Scottish Parliament Region: Central Scotland

Case 200502016: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; Nursing

Overview

The complainant (Ms C) raised concerns about the nursing care received by her mother (Mrs A).

Specific complaint and conclusion

The complaint which has been investigated is that nursing staff failed to adequately supervise and monitor Mrs A's condition *(not upheld)*.

Redress and recommendations

The Ombudsman has no recommendations to make but suggests that consideration should be given to when it is appropriate for patients to be shut off from observation.

Main Investigation Report

Introduction

1. On 14 January 2005, Mrs A was admitted to Wishaw General Hospital (the Hospital) having fallen at home suffering a fractured right femur. Ms C was advised that surgery would be delayed until the following week because Mrs A had a prescription for Warfarin. During visiting hours that evening, Mrs A did not give Ms C any cause for concern. However, the following afternoon Ms C was extremely concerned at the apparent deterioration in her mother's mental and physical condition. Ms C spoke to a nurse about her concerns and was reassured that her mother was fine.

2. At 22:30, Ms C received a telephone call from her sister and was advised to attend immediately. When she arrived at the Hospital, she was told that Mrs A had died. Ms C was informed that Mrs A had fallen out of bed and staff had found her on the floor of her room. They tried to resuscitate her but did not succeed.

3. On 1 June 2005, Ms C complained to Lanarkshire NHS Board (the Board). The Board obtained a report from the Senior Nurse on the ward where Mrs A had been a patient (the Ward). On 29 June 2005, the General Manager of the Hospital (the General Manager) replied to Ms C. Details were given of Mrs A's care during the day and the evening. At 21:35 a Staff Nurse checked Mrs A's observations. At 22:30 Mrs A was found lying on the floor. She was not breathing and had no pulse.

4. Ms C complained to the Ombudsman on 20 October 2005 that the Board failed in their duty to care for Mrs A who was a frail, elderly patient and who fell out of bed following her admission for a fractured hip. She complained that there was about a one hour gap in checking Mrs A's condition and Mrs A’s room door and curtains were closed. Ms C is most concerned about the time delay in checking Mrs A's condition.

5. The complaint from Ms C which I have investigated is that that nursing staff failed to adequately supervise and monitor Mrs A's condition.

Investigation

6. My investigation is based on the documentation provided to me by Ms C and the Board. This includes correspondence between Ms C and the Board,

the Board's complaints file and the Incident Record Form. I have also reviewed Mrs A's medical records and sought advice from the Ombudsman's Clinical Adviser (the Adviser).

7. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

Complaint: Nursing staff failed to adequately supervise and monitor Mrs A's condition

8. Nursing staff stated that, as far as they were aware, Mrs A did not at any time previously attempt to get out of bed, cot sides were in place at all times and her buzzer for nurse call was within reach. This is confirmed by Mrs A's medical notes and by the Incident Form which was completed. At 22:30, a Clinical Support Worker found the door and curtain to Mrs A's room to be closed and Mrs A was lying on the floor. The Clinical Support Worker called for help. Cardiopulmonary resuscitation was carried out but unfortunately resuscitation attempts were not successful and Mrs A was pronounced dead at 22:40.

9. Mrs A's care plan indicates that observations should be carried out every four hours. Mrs A's observation chart shows that her observations were taken by a Staff Nurse at 21:35. The Incident form states that Mrs A did not use the nurse call system and that no noise was heard by staff of the patient climbing out of bed. Staff were busy attending to other patients nearby and the Adviser has explained that this is a busy time in any ward.

10. The Adviser has stated that it is her opinion that nurses were attentive to Mrs A's needs on 15 January 2005 and that the frequency of observations was reasonable. There is no comment in Mrs A's notes about any adverse effect of analgesia such as sleepiness, slowness or confusion. She commented that it is not possible to say whether the fall was a result of a change in the patient's condition or associated with sedation. The Adviser also commented that 'even when a patient has sustained a fall and it is recognised that it may happen again, it is difficult to ensure patient safety at all times. No matter how frequently it is planned to observe a patient, there will be times when the patient is unobserved'.

Conclusion

11. Nursing staff checked on Mrs A at 21:35 and checked on her again at 22:30. Given her condition, immobility and the presence of cot sides, Mrs A's fall could not have been predicted by nursing staff. The Adviser has stated that nurses were attentive to Mrs A's needs on 15 January 2005. I have been unable to determine why the door and curtains to Mrs A's room were closed. Whilst this was unfortunate, I do not consider that this had a significant impact on the events leading to this complaint. I recognise that this experience was distressing for Ms C and her family as they were not expecting that Mrs A would die during her hospitalisation. Nonetheless, the evidence shows that nursing staff's supervision and monitoring of Mrs A were appropriate. I, therefore, do not uphold this complaint.

Recommendations

12. The Ombudsman has no recommendations to make but suggests that consideration should be given to when it is appropriate for patients to be shut off from observation.

Other

13. On perusing the medical records, the Adviser noted that there were some probable inaccuracies in Mrs A's I.V. Therapy Prescription Chart. The Board have informed me that an entry on this chart was made in error and that this entry should have been made on another patient's chart. The Chart also appears to show that a pack of normal saline ran for two hours longer than prescribed. The Board accepts criticism of the chart and, as a result of the identification of the errors, the Senior Nurse discussed the importance of accurate documentation and other learning points individually with each member of nursing staff on the Ward and with other Charge Nurses in the Directorate.

14. In her response to the draft of this report, Ms C questioned whether the fact that the normal saline ran for longer than prescribed could have had an effect on Mrs A cognitive ability. The Adviser advised that she did not consider this a significant factor. The notes record that Mrs A had been confused on admission and that her dietary intake had been poor and the Adviser does not consider that the infusion running for longer than prescribed would have had any significant effect on Mrs A's cognitive ability.

15. The Board informed me that an action plan was produced following this

incident. The action plan covers the issues of:

- the completeness of nursing records;
- the observation of patients;
- the incident reporting mechanism; and
- the administration of I.V. fluids.

16. The action plan was reviewed by the Adviser and she is satisfied that the Board took appropriate action in respect of groups of staff and individual members of staff.

23 May 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mrs A	Ms C's mother
The Hospital	Wishaw General Hospital
The Board	Lanarkshire NHS Board
The Ward	The ward in which Mrs A was a patient
The General Manager	The General Manager of the Hospital
The Adviser	The Ombudsman's Clinical Adviser