Scottish Parliament Region: North East Scotland

Case 200600407: Tayside NHS Board

Summary of Investigation

Category

Health: Admission to hospital, treatment and complaints handling

Overview

The complainant (Mrs C) raised a number of concerns relating to her husband (Mr C)'s admission to Ninewells Hospital, Dundee (the Hospital), his treatment during his stay and the way in which her complaint was handled by Tayside NHS Board (the Board).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C's belongings were never recorded on his admission to the Hospital (*upheld*);

(a) no response was made to Mr C's cardiac monitor sounding an alarm at various points during his stay in the ward and it was entirely ignored during the night (*no finding*);

(b) Mr C was given contradictory information about how he could get his cardiac monitor reset (*no finding*);

(c) Mr C's pressing of the call button was not answered for one hour (*no finding*);

(d) staff on duty in the ward were not appropriately qualified (*not upheld*); and

(e) there were inadequacies in the handling of Mrs C's complaint by the Board (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) remind staff of the need to comply with the 'Patients' Funds and Property Procedure' when admitting patients to the ward;

(ii) ensure that all staff, especially bank nurses, are reminded of the importance of accurate record-keeping; and

(iii) take action to remind appropriate staff of the need to comply with the relevant procedures, in relation to investigating and responding to complaints within the required timescales.

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

Main Investigation Report

Introduction

1. Mr C was admitted to Ninewells Hospital, Dundee (the Hospital) on 18 February 2006 after experiencing problematic palpitations and chest pain. Tests for coronary heart disease or other problems that can present with chest pain were negative, therefore, he was discharged from the Hospital the following day.

1. Mr C's wife (Mrs C) told me that, on his admission to the ward, Mr C's personal belongings were not recorded. She said that, during his stay in the Hospital, his cardiac monitor alarm sounded several times, however, no-one investigated the reason for this or came to reset the monitor. When Mr C asked about getting his monitor reset he was given conflicting information and, when he pressed the call button for assistance, no-one responded for one hour. She went on to say that, based on Mr C's experience, she considered that the staff on duty were not suitably qualified to offer the necessary care.

2. Mrs C complained to Tayside NHS Board (the Board) expressing her concerns around her husband's treatment. She was not satisfied with the Board's final response to her complaints or with the way in which her complaint had been handled and, therefore, asked the Ombudsman to investigate.

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

(a) Mr C's belongings were never recorded on his admission to the Hospital;
(b) no response was made to Mr C's cardiac monitor sounding an alarm at various points during his stay in the ward and it was entirely ignored during the night;
(c) Mr C was given contradictory information about how he could get his cardiac monitor reset;
(d) Mr C's pressing of the call button was not answered for one hour;
(e) staff on duty in the ward were not appropriately qualified; and
(f) there were inadequacies in the handling of Mrs C's complaint by the Board.

Investigation

4. I examined correspondence between Mrs C and the Board, the Board's 'Patients' Funds and Property Procedure' and the medical records relating to Mr C's time in the Hospital. I made further written enquiries of the Board to

seek clarification or additional information relating to the complaint and I obtained advice from a nursing adviser to the Ombudsman (the Adviser).

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

(a) Mr C's belongings were never recorded on his admission to the Hospital

6. Mr C attended Accident and Emergency services on 18 February 2006 complaining of palpitations. Following assessment, he was admitted to the Hospital to allow for tests for coronary heart disease or other problems associated with chest pains. These tests confirmed that Mr C did not suffer from heart disease and he was discharged from the Hospital the following day.

7. The Board said in their letter of 3 May 2006 that 'unfortunately, on the night Mr C was admitted Ward 15 was experiencing a very high dependency shift with emergency situations which demanded a high proportion of the nursing time'.

8. Mrs C told me that no record was taken of her husband's personal belongings on his admission to the Hospital.

9. I asked the Board if Mr C was given the opportunity to deposit his valuables on his admission to the ward and, if so, to provide me with a copy of the record of valuables provided by him.

10. The Board advised me that Mr C was not specifically given the opportunity to deposit his valuables and they held no record of the valuables Mr C came into the Hospital with, however, they also said that the Board's policy on valuables was discussed with him on his admission to the ward. However, the Board also confirmed that there was no record of this discussion and, therefore, no supporting documentation.

11. At the time of my enquiries, the Board had developed a draft updated version of their ‘Patients’ Funds and Property Procedure’ and provided me with a copy of this document. They explained that although recently revised, these procedures reflected the process in place when Mr C was admitted to Hospital. I noted that this policy document stated:

'Patients, on their admission and during the course of their stay, if appropriate, should be advised that the organisation cannot accept responsibility for their cash and property unless it is deposited with the organisation for safekeeping and an official receipt is obtained.'

12. The 'Patients' Funds and Property Procedure' goes on to provide more detailed guidance to be followed on admission to the ward. It states that, on admission, the nurse in charge has responsibility for ensuring that a personal disclaimer form is completed by the patient (or the patient's relative or friend) if the patient is to retain their money or property.

13. As a result of my enquiries, the Board advised me that staff now ask patients on admission if they have anything of value in their possession. If they do, they are offered the opportunity to pass these valuables to the cashier to keep safely on their behalf. Should they decline, staff will document this and strongly recommend that the patient gives their valuables to a relative for safe keeping.

(a) Conclusion

14. While the Board have accepted that they did not record Mr C's valuables, in considering the overall context of Mr C's admission to the Hospital, I am aware that the ward was experiencing a very high dependency shift with emergency cases, which demanded a high proportion of the available nursing time. I am also aware that staff shortages necessitated the assistance of nurses from the nurse pool, who would not normally work on the ward.

15. In these circumstances, and with the priority of service being directed to those in greatest need, it is perhaps understandable that the question of Mr C's valuables was not addressed immediately upon his admission to the ward.

16. However, the Board procedures required that Mr C's belongings were recorded on his admission to the Hospital. They were not and I, therefore, uphold this aspect of the complaint.

(a) Recommendation

17. The Ombudsman recommends that the Board reminds staff of the need to comply with the 'Patients' Funds and Property Procedure' when admitting patients to the ward.

(b) No response was made to Mr C's cardiac monitor sounding an alarm at various points during his stay in the ward and it was entirely ignored during the night; and (c) Mr C was given contradictory information about how he could get his cardiac monitor reset

18. Mrs C advised me that during the night Mr C's cardiac monitor alarm was continually going off. She said that when he asked a nurse if she could reset the alarm, he was advised that he would have to see the doctor. When he asked the doctor, he was told he would need to see the nurse. Mrs C said that the alarm continued to sound all night 'and nothing was done'.

19. In their response to the complaint, the Board accepted that Mr C's cardiac monitor alarm had sounded through the night, however, they said that this occurred when Mr C was restless and, each time, staff reset the monitor.

20. The nurse on duty said that Mr C's monitor did sound on numerous occasions but only when he was restless and it was reset. She went on to say that when Mrs C telephoned in the morning, she was advised that Mr C had experienced some anxiety overnight.

21. Scrutiny of the nursing notes completed during Mr C's night in the Hospital indicated that he was admitted via Accident and Emergency following 'several weeks history of palpitations'. The records reflected that 'at 13:45 cardiac monitor in situ'. The nursing notes also indicate:

'15:00 continue cardiac monitoring
17:30 Ward round
06:50 (19/2/06) Recordings stable. Home after ward round.'

22. There is nothing in the nursing record to indicate that Mr C had a restless night or that there were problems with his cardiac monitor alarming.

23. The notification sent from the Hospital to Mr C's General Practitioner to advise him of the Hospital visit stated that Mr C was kept in overnight on a cardiac monitor, during which time he developed no further symptoms. Again, there is nothing to suggest that the cardiac monitor alarmed or that Mr C had been anxious or unsettled during the night.

24. I asked the Adviser if 'restlessness' would cause a cardiac monitor to alarm. She said that restlessness could indeed have made the cardiac monitor alarm, however, if restlessness was an observed problem and was interfering

with the functioning of the monitor she would have expected nursing staff to explore possible causes and to make appropriate comments in the nursing notes.

25. She further advised me that rest is an important factor in the care of a patient with Mr C's problem, so anything that interfered with his rest was relevant to his care and should have been recorded.

26. She noted that there were no comments on Mr C's nursing notes in relation to either the sounding of the alarm or the fact that he had been restless through the night. She further noted that Mr C had his temperature, pulse, respirations and blood pressure recorded at 21:50, 02:00 and 06:00 overnight 18/19 February 2006 and they were indeed stable.

27. I asked the Board if the reasons for Mr C's cardiac monitor alarming were explored and to comment on why this was not recorded in the nursing notes. The Board responded by explaining that is not uncommon for the alarm of a cardiac monitor to sound if a patient moves into an awkward position and occasionally the sensor wires can become tangled or dislodged, causing the monitor to alarm. The Board, however, stressed that staff check that all the connections are in place when the monitor alarm sounds, as standard procedure, and would not have simply reset the machine.

28. Mrs C said that, during the night when Mr C's cardiac monitor alarm sounded, he asked a nurse if she could reset the alarms and was advised that he would have to see a doctor. When he asked the doctor, he was advised that he would have to see a nurse.

29. As reported in paragraph 23, there is no indication in the nursing record to indicate that Mr C had problems with his cardiac monitor alarming and nothing to indicate that he asked for the monitor to be reset. The Board said, however, in their response to the complaint that each time the cardiac monitor alarmed, staff reset it.

(b) Conclusion

30. The monitor alarm alerts the nursing staff that something is wrong. This could relate to the patient and his condition and would be the first consideration the nurse would have. Alternatively, the alarm may be an indication that there is a technical problem with the monitor. There is agreement that Mr C's alarm

was sounding during the night, therefore, I would have expected the nursing notes to have reflected this.

31. However, the absence of a record in the nursing notes does not verify that Mr C's alarm was ignored; indeed the Board have acknowledged that the alarm was an issue but, as there is no record of this, the Adviser told me that this was a shortcoming on the part of the Board. I have, therefore, concluded that Mr C's nursing notes were not kept to a reasonable standard.

32. It is important to maintain accurate records so that any other healthcare professional who sees the patient later can understand properly what has been happening. This is essential to help healthcare professionals make appropriate decisions on the future care and treatment of the patient.

33. The questions I have been asked to consider, however, are whether or not a response was made to Mr C's cardiac monitor sounding an alarm at various points during his stay in the ward; and whether or not the alarm sounding was entirely ignored during the night.

34. Mrs C contended that Mr C's cardiac alarm was not responded to several times and was ignored throughout the night, while the Board stated that the monitor was reset each time the alarm sounded.

35. Each side has given an account of events which is contradictory to the other. There is no record in the nursing notes of the alarm sounding on numerous occasions (although this does not appear to be in doubt) and there is no independent corroboration of what actually happened, therefore, I have been unable to clarify what did or did not happen when the monitor alarm sounded. While this is unfortunate, I am unable to reach a finding on this complaint.

(b) Recommendation

36. Although I have made no finding on this complaint, the Ombudsman wishes to make a general recommendation as a result of the issues raised in relation to record-keeping, she recommends, therefore, that the Board ensure that all staff, especially bank nurses, are reminded of the importance of accurate record-keeping.

(c) Conclusion

37. As reported in paragraph 35, there are conflicting accounts of if and how the cardiac monitor was reset when the alarm sounded; and the absence of any reference to the cardiac monitor alarming in the nursing notes means I am unable to clarify what did or did not happen when Mr C enquired about getting the monitor reset. In the circumstances, I am unable to reach a finding on this complaint.

(c) Recommendation

38. The Ombudsman's recommendation in relation to this matter is as set out in paragraph 37.

(d) Mr C's pressing of the call button was not answered for one hour

39. Mrs C told me that, during the night, Mr C pressed his call button to advise nursing staff that another patient in the ward had disconnected his drip. She said that nursing staff did not respond to his call for one hour.

40. In writing to the Board to make enquiries in relation to the complaints raised by Mrs C, I asked the Board to comment on the suggestion that nursing staff had not responded to Mr C's call button for one hour.

41. In their response, the Board advised me that they could find no evidence of this occurring.

(d) Conclusion

42. Once again, I am faced with conflicting accounts of what actually happened. In the absence of any evidence to support a finding one way or another, I am unable to reach a finding on this complaint.

(e) Staff on duty in the ward were not appropriately qualified

43. Mrs C complained that staff on the ward were not appropriately qualified. She said that she had asked a nurse if she knew what she was looking for on the cardiac monitor and the nurse had confirmed she did not.

44. As I reported in paragraph 8, the Board said that, on the night Mr C was admitted to the Hospital, the ward was experiencing a very high dependency shift with emergency situations, which demanded a high proportion of the nursing time.

45. The Board further said that pressure on nursing staff was exacerbated as the number of permanent staff on the ward was reduced, therefore, there was a need to enlist the assistance of the nurse bank to ensure an appropriate number of staff were working.

46. While there is no written evidence to support Mrs C's contention that the nurse did not know what she was looking for on the cardiac monitor, it is clear, from a statement provided by one of the bank nurses to the Board in the investigation of this complaint, that she was fairly recently qualified and without specific prior experience in a similar clinical setting. She would not, therefore, be as competent as the permanent ward nursing staff and so would need support. She herself indicated, however, that she did ask questions and seek advice when in doubt during her time on duty.

47. In their letter of 3 May 2006, the Board acknowledged that the bank nurses, while not completely apprised of all manner of the ward care, were nonetheless competent in practice. The bank nurses accepted that their knowledge of cardiac monitors was not of the standard of permanent staff in the ward, however, in recognising this they ensured that the appropriate questions were asked of the permanent staff on the ward to afford the best standard of care possible.

48. The Board's letter also accepted that, on the occasion of Mr C's admission to the ward, the skills mix of the nursing staff had unfortunately contributed to a less than desirable service for those patients who did not require intensive levels of nursing care. However, the Board considered that at no time could the standard of care have been considered unsafe.

49. In responding to Mrs C about her complaint, the Board apologised that Mr C had such a disturbed night, stating that the ward experienced several difficulties that night relating to a very poor skill mix, high workload and emergency situations which demanded a significant proportion of nursing time. These all contributed to other patients in the ward receiving 'a less than desirable service'.

50. However, the Board considered that all bank nurses were aware of how to attach a patient to a cardiac monitor and to operate it. They said there was no requirement for bank staff to complete any specific training to interpret readings on the cardiac monitor, as it would not be their job to do so. The Board

explained that bank nurses were employed to supplement staffing levels either due to increased clinical activity or staff shortages; they are engaged to provide support to the existing nursing team.

51. The Board further stated that the nurse in charge of each ward assessed the bank nurse's clinical experience, knowledge and skills to determine their best use and that care is always taken to allocate patients to nursing staff with the appropriate knowledge. The Board assured me that support and guidance was available for the nursing staff in the ward.

52. The Adviser confirmed that all registered nurses have the knowledge, competence and skills to perform the range of duties required. They also have the ability to identify where gaps in their experience necessitate the need for additional support and supervision, as happened in this case.

(e) Conclusion

53. It is unfortunate that the ward experienced staff shortages on a high dependency shift, coupled with emergency situations, when Mr C was admitted to the Hospital.

54. This situation necessitated the need to use bank nurses and the Board have acknowledged that this resulted in a less than desirable service for those patients who required less intensive levels of nursing care.

55. This does not mean, however, that the staff on duty were not appropriately qualified; rather it suggests that because their attentions were prioritised for those in most need, the nursing care provided to other patients was not to the usual standard.

56. In considering the evidence available, together with the advice received from the Adviser, I have found nothing to indicate that the staff on duty in the ward were not appropriately qualified. On that basis, I do not uphold this complaint.

(f) There were inadequacies in the handling of Mrs C's complaint by the Board

57. Mrs C's letter of complaint was received by the Board on 26 February 2006, with an acknowledgement letter and a copy of the NHS complaints leaflet being sent to her on 7 March 2006. The Board explained that

they aimed to provide Mrs C with a response to her complaint within four weeks but if this was not possible she would be advised of the reason for any delay.

58. On 7 March 2006 the Board's Complaints and Advice Co-ordinator contacted the key stakeholders involved in Mr C's case, asking them to consider the complaint and to provide a detailed response by 17 March 2006. This deadline would have allowed sufficient time for a full response to be issued to Mrs C, unfortunately, however, responses from the relevant Consultant and the Senior Charge Nurse were received after the required deadline and the Board experienced difficulty in contacting the bank nurses who had been on duty on the night in question.

59. A formal response was issued to Mrs C on 3 May 2006, however, she had not been advised of the reason for the delay in responding, as the Board in the meantime had committed to in their letter of 7 March 2008.

60. The Board's internal 'Complaint Response Summary' on Mrs C's complaint recorded that the Board did not meet the 20 day response target due to a delayed response from nursing staff and that an apology had been given, together with an explanation of what happened and an assurance that appropriate action would be taken.

61. On 5 May 2006 Mrs C called the Board to explain her dissatisfaction with their response and to request a further investigation.

62. Further enquiries were commenced by the Board to investigate the matter and on 25 July 2006 Mrs C was sent an update explaining that it had taken longer than expected to obtain the necessary information, apologising again for the delay in issuing a full response.

63. On 27 September 2006 the Board issued their final response to Mrs C and sincerely apologised for the delay in responding.

(f) Conclusion

64. The Board did not meet the requirement to acknowledge Mrs C's complaint within three working days of receipt or to respond to the complaint within 20 working days of receiving it.

65. While the Board's formal response of 3 May 2006 to Mr C's complaint apologised that she had cause to complain, they did not apologise for, or explain the reason for, their delay in responding.

66. On escalating the complaint to the next stage of the complaints process, the Board took six weeks to issue a progress report to Mrs C, and a further nine weeks to advise Mrs C of the outcome of their investigation.

67. Based on the evidence I have examined, the Board did not meet the required timescales to investigate Mrs C's complaint and did not provide her with sufficient updates to keep her informed of their progress. Accordingly, I agree that there were inadequacies in the way that the Board handled the complaint and I, therefore, uphold this aspect of Mrs C's complaint.

(f) Recommendation

68. The Ombudsman recommends that the Board take action to remind appropriate staff of the need to comply with the relevant procedures, in relation to investigating and responding to complaints within the required timescales.

69. 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

Mr C	The complainant's husband
The Hospital	Ninewells Hospital, Dundee
Mrs C	The complainant
The Board	Tayside NHS Board
The Adviser	A nursing adviser to the Ombudsman

Annex 2

List of legislation and policies considered

The Board's 'Patients' Funds and Property Procedure'