Scottish Parliament Region: South of Scotland

Case 200501115: Lanarkshire NHS Board

Summary of Investigation

Category

Health/FHS: Community & district nurses & midwives; Clinical treatment; diagnosis

Overview

The complaint concerned the actions of two district nurses at a home visit. The complaint was that the nurses failed to adequately assess the patient or arrange for a hospital admission.

Specific complaint and conclusion

The complaint which has been investigated is that there was failure to adequately assess Mrs C's medical condition or admit her to hospital (*upheld*).

Redress and recommendation

The Ombudsman recommends that the Division ensures that the two district nurses receive training in the appropriate actions to be taken in such cases and in the importance of record keeping as identified by the Adviser. Such record keeping is not only important in itself but is crucial to the delivery of appropriate care. They should be given the opportunity to reflect on the lessons to be learned from this case with a clinical supervisor and specifically to consider when to seek medical advice in the future.

The Division have accepted the recommendation in full.

Main Investigation Report

Introduction

1. On 20 June 2005 the Ombudsman received a complaint from a woman (Miss C) about the treatment which her late mother (Mrs C) received from her local medical practice (the Practice) in February 2005. In particular, Miss C complained that two district nurses who made a home visit on 11 February 2005 failed to take appropriate action or admit Mrs C to hospital. Mrs C died in hospital on 13 February 2005.

2. The complaint from Miss C which I have investigated is that there was failure to adequately assess Mrs C's medical condition or admit her to hospital.

Investigation

3. The investigation of this complaint has involved reading all the documentation supplied by Miss C, Mrs C's medical records and the complaint file (Miss C also complained about the treatment provided by a GP at the Practice. The GP was the subject of a separate investigation [see Case 200500798]). Clinical advice has been obtained from one of the nursing advisers to the Ombudsman (the Adviser). Although the district nurses are attached to the medical practice, the line management responsibility lies with the Lanarkshire NHS Board - Primary Care Operating Division (the Division). A written enquiry has been made of the Division. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report can be found at Annex 1 and a glossary of medical terms used is at Annex 2. Miss C and the Division have been given an opportunity to comment on the draft of the report.

Background

4. Mrs C, who was 73 years of age and had a history of heart disease and chronic bronchitis, lived at home with support from her family and occasional visits from the District Nursing Service. Mrs C became unwell and a General Practitioner (GP) made a home visit on 9 February 2005. The district nurses made a home visit on 11 February 2005 to fit a catheter. The family called for an ambulance on 12 February 2005 as they were concerned about Mrs C's health and she was admitted to hospital that day. Mrs C's condition continued to deteriorate and she

died in the early hours of 13 February 2005. The cause of death was stated to be pneumonia with chronic obstructive airways disease and congestive cardiac failure.

Complaint: That there was failure to adequately assess Mrs C's medical condition or admit her to hospital

5. Miss C complained in a letter to the Division that she telephoned the Practice on 11 February 2005 to request that a district nurse visit to catheterise her mother, as she was unable to get in or out of bed. Her mother had fallen from the bed and an ambulance crew had to be called to lift her back into bed. Two district nurses visited later that day. They catheterised Mrs C and gave Miss C a brief instruction on how to care for the catheter. Miss C stated they both commented that Mrs C had a blue face which was caused by circulation problems and that they would try and get someone from the Social Work Department out on the following Monday morning to assess what was needed to help her condition. This could include extra help and a hoist but she might have to go into hospital for a while until the equipment could be obtained. The district nurses said they could do no more for Mrs C and left. Miss C felt that the district nurses should have made arrangements for her mother to be seen by a doctor or referred to hospital.

6. During the local resolution stage of the complaint, the Chief Executive of the Division wrote to Miss C in a letter dated 27 April 2005. He explained that, when the district nurses arrived at the house between 14:00 and 15:00 hours, they noted that Mrs C was not breathless or wheezy and that she was alert and lucid with no slurred speech. Mrs C was, however, found to be cyanosed and her limbs were cold and the nurses asked her to consider being transferred to hospital but she declined. As Mrs C was having difficulty getting up to go to the toilet, a urinary catheter was inserted and instruction was given on how to drain the bag. The district nurses considered that Mrs C would require long-term home care or equipment if her mobility remained restricted. On return to their base, a request was made to the Social Work Department for urgent home care visits.

7. Miss C did not accept the response from the Chief Executive as no members of the family had heard the district nurses mention a hospital admission to Mrs C. Miss C attended a meeting with senior staff from the Division on 19 May 2005. The Chief Executive sent Miss C a further letter on 13 June 2005 in which he explained that the complaint had been reviewed again and that the district nurses

continued to believe that they had discussed a hospital admission with Mrs C on at least two occasions, with one being in the presence of a family member. As the district nurses considered that Mrs C was unwilling to be admitted into hospital, they sought to make an urgent referral for social work assessment, with the expectation that greater input into the home could be provided.

8. The Adviser commented that the only nursing records available pertaining to Miss C's complaint is a written statement from one of the district nurses dated 20 April 2005; an incomplete assessment document; and a record of one visit on 11 February 2005. The district nurse's statement, which was written after Miss C had made her formal complaint, stated that an ambulance crew had put Mrs C back to bed following a fall and that the nurse had assessed Mrs C's condition. However, the actual nursing records do not refer to attendance by an ambulance crew or any evidence that a full nursing assessment had been carried out prior to the catheterisation. The actual catheterisation procedure is not documented in much detail, so the plan of care relating to this procedure is unclear. The Adviser's opinion is that the district nursing records which were made available are poor and do not provide a reasonable record of events nor do they provide an audit trail of events. From the information available, the Adviser said it was not possible to determine what actually happened at the time of the event.

9. The Division were contacted to establish whether the district nursing records which were provided at the start of my investigation were complete. In response to my enquiry, the Division explained that they had forwarded all available documentation.

10. The Adviser told me that the district nurse who completed the statement on 20 April 2005 said that, at the visit on 11 February 2005, it was noted that Mrs C was cyanosed and cold and they advised her to reconsider admission to hospital but that she still refused to go. The nurse had stated that she had no idea of the cause of these signs, however, there is no mention of requesting a GP to visit for a diagnosis. The nurse also wrote that she saw no reason for much nursing intervention although Mrs C might require long term care. The nurse also stated that she did not know too much about what was happening with regard to care and social work involvement and saw no need to arrange a single shared assessment at this time. She did state that she had contacted social services and requested an

urgent visit for home care. She had planned to review the catheter the following Monday. The Adviser concluded that there was evidence of a sudden change in care need for Mrs C at this time but, from the limited evidence from the district nursing records, there is nothing to support the view that the district nurses who attended to Mrs C had considered anything more than the immediate problem of elimination of urine. They had not considered the wider holistic needs and issues.

11. The Adviser is of the opinion that, not only is the record keeping not to the standards of the registering and monitoring body for nurses in the United Kingdom, the Nursing and Midwifery Council (NMC), they are limited and not what would be expected from a registered nurse with a Community Nursing qualification. The NMC view is that record keeping should be a fundamental part of nursing, midwifery and specialist community public health nursing practice. Records are a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow. The NMC guidance further suggests that good record keeping helps to protect the welfare of the patients and clients by promoting high standards of clinical care; continuity of care; better communication and dissemination of information between members of the inter-professional health care team; an accurate account of treatment and care planning and delivery; and the ability to detect problems such as changes in the patient's or client's condition at an early stage.

12. The Adviser said that in Mrs C's case, the records make it difficult to clarify what actually happened, what the plans for care were and what actions were taken. She further commented that the nurses should have contacted the GP when they noticed Mrs C's poor colour. This is a matter of professional opinion but good practice would suggest that they should have discussed her condition with a doctor and sought advice on the actions to take. The patient's refusal to go to hospital is not sufficient reason not to inform the doctor of her condition as he is the responsible practitioner for her care at home. Nurses have a duty of care, which is not to say they cannot respect the patient's opinion, but should advise that they will need to discuss her decision with the doctor. The Adviser recommended that the two district nurses should receive training relating to their role and responsibilities for records and record keeping as a matter of urgency.

Conclusion

13. Miss C complained that although when the district nurses visited her mother they noticed that she had a poor colour, they took no action to have her examined by a doctor or offer to arrange a hospital admission. The district nurses fitted a catheter and said they would arrange for the Social Work Department to assess what assistance they could provide for Mrs C to enable her to stay at home. The district nurses maintain that they did notice that Mrs C was cyanosed and her limbs were cold and they asked her to consider a hospital admission, which was refused. The district nurses considered that Mrs C would require long term home care or equipment to remain at home. They made an urgent referral to the Social Work Department for an assessment to be carried out.

14. The advice which I have received, and accept, from the Adviser is that the district nursing records which were made available are poor and do not provide a reasonable record of events. The records indicated that the district nurses fitted a catheter and noted Mrs C's poor colour and asked her to reconsider her decision not to be admitted to hospital. Contact was also made with the Social Work Department. The records do not show evidence that the district nurses carried out a full nursing assessment prior to the catheterisation or that a plan of care had been considered. The records fall below the standards required by the NMC. It was only on 20 April 2005, some nine weeks after the event, that one of the district nurses gave more information about her recollection of Mrs C's condition at the visit. While I have no reason to doubt the accuracy of the district nurse's recall after such a period, had some of that information been entered into the district nursing records at the time then it would have held more credence.

15. In stating that they asked Mrs C to consider hospital admission, the district nurses have acknowledged that they considered such admission was necessary or desirable. I also note that the Adviser is of the view that the patient's refusal to go to hospital is not sufficient reason not to inform the doctor of her condition as he is the responsible practitioner for her care at home. Further, the Adviser considered that, in any event, the district nurses should have contacted the GP when they noticed Mrs C's poor colour in order to receive advice on the appropriate actions to take.

16. I have reached the view that as the district nurses failed to make a full record of their assessment of Mrs C's needs, it is not possible to state whether they adequately assessed her medical condition. While they later recorded that they asked Mrs C to consider a hospital admission, they took no further action with the exception of contacting the Social Work Department. That was insufficient in the circumstances. I, therefore, uphold this complaint to the extent that the district nurses failed to notify the GP or seek advice in relation to their concerns about Mrs C's health; and failed to inform the GP of her refusal to be admitted to hospital.

Recommendations

17. The Ombudsman recommends that the Division ensures that the two district nurses receive training in the appropriate actions to be taken in such cases and in the importance of record keeping as identified by the Adviser. Such record keeping is not only important in itself but is crucial to the delivery of appropriate care. They should be given the opportunity to reflect on the lessons to be learned from this case with a clinical supervisor and specifically to consider when to seek medical advice in the future.

28 November 2006

Annex 1

Explanation of abbreviations used

Miss C	The complainant
Mrs C	Miss C's mother
The Practice	The medical practice where Mrs C was a registered patient
The district nurses	The district nurses who visited Mrs C at home on 11 February 2005
The Chief Executive	The Chief Executive of the Division who has responsibility for the district nursing service
The Adviser	The medical adviser to the Ombudsman
The Division	Lanarkshire NHS Board – Primary Care Operating Division
NMC	Nursing and Midwifery Council

Annex 2

Glossary of terms

Catheter	A hollow flexible tube inserted into the bladder to drain urine
Chronic Obstructive Airways Disease	Chronic slowly progressive disease which obstructs the airways
Congestive cardiac failure	Inability of the heart to maintain adequate blood circulation causing shortness of breath
Cyanosed	A bluish discolouration of the skin caused by a lack of oxygen in the blood
Pneumonia	Inflammation of the lung caused by infection