Scottish Parliament Region: South of Scotland

Case 200702695: Borders NHS Board

Summary of Investigation

Category

Health: Hospital; nursing care

Overview

The complainant (Mrs C) raised a number of concerns about the level of nursing care which her late husband (Mr C) received at Borders General Hospital (the Hospital) during two admissions in 2006 and 2007.

Specific complaint and conclusions

The complaint which has been investigated is that, during two admissions to the Hospital in 2006 and 2007, staff failed to ensure that Mr C received an adequate level of nursing care (*upheld*).

Redress and recommendations

The Ombudsman recommends that Borders NHS Board (the Board):

(i) conduct an audit of the cleaning regime which is in use throughout the Hospital and advise her of the outcome;

(ii) provide evidence of the systems in place to monitor and audit the nursing notes (which would include patient assessment and the care plan);

(iii) remind staff of the importance to record incidents of injury to patients in the nursing records, in addition to completing incident reports;

(iv) provide evidence that there are measures in place to monitor compliance with the Administration of Medicines Policy; and

(v) share this report with the Senior Charge Nurse on the ward and consider, in light of the issues which have been raised, whether additional education and development is required.

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

Main Investigation Report

Introduction

1. On 25 January 2008 the Ombudsman received a complaint from Mrs C about the level of nursing care which her late husband (Mr C) received at Borders General Hospital (the Hospital) during two admissions in 2006 and 2007. Mrs C complained that her husband was scalded by a hot drink; sustained a fall which required stitches; and had to wait for urgent medication. She also complained that the hospital cleaning regime was poor. Mrs C complained to Borders NHS Board (the Board) but remained dissatisfied with their response and subsequently complained to the Ombudsman.

1. The complaint from Mrs C which I have investigated is that, during two admissions to the Hospital in 2006 and 2007, staff failed to ensure that Mr C received an adequate level of nursing care.

Investigation

2. In writing this report I have had access to Mr C's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional nursing advisers (the Adviser) regarding the nursing aspects of the complaint. I also met with Mrs C.

3. 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 is contained in Annex 1. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Complaint: During two admissions to the Hospital in 2006 and 2007, staff failed to ensure that Mr C received an adequate level of nursing care

4. Mrs C complained to the Board on 31 October 2007 about the number of failings in the nursing care which Mr C had received during his two admissions to the Hospital. During the first admission on 12 September 2006 Mr C lost his glasses and, despite the nurses looking for them, Mrs C found them under his bed four days later. She also recalled that Mr C was sitting on a chair at the side of the bed attached to a drain when a cleaner approached to clean the area. Mr C offered to move so that the cleaner could have better access but was told not to bother and that she would clean around the area. Mrs C also said that, on one occasion, the container which held fluids from Mr C's lung had been knocked over. A nurse placed absorbent sheeting over the spill and

wiped up the mess. However, no cleaning or neutralising agent was used, which meant that anybody walking through that area could transmit and spread any germs or bacteria. Mrs C said Mr C was then transferred to another hospital where his wound dressing was changed every day, whereas in the Hospital the dressing was only changed eight days after his admission. She wondered why the regime for changing the dressings was so different.

5. During Mr C's second admission to the Hospital on 21 April 2007 he was admitted late at night with confusion and Mrs C telephoned the ward at 09:00, 12:00 and 13:00 the following day to enquire if he had been seen by a doctor. She was told by nursing staff that a doctor had not seen Mr C at that time, yet when she contacted her GP she eventually found out that he had, in fact, been seen by a doctor at 09:00 that day. Mrs C was concerned that staff did not communicate this to her. She complained that families and friends were concerned about patients in hospital and that informing the family was paramount to the wellbeing of everyone involved.

6. On 23 April 2007, Mrs C said she was visiting Mr C, who was very shaky, and she put a plastic apron around him as an auxiliary was giving out drinks. Mr C took coffee and because he had no coordination or ability to hold the cup, he dropped the hot liquid. Mrs C pressed the alarm and a nurse appeared promptly. However, the hot liquid had scalded Mr C's bottom. Mrs C wondered why Mr C was not given a cup with a lid which would have avoided the accident. The following day, Mrs C asked a nurse how Mr C's bottom was and whether staff had applied cream or ointment. Mrs C complained that the nurse was not aware of the scalding incident. At Mrs C's prompting, the nurse applied cream to the scald. A few days later, Mrs C found Mr C sitting up in bed covered in blood, waiting for a doctor. He had fallen in the toilet and had cut his head on the floor. Mrs C wondered why her husband had not been escorted to the toilet or why the cot sides had not been put up, considering he had recently scalded himself with the coffee and that he had a lack of coordination and orientation.

7. Mrs C said that, at the end of visiting on 29 April 2007 the following day, Mr C was in pain at 20:00 and she approached a nurse to ask for some pain relief. The nurse said she would be two to three minutes but Mrs C felt unsettled about leaving Mr C so she stayed with him. She said Mr C's pain continued and she pressed the alarm at 20:20. However, the nurse said they were in the middle of a staff change over and Mr C would have to wait for a couple of minutes. Mr C eventually received the pain relief at 20:45 and Mrs C

wondered what would happen should a patient fall on the floor or suffer a heart attack while the staff change over was taking place.

8. Mrs C wanted the Board to answer her concerns and detail the actions which had taken place to prevent the same situation happening to another patient.

9. On 17 December 2007 the Board's Director of Integrated Services (the Director) responded to Mrs C's complaint. In regard to the first admission, the Director explained that when Mr C's glasses had been reported as missing, his bed had been completely stripped, pulled out and the locker removed, without success. The Director apologised that the cleaning schedule had not been carried out for a five day period and stated that a member of the cleaning staff had been reminded of the ward cleaning policy about moving chairs to gain access. He also said that there was no record of a drain spill at the time Mrs C had mentioned but the ward sister had apologised if the nurse had dealt with the spill as Mrs C had described. The staff would be reminded of the policy at the next team discussion. An apology was also given that Mr C's dressings were not carried out to an appropriate standard. Insofar as the second admission was concerned, the Director explained that it was accepted that giving information to relatives is paramount to the wellbeing of everyone involved. It was recorded that a doctor had seen Mr C at 09:10 and nursing staff should have been aware of this and advised Mrs C accordingly. An apology was made for the breakdown in communications and the importance of good communications would form part of the customer care training programme, which was due to be implemented in 2008.

10. The Director then addressed the scalding incident with the cup of coffee. He said that there was no record of the scalding incident on 23 April 2007, therefore, the nurse on 24 April 2007 would not have been aware of it. The Director said that it was likely that staff had failed to document the incident and it was accepted they should have done so. The Director then commented about Mr C's fall. It was recorded that on 27 April 2007 he was showing no tremor, was less sleepy and had showered independently. On 28 April 2007, Mr C was drowsy and vague. At 18:00 he went to the toilet unaided and fell when putting a bottle on the floor. Due to the medicine round taking place, staff were not aware that Mr C had left his bed. Mr C was given emergency treatment, an incident form was completed and he was told to contact staff if he needed help to go to the toilet. The Director stated it was not appropriate to nurse Mr C in

bed or with the cot sides in situ. However, he said a bed rails policy was being drafted, as it was a challenge for staff to weigh up the benefits and risks of using cot sides and the ward sister has apologised to Mrs C on 30 April 2007 for the incident.

11. The Director continued that Mr C received pain relief at 19:00 on 29 April 2007 and that he should have had stronger pain relief at 20:00 but this was not given until 20:45. The changeover should have been completed by 20:00 but there is no record of why a delay had occurred. He said that, due to the time which had elapsed since the incident, it would not be possible to establish the cause of the delay. Nevertheless, he commented that there should always be two trained staff in the ward while the handover takes place and they should be able to attend to patients. In addition, he advised that all staff are available should an emergency take place.

12. When Mrs C received the Board's response to her complaint she was unhappy at the number of apologies and expressions of regret. She felt that at no time had the Board given her any hope that such problems would not occur again.

13. The Adviser told me that she could add no more to the response made by the Board in regard to the substance of Mrs C's complaint. The Board had accepted there were failings in the nursing care which had been provided to Mr C and that appropriate apologies had been made. In particular, the Adviser was pleased to note that the cleaner had been given more detailed instruction and that nursing staff had been reminded of the correct cleaning procedure to be used when body fluids spill onto the floor. Nevertheless, she felt that there were implications in this for the organisation, in that they needed to demonstrate better that lessons had been learned.

14. Although the Board used unitary notes (clinical and nursing) which the Adviser stated should be commended, when she reviewed Mr C's nursing record she could not locate a care plan or other documentation which fulfilled the same purpose. She advised that each patient should have their nursing needs assessed and a plan for nursing intervention devised, which makes it clear to all nursing personnel involved in the care exactly how to meet the patient's needs. Progress against the plan should be given in the nursing continuation note as this is recognised as good practice and, indeed, the patient should be actively involved in developing the plan. The Adviser felt that, had

there been a clear plan in Mr C's case, it was likely that the scalding incident could have been avoided and the approach to bathing and mobility would have been clear.

15. The Adviser continued that she was concerned that Mr C did not receive his morphine at the time prescribed, which she considered to be poor practice. In addition, she pointed out that Standard 26 of the guidance – Standards for Medicines Management issued by the Nursing and Midwifery Council states:

> 'Registrants should ensure that patients prescribed Controlled Drugs are administered these in a timely fashion in line with the standards for administering medication to patients.'

Conclusion

16. Mrs C has complained about the poor level of nursing care which Mr C received during the two admissions. These related to issues of poor ward cleaning regime; lack of changing dressings; failures in communication with relatives; lack of an assessment of Mr C, which led to him being scalded by hot coffee; falling when he walked to the toilet unaided; and a delay in administering pain relief medication. It is clear that the Board have accepted the complaints made by Mrs C and have offered appropriate apologies.

17. I agree with the Adviser that nothing more would be achieved by considering the substance of Mrs C's complaint, due to the time which has elapsed since the events complained of and the fact that the Board have accepted that the accounts provided by Mrs C were accurate. However, when considering a complaint and failings are found, it is appropriate not only that an apology is made but also that information is provided about what steps have been taken to prevent a repeat occurrence. The advice which I have received is that the Board did not adequately explain to Mrs C the actions they would be taking to ensure the failings did not occur again and, accordingly, I uphold this complaint. I hope that the recommendations made in the following paragraph will go some way to satisfy Mrs C that steps will be taken to identify areas of concern, so that action can be taken which will lead to an improvement in nursing care.

Recommendations

18. The Ombudsman recommends that the Board:

(i) conduct an audit of the cleaning regime which is in use throughout the Hospital and advise her of the outcome;

(ii) provide evidence of the systems in place to monitor and audit the nursing notes (which would include patient assessment and the care plan);

(iii) remind staff of the importance to record incidents of injury to patients in the nursing records, in addition to completing incident reports;

(iv) provide evidence that there are measures in place to monitor compliance with the Administration of Medicines Policy; and

(v) share this report with the Senior Charge Nurse on the ward and consider, in light of the issues raised, whether additional education and development is required.

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

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	Mrs C's husband
The Hospital	Borders General Hospital
The Board	Borders NHS Board
The Adviser	Professional medical adviser
The Director	The Board's Director of Integrated Services