Scottish Parliament Region: North East Scotland

Case 200503444: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C) raised a number of concerns about the care of her father (Mr A). She complained about aspects of Mr A's nursing care and also the amount of medication which he was given.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) management of Mr A's catheter was poor (*upheld*);

(b) nursing staff did not adequately monitor Mr A (*not upheld*);

(c) contradictory reasons were given for the bruising on Mr A's forehead (*not upheld*); and

(d) the quantity of drugs given to Mr A was excessive (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board apologise to Mr A's family for their failure to adequately manage Mr A's catheter and for the distress which this caused to Mr A and his family.

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

Main Investigation Report

Introduction

1. Mrs C complained about the care received by her late father, Mr A, in Ninewells Hospital (the Hospital). Mr A had Chronic Obstructive Pulmonary Disease (COPD). He was admitted to the Hospital on 13 September 2005. He had recently lost a great deal of weight and had no appetite. He also had been constipated for some time. During his stay in the Hospital, Mr A collapsed at the bottom of the stairs outside his ward after leaving his room, unnoticed by staff. Later the same day, Mr A was found dead in his bed. When Mr A's family paid their last respects, they were concerned to note bruises on his forehead.

2. Mrs C's brother (Mr B) complained to Tayside NHS Board (the Board) on 13 September 2005 and met with a Complaints Officer from the Board on 16 September 2005. He raised complaints about the attitude of a member of nursing staff and the delay in catheterising Mr A. He also complained that the low number of nursing staff on the ward had resulted in a failure to adequately supervise Mr A, who wandered from the ward and collapsed at the bottom of the stairs.

3. The Board responded on 24 November 2005. They apologised that the nurse had caused offence during a conversation with Mr B. They explained that Mr A's catheter had become dislodged at 02:00 but was unable to be reinserted at that time due to the doctor being busy. A uridome was applied and a catheter was re-inserted the same evening. They also told Mr B that staff had felt it unlikely that Mr A would have been able to mobilise independently and, therefore, could not have foreseen his fall. They explained that, due to the layout of the ward, all patients cannot be constantly observed. They also informed Mr B that the bruising on Mr A's head may have been caused by his fall.

4. Mrs C complained to the Ombudsman on 10 March 2006.

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

(a) management of Mr A's catheter was poor;
(b) nursing staff did not adequately monitor Mr A;
(c) contradictory reasons were given for the bruising on Mr A's forehead; and
(d) the quantity of drugs given to Mr A was excessive.

Investigation

6. During the course of this investigation, I have reviewed the correspondence between Mr B and the Board as well as the Board's complaints file on this matter. I have discussed the events with Mrs C, obtained copies of Mr A's medical records from the Board and have asked both a nursing adviser (the Nursing Adviser) and a medical adviser (the Medical Adviser) to review these and advise me on Mrs C's complaints.

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

(a) Management of Mr A's catheter was poor

8. Mrs C explained that, on one occasion when the family visited Mr A, they were told that he had pulled his catheter out at 03:00. She told me that Mr A was still without catheter in the evening and that his pyjamas and socks were saturated with urine. A nurse told them that the catheter had to be reinserted by a specialist nurse and none was available. Mr A told his family that the catheter had not been reinserted for several hours after they left.

9. In their response to Mr B, the Board explained that Mr A's catheter had become dislodged at 02:00 on 22 September 2005 but was unable to be reinserted due to the doctor on call dealing with another patient. They stated that a uridome was applied and the catheter was reinserted in the evening and drained good volumes thereafter. They stated that, if there had been any indication that Mr A had been in any discomfort during the time in which the catheter was not in situ, then medical staff would have reinserted it at an earlier time.

10. Mr A's nursing notes indicate that he pulled out his catheter at 02:00 and that a uridome was applied. The Doctor on call was advised to re-catheterise but he was very busy with another patient at the time. The notes do not indicate whether or not Mr A was passing urine via the uridome but indicate that Mr A was re-catheterised at 18:00. The Board informed me that verbal information provided by staff indicated that Mr A was passing urine via the uridome. The Nursing Adviser informed me that she would have expected more fluid charts in Mr A's notes, especially as Mr A was on IV fluids. She stated that the fluid charts in Mr A's medical notes are insufficient and have not recorded the necessary information to determine whether urine was being passed.

11. In her comments on the draft version of this report, Mrs C informed me that Mr A had told her that he was not re-catheterised before 20:00 and that she considers that Mr A's nursing notes are inaccurate. In these circumstances, it is not possible to determine the exact time when Mr A was re-catheterised.

12. The Nursing Adviser stated that it would be difficult to believe that there was nobody available in a large, acute hospital to catheterise for 16 hours or longer. She also advised that there was no evidence that the decision was to try the uridome as an alternative to prevent the need for further catheterisation. The Nursing Adviser advised that, in these circumstances, she considers a 16 or 18 hour delay too long.

13. The Board accept that the fluid charts in the written records are inadequate and informed me that the Practice Development Team are developing an improvement plan for this. The Board stated that it is not normal practice to allow this time period to pass before re-catheterisation, especially if a patient is complaining of pain or discomfort. The Senior Charge Nurse has confirmed that there was no male registered nurse on duty that evening but that it is unlikely that in an acute hospital setting, there was no other individual available with this skill.

14. The Board's clinical skills education pack on catheterisation was reviewed by the Nursing Adviser and she commended the Board for the quality of this material. The Board informed me that the pack enables them to provide education to Registered Nurses and to reduce reliance on male staff undertaking this procedure. In addition, the Urology Specialist Nurses provide educational sessions, including simulated practice. This includes monitoring patients following removal of the catheter and emphasises the importance of understanding why the catheter was inserted, maintaining accurate records of urinary output, ongoing monitoring of the patient for pain or discomfort and follow up assessment if the patient has not voided urine within 4-6 hours. Furthermore, as of August 2006, the Hospital at Night Model was introduced to the Hospital. In essence this means that 'out-of-hours' there is now a Senior Nurse Co-ordinator with responsibility to filter and prioritise all requests for assistance or medical input. The Hospital at Night Senior Nurse Co-ordinator and practitioners all have advanced clinical skills and core clinical skills, one of which is catheterisation for male and female patients.

15. The Nursing Adviser has reviewed the points of improvement in the Board's plan and advised that these are appropriate.

(a) Conclusion

16. Mrs C stated that Mr A was incontinent. There is no indication, in his medical records, that Mr A was continent with the uridome in situ and it is difficult to assess his progress due to the lack of records, especially fluid charts. It appears that the uridome was applied as a temporary measure pending Mr A's re-catheterisation. Although the doctor on call was contacted to re-catheterise Mr A there is no evidence that, during the 16 or 18 hours when he was not catheterised, any attempt was made to find another member of staff who could have carried out the procedure. Although the Board have told me that Mr A was passing urine via the uridome, there was no evidence to back this up. The Nursing Adviser stated that the delay before re-catheterisation was too long and, in these circumstances, I uphold this complaint.

(a) Recommendation

17. The Board have already taken extensive action to improve their practices around catheterisation. The Nursing Adviser considered that the action taken by the Board was appropriate and should help to prevent similar problems recurring in the future. She also praised the quality of the Board's catheterisation education programme. I commend the Board for taking this action. Nonetheless, the Board failed to recognise during their complaints process, that their management of Mr A's catheter had been inadequate. The Ombudsman recommends that the Board apologise to Mr A's family for their failure to adequately manage Mr A's catheter and for the distress that this caused to Mr A and his family.

(b) Nursing staff did not adequately monitor Mr A

18. Mrs C complained that inadequate monitoring by nursing staff made it possible for Mr A, who was in a frail condition and connected to oxygen and a catheter, to make his way out of the ward and down several flights of stairs where he was later found in an unresponsive state.

19. According to his medical records, in the early hours of 28 September 2005, Mr A, who had earlier been exhibiting some confusion, wandered from his bed and was found sitting at the bottom of a flight of stairs outside the ward.

20. The ward contains 30 beds and is acute and busy. There were four members of staff on duty at the time the incident occurred, two registered nurses and two assistants. This is within the appropriate staffing levels for the ward, which have been reviewed by the Nursing Adviser. Mr A probably wandered from the ward sometime around 05:30 and the Nursing Adviser has commented that staff are often busy at this time delivering care to patients.

21. The Nursing Adviser commented that she could fully understand why staff could not anticipate that Mr A would be capable of this level of unassisted activity due to his frailty and medical conditions. She advised that the level of monitoring was adequate and that it would not have been possible for staff to deliver on the family's expectations. She explained that it is difficult to ensure patient safety at all times and that, no matter how frequently it is planned to observe a patient, there will be times when the patient is unobserved.

22. The Medical Adviser also commented that it is certainly possible, and seen frequently in his professional experience, that even a confused, frail and ill elderly person can summon up the strength against all odds to climb out of bed despite being tethered to a catheter and oxygen mask, and manage to walk some distance including negotiating stairs. The Medical Adviser stated that the combination of this effort and subsequent lack of oxygenation would almost certainly have caused Mr A's collapse, however, that Mr A's action could not have been predicted and, therefore, to have provided constant observation by nurses would have been unrealistic. He advised that tragic and concerning though this event undoubtedly was, he does not think blame can be levelled at nursing staff, who frequently observed Mr A.

(b) Conclusion

23. The Nursing and Medical Advisers both stated that it would not have been possible to anticipate this incident and that the level of nursing supervision was adequate. I, therefore, do not uphold this complaint.

(c) Contradictory reasons were given for the bruising on Mr A's forehead

24. Mrs C explained that Mr B and their mother (Mrs A) had visited Mr A on the afternoon before his death. At this time there was no bruising on Mr A's forehead. After Mr A's death, when Mrs A and Mr B visited to pay their last respects, they noticed bruising on his forehead. Mrs C told me that a nurse had advised her that the bruising on Mr A's head was caused by his fall, yet she was

advised by another member of staff that the bruising was caused by Mr A hitting his head on the cot sides.

25. The Nursing Adviser stated that it would be difficult to be absolutely certain of the cause of bruising but that it was more likely that it had been caused by the cot sides. There is no evidence that Mr A actually fell, as the notes record that he was found 'sitting on the stairs' and that it was 'unlikely the patient has had a fall as there are no obvious injuries'. The Nursing Adviser explained that, if the bruising had happened during the incident on the stairs, it would most likely have been visible when Mr B and Mrs A visited on the afternoon after the incident.

26. The contemporaneous nursing records for 28 September 2005 record that a nurse (Nurse 1) discussed the bruising on Mr A's forehead with Mr B and explained that Mr A's head was against the cot side when he had found Mr A. Mr B and Mrs A had also spoken to the Senior Charge Nurse (Nurse 2) and this conversation is recorded in Mr A's nursing records. Nurse 2 recorded that she had explained to the family that Mr A was lying against the cot side when he had died and that this was the presumed cause of the bruise as it had not been present earlier. There is also the record of a telephone conversation with Mrs C which states that a nurse explained that, as far as she was aware, Mr A must have hit his head on the cot sides. The medical notes later also record that Mr A's head injury was consistent with damage from the cot sides.

27. In the Board's response to Mr B's complaint, they stated that the bruising to Mr A's forehead may have been caused by his fall. It is unclear why the Board responded in this way.

(c) Conclusion

28. The family were apparently given different explanations for the bruising on Mr A's forehead. Mr A's nursing notes clearly record that his family were told on several occasions that the bruising on his forehead was most probably due to the fact that he was found with his head against the cot sides. The Nursing and Medical Adviser both agree that this was the most probable cause of the bruising. It is not, however, possible to determine conclusively what the cause of the bruising was and this was also the case for clinical staff. This is the most probable reason why the family were given two different reasons for the bruising. I cannot find any fault in this fact and, therefore, do not uphold this complaint.

(d) The quantity of drugs given to Mr A was excessive

29. Mrs C told me that Mr A was alert when he was first admitted to the Hospital but that he became increasingly confused during his stay. Mrs C explained that it was her opinion that Mr A was given too many drugs which made him sleepy and confused.

30. Mr A's records do not indicate that he had cognitive or memory impairment prior to admission to the Hospital. Neither medical nor nursing notes on his admission indicated that he was confused at that stage. The Medical Adviser stated that he might have expected Mr A to be confused when his breathing was bad because of low oxygenation or CO_2 retention. Mr A was not recorded as being confused on 18 September 2005 at 06:30 when his oxygen saturation fell. Mr A was also given dihydrocodeine for pain. The Medical Adviser has stated that this can cause confusion in older people. The daily nursing records suggest that Mr A tolerated the oxygen mask well and was not confused. It was not until 24 September 2005 that Mrs C noticed that Mr A was confused for the first time. There are no records of the confusion until the evening of 27 September 2005, when Mr A's condition had clearly deteriorated and he was suffering from swollen ankles and an abnormal D-dimer blood result, raising the possibility of pulmonary embolism. Mr A was, therefore, given heparin and frusemide. He was later reported as sitting confusedly on his bed. Some hours later, it appeared he climbed unobserved out of bed over the cot sides and was found collapsed on the stairs outside the ward. He had been given his usual dose of lorazepam at 22:00.

31. Mrs C complained that her father had also been given morphine and that this had made him more confused. Morphine was ordered by the doctor on 27 September 2005 and was prescribed to be administered at a dose of 5mg over two hours. The Nursing Adviser advised that this was reasonable. She explained that the morphine may have contributed to Mr A's confusion but that the dosage was not excessive. Furthermore, Mrs C reported that Mr A had been confused from the 24 September 2005 before he was given morphine.

32. The Medical Adviser advised that the confusion Mr A exhibited that evening was almost certainly due to the onset of heart failure, which was treated with appropriate medication, and not due to any other, or inappropriate, medication.

(d) Conclusion

33. The Medical Adviser advised that Mr A was given appropriate medication and that his confusion was almost certainly due to the onset of heart failure. The Nursing Adviser has also reviewed the medication and specifically the morphine prescribed and advised that this was appropriate. I, therefore, do not uphold this complaint.

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

22 August 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant, Mr A's daughter
Mr A	The aggrieved
The Hospital	Ninewells Hospital
COPD	Chronic Obstructive Pulmonary Disease
Mr B	The complainant's brother, Mr A's son
The Board	Tayside NHS Board
The Nursing Adviser	The Ombudsman's nursing adviser
The Medical Adviser	The Ombudsman's medical adviser
Mrs A	Mr A's wife
Nurse 1	A nurse who spoke to Mr A's family about the bruising on his forehead
Nurse 2	A Senior Charge Nurse

Annex 2

Glossary of terms

Catheter	A flexible tube inserted through the urethra into the bladder to drain urine;
Chronic Obstructive Pulmonary Disease (COPD)	An umbrella term for a group of respiratory tract diseases that are characterised by airflow obstruction or limitation;
D-dimer	A blood test performed to diagnose thrombosis;
Dihydrocodeine	A pain relief drug;
Frusemide	A diuretic drug;
Heparin	A drug which helps prevent blood clots from forming;
Lorazepam	A minor tranquiliser used to treat anxiety, tension and insomnia;
Oxygen saturation	The amount of oxygen in the blood;
Pulmonary embolism	A blood clot in the lung;
Uridome	A penile sheath for external urine collection.