Scottish Parliament Region: North East Scotland

Case 200503486: Tayside NHS Board

Summary of Investigation

Category

Health: District Nurses

Overview

The complainant's (Misses C) raised a number of concerns that their late mother (Mrs C) had been inappropriately treated by a district nurse (Nurse 2) at a home visit.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Nurse 2 provided inadequate care and treatment leading to a loss of dignity for Mrs C (*partially upheld*);

(b) there were communication failures between nursing staff *(upheld*); and

(c) Tayside NHS Board had failed to deal with appropriately and investigate thoroughly Misses C's complaint (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 13 March 2006 the Ombudsman received a complaint from two sisters (Misses C) about the treatment that their late mother (Mrs C) received from a district nurse (Nurse 2) on 28 December 2004. Mrs C died on 13 January 2005. In particular Misses C were concerned that Nurse 2 failed to treat Mrs C with dignity, that there had been a lack of communication within the district nurse service and that on complaining to Tayside NHS Board (the Board) they failed to properly investigate the complaint.

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

(a) Nurse 2 provided inadequate care and treatment leading to a loss of dignity for Mrs C;

(b) there were communication failures between nursing staff; and

(c) the Board had failed to deal with appropriately and investigate thoroughly Misses C's complaint.

Investigation

3. The investigation of this complaint has involved reading all the documentation supplied by Misses C, Mrs C's community nursing records and the Boards complaints file. Advice has been obtained from one of the nursing advisers to the Ombudsman (the Adviser). Written and verbal enquiries have been made of the Board.

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

(a) Nurse 2 provided inadequate care and treatment leading to a loss of dignity for Mrs C

5. On the evening of 27 December 2004, NHS 24 arranged for a district nurse (Nurse 1) to attend to Mrs C. Nurse 1 did not have the appropriate dressing and so arranged for another nurse to come the following day. On 28 December 2004, Nurse 2 attended to Mrs C. Misses C have complained about Nurse 2's failure to bring appropriate dressings for Mrs C, the degrading manner in which she applied cream to Mrs C's backside and how Nurse 2 generally treated Mrs C.

6. Misses C have specifically complained that Nurse 2 did not introduce herself to Mrs C on arrival despite the fact that Mrs C was registered blind and could not tell who had entered the room. Misses C complained that throughout the appointment Nurse 2 did not address Mrs C directly. They also complained that Nurse 2 used inappropriate language whilst examining Mrs C, stating that Mrs C was not constipated only that she was 'unable to push it out'.

7. Misses C stated that Nurse 2 left Mrs C exposed and was rough whilst she showed them cuts on Mrs C's backside, making Mrs C physically and emotionally uncomfortable. Misses C have stated that Nurse 2 failed to ensure that Mrs C was positioned comfortably before leaving as other nurses had done.

8. Misses C have stated that Nurse 2 applied diprobase cream to Mrs C's backside by 'slapping' it onto her skin with no regard for the patient's welfare. When questioned by the Board Nurse 2 has strongly denied applying the cream to Mrs C and has maintained that she advised Misses C to keep the area moisturised with diprobase cream.

9. Misses C raised concerns over Nurse 2's general manner towards Mrs C as they felt this was not acceptable from the nursing profession. In their letter of complaint to the Board Misses C stated that their overall impression of the district nurses that had attended to Mrs C was excellent, but that Nurse 2's attitude should have been different and more caring.

10. In a response to a series of questions asked by Misses C, Nurse 2 said (via the Board) that she recognised she did not address Mrs C directly, that she was extremely sorry for this and that she would make every effort in the future to ensure she is aware of the need to address patients directly, as well as addressing members of the family. Regarding the comments made about Mrs C's constipation, Nurse 2 said that she was trying to explain the situation and in no way intended to insult Mrs C. Nurse 2 sincerely apologised if her remarks were perceived as insulting. Nurse 2 has personally apologised (via the Board) for any upset or distress she may have caused the family and stated that it was not her intention to cause any loss of dignity to Mrs C.

11. Additional leadership training for Nurse 2 focusing on self-awareness and communication skills was identified and undertaken.

(a) Conclusion

12. With regards to the application of the cream it is clear that the parties present strongly disagree over what happened. Misses C are adamant that Nurse 2 applied the cream. Nurse 2 strongly denies this. The community nursing records do not indicate that Nurse 2 applied the cream herself. Without an independent witness to the event, I am unable to make any conclusion about this matter.

13. I am of the view that any failings on Nurse 2's part had been identified and dealt with by the Board appropriately, before the complaint was made to the Ombudsman. I commend the Board for taking the issue seriously and for ensuring that appropriate training was given to Nurse 2.

14. Nonetheless Nurse 2 has accepted that her lack of direct communication caused Mrs C to experience a loss of dignity and has apologised (via the Board) for any distress caused to Mrs C and Misses C. I, therefore, partially uphold this aspect of the complaint.

(b) There were communication failures between nursing staff

15. Misses C also complained about communication failures between the nursing staff, specifically whether Nurse 2 had been told before her visit that particular dressings were required for Mrs C. Misses C also raised concerns about the failure of Nurse 2 to advise them that she would not be attending to Mrs C until later on in the day.

16. Misses C said Nurse 2 should have telephoned them following their calls to NHS 24 to advise that she would be visiting later that day. They also said that Nurse 2 should have been aware of the dressings required for Mrs C and should have brought these with her.

17. During their investigation of the complaints, the Board ascertained that Nurse 1 did not pass the message to Nurse 2 directly, as she left the message for the day staff to review Mrs C's dressings, but did not specify a dressing. Therefore, Nurse 2 did not bring the specific dressing. In addition, Nurse 2 specifically told Misses C that she did not believe the dressings were appropriate for Mrs C's sores and would not have used them anyway. Nurse 2 recommended that the area be kept clean and moisturised with diprobase cream.

18. A Significant Events Analysis (SEA) was conducted on 28 June 2005 about the incident. The purpose of the SEA was to reflect and learn from the event. A detailed action plan was produced following the SEA.

19. The SEA set out the following events. NHS 24 contacted Perth City Evening Service by telephone to attend to Mrs C to asses her dressing needs, following a telephone call from Misses C to state that they had run out of the required dressing. A visit by Nurse 1 was carried out on the evening of 27 December 2004; however, she had been unable to obtain the specific dressing before visiting. The documentation that was completed stated that a referral would be made to the day staff to visit Mrs C the following day, however, no time was specified.

20. Perth City Evening Service tried to leave a message for the day staff but their mobile telephones were switched off and a message could not be left on the base telephone answering machine as it was a public holiday. Perth City Evening Service left a message the following morning with a day service district nurse and this message was passed to Nurse 2 to arrange a visit.

21. Subsequently Nurse 2 visited later that day. However, Misses C had already contacted NHS 24 again earlier on 28 December 2004 to request a district nurse visit.

22. Arising out of the SEA the following actions were identified. The need to raise patient and carer awareness of the role of the out-of-hour's services and the evening district nurses. Where additional visits are requested by Perth City Evening Service at weekends and public holidays the day staff district nurse should telephone the patient or carer to arrange a suitable time. The day service staff should use their own work mobile telephones on public holidays. All district nurses should record the time of a call from NHS 24, what was required and the time of the visit to the patient on the evaluation sheet of the patient's record. Where verbal telephone advice is given to a patient following referral from NHS 24 then the advice should be properly documented.

(b) Conclusion

23. The district nursing team on duty that day were contacted by the on call nurse requesting that a district nurse visit Mrs C to review her care and her dressing needs. The message left by the team did not specify that a particular dressing was required.

24. Nurse 2 accepted that she could have telephoned Misses C to inform them that she would not be attending to Mrs C until later on that day, and apologised for not keeping them informed. She explained that she had made the decision not to visit Mrs C until later in order that she could spend more time assessing her.

25. Whilst it appears that there were areas of the internal communications between evening and day staff that could be improved on, it is unlikely that Misses C's specific complaint that Nurse 2 failed to bring with her the correct dressing would have been avoided by better communication. This is largely due to the fact that Nurse 2 did not believe the dressing was appropriate for Mrs C's sores and would not have used them anyway.

26. The SEA identified and addressed areas where internal communications could be improved. Whilst I do not think that any of the failures in communication identified at the SEA had any significant impact on Mrs C's treatment, I uphold the complaint, as the procedures for communicating between the evening and day staff during public holidays were lacking.

27. The Ombudsman has no recommendations to make in this case and I commend the Board for taking the necessary action to ensure the problems which were indentified in their investigation do not recur.

(c) The Board had failed to deal with appropriately and investigate thoroughly Misses C's complaint

28. Misses C made a verbal complaint to the Board on 31 January 2005 about Nurse 2's attitude and treatment of Mrs C. This was discussed between Nurse 2 and Nurse 2's line manager (the Community Nurse Manager) on the same day. On 2 February 2005, the Board also spoke to Nurse 1 about the information that was relayed following her visit on 27 December 2004.

29. Misses C initially made their complaints verbally to the Community Nurse Manager. On 8 February 2005, Misses C met with the Community Nurse Manager and the Head of nursing and public health in Perth to discuss their concerns.

30. On 25 February 2005, Misses C made a formal written complaint to the Board detailing their concerns. On 10 March 2005, Misses C met again with the

Community Nurse Manager and the Head of Nursing and Public Health in Perth to discuss their formal complaint and the possibility of an SEA.

31. On 23 March 2005, the Board responded to the complaint. The Board offered an unreserved apology that Misses C had felt the standard of nursing care was unacceptable. They assured Misses C that their concerns had been thoroughly investigated and an action plan was enclosed including specific actions to be taken following the issues raised. The Board also stated that the concerns about attitude had been discussed fully between Nurse 2 and the Community Nurse Manager, and that Nurse 2 personally apologised for any distress she may have caused and recognised the need for her to be more aware of how she deals with patients and carers.

32. Following a telephone call from Misses C to the Board's complaints manager a further response was sent on 11 April 2005 restating their apology and explaining how the complaints procedure worked and which members of staff were responsible for investigating. From this response it appears that Misses C felt they were misled as to who would be conducting the investigation. It seems they believed that the Board's complaints manager and/or the Head of Nursing and Public Health in Perth would be handling the investigation directly. It was explained that this task was delegated to the Community Nurse Manager as Nurse 2's line manager.

33. On 12 April 2005, Misses C asked a number of questions in a telephone call to the Board's complaints manager which were responded to on 20 April 2005 by the Head of service, Primary Care Division. Misses C then posed a further 11 questions to be put directly to Nurse 2, which they felt had been raised, but not answered and requested a copy of the notes left by Nurse 1 for Nurse 2 regarding Mrs C. Responses to these questions were sought of Nurse 2 on 18 May 2005. Misses C met again with the Community Nurse Manager, the Head of nursing and public health in Perth and the Board's complaints manager on 19 May 2005 to discuss the answers to the 11 questions. Misses C have stated that they were very disappointed with the way that meeting was conducted, as they were not given a copy of the notes detailing Nurse 2's answers. It also appears that they did not believe the Head of nursing and public health in Perth was familiar with all the points of their complaint, despite the 11 questions.

34. On 21 June 2005 Misses C were provided with a copy of the entries relating to Mrs C in the district nurse diaries. They were also advised that the Community Nurse Manager and the Head of nursing and public health in Perth were both relatively new to their posts at the time the complaint was received and as a consequence had not had the opportunity to familiarise themselves with the practices used at that time, which is why they may have appeared unfamiliar with the complaint.

35. Whilst they were new to their respective posts the Board have stated that both were familiar with the Board's complaints procedures.

36. The Head of service, Primary Care Division, wrote to Misses C on 28 June 2005 stating that he had reviewed all the correspondence and was of the opinion that the complaint had been investigated and addressed in full and advised Misses C to either request an independent review, or approach the Ombudsman's office. This position was reiterated on 4 July 2005 by the Director of nursing.

37. On 27 July 2007, the Director of nursing wrote to Misses C, following a conversation she had had with their local councillor, offering to meet with them to discuss Mrs C's care. They met on 18 August 2005 and the Director of nursing wrote to them on 23 August 2005 apologising for the 'shortcomings' of the staff involved in dealing with their complaint and for the 'poor experience' they had had with Nurse 2. She also explained some of the measures that were to be implemented to ensure patient dignity is maintained, including a training DVD as recommended by Misses C.

38. On 2 November 2005, the Director of nursing wrote to Misses C to update them on the progress of the follow-up work and to advise that she would be attending district nurse meetings to show the DVD and speak about the importance of treating patients and relatives with respect and dignity. She also said she would evaluate these meetings and report back to Misses C.

39. In an email to the Director of nursing dated 2 December 2005, Miss C stated that she was still unhappy with the situation as she thought that the Director of nursing would meet personally with Nurse 2 to establish whether in her professional opinion Nurse 2 was telling the truth. Miss C also said the question of application of the cream was, in her opinion, still not resolved. The Director of nursing responded on 23 December 2005 stating that she was

unable to meet with Nurse 2 personally as she had been advised against this due to Nurse 2 engaging her professional body the Royal College of Nursing (RCN). However, that the Director of nursing was assured that the concerns had been discussed fully with Nurse 2 and that it has had a 'profound' effect on her.

40. The Director of nursing then wrote to Nurse 2 on 6 January 2006 specifically asking whether or not she had applied the diprobase cream to Mrs C. On 6 February 2006 the Director of nursing responded to Misses C stating that Nurse 2 (via the RCN) states that she is clear she did not apply the cream. The Director of nursing concluded that in order to pursue this matter further Misses C would need to approach the Ombudsman's office.

41. On the issue of Nurse 2, the Adviser felt that she has answered all of the questions from her perspective and given an apology in answer to some. Given that she obviously felt very vulnerable having resorted to involving the RCN, the Adviser felt that Nurse 2 was not likely to provide any different answers at this stage. In addition, the Board has said that they will monitor her performance and behaviour and see that she attends the relevant training sessions.

42. It was the Adviser's view that this complaint was taken seriously by the Board and the evidence provided indicates that they have taken the appropriate actions and learnt from the issues raised by Misses C's complaints.

(c) Conclusion

43. Misses C's complaint was that the Board failed to appropriately and thoroughly investigate their complaint. In my view this complaint was taken seriously by the Board and failures were identified and admitted.

44. The Board and Nurse 2 have offered numerous apologies for any upset caused to Mrs C and Misses C. Specific training for Nurse 2 was identified, as was wider training on patient dignity for the district nursing team and student nurses. A SEA was conducted resulting in an action plan. Various meetings were held with Misses C about their complaints. The Director of nursing became involved and met with Misses C and with Nurse 2's managers on several occasions. The Director of nursing apologised for the shortcomings she had indentified in the complaints handling and explained the remedial action that was taken.

45. In the circumstances, the Board acted properly in their handling and investigation of the complaint. The evidence shows that the Board went to great lengths to address Misses C's concerns. The Board responded appropriately to the issues that were raised and took the necessary remedial action where problems were identified. I, therefore, do not uphold this aspect of the complaint.

21 November 2007

Annex 1

Explanation of abbreviations used

Misses C	The complainants
Mrs C	Misses C's mother
Nurse 2	The district nurse that visited Mrs C on 28 December 2004
The Board	Tayside NHS Board
The Adviser	The Ombudsman's nursing adviser
Nurse 1	The district nurse that visited Mrs C on 27 December 2004
SEA	Significant Events Analysis
The Community Nurse Manager	Nurse 2's line manager
Miss C	One of the complainants
RCN	Royal College of Nursing