delivered.

(b) *Recommendation*

21. The Ombudsman recommends the Board should ensure that any discussion with a staff member relating to a complaint made is documented and that additional support to the staff member through education and training is offered. In addition the Board should also ensure that each newly qualified staff member in a specialised unit such as the neonatal unit, as well as having clinical competencies to achieve, should be assessed on their skills in managing stress and difficulties within the family to ensure full support is available from the unit.

26 September 2006

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Baby C	Ms C's child
Nurse 1	A staff nurse who cared for Baby C
The Board	Greater Glasgow and Clyde NHS Board
The adviser	A professional nursing adviser appointed to provide clinical advice to the Ombudsman
The educator	A neonatal midwife educator
The specialist	A clinical midwife specialist

Annex 2

Glossary of terms

Hypertonia	Stiff muscle tone
Microcephaly	Small head size
Naso-gastric feeding	The passing of a small bore plastic tube (NG tube) via the nose into the stomach to facilitate feeding
NG Tube	Naso-gastric tube
NPSA	National Patient Safety Agency
Preceptor	An expert or specialist who gives practical experience and training to an individual, especially in medicine or nursing