Scottish Parliament Region: North East Scotland

Case 200500578: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; Palliative Care

Overview

The complainant (Mr C) raised concerns about the failure by Inverurie Hospital (the Hospital) to admit his wife to a palliative care suite.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) staff failed to communicate effectively with Mrs C's GP prior to transfer *(upheld);*

(b) staff made ineffective use of the palliative care suite *(not upheld)*;

(c) staff failed to communicate effectively with Mrs C's family *(no finding);* and

(d) the nursing records failed to comply with the regulations *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologises to the family for their communication failures; and

(ii) provides evidence to show the new documentation tool has been audited to demonstrate that nursing records adhere to minimum standards.

Main Investigation Report

Introduction

1. On 27 May 2005 the Ombudsman received a complaint from a man referred to in this report as Mr C that his wife (Mrs C) had failed to be admitted to palliative care suite as had been agreed with her GP. This had been distressing for the family and meant that only one member of the family was with her when she died.

2. Mr C complained that his wife, who had been suffering from advanced cancer, had been admitted to Inverurie Hospital (the hospital) to treat her symptoms of constipation on the basis that she would be admitted to the palliative care suite. This would have allowed the district nurse time to arrange a homecare package to enable Mrs C to die at home. Instead, she had been admitted to the general ward, which had been distressing for the family and other patients as Mrs C had been in pain and distress. Only one member of the family had been allowed to stay with Mrs C outwith visiting hours and she died later that afternoon.

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

(a) staff failed to communicate effectively with Mrs C's GP prior to her transfer;
(b) staff made ineffective use of the palliative care suite; and
(c) staff failed to communicate effectively with Mrs C's family.

As the investigation progressed, I identified issues concerning the nursing records. I, therefore, informed Grampian NHS Board (the Board) and Mr C that the investigation would additionally consider whether:

(d) the nursing records failed to comply with the regulations.

Investigation

4. In writing this report I have had access to the complaint and documents provided by Mr C, Mrs C's clinical records covering the period of the complaint and the correspondence relating to the complaint from the Board. I have obtained advice from an Independent Professional Adviser to the Ombudsman on the nursing and record-keeping aspects of this complaint (the Adviser).

5. The Nursing and Midwifery Council Guidelines for Records and Record Keeping (2005) (the guidelines) were also reviewed. These state that nursing

records should be able to demonstrate 'a full account of your assessment and the care you have planned and delivered' and 'relevant information about the condition of the patient at any given time and the measures you have taken to respond to their needs'. Also, 'recordkeeping is an integral part of nursing, midwifery and community specialist nursing practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and is not an optional extra to be fitted in if circumstances allow'.

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

(a) Staff failed to communicate effectively with Mrs C's GP prior to transfer

7. On 16 October 2004, the family made a formal complaint to the Board that despite making arrangements with Mrs C's GP (the GP) to admit her to the palliative care suite, staff had admitted her to the general ward.

8. The Board responded that Nurse 1 had told the GP the suite was empty but another patient was due to be admitted two days later and each individual patient is assessed on admission.

9. The Adviser said the GP's records clearly show his understanding that Mrs C was going to the suite on her admission to hospital. This was not the case, which caused distress for Mrs C and her family. Nor does it appear from the GP's records or the statements[1] from the relevant medical staff that he had been informed by medical staff of their decision not to place Mrs C in the suite. Nurse 1's statement of her telephone call with the GP, prior to Mrs C's transfer, records her agreement to admit Mrs C but not that her placement in the suite was in question. The record by Nurse 1 on Mrs C's admission states 'emergency admission via [GP] for palliative care'.

(a) Conclusion

10. Notwithstanding the difficulties in determining exactly what was said, the evidence shows that on the balance of probability Nurse 1 had failed to communicate the position to the GP. Accordingly, I uphold the complaint. The Adviser said that information provided to GP's is sometimes different from the

[1] These statements were obtained as part of the Board's investigation into the complaint.

actual service that can be offered to patients once they arrive in hospital, which can lead to upset and complaints from patients and their relatives. Effective communication is essential to avoid this. However, in response to the family's second complaint to the Board (see paragraphs 12-14), the Board has written an admission of protocol regarding the use and function of the pallaitive care suite and circulated it to all general practitioners within their catchment area. I am satisfied the Board's action on that matter will help to improve communication and prevent this situation arising again.

(a) Recommendation

11. Although I am satisfied with the remedial action taken by the Board, I recommend they formally apologise to the family for the distress caused by their communication failures.

(b) Staff made ineffective use of the palliative care suite

12. The family complained to the Board that Mrs C had not been placed in the suite despite its availability when she was admitted to hospital.

13. The Board responded that the normal procedure was for the on duty staff nurse to assess each patient on admission and make a decision to place them in the suite on the basis of priority of need. When Mrs C had been admitted to hospital, the suite had been booked for another patient for two days later and Nurse 1 did not believe it would have been fair to have moved Mrs C out of the suite after two days. However, the Board admitted that Mrs C could have been moved to the suite temporarily.

(b) Conclusion

14. I can understand the frustration and distress of Mrs C's family when she was not placed in the suite despite its availability for at least two days. The Board should have placed Mrs C in the suite on a temporary basis and reassessed the situation when the next patient was due. In the event, Mrs C had died the same day so this would have allowed her family time in private. However, when the family raised their concerns, the Board wrote the protocol and disseminated it to staff, which should ensure the suite is used more effectively in the future. I am satisfied that the Board dealt with this issue prior to the complaint to the Ombudsman's office and took appropriate remedial action. For that reason I do not uphold this aspect of the complaint. Had remedial action not been taken it is likely that I would have upheld the complaint.

(c) Staff failed to communicate effectively with Mrs C's family

15. The family complained to the Board that several members of staff had told the family different accounts of the position of the suite.

16. Given the Board's response to the family's complaints were made largely during meetings with them, it is difficult to find a written record of the Board's position on this complaint. However, following one of the meetings, the Board wrote to the family saying staff should, through discussions with relatives, agree an amicable and sensible interim use of the suite and should achieve better outcomes through improved communication and dialogue with relatives.

(c) Conclusion

17. Assessing the communication between the family and the staff is problematic given the passage of time since the event and the difficulty in corroborating an oral account by either the family or the staff. The nursing records do not record any communication with Mrs C's family (see paragraph 18) although the Board seem to have accepted implicitly that there had been communication difficulties by referring to 'improved communication'. However, there is insufficient evidence to suggest that on the balance of probability there had been communication failures between staff and the family. I am, therefore, unable to make a finding on this aspect of the complaint. However, I am concerned about the Board's recordkeeping. I deal with this issue below (complaint (d)) and make a recommendation which addresses the failures identified in this aspect of the complaint (see paragraph 22).

(d) The nursing records failed to comply with the regulations

18. The Adviser has criticised the brevity of the nursing records. They consist of a 'Patient Profile' which does not indicate arrangements for visiting or whether Mrs C's family wanted to be contacted at any time if necessary. These should have been completed given the seriousness of Mrs C's condition. A full nursing care assessment should have been carried out with a Care Plan relating to Mrs C's terminal illness, pain needs, constipation and anxiety. The nursing progress notes consisted only of two entries, one on admission and the second to record her time of death. Although it is clear that Mrs C had been very unwell on admission, there are no records of her continuing decline during the shift. Nor is there a record of any communication with her family despite their discussions with staff about their unhappiness with the admission arrangements. Although Mrs C was not on the ward for any length of time, a

more in-depth record for nursing needs and care should have been carried out and documented as well as a record of communication with her family.

19. In response to enquiries about the nursing records, the Board said staff levels at that time had been reduced due to sickness although bank replacement had given some support. Other ward activity and casualty activity sometimes had an impact on documentation and record-keeping. Nursing staff commitment to patient care often overrode attention to records although they were fully aware of the importance of documentation. Documentation was often completed at the end of a shift on staff time. The skill mix in the ward had been changed in that an additional trained nurse had been introduced during evening shifts. Following a recent staff review, a 12 hour shift system had been implemented to improve patient care and allow more time for administration. However, the Adviser has said the Board's explanation regarding the lack of record-keeping is not acceptable and is specifically deemed as unacceptable in the guidelines.

20. I also requested the results of a documentation audit undertaken in July 2004, prior to the introduction of the new tool in January 2005. However, the Adviser said the results identified some problem areas, but that the new tool had not yet been subject to audit, which the Adviser would have expected.

(d) Conclusion

21. It is clear from the Adviser's comments that the nursing records did not comply with the guidelines. I am not satisfied with the Board's explanation as to why this happened. I uphold the complaint.

(d) Recommendation

22. The Ombudsman recommends that the Board should provide evidence that the new tool has been submitted to scrutiny via audit, and that the problems identified in the 2004 audit of the old documentation tool have been addressed and improved upon so that assurances can be given to the Ombudsman's office that nursing records adhere to the minimum standards required by the guidelines.

23 May 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	The complainant's wife
The Hospital	Inverurie Hospital
The Board	Grampian NHS Board
The Adviser	An adviser to the Ombudsman
The GP	General practitioner in Aberdeenshire
Nurse 1	The nurse who arranged Mrs C's admission to hospital

Annex 2

List of legislation and policies considered

Nursing and Midwifery Council Guidelines for Records and Record Keeping (2005)