Scottish Parliament Region: North East Scotland

Case 200601374: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; Medical and Nursing Care

Overview

The complainant (Mrs C) raised a number of concerns about the care given to her mother (Mrs A) at Perth Royal Infirmary (the Hospital) following her admission for a suspected oesophageal stent blockage on 9 August 2005.

Specific complains and conclusions

The complaints which have been investigated are that Tayside NHS Board (the Board):

(a) prescribed morphine unnecessarily (*no finding*);
(b) failed to provide appropriate nursing care (*partially upheld*);
(c) failed to maintain accurate records (*upheld*); and
(d) failed to provide an adequate complaint response (*partially upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) emphasise to nursing staff in the relevant ward the importance of recording in the clinical records any change in the condition of the skin or injury and of ensuring that the commensurate care plan is also formulated and recorded;
(ii) apologise to Mrs C for the confusion and distress caused by the apparently contradictory nature of some of the responses to her complaints;
(iii) review the operation of the admission assessment and adopt a consistent process for recording alterations within the assessment;
(iv) use the events of this complaint in a multi-disciplinary team meeting to illustrate the impact of poor complaint handling and record-keeping on the patient/carer experience; and
(v) ask that those responsible for providing complaint responses ensure that, where possible, evidence, comment or information is obtained from and checked against, original sources.

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

Main Investigation Report

Introduction

1. On 11 August 2006 the Ombudsman received a complaint from the complainant (Mrs C) on behalf of her late mother (Mrs A). Mrs C raised a number of concerns about the care given to Mrs A at Perth Royal Infirmary (the Hospital) following her admission for a suspected oesophageal stent blockage in August 2005. Mrs C complained to Tayside NHS Board (the Board) on 15 September 2005 and received a response from the Board on 20 December 2005. Mrs C was not satisfied with this response and wrote again on 23 January 2006, raising a number of additional concerns and received a further response on 20 April 2006. Mrs C was concerned at the accuracy of several aspects of this response and requested a copy of Mrs A's clinical records. Mrs C remained concerned about a number of aspects of Mrs A's care and treatment and a number of issues about the clinical records and complaint response and approached the Ombudsmans office with her complaint.

2. The complaints from Mrs C which I have investigated are that the Board:

(a) prescribed morphine unnecessarily;
(b) failed to provide appropriate nursing care;
(c) failed to maintain accurate records; and
(d) failed to provide an adequate complaint response.

Investigation

3. Investigation of this complaint has involved obtaining and reviewing the clinical records and the NHS complaint file. I have spoken with Mrs C and also sought clinical advice from medical (Adviser 1) and nursing (Adviser 2) advisers to the Ombudsman. I have sought further comments from the Board particularly in relation to the quality of clinical records available in this case. Timely progress of this investigation has been hampered by poor record-keeping demonstrated in some of the records and referred to in the complaint itself.

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

Medical Background

5. Mrs A was admitted to the Hospital on 9 August 2005 as she had been vomiting for several days without any known cause. A blocked oesophageal

stent was suspected and she was admitted for investigation. Mrs A had oesophageal cancer with a stent in place since September 2004. On 9 August 2005 she had been vomiting after eating for several days. An endocscopy was planned after admission to review the condition of the stent. Mrs A also had a diagnosed chest infection at this time which was being treated with antibiotics. Prior to admission Mrs A was taking co-codamol in the morning and evening to mange pain in her lower left back.

6. Mrs A was seen on admission by a doctor (Doctor 1) who noted the current problems and overall plan but made no reference in the record to current pain or confusion. Doctor 1 noted pain relief should continue as before. Mrs A was admitted to Ward 4 of the Hospital.

(a) The Board prescribed morphine unnecessarily

7. On 10 August 2005 Mrs A's records at 08:00 state that Mrs A reported '... she was in agony and felt unwell ...'. At 08:25 the records state 'prior to giving morphine she seemed very distressed, clammy and tachycardic ... Complaining of pain all over'. These two entries are initialled by the same individual but the initials and full name/title are not entered in the Multidisciplinary Acute Record of Care as required. Subsequent enquiries by the Ombudsman's office have identified this individual as a staff nurse (Nurse 1) who no longer works with the Board (see paragraph 16).

8. At 08:27 and again at 10:40 on 10 August 2005 Mrs A was administered 5mg of morphine. The first prescription is noted as being given by the nurse subsequently identified as Nurse 1 (see previous paragraph) but it has not been possible to ascertain the identity of the doctor who prescribed this dose of morphine at 08:20 (see paragraph 16). The second dose was prescribed by Doctor 1 at approximately 10:30.

9. The clinical records indicate a rise in temperature from normal to fever level between 04:00 and 08:45 (shortly after the first morphine injection) on 10 August 2005. The Admission Nursing Assessment completed on 9 August 2005 indicated there was no pain on admission. This entry was subsequently amended (see paragraph 30) to indicate there was pain on admission. Similarly a tick was added later to indicate 'confusion or agitation' on admission and that a catheter was in place.

10. At some time after 10:40 on 10 August 2005 Mrs A was moved to Ward 3 but there is no indication in the records of when this was (or indeed that this transfer had even occurred). Mrs C called that morning to enquire after Mrs A and was advised she was in pain and had had a 'bad night' and Mrs C should delay coming in until later in the day. Mrs C told me that when she arrived in the early afternoon to see Mrs A in Ward 3 she found her in a very distressed condition (see paragraph 18) and immediately questioned several aspects of Mrs A's care. Mrs C told me she was shocked at the change in Mrs A's demeanour and to learn that Mrs A had been given morphine.

11. At approximately 16:40 on 10 August 2005 Mrs C met with a doctor (Doctor 2) and asked for details of who had authorised the prescription of morphine for Mrs A earlier on 10 August 2005. She was advised it was a middle rank doctor (Doctor 3) and a nurse (subsequently identified as Nurse 1) in Ward 4 but she was not provided with specific names. Doctor 2 advised that he had reviewed Mrs A shortly after the first morphine was administered and found her confused but settled and that Nurse 1 had assured him that Mrs A had been confused prior to the administration of the morphine. Doctor 2 also noted that Mrs A had been catheterised because she was now immobile.

12. Mrs C disputed the need for morphine as Mrs A had not been confused prior to admission and had not required a catheter as she mobilised fully with limited assistance. She also noted that her pain had been being successfully managed with the co-codomol previously prescribed. Mrs C asked that Mrs A not be given morphine again at this point (although she recognised that as her illness progressed this may be necessary). Doctor 2 agreed to this and noted in the medical record 'Confusion – likely secondary to pneumonia but ?? to morphine'. A decision was taken to delay the endoscopy until Mrs A was in better health.

13. In their response to Mrs C dated 20 December 2005, the Board noted again that Mrs A had been found to be confused on admission and that the confusion may not be solely attributable to the morphine. The Board also noted that Mrs A was noted to be distressed by nursing staff on the morning of 10 August 2005 and that Doctor 1 had prescribed morphine for pain relief.

14. Mrs C challenged this view as she felt Mrs A was not confused on admission and that she had been informed on the day that it was a middle ranked doctor who had prescribed the morphine. She questioned what

symptoms of distress were noted by the nurses prior to the administration of morphine.

15. Adviser 1 told me that it is very possible that Mrs A suffered a sudden (and short lived) onset of severe pain perhaps caused by infection and that the level of morphine prescribed and administered was not unreasonable for Mrs A. Adviser 1 noted that Mrs A continued to exhibit symptoms of distress and confusion overnight on the 10/11 August 2005, at which time the morphine prescribed earlier would have ceased to have affect, which indicated her distress may have had on-going causes other than the morphine. He also noted that the immediate effect of the morphine appeared to have settled Mrs A. Adviser 1 concluded that the confusion and distress was most likely to be due to infection rather than inappropriate medication.

16. In response to a specific enquiry the Board advised me that they were unable to identify Doctor 3 who first prescribed morphine for Mrs A and that they had identified the nurse who had counter-signed his morphine prescription for Mrs A as Nurse 1, but she was no longer with the Board. The Board confirmed that the second prescription was written by Doctor 1.

(a) Conclusion

17. Mrs C's concern at discovering Mrs A in such a changed condition on her arrival at the Hospital in the afternoon of 10 August 2005 is quite understandable. Her concern that the decision to prescribe morphine for Mrs A may have been made with undue haste and without proper consideration was sadly only heightened by the apparently conflicting responses she received, which gave rise to further suspicions on her part. I have dealt with the record-keeping and complaint handling aspect of this in complaints (c) and (d). With respect to the specific complaint that the prescription of morphine was not clinically appropriate, based on the medical advice I have received, I have concluded that there may have been sufficient medical grounds to indicate this was an appropriate course of action but that there is no evidence in the records of medical assessment prior to the first administration. I cannot uphold or reject this aspect of the complaint and must, therefore, conclude that no finding is possible. I note also that the confusion over who initially authorised the prescription and the lack of any recorded medical basis on which this was done were major contributory factors to the escalation of this complaint.

(b) The Board failed to provide appropriate nursing care

18. Mrs C told me that on Mrs A's admission to Ward 4 she (Mrs C) had advised nurses that Mrs A would need extra pillows as she required to sleep propped upright because of the oesophageal stent. She also requested an air mattress for Mrs A as she had a pressure sore. Mrs C was advised by the nurses they would do their best to arrange both of these. Following Mrs A's transfer to Ward 3 Mrs C told me she arrived to visit Mrs A in the early afternoon and found her lying across the bed in a state of undress having been catheterised and extremely distressed. Mrs C could not find a call button to summon help but called for a nurse. When a nurse (Nurse 2) arrived, Mrs C asked that the bed side rails be raised to prevent Mrs A falling and an air mattress supplied. At Mrs C's own admission a heated discussion followed in which Mrs C asked for information about how Mrs A had come to be in such a condition (see complaint (a) above) and why she was not sitting in a raised position with treatment for her pressure sore as requested. Nurse 2 advised Mrs C that her attitude was very aggressive. Mrs C told me that she denied this saying she was demanding but not aggressive and that she felt any of the nurses on duty that day would have felt the same way had it been their mother in such a state.

19. Mrs C later spoke with a senior charge nurse (Nurse 3) who apologised that Mrs A had not been attended to properly as she had arrived on Ward 3 during a change-over of staff but that she would now be well looked after.

20. During a meeting with a nurse (Nurse 4) on Ward 3 on 12 August 2005, Mrs C noted an injury to Mrs A's leg which Nurse 4 advised had occurred the previous evening when Mrs A had been trying to get our of bed. Mrs C asked that the wound be dressed and that Mrs A's swollen legs be brought to the attention of the medical staff. The wound remained undressed for two days and Mrs C was told by Nurse 5 that the wound must have been in place on admission from Ward 4. Mrs C denied this and stated that Nurse 4 had told her it had occurred in Ward 3. Mrs C questioned why there was not a record of the injury in the nursing record. The leg wound was subsequently dressed and treated but required further treatment with antibiotics and it was noted on Mrs A's discharge letter to her General Practitioner that she had an infected leg wound.

21. Mrs C continued to raise concerns about the quality of Mrs A's care throughout her stay and had number of meetings with nursing and medical staff.

Mrs C told me, and mentioned in her complaint to the Board, that the care provided by a number of the nurses was exemplary and that Mrs A was shown great kindness by some staff. Mrs C summed up her concerns in her complaint to the Board: 'My mother was admitted to hospital for an endoscopy to identify the cause of vomiting. The actions of staff concerned not only delayed her procedure but also caused great distress to my mother and her family.'

22. Adviser 2 told me that the majority of the care as recorded in the nursing plan is well documented and that staff were clearly aware from an early stage of the need to communicate with Mrs C about Mrs A's care. Adviser 2 noted that there was a clear, serious omission in not recording the leg injury and inconsistencies in the admission document (see paragraph 30) as well as inaccuracies in dates/times of a few entries.

23. Adviser 1 said that Mrs C was noted in the records to be very distressed when, following Mrs A's endoscopy, she found her lying in the recovery position rather than sitting propped upright but that nothing further was noted on this issue in the clinical records. Adviser 1 stated that he considered it was appropriate to protect the airway by placing Mrs A in a lying down position post-endoscopy rather than sitting upright (which would be appropriate once she was fully recovered from the anaesthetic used for the procedure).

24. Adviser 1 noted that there was no leg injury recorded in the records, no accident form was completed and no management plan was noted in the nursing plan but that an injury had clearly occurred while Mrs A was resident in Ward 3 (not Ward 4 as Nurse 5 had stated). A leg injury is recorded as being swabbed and dressed but with no indication of when or how this had happened.

25. In response to a specific enquiry the Board advised me that while patients with an oesophageal stent in place are usually supported in an upright position it is the usual practice to place patients in the recovery/prone position following endoscopy and that this was the appropriate course of action in this case. The Board also noted that this had been explained to Mrs C at the time of Mrs A's first endoscopy. I note that following Mrs A's oesophageal stent insertion on 17 August 2005 it is recorded that the appropriate recovery position is lying on the side but propped up by at least 3 pillows. While different procedures can demand different aftercare the difference in processes post-endoscopy and post-stent insertion was never explained by the Board. The Board had previously accepted and apologised for the failure to properly record the injury

to Mrs A's leg and the consequent failure in management of this injury to Mrs A's leg. The Board also accepted that there were other omissions in the record-keeping and advised me that staff had been reminded of their duties under the Nursing and Midwifery Council guidelines on record-keeping to keep clear and accurate records.

26. In response to a draft of this report Mrs C noted that while there is no specific entry relating to Mrs A's leg injury in the clinical record she was told by Nurse 4 that it had occurred on the evening of 11 August 2005. Mrs C noted that this coincided with the only recorded episode of incontinence and that Mrs A had told her that she had attempted to get out of bed but been denied assistance and this is when her injury had occurred.

(b) Conclusion

27. Mrs C complained about a number of aspects of Mrs A's nursing care: primarily that they had failed to provide the level of supervisory care Mrs A had needed at the time of her transfer to Ward 3 and on occasion thereafter, failed to prevent or properly treat an injury to her leg and failed to maintain her in the necessary propped position required by her oesophageal stent. Mrs C received an apology from nursing staff for the failure to properly care for Mrs A on transfer and the Board have acknowledged the failure to record (and record a plan in the overall care plan for) the leg injury. I acknowledge Mrs C's continuing frustration that the lack of any clear record prevents my reaching a specific conclusion as to the cause of the injury. Mrs C was offered an explanation for the positioning of Mrs A after her endoscopy which I am advised is a reasonable medical one. Mrs C raised her concerns about Mrs A's positioning on admission and the records do indicate that staff were aware of the need to prop up Mrs A although no explanation was offered for the differing practices post-operatively. I accept that this does not necessarily indicate any error in practice. Overall I conclude that there were failures in a number of, but not all, aspects of the nursing care raised in Mrs C's complaint. I, therefore, partially uphold this complaint.

(b) Recommendation

28. The Ombudsman recommends that nursing staff in the relevant ward are reminded of the importance of recording in the clinical records any change in the condition of the skin or injury and of ensuring that the commensurate care plan is also formulated and recorded.

(c) The Board failed to maintain accurate records

29. Mrs C first raised a concern about the clinical records at the time of Mrs A's admission with specific reference to the failure to record how and when the injury to Mrs A's leg had occurred (see paragraph 20). In their response of 20 December 2005 the Board noted that there was no record of a leg infection in the nursing notes but that this was indeed mentioned in the discharge note. This was clearly a discrepancy and the Board apologised for this.

30. The investigation of this complaint has involved a far higher level of forensic examination of the clinical records than is routine for the cases considered by the Ombudsman's office. I have reviewed the original records (rather than a copy) and sought to reconcile signatures to those named on the record. I have been unable to do so on all occasions. Most notably the entries concerning Mrs A's condition at the time of the first prescription of morphine and the identity of Doctor 3 (see paragraph 16). Further enquiries by the Board have provided some of the staff member's names but the identity of Doctor 3 is still not known. My examination of the record also indicated that the nursing documentation of Mrs A's condition on admission had been altered subsequently and as a consequence at first glance appears to indicate that Mrs A's condition on admission was more complex than it actually was. I have discussed this with Mrs C and with Board staff. Mrs C is concerned that the changes were made deliberately by staff on Ward 3 or Ward 4 to cover up incorrect decisions to prescribe morphine to Mrs A; while the Board have concluded that the alterations were probably made to reflect a change in Mrs A's condition after the administration of morphine at around the time of her transfer to Ward 3 on 10 August 2005.

(c) Conclusion

31. The alteration of the record, while apparently done with the best of intentions, has caused considerable difficulties in this complaint as it has given rise to errors in the complaint response which were based on Mrs A's condition reflected in the altered record. This has caused the complaint to be considerably prolonged both at the Board response level and while it has been with the Ombudsman's office. It has also caused the complaint to escalate both in quantity and degree of seriousness. The concerns expressed by Mrs C only being strengthened by the fact that the injury to Mrs A's leg was not recorded in the nursing notes. Poor record-keeping is an all too common feature of complaints to the Ombudsman. Mrs C's complaint amply illustrates the distress

and confusion that this can cause and the considerable amount of NHS staff time that is taken up addressing these concerns.

32. The Board have already apologised for certain record-keeping failures in this case and I conclude that further inaccuracies and omissions have occurred which impacted on the negative experience of Mrs C at the time of Mrs A's admission and the subsequent pursuit if her complaint. I uphold this aspect of the complaint.

(c) Recommendation

33. In light of this conclusion the Ombudsman recommends that the Board apologise to Mrs C for the confusion and distress caused by the apparently contradictory nature of some of the responses to her complaints. The Ombudsman also recommends that the Board review the operation of the admission assessment and adopt a consistent process for recording alterations within the assessment. The Ombudsman further recommends that the events of this complaint be used in a multi-disciplinary team meeting to illustrate the impact of poor complaint handling and record-keeping on the patient/carer experience.

(d) The Board failed to provide an adequate complaint response

34. Mrs C first made a formal written complaint to the Board on 19 September 2005. She had previously raised concerns at ward level during Mrs A's admission but remained concerned about aspects of Mrs A's medication for pain relief and nursing care which she felt had not been adequately answered by informal discussions. Mrs C had also previously passed on her contact details to ward staff, at their request, to be passed to the complaints staff but as she had received no contact from them she decided to submit a written complaint. There is no indication in the clinical record or the complaint file that this information was ever received by complaints staff. Following her formal complaint Mrs C was initially advised she should expect a response within four weeks in line with the NHS complaints procedure but was further advised in letters dated 14 October 2005 and 13 November 2005 that the response was taking longer than expected because of delays in receiving the information requested. Mrs C received a full written response on 20 December 2005, which included an apology for the time taken to respond and a number of other omissions.

35. The Board's response of 20 December 2005 makes reference to concerns expressed by more than one member of staff that Mrs C was very aggressive in her conversations with them. The Board acknowledged that Mrs C was in a very stressful situation but felt that staff had tried to address Mrs C's concerns as best they could and had felt that the discussions they had held with her at the time had been helpful.

36. I have discussed in paragraph 31 the problems caused by the failure to properly record the identity of Doctor 3 and Nurse 1. I have also noted that the alterations to the admission assessment caused considerable difficulties and indeed gave rise to a number of elements of this complaint.

(d) Conclusion

37. The identity of Doctor 3 would have been available to staff at the time Mrs C first raised her concerns but nothing in the correspondence I have read suggests that Doctor 3 was ever approached to give his or her account of Mrs A's condition prior to prescribing the morphine and the reasons why he/she considered it appropriate. Consequently Mrs C has been given apparently conflicting accounts of the sequence of events and no explanation of the prescription from the medical personnel directly involved in the initial prescription. Complaints staff would in any event be hampered in any attempt to do so by the lack of information in the medical record regarding the identity of Doctor 3. Changes made to the nursing record also led to inconsistencies in the complaints response which have only served to exacerbate Mrs C's concerns that there was an attempt to cover up events.

38. It is regrettable that complaints staff were unable to meet with Mrs C at the early opportunity as this may have given Mrs C confidence that the matter was being taken seriously and addressed appropriately. It is extremely unfortunate that poor record-keeping then gave rise to a degree of inaccuracy in the initial complaint response and in turn raised further concerns and the complaint escalated. Overall I partially uphold this aspect of the complaint as I consider a more accurate response would have been possible and helpful, however, I accept that the information available to complaints staff was unclear (in retrospect) and that gave rise to many of the concerns subsequently expressed by Mrs C.

(d) Recommendation

39. The Ombudsman recommends that those responsible for providing complaint responses ensure that where possible evidence, comment or information is obtained from and checked against original sources.

40. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant (Mrs A's daughter)
Mrs A	The aggrieved
The Hospital	Perth Royal Infirmary
The Board	Tayside NHS Board
Adviser 1	Medical Adviser to the Ombudsman
Adviser 2	Nursing Adviser to the Ombudsman
Doctor 1	The doctor who first assessed Mrs A on admission
Nurse 1	The nurse who administered the first morphine prescription and who made entries in the clinical record on 10 August 2005 concerning Mrs A's condition
Doctor 2	The doctor who met with Mrs C on 10 August 2005
Doctor 3	The doctor who first prescribed morphine to Mrs A
Nurse 2	The nurse who spoke with Mrs C following her arrival at Ward 3 on 10 August 2005
Nurse 3	The senior charge nurse who spoke with Mrs C on 11 August 2005

Nurse 4	The nurse who spoke with Mrs C on 12 August 2005
Nurse 5	The nurse from Ward 3 who advised Mrs C (incorrectly) that the leg wound must have occurred on Ward 4

Annex 2

Glossary of terms

Endoscopy	Direct visual examination of any part of the inside of the body, using an optical viewing instrument
Oesopheogeal cancer	Cancer in the gullet
Stent	A small tube inserted to keep the oesophagus unblocked
Tachycardic	Rapid heart rate