Case 200500299: Lanarkshire NHS Board

Introduction

1. On 28 April 2005 the Ombudsman received a complaint from a woman (referred to in this report as Mrs C) about the nursing care her late father (Mr C) received at Hairmyres Hospital, East Kilbride (the hospital) in October and November 2004.

2. Mr C was a 71-year-old man who was admitted to the hospital in October 2004 with a history of increasing confusion and decreasing mobility. He had a medical history of diabetes, Alzheimer's disease and had previously suffered a stroke. His family had found it increasingly difficult to cope with him at home. Mr C was initially cared for in the acute admissions unit before being transferred to Ward 9 at the hospital, where he remained for two weeks and was then transferred to a nursing home. He suffered a further stroke and was admitted to another hospital. He died on 2 February 2005.

3. The complaints from Mrs C which I have investigated were that:

(a) nursing staff failed to maintain Mr C's personal hygiene and dignity;

(b) nursing staff failed to ensure Mr C's nutritional needs were met;

(c) nursing staff responded poorly to family concerns; and

(d) the Board's response to Mrs C's complaint was inadequate.

4. Following the investigation of all aspects of this complaint, I came to the following conclusions:

(a) upheld, see paragraph 16;

(b) upheld, see paragraph 23;

(c) upheld, see paragraph 29;

(d) upheld, see paragraph 35.

5. In summary, I uphold fully Mrs C's complaints about the failures in the care which Mr C received; the shortcomings in communication with the family; deficiencies in Mr C's clinical records; and that the Board had provided an inadequate response to the complaints which Mrs C had raised.

6. Specific recommendations the Ombudsman is making resulting from this investigation are that the Board should:

i ensure, as a matter of urgency, that a system of identifying patients at risk, such as the 'red tray' system whereby patients are given food served on a red tray to highlight the need for support in feeding is introduced. This should be implemented on all wards where vulnerable patients may be cared for;

ii explore ways of having individual headphones or some other means of personalising listening to the television available;

iii ensure, as a matter of urgency, that there is a transfer sheet which documents the needs of patients moving between wards in the hospital;

iv explore ways of supporting staff working in acute wards to look after patients with Alzheimer's with confidence;

v issue a formal apology to Mrs C for the failings which have been identified.

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

Investigation and findings of fact

8. The investigation of this complaint has involved reading all the documentation supplied by Mrs C; Mr C's medical records; and the complaint file and conducting interviews.

9. It was felt that, due to the time which had elapsed since the events complained of, an investigation into the substance of the complaint would be unlikely to reveal any further information. I was aware of the ward sister's view of the complaint, however the documentation provided raised concern that the care was inadequate on the ward. I, therefore, decided to investigate the complaint, to review the level of care that patients were receiving. A professional nursing adviser (the adviser) was appointed. The focus of the investigation was to establish, if possible, what had happened while Mr C was a patient and what had changed since then. The adviser's comments are set out in quotes throughout this report. The adviser and I interviewed the ward sister, a senior nurse and the Associate Director of Nursing (ADN). The issues discussed with the staff included staffing, skill mix and ward structure; assessment, planning and evaluation of care; nursing documentation; communication; nutrition; safety; and training and development.

10. I now set out, for each head of Mrs C's complaint, my findings of fact and conclusions. In addition, the investigation identified concerns about other issues such as hospital records and I deal with these from paragraph 35. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board have had the opportunity to comment on a draft of this report.

(a) Nursing staff failed to maintain Mr C's personal hygiene and dignity

11. Mrs C said that prior to the hospital admission her father had been relatively well and was mobile, talkative and continent. However, on the first visit to see him in hospital she found that he had visibly deteriorated and was very weak, barely able to speak, unable to feed himself, incontinent and his right arm was paralysed. At subsequent visits, the family would often find Mr C lying in bed soaked in urine and sweat with the constant struggle of trying to get up. They frequently had to ask for the linen to be changed before the visit could start. They often found him to be unshaven and on occasions lying in bed covered in nothing more than an incontinence pad. The nurses told the family that he was constantly wandering around and they had to put up the bed sides to try and contain him.

12. During the local resolution stage of Mrs C's complaint the Board commented that, although staff do their utmost to attend to each patient on the ward, they cannot provide one-to-one nursing care to patients and it was regretted that Mrs C felt that staff did not do enough for her father. An apology

was given that the family had often found Mr C soaked in urine. While staff try to ensure that patients' needs are attended to, this is often difficult due to other priorities. The ward sister had advised that nursing staff had constantly changed Mr C and they frequently check on patients to ensure that they are comfortable. It was also mentioned that Mr C frequently undressed himself and this would appear to be the reason he was found with only an incontinence pad on. There was also an occasion when a staff nurse recalled that no hospital pyjamas were available and she could find no clean pyjamas in his locker so Mr C had to wear a gown until the family arrived with clean pyjamas.

13. It was also explained that the reason Mr C was frequently unshaven was that he was often confused and agitated; also that it was difficult to work with him and this would appear to be the reason he was left unshaven.

14. *Adviser's comments*

'Whilst Mr C was a patient in Ward 9, he was frequently confused along with this he displayed symptoms of his Alzheimer's disease. There were major issues of inability to communicate with him and the staff found it increasingly difficult to maintain his dignity. As he suffered from urinary incontinence they felt it was necessary for him to wear an incontinence pad. This he frequently removed, he was then incontinent in his bed and relatives would find him this way when they visited. He was nursed in a four-bedded bay, which contributed to the lack of privacy/dignity afforded to him. There was also a failure on the part of nursing staff to ensure that Mr C was supported in his daily hygiene needs such as shaving him on a regular basis and ensuring that all of his hygiene needs were met. The family had also complained of the television blaring aloud with no-one listening to it and felt it contributed to Mr C's confusion. The staff interviewed acknowledged that there could have been much better communication with the family relating to Mr C and sought their help and support in caring for him.'

15. *Staff response at interview*

'The Board has recognised the failure in care and have reinforced with all nursing staff the need to approach the relatives of patients who are confused or mentally ill and discuss the ongoing problem there may be with maintaining the patient's dignity. This would then be clearly documented in the clinical record. New clinical

documentation sheets will support staff in identifying patient needs.'

Nursing staff failed to maintain Mr C's personal hygiene and dignity: Conclusions

16. It is clear that Mr C required assistance to maintain his personal hygiene and dignity. He was incontinent and confused and staff found it difficult to communicate with him. There were numerous episodes where his family found him to be unshaven and lying in bed covered in only an incontinence pad. The Ombudsman's adviser, in reviewing the case, commented that a lack of confidence in handling patients with Alzheimer's could be at the root of this. While it is not possible to state the exact reasons why this was allowed to happen, the Board have recognised the failure in care and have taken action to ensure that staff approach the relatives of confused patients and make them aware that there could be problems in maintaining their dignity. I uphold this aspect of the complaint.

(b) Nursing staff failed to ensure Mr C's nutritional needs were met

17. Mrs C said that her father was well nourished before he was admitted to hospital. However, when they visited after meals they found food all over the bed. Given that he was unable to feed himself, they wondered whether he had actually eaten or drunk very much. When approached by staff to choose from the menu, Mrs C thought that they did not understand he was unable to comprehend, let alone answer them.

18. The Board's response to this issue was that Mr C did eat and drink at meal times and staff regularly go around the ward after meal times to change beds and settle patients if required. However, this would depend on the other demands within the ward and, as the ward is an acute medical ward, staff are often held up because they are dealing with particularly ill patients.

19. *Adviser's comments*

'Mr C was unable to discuss his needs relating to food choices or fluid intake with the nursing staff, he depended totally on the nurses to ensure these needs were met. His family frequently complained that he had not eaten his meals. There was no nutritional assessment carried out, nor evidence that fluid or food charts were being completed. The nursing staff on Ward 9 recognised this failure in their care.'

20. *Staff response at interview*

'The Board has recognised the failures in care delivered to Mr C and has set up a group to review nutritional needs across the Board. The ward sister has also ensured that it is now the responsibility of the ward hostess to complete the menu for and with each patient, ensuring that where a patient is unable to contribute, a nurse is informed and appropriate action is taken. The ward hostess serves the meal and where patients require assistance the nurses give this. The ward sister is now a member of the Clinical Incident Group and notes incidents relating to nutrition.'

21. *Adviser's comments*

'The Board has improved the documentation they are using to assess the patient's nutritional needs. The minutes provided of the 'Food, Fluid and Nutrition' care group show representations from many of the wards in the hospital including medical and professional staff other than nursing. Each item discussed has an action point and an individual responsible for reporting back to the group. The group will meet every two months and along with sub-groups such as elderly care and swallowing assessment being set up, there is every confidence that there will be a big improvement within the Board.'

22. *Adviser's recommendation*

'The Board should as a matter of urgency ensure that a system of identifying patients at risk, such as the 'red tray' system whereby patients are given food served on a red tray to highlight the need for support in feeding. This should be implemented on all wards where vulnerable patients may be cared for.'

Nursing staff failed to ensure his nutritional needs were met:

Conclusions

23. I have already mentioned that Mr C had difficulties with communication and his family questioned whether he had in fact eaten the meals or taken drinks which had been presented to him due to the presence of food found on his bed. The Board's response was that staff do go around the ward after meal times and settle patients, however this would depend on the other demands on staff at the time. I accept the adviser's advice that the nursing records show no evidence that nutritional assessments were carried out or that fluid or food

charts had been completed. I note the Board have recognised this failure and I am pleased they have set up a group to review nutritional needs across the Board and have put in place improved documentation to assess nutritional needs. A ward hostess is now responsible for completing patient menus and any concerns about the patient's ability to choose or eat a meal are referred to nursing staff. I uphold this aspect of the complaint and the Ombudsman recommends that the Board considers implementing a 'red tray' system to identify patients who are at risk and require support in feeding as indicated by the adviser.

(c) Nursing staff responded poorly to family concerns

24. Mrs C said that during visits the family found out that Mr C had taken money from a patient and had removed an IV drip from a patient. When they reported this to the nursing staff, they were told not to worry as nobody would know. When they reported their concerns about Mr C lying in only an incontinence pad, they were told by the nursing staff that there were no laundry facilities at the weekend and that they had not brought in pyjamas. However, the family had brought them in and they were in Mr C's locker but staff had not checked for them. When a telephone call was made to the ward requesting information on Mr C's condition, this was not returned.

25. As part of the local resolution stage of the complaint, the Board commented that there was no record of Mr C taking money from a patient or removing an IV drip. An apology was given that the member of staff to whom it was reported was flippant. The ward sister had been unable to identify the nurse concerned but such situations were taken seriously. It was also explained that staff try to provide as much information as possible to relatives and they are asked to call back later for updated information if a ward round was going on at the time. It would not be normal practice for staff to say they would contact a relative later and an apology was made if that was the advice which was given.

26. *Adviser's comments*

> 'A major aspect of the complaint was the perception of Mr C's family that they were not listened to or communicated with by the ward team. They were extremely anxious and concerned about Mr C and his condition, particularly as on several occasions they found him to be in an unkempt and undignified position. When the family tried to discuss their concerns on several privacy and dignity issues, they

were often advised not to worry or no note of what was being said was taken. They did not feel that they were ever well communicated with in relation to a treatment plan.'

27. *Staff response at interview*

'The ward sister holds regular staff meetings, which are minuted, and reinforces the need to listen to what patients and their relatives are saying, document concerns and take necessary action. The senior nurse for the unit meets with the ward sisters on a regular basis and asks searching questions around patients who may be unhappy with their care or relatives who have concerns. Ward sisters are aware that complaints or incidents need to be raised with senior staff as soon as possible after their occurrence. The meetings held are managed formally with items such as Personal Development Plan, Complaints, Accident or Incidents, Audit, Staffing issues and Clinical issues being discussed. The Senior Nurse then meets with her line manager, the ADN, and discusses any complaints that have been made to the ward. The ADN is always advised of any serious complaints and becomes involved appropriately. An action plan to monitor the leadership skills of Ward 9 has also been put in place with key objectives and key result areas and dates being identified for measurement of achievement.'

28. *Adviser's opinion*

'The senior staff who line manage the ward sisters have taken the communication issues raised in the complaint very seriously. The ward sister has reassured us that both she and the senior staff on her ward now regularly approach the visiting relatives and ask whether they feel they have all the information they need or give additional information on the patient's treatment and care. She has recognised the need to be proactive with relatives.'

Nursing staff responded poorly to family concerns:

Conclusions

29. The family voiced their concerns to nursing staff but felt that they were not being listened to and that they were not being taken seriously. The Board's response to this issue did nothing to indicate that action had been taken to address the concerns. At interview, it was established that staff now approach relatives and enquire if they need information about the treatment and care that

the patient is receiving. The ward sisters inform senior staff about complaints and have regular meetings with the senior nurse to discuss matters further. I am satisfied that, at the time of Mr C's admission, there were failings by staff to respond to family concerns and accordingly uphold this aspect of the complaint. The actions subsequently taken should ensure an improvement in communications with relatives and assure them that their concerns are being taken seriously and that appropriate action will be taken.

(d) The Board's response to Mrs C's complaint was inadequate

30. Mrs C wrote a letter of complaint to the Board on 30 December 2004. She set out her concerns about the care her father had received in respect of his personal hygiene and dignity; nutritional needs; and the response of nursing staff to her concerns. She pointed out that the care he received in Ward 9 was in complete contrast to that which he received in the second hospital. There, she had found that her father had been put in a quiet room with a special mattress to help with a pressure sore; visiting was controlled but flexible when required; the nursing staff were very attentive and made sure he was fed and given drinks; he was always found to be clean, shaven and comfortable; and the family were encouraged to help when they visited. The reason Mrs C had raised her complaint was that she wanted to know that someone would look into the serious issues which she had raised and do something about it. She made the point that both hospitals were new and had every facility and that there was no excuse for such differing standards.

31. The general manager responded to the complaint on 1 February 2005 as part of local resolution. I have already referred to the response in the previous paragraphs. Mrs C did not accept the response and wrote to the Board again on 5 March 2005. She mentioned that the response did not address the concerns which she had raised. She had still not had an explanation why her father was often found unshaven, undressed and soaked in urine. She was disappointed with the response, which included a number of instances where the information given by staff was completely incorrect. She did not feel that the issues which she had raised had been taken seriously.

32. *Adviser's comments*

> 'The initial response to the formal complaint made by the family of Mr C was extremely poor in that the ward sister was asked by the general manager to make a statement in relation to the allegations made in the complaint. She wrote an extremely defensive response,

which did not include an apology for the perceived lack of care to Mr C. In many respects, the ward sister blamed Mr C's condition rather than review the care delivered in an objective way. There was no commitment from her at that time to investigate the issues of complaint further. Sadly the general manager accepted this statement and wrote a response to Mrs C based on this evidence. Neither the Senior Nurse nor the ADN were aware of the response at that time.'

33. *Staff response at interview*

'All of the staff interviewed recognised how poorly the complaint had been managed and were extremely sorry for the additional distress that this had caused the family. The Board has developed a revised 'Complaints Policy and Procedure Guidance for Staff'. The document includes guidance for staff writing statements and advice on how they access support. Senior staff have been involved throughout this year with the development of the document, and complaints and patient affairs officers have been involved in cascading this throughout the Board. The ADN and senior nurses in the Board feel much more confident that responses to complaints will be dealt with in a much more timely and sensitive manner.'

34. *Adviser's conclusion*

'The Board staff who were interviewed have recognised that all of the concerns raised in the complaint by Mrs C about her father's care were justified. They are committed to ensuring that they minimise the possibility of the same issues arising in the future. The Board has made a great effort to review documentation, audit nursing and midwifery care, set up groups to review assessment of current practice and involved staff who may previously not have had the same level of support. The ward sister is now actively supported by both her professional and managerial line managers and is very aware of the need to request further help and guidance should she need it. The ADN has added to Ward 9 complement of staff by adding an experienced deputy charge nurse to support and enhance patient care. The Board has also accessed information such as 'Clinical Standards for Older People in Hospitals' and is working towards embedding these in their everyday practice.'

The Board's response to Mrs C's complaint was inadequate: Conclusions

35. The evidence obtained during the investigation is that the response from the Board to Mrs C was inadequate. It appeared defensive and focused on Mr C's condition rather than an objective review of the care which was provided. There was no indication that the complaint would be investigated further and that the Board's consideration was at an end. I am particularly concerned that the investigation was conducted and the response was issued without being reviewed by a senior member of nursing staff of at least senior nurse level. I am pleased to note the action which has been taken following Mrs C's complaint, in that the Board have developed a revised 'Complaints policy and procedure guidance for staff', which should ensure that responses to complaints will be dealt with in a much more timely and sensitive manner. I uphold this aspect of the complaint.

36. In addition to commenting on the individual heads of Mrs C's complaint the adviser provided the following comments on issues relevant to Mr C's care.

37. ***Environment and Staffing levels***

> 'During the period when Mr C was a patient in Ward 9, the ward sister advised us that she believes the ward was understaffed. Ward 9 is a 24-bedded general medical ward but is also the specialist ward for diabetic patients. The dependency level of patients can vary on the ward, and occasionally requires additional nursing support where there may be confused or very ill patients. The level of sickness amongst senior nurses on Ward 9 at that time was higher than average and staff turnover was also higher than average. The number of nurses on Ward 9 was equal to that on other similar wards in the hospital.'

38. *Staff response at interview*

> 'The senior nurse advised that although the funded establishment (number of nurses that the budget allows) had not been increased since the time of Mr C's admission, there was now a safety measure in place where an additional or 'floating' nurse would be used to give additional support. If the ward sister had concerns regarding a shortage of nurses she would identify this, in writing if necessary, to the senior nurse. It would then be the responsibility of the senior

nurse to take the necessary action to ensure the environment was safe. The senior nurse now receives a daily report about patient dependency levels, this helps inform decisions on staff cover for potential shortfalls on staffing.'

39. *Adviser's opinion*

'On interviewing the Senior Nurse and the ADN, I felt confident that the ward was well supported with regard to staffing measures.'

40. ***Caring for a confused patient***

'Mr C was extremely confused and agitated during his admission and nursing staff found it difficult to communicate with him. He was also at risk from falls and a decision to place cot sides on his bed was made without any of the appropriate and necessary assessments being made. The ward sister believes that nurses may have been making a visual assessment of the patients as they went around the ward but they have failed to provide any written information to support this. The family had also complained of the television blaring aloud with no-one listening to it and felt it contributed to Mr C's confusion.'

41. *Staff response at interview*

'The ward sister has recognised the failings that occurred in not properly assessing Mr C's needs. She has advised that a full assessment of the patient's confusional state would now be carried out, in particular an assessment of the need to use cot sides before they are applied. A care plan with clear actions and interventions would be started and supported by regular evaluations. There are ongoing audits of the nursing care taking place across the hospital; these audits include risk assessments of patients. The ward sister is also much more aware of the need to be proactive in discussing how relatives can support nursing staff in caring for patients who suffer from confusion for any reason. The ward sister did not think much could be done about the television noise as there was only one television in the bay and other patients may wish to have it on.'

42. *Adviser's recommendation*

'The ward sister was asked as a matter of urgency, to consider approaching facilities management to explore ways of having individual headphones or some other means of personalising listening to the television introduced.'

43. I fully accept the opinion of the adviser on this issue and the Ombudsman recommends that the Board takes action, as suggested by the adviser, to explore whether there are means of personalising listening to the ward television to prevent possible distress to patients.

44. ***Assessing, planning, evaluating and documenting care***

'There was a failure by the nursing staff to adequately assess the patient's needs, plan the care and evaluate actions taken. The nursing records included three very poorly completed care plans that do not in any way contribute to assessment and planning of care. The evaluation sheets are written in the old Kardex style (not related to individualised patient care) and do not include reference to the patients daily needs. The ward sister's own opinion of the documentation when she reviewed it was that it was 'appalling'. When Mr C was transferred from the Admissions unit to Ward 9 there may or may not have been a telephone handover of the patient's condition. It is understood that telephone handovers were fairly common practice, written information was not always available.'

45. *Staff response at interview*

'A lot of work has been undertaken by the Board to review the documentation used. New documentation is currently being piloted on medical and surgical wards and will ensure that for the first time there will be standardisation for much of the documentation across the Board. There is evidence of new assessment sheets and pre-printed care plans to aid staff in identifying the problems.

An audit of nursing and midwifery care delivered has been carried out by the Board during July/August and September of this year (2005). The feedback from the audit carried out on Ward 9 is very positive showing that the ward has achieved a good score with the need for some minor updating. Documentation is well written, care planning in place and clinical supervision of nurses is happening. There is a

review date of December 2005 documented. The ward sister has also ensured that her staff are attending specific documentation training courses and is very satisfied that real changes have been made in this area of care. The ward sister is also involved in peer review of completion of documentation on other wards. The ADN advised that the Board is also considering how they can replicate or introduce a form of 'Essence of Care'[2] across the Board as it is in England.'

46. *Adviser's opinion*

'The Board has put a great deal of effort into ensuring that documentation has been thoroughly reviewed, views on the new documentation have been sought through piloting the documents and senior staff have been involved throughout. Audit of nursing and midwifery care appear to have been robust with review dates clearly identified.'

47. *Adviser's recommendation*

'The Board should ensure as a matter of urgency that there is a transfer sheet, which documents the needs of patients moving between wards in the hospital.'

48. Clearly there were problems with staff failing to make entries in the nursing documentation at the time Mr C was a patient. This means that there is no corroboration that appropriate assessments had been conducted or that appropriate care plans had been developed. The assessments and care plans are required to show that the patient has been properly assessed and that a care plan has been developed to deal with any problem. It also makes it extremely difficult to provide an adequate response, should a complaint be raised about a patient's care and treatment. I welcome the moves the Board have taken in respect of reviewing the documentation and that there has been an improvement in the standard of record-keeping in the ward. The Ombudsman recommends that the Board act on the adviser's comment that a transfer sheet is implemented which documents the needs of patients moving between wards in the hospital. The Ombudsman is also pleased to note, from the Board's recent response to her recommendation in another investigation - case number S.42/03-04, issued 3 August 2005 - that they have completed a

[2] A benchmarking tool produced by the Department of Health, February 2001

review of nurse care planning, taking account of the ‘Essence of Care’, best practice standards and statements and SIGN Guidelines.

30 May 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	The complainant's father
The ward sister	The ward sister on Ward 9
The senior nurse	The ward sister's clinical and professional lead
The ADN	The Associate Director of Nursing
The hospital	Hairmyres Hospital, East Kilbride
SIGN	Scottish Intercollegiate Guidelines Network