SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

# Investigation Report

UNDER SECTION 15(1)(a)

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**Scottish Parliament Region: South of Scotland**

**Case ref: 201405009, Borders NHS Board**
**Sector:** Health
**Subject:** Hospitals; clinical treatment; nursing care; communication

**Summary**
Mr A was admitted to Borders General Hospital with a heavy nose bleed and in considerable pain. He had lung cancer and several other medical conditions, and he was terminally ill. Mr A was initially admitted to the emergency department and then transferred to the medical assessment unit (MAU). Mr A's partner (Ms C) said that there were a number of failures in the care and treatment Mr A received in hospital. She complained that the bedside oxygen equipment did not work, that Mr A was not given adequate pain relief or his own medication, and that he was shown a lack of compassion by nursing staff. She said that Mr A discharged himself from hospital the day after his admission because of the poor care and treatment he had received, and so that he could receive the medication he needed. He died at home three days later.

I obtained independent advice from a nursing adviser and a medical adviser who is a hospital consultant in acute internal medicine. Ms C complained that the medical treatment Mr A received in hospital was unreasonable. My medical adviser noted that the failure of the oxygen equipment in the emergency department would have increased Mr A's feelings of distress. The board said they had already made changes to ensure that equipment was checked more often, so I asked to see evidence of this. I also asked to see evidence of the other positive action the board said they had made following Ms C's complaint. This was to make sure that patients arriving in the MAU were assessed within sixty minutes, whereas Mr A's medical review took place over two hours after arriving on the ward.

My medical adviser said that there was no record of a pain assessment in the emergency department though, on arrival in the MAU, Mr A was assessed as experiencing severe pain. My adviser considered that pain relief should have been provided earlier in the emergency department. There was also no record of pain assessment overnight in the MAU. The advice I have received is that Mr A, who was in acute pain and terminally ill, appears to have received inadequate pain control and was left in pain for considerable periods. I noted my medical adviser's comment that he could imagine Mr A's frustration at

having been left in pain. In his view, this led Mr A to discharge himself from hospital, leaving his symptoms untreated and with no investigation into the cause of his pain. Therefore, he was potentially put at significant risk of harm or death. I upheld the complaint and made several recommendations.

The nursing advice I received identified a number of serious failings in Mr A's nursing care and found that, overall, the nursing care Mr A received in the MAU was unacceptable and poor practice. My nursing adviser found that nursing staff had failed in their duty to appropriately assess, monitor and alleviate Mr A's pain and did not appear to have followed Nursing and Midwifery Council Standards regarding the prescribing of pain relief medication to Mr A. My nursing adviser considered that Mr A must have been frustrated not to have had his severe pain relieved despite having his own pain relief medicines with him, which he should have been allowed to self-administer. My adviser also considered that written statements from the nurses involved in Mr A's care showed a lack of compassion for, or understanding of, his situation and feelings. I am critical of the board for these failings and the lack of compassion shown to Mr A. I am concerned that he had such a painful and distressing experience, and I also acknowledge the upset and distress this has caused to Ms C. I upheld this complaint and made the following recommendations.

**Redress and recommendations**

| The Ombudsman recommends that the Board: | *Completion date* |
|---|---|
| (i) provide evidence of the action to ensure that oxygen equipment checks are made between patients in addition to standard twice daily checks carried out; | 18 January 2016 |
| (ii) provide evidence of the action taken to ensure that the assessment of a patient is completed within sixty minutes of the patient arriving in the MAU; | 18 January 2016 |
| (iii) ensure the comments of the medical adviser in relation to the treatment of Mr A's pain control are brought to the attention of relevant medical staff and they reflect on this; | 18 January 2016 |
| (iv) apologise to Ms C for the failings identified in Mr A's medical care and treatment; | 18 December 2015 |
| (v) reflect again on Ms C's complaint by reviewing what went wrong and what learning has taken | 18 January 2016 |

| | | |
|---|---|---|
| | place; | |
| (vi) | consider implementing learning and development training in early resolution of concerns and complaints for front line nursing staff in the MAU; | 18 January 2016 |
| (vii) | carry out a review of nursing in the MAU to explore the leadership and culture within the ward - to include a review of pain assessment and monitoring of patients in the hospital and, in particular, in the unit; and | 18 January 2016 |
| (viii) | apologise to Ms C for the failings identified in Mr A's nursing care and treatment. | 18 December 2015 |

**Who we are**

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

## Introduction

1. Ms C complained to the Ombudsman about the care and treatment her partner, Mr A, received while he was a patient at Borders General Hospital (the Hospital) following his admission there on 10 September 2014. Mr A discharged himself from the Hospital on 11 September 2014 and sadly died at home on 14 September 2014.

2. The complaints from Ms C I have investigated are that:

(a) the Hospital's medical treatment during Mr A's admission from 10 September 2014 was unreasonable (*upheld*); and

(b) the Hospital's nursing care during Mr A's admission from 10 September 2014 was unreasonable list (*upheld*).

## Investigation

3. In order to investigate Ms C's complaint, my complaints reviewer examined all information provided by Ms C, a copy of Mr A's clinical records and the Board's complaint file. My complaints reviewer also obtained independent advice from a hospital consultant in acute internal medicine (the Medical Adviser) and a nursing adviser (the Nursing Adviser). In this case, we have decided to issue a public report on the complaint because the failings I found led to a significant personal injustice to Mr A who at the time was terminally ill.

4. 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 Borders NHS Board (the Board) were given an opportunity to comment on a draft of this report.

### *Background*

5. Mr A was admitted to the Hospital with a heavy nose bleed and because he was in considerable pain on 10 September 2014. At the time of Mr A's admission he had lung cancer and a number of additional medical conditions and was terminally ill. Mr A was initially admitted to the Hospital's Emergency Department (ED) and then transferred to Ward 6, the Medical Assessment Unit (MAU).

6. Ms C complained that there was a number of failures in the care and treatment Mr A received while he was in the Hospital. Ms C was concerned the oxygen equipment at Mr A's bed was not working; Mr A was given inadequate pain relief; nursing staff failed to give Mr A the medication he had brought with

him into the Hospital because they were in dosette boxes and not in their original packets; and there was a lack of care and compassion shown by nursing staff towards Mr A.

7. Ms C said that Mr A discharged himself from the Hospital on 11 September 2014 because of the poor care and treatment he had received.

8. Ms C was dissatisfied with the Board's investigation of her complaint and sought an independent investigation of the concerns she had raised concerning Mr A's care and treatment.

**(a) The Hospital's medical treatment during Mr A's admission from 10 September 2014 was unreasonable**

*What Ms C said*

9. Ms C said that Mr A had been diagnosed with lung cancer and pulmonary fibrosis and had a life expectancy of approximately three to six months. Ms C said that Mr A suffered considerable pain and although he had been prescribed morphine, (oramorph and zomorph) his pain was not as yet under control. On 10 September 2014, Mr A had a heavy nose bleed, he was in unbearable pain and appeared to have suffered an attack of colitis. Ms C said she, therefore, contacted Mr A's district nurse who in turn contacted Mr A's GP and arrangements were made for Mr A to attend the Hospital's ED. Ms C said she and her daughter accompanied Mr A to the Hospital.

10. Ms C said that Mr A needed oxygen to assist him with his breathing and so brought his portable oxygen equipment with him to the Hospital. While in the ED, Mr A was transferred from his portable oxygen supply to the oxygen equipment at his bedside. However, Ms C said this oxygen equipment was not working and there was a note at the end of Mr A's bed which stated this. Ms C said that she had to bring this to the attention of a member of the nursing staff and Mr A had to use his own oxygen equipment until a portable oxygen cylinder was supplied.

11. Ms C said while Mr A was in the ED he eventually received intravenous morphine for pain relief which was administered by one of nursing staff who also was able to stop Mr A's nose bleed. Ms C said she was thankful for the actions of this particular nurse.

*The Board's response*

12. The Board said they were 'sorry' to learn of Ms C's dissatisfaction with the care provided for Mr A. The Board noted Ms C's concern and apologised for any distress caused to Mr A due to the oxygen equipment provided for him not working while he was in the ED. According to the Board, as soon as the nurse who administered morphine to Mr A became aware of the situation a portable oxygen cylinder was provided. The Board also said they had taken action to ensure that prompt attention was given to oxygen cylinder changes in ED and to ensure that equipment checks were made between patients in addition to the standard twice daily checks carried out.

13. The Board said that their investigation of Ms C's complaint had highlighted that Mr A had waited for approximately two hours for a medical review following his transfer from ED to the MAU. The Board said that the senior charge nurse in the MAU had been asked to ensure that the assessment of a patient was completed within sixty minutes of a patient arriving in this ward.

*Medical advice*

14. The Medical Adviser told my complaints reviewer that Mr A had presented to ED with a nose bleed at around 17:00 on 10 September 2014. The Medical Adviser said that Mr A, who was 55 years old, had a background of terminal lung cancer, pulmonary fibrosis, ulcerative colitis, diabetes and ischaemic heart disease. The Medical Adviser noted from Mr A's medical records that his nose bleed was readily treated with minimal treatment. It was also recorded in Mr A's medical records that he had a one week history of lower back pain and he was admitted to the Hospital for pain control. The Medical Adviser said that while Mr A was in ED he received oramorph at 17:20.

15. The Medical Adviser said that the failure of the oxygen equipment initially provided for Mr A in the ED would have increased his feelings of distress brought about by breathlessness. The Medical Adviser told my complaints reviewer that whilst this was clearly potentially serious, it was rapidly spotted and corrective action taken without any lasting harm to Mr A.

16. The Medical Adviser noted that Mr A was transferred to the MAU at 21:00 and his case was referred to a member of the medical staff at 21:20. The Adviser considered that Mr A had been in the MAU for a maximum of 20 minutes before the request for a medical review was made and this was reasonable, although Mr A then waited approximately two hours for a medical

review. The Medical Adviser told my complaints reviewer there was no documentation about Mr A's pain immediately prior to his transfer to the MAU. The Medical Adviser said that on arrival in the MAU Mr A was assessed as having a pain score of 7/10 which, according to pain guidelines, usually required a patient receiving intravenous pain relieving medication. The Medical Adviser considered that the severe pain which Mr A was experiencing should have been addressed in ED prior to his transfer to the MAU.

17. The Medical Adviser said that Mr A was given intravenous morphine at 23:10 and he was medically assessed at 23:30. It was recorded in Mr A's medical records that Mr A described having 'colitis pain' in his 'back passage and abdomen' and an abdominal examination was carried out which revealed some 'vague tenderness at the left side' with no signs of an acute surgical problem. Mr A's general appearance was noted as 'looking sore'. Although it was recorded in Mr A's medical records that he required morphine at 05:40 for back and abdominal pain the Medical Adviser noted there was no corresponding record for this on Mr A's drug chart for that time and there was no assessment of Mr A's pain overnight.

18. The Medical Adviser said at a ward round at 06:45 on 11 September 2014 an abdominal x-ray was reviewed which showed that Mr A had right sided faecal loading and a diagnosis of epistaxis (a nose bleed), abdominal pain and lung cancer. It was also recorded that Mr A was expected to be discharged that day and the suggested management plan listed making Mr A's oncologist aware of his admission, giving Mr A petroleum jelly to prevent recurrent nose bleeds and prescribing laxatives. The Medical Adviser said that a comprehensive referral was written and faxed to Mr A's oncologist concerning Mr A's admission.

19. The Medical Adviser noted that an entry in Mr A's medical records recorded that at 08:10 on 11 September 2014 a nurse had attempted to give Mr A oramorph, zomorph, gabapentin and paracetamol which he had refused stating 'they did not work'. It was also recorded that the nurse concerned had then returned with another nurse and offered Mr A's his own medications which he had brought with him into the Hospital but he had also refused them. The Medical Adviser told my complaints reviewer that he considered it was unwise of Mr A to refuse the pain medication when this was offered to him given that his primary complaint was pain.

20. The Medical Adviser noted from an entry in Mr A's medical records that at 09:50 on 11 September 2014 a junior doctor saw Mr A in response to an enquiry from a lung cancer specialist nurse. The doctor had found Mr A angry about the care he had received and that Mr A had said he had asked repeatedly for analgesia this morning because of severe pain but that it never arrived.

21. The Medical Adviser also noted further entries in Mr A's medical records for 11 September 2014 which stated that nursing staff had reported that Mr A was either ignoring staff or being aggressive with them and he had refused to listen to the junior doctor who had advised him to stay in the Hospital for further investigation and pain management. It was also recorded that nursing staff had apologised to Mr A for his experience but he had discharged himself against medical advice although he intended to keep his appointment with his oncologist scheduled for that afternoon and the lung cancer specialist nurse was trying to arrange for a palliative care nurse to see Mr A at the same time.

22. The Medical Adviser said there were always competing priorities on a hospital admissions unit overnight and the reality of this fact should be noted. The Medical Adviser also told my complaints reviewer that Mr A's pain control was not easy and this was the situation with him prior to his admission to the Hospital. The Medical Adviser considered Mr A's best hope for pain control was to remain in the Hospital so he could be reviewed and this was offered to him. The Medical Adviser, however, was of the view that Mr A's pain control was not achieved as quickly as it should have been and that, in all likelihood, Mr A received inadequate pain control and was left in pain for considerable periods. According to the Medical Adviser, Mr A's documented behaviour suggested that he was not in a state of mind to see or accept medical advice although the Medical Adviser did not consider Mr A lacked the capacity to make decisions about his care. The Medical Adviser said he could well imagine Mr A's frustration at having been left in pain and, as a result, had led to Mr A refusing medication to relieve his pain and discharging himself because he was upset at his treatment. In discharging himself, Mr A had prevented the investigation of the cause of his pain which, in the view of the Medical Adviser, potentially put him at a significant risk of harm or death.

**(a) Decision**

23. The Board have accepted there were failings in relation to the oxygen equipment provided for Mr A while he was in the ED and there was also delay before a medical review of Mr A was carried out following his transfer from ED

to the MAU. I acknowledge the action taken by the Board as a result of these failings and I have asked the Board in my recommendations to provide me with evidence of the action they say they have taken.

24. It is of serious concern that Mr A, who was in acute pain and was terminally ill, appears to have received inadequate pain control and was left in pain for considerable periods. I note the Medical Adviser told my complaint reviewer that Mr A's pain control was not achieved as quickly as it should have been and he could well imagine Mr A's frustration at having been left in pain. The result of which had led Mr A, in the view of the Medical Adviser, to discharge himself from the Hospital thus preventing the alleviation of his symptoms and an investigation of the cause of his pain and potentially putting him at significant risk of harm or death.

25. Given the failings identified I am satisfied that the Hospital's medical treatment during Mr A's admission from 10 September 2014 was unreasonable. Therefore, I uphold this complaint.

26. I have, therefore, made the following recommendations, which include a recommendation that the Board should apologise to Ms C.

**(a) Recommendations**

| 27. I recommend that the Board: | *Completion date* |
|---|---|
| (i) provide evidence of the action to ensure that oxygen equipment checks are made between patients in addition to standard twice daily checks carried out; | 18 January 2016 |
| (ii) provide evidence of the action taken to ensure that the assessment of a patient is completed within sixty minutes of the patient arriving in the MAU; | 18 January 2016 |
| (iii) ensure the comments of the Medical Adviser in relation to the treatment of Mr A's pain control are brought to the attention of relevant medical staff and they reflect on this; and | 18 January 2016 |
| (iv) apologise to Ms C for the failings identified in Mr A's medical care and treatment | 18 December 2015 |

**(b) The Hospital's nursing care during Mr A's admission from 10 September 2014 was unreasonable**

*What Ms C said*

28. Ms C said that during the period Mr A was in the MAU he received insufficient pain relief. According to Ms C, Mr A had told her that he had asked nursing staff three times for morphine for pain relief because he was in 'agony'. Ms C said that nursing staff had refused to give Mr A, who was capable of self-medicating, his own medication which he had brought with him into the Hospital because they were in dosette boxes rather than in their original packets. Ms C also said that the Hospital did not have all the medication that Mr A required and when Mr A was eventually offered oramorph the dose offered was less than he was used to taking when he was at home.

29. Ms C said she spoke on the telephone to a member of the nursing staff at 08:30 on 11 September 2014, who complained to her about Mr A's behaviour. However, it appeared to Ms C the nurse concerned had been argumentative towards Mr A, lacked compassion and appropriate training and did not understand that Mr A was in pain. Ms C said following this telephone conversation she immediately went to the Hospital. Ms C said that on her arrival she witnessed a member of the nursing staff arguing with Mr A. Ms C also said that Mr A told her that he had decided to discharge himself so he could receive the medication he needed and as he felt he was not receiving care and treatment.

30. Ms C said that Mr A's experience in the Hospital had caused him great distress and upset and she felt Mr A's subsequent days before he died were 'blighted' as a result.

*The Board's response*

31. The Board said that Ms C's concerns about the care provided to Mr A and the conduct of the nursing staff in the MAU had been discussed with staff involved. This included obtaining written statements from two members of the nursing staff, copies of which were supplied to my office by the Board. According to the Board, on Mr A's arrival in the MAU at 21:00 he had asked for pain medication. However, nursing staff were not able to dispense pain medication at that time because this had not been prescribed by medical staff. Nursing staff had requested an urgent medical review and following an examination and assessment of Mr A pain relief was given to him at 23:10.

32. The Board said that nursing staff could not dispense the medication that Mr A had brought with him into the Hospital as these medications were not labelled. According to the Board, nursing staff asked Mr A to administer the medication he had brought with him but he did not wish to do so and he refused medication from the Hospital's own stock. Unfortunately, this had resulted in Mr A not receiving pain relief.

33. The Board stated they appreciated this was a particularly stressful time for Mr A and also for Ms C and they were sincerely sorry that their experience was so upsetting for them both. However, the Board said they had to adhere at all times to the Nursing and Midwifery Council (NMC) Standards for medicines management and NHS Borders Code of Practice for the Control of Medicines. According to the Board, both of these policies state that medications must be prescribed by an authorised prescriber before they can be dispensed and given to patients by nursing staff. In addition, dispensing and administration of any controlled medicines, such as morphine, are subject to stringent standards, they must be stored in a locked cabinet and they must be checked and dispensed by two registered nurses. The Board said that for these reasons it was not possible to store a patient's own controlled drugs at their bedside and were instead stored and dispensed from the ward controlled drugs cupboard.

*Nursing advice*

34. The Nursing Adviser noted that Mr A came into the Hospital because he was in severe pain and had a nose bleed and he knew he had terminal cancer. The Nursing Adviser told my complaints reviewer that priority must be given to relieving a patient's pain and distress.

35. The Nursing Adviser noted that Mr A was given intravenous morphine (a strong opiate painkiller) at 18:25 while he was in ED. Mr A was transferred to the MAU around 21:00 when his vital signs were recorded (and then again during the night at 02:00 and 06:00). At 21:20 a member of the nursing staff nurse had recorded that a doctor had been asked to review Mr A as soon as possible for pain control and that Mr A's pain score was recorded as 7/10.

36. The Nursing Adviser said that at 22:00 Mr A had self-administered the medication he had brought with him with the exception of his regular dose of oramorph, oral morphine, which was withheld by a member of the nursing staff. The Nursing Adviser told me that the nurse recognised Mr A was in pain as she had recorded Mr A had a pain score of 7/10 and had asked for an urgent

medical review. Therefore, according to the Nursing Adviser, the nurse concerned should have at that time allowed Mr A to have his own oral morphine medicine. The Nursing Adviser told my complaints reviewer that the reason for withholding Mr A's planned dose of oramorph had not been recorded in his records and she could not understand why this action was taken.

37. The Nursing Adviser explained that NMC Standards for medicines management are clear on this matter and state:

> 'Standard 5: Patient's own medicines
>
> 1 Registrants [nurses] may use patients' own medicines in accordance with the guidance in this booklet Standards for medicines management.
>
> 4 These medicinal products including controlled drugs remain the patient's property and must not be removed from the patient without their permission and must only be used for that named individual.'

38. The Nursing Adviser considered that Mr A should have been allowed to self-administer his oramorph along with the other drugs at 22:00. If this had been done his pain may well have been relieved.

39. The Nursing Adviser noted that at 23:10 Mr A was eventually given five milligrams of intravenous morphine. While at 5:40 it was recorded that Mr A required morphine for back pain, the Nursing Adviser said no further pain medication appeared to have been given to Mr A until 08:00.

40. The Nursing Adviser also noted that while Mr A's vital signs were checked every four hours, which was reasonable, there was no further pain assessment of Mr A during the night and she questioned why pain relief was not included in the Standard Early Warning System (SEWS) chart, which is a patient observation chart. The Nursing Adviser was of the view that the lack of any assessment/scoring of Mr A's pain after his admission to the MAU showed that nursing staff had failed in their duty to appropriately assess, monitor and alleviate Mr A's pain. The Nursing Adviser told my complaints reviewer she considered this was very poor practice, particularly in a medical admissions unit and with a patient who came into hospital because of being in pain. Accordingly, the Nursing Adviser said this aspect of Mr A's nursing care was unreasonable and unacceptable. The Nursing Adviser also considered it must

have been frustrating for Mr A to have been in severe pain and for the pain not to be relieved despite him having his own pain relief medicines with him.

41. The Nursing Adviser also considered the response by both the nurse who withheld Mr A's oramorph at 22:00 on 10 September 2014 and the nurses who attended Mr A the following morning were lacking in compassion. In the view of the Nursing Adviser the nurses concerned did not seem to take into account that Mr A was terminally ill and probably very distressed. In the view of the Nursing Adviser the statements provided by the Board from these nursing staff concerning what occurred on the morning of 11 September 2014 did not appear to take into account the reasons for Mr A's behaviour.

42. Furthermore, the Nursing Adviser considered that the nurses who attended Mr A, on the morning of 11 September 2014 did not appear to have the insight to ask for support from a more senior colleague about Mr A, who at the time was obviously very distressed and which had manifested as anger, in order to talk through the issues and perhaps find a solution. In the view, of the Nursing Adviser, the nurses concerned should have escalated Mr A's concerns to a more senior member of staff.

43. The Nursing Adviser said she was concerned that Mr A who was dying had such a poor experience in the Hospital which had resulted in a very distressing and painful experience for Mr A and Ms C.

44. The Nursing Adviser considered that, overall, the nursing care which Mr A received in the MAU was unacceptable and poor practice. The Nursing Adviser told my complaints reviewer this may have been due to staff inexperience and/or lack of support or training. The Nursing Adviser also told my complaints reviewer that the Board should, therefore, consider implementing learning and development training in early resolution for front line nursing staff in the MAU to identify ways for them to escalate issues to more senior staff and ensuring they have enough support when difficulties arise.

45. The Nursing Adviser also told my complaints reviewer that the Board should reflect again on Ms C's complaint, by reviewing what went wrong and what learning has taken place. The Nursing Adviser questioned if the nursing staff concerned in Mr A's care had an opportunity to reflect on what had occurred and whether they had considered their learning from this. This included withholding the oramorph from Mr A on the evening of

10 September 2014, why it appeared from a review of the Mr A's records that he received no further pain killers after 23:10 on 10 September 2014; why no further dose of morphine appeared to have been given to Mr A at 05:00 the next morning, although, it had been recorded that Mr A had requested pain relief at this time, and the apparent lack of compassion shown by nursing staff to Mr A on both 10 and 11 September 2014. This was all, in the view of the Nursing Adviser, unacceptable and poor practice.

46. The Nursing Adviser considered the Board should reflect on Mr A's experience by carrying out a review of nursing in the MAU to explore the leadership and culture within the ward. In addition, any review should also include pain assessment and monitoring of patients in the Hospital and, in particular, in the MAU as this is an important part of any patient's care in hospital.

47. The Nursing Adviser also noted that in the Board's written response to Ms C following her complaint had stated that Mr A requested pain medication on his arrival at the MAU at 21:00 on 10 September 2014 but nursing staff were unable to dispense Mr A's pain medication at the time as they were 'not clearly labelled' but had asked Mr A to 'administer' his own medication. The Nursing Adviser told my complaints reviewer that this incident related to an entry in Mr A's records made at 09:00 on 11 September 2014, and not the previous evening as implied in the response letter. The Nursing Adviser considered the Board's response to the complaint on this matter was wrong and misleading.

**(b) Decision**

48. The nursing advice I have received has identified a number of serious failings in Mr A's nursing care and that, overall, the nursing care Mr A received in the MAU was unacceptable and poor practice. Furthermore, that nursing staff did not appear to have followed NMC Standards in relation to the prescribing of pain relief medication to Mr A. I am critical of the Board for the failings identified. Furthermore, I am concerned there was a lack of compassion shown to Mr A, who was terminally ill, and that he had such a painful and distressing experience which in the words of his partner, Ms C, had 'blighted' the days before he died. I also acknowledge the upset and distress this has caused to Ms C.

49. Therefore, I uphold this complaint and make the following recommendations.

**(b) Recommendations**

| 50. I recommend that the Board: | *Completion date* |
|---|---|
| (i) reflect again on Ms C's complaint by reviewing what went wrong and what learning has taken place; | 18 January 2016 |
| (ii) consider implementing learning and development training in early resolution of concerns and complaints for front line nursing staff in the MAU; | 18 January 2016 |
| (iii) carry out a review of nursing in the MAU to explore the leadership and culture within the ward; to include a review of pain assessment and monitoring of patients in the Hospital and, in particular; in the MAU; and | 18 January 2016 |
| (iv) apologise to Ms C for the failings identified in Mr A's nursing care and treatment. | 18 December 2015 |

51. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

**Annex 1**

## Explanation of abbreviations used

| | |
|---|---|
| Ms C | the complainant |
| Mr A | Ms C's partner and the subject of the report |
| the Hospital | Borders General Hospital |
| the Medical Adviser | the Ombudsman's medical adviser |
| the Nursing Adviser | the Ombudsman's nursing adviser |
| the Board | Borders NHS Board |
| ED | the Emergency Department of Borders General Hospital |
| the MAU | the Medical Assessment Unit of Borders General Hospital |
| NMC | the Nursing and Midwifery Council |

**Annex 2**

## Glossary of terms

| | |
|---|---|
| dosette box | a pill organiser |
| faecal loading | a large amount of faeces building up in the bowel |
| gabapentin | a medicine used to treat pain |
| ischaemic heart disease | a condition that affects the supply of blood to the heart |
| morphine | a strong opiate painkiller |
| oramorph | a medicine containing morphine |
| paracetomol | a medicine used to treat pain |
| pulmonary fibrosis | a lung condition |
| ulcerative colitis | a form of inflammatory bowel disease |
| zomorph | a medicine containing morphine |

**Annex 3**

## List of legislation and policies considered

NHS Borders Code of Practice for the Control of Medicines

Nursing and Midwifery Council (NMC) Standards for medicines management