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Fareham and Gosport NHS
Primary Care Trust

Summary of Complaint Investigation

An investigation into the nursing care of Mrs D Middleton deceased.

Investigating Officer: **Jane Williams**
Nurse Consultant Stroke Care/Older People

Commissioning Officer: **Fiona Cameron**
Operational Director
Fareham & Gosport Primary Care Trust

Background to Investigation

Mrs Middleton was a patient on Daedalus Ward, Gosport War Memorial Hospital between 29th May 2001 and 16th August 2001. She was admitted from the Royal Hospital Haslar following a stroke on 10th May 2001. Mrs Middleton was subsequently transferred to Gosport War Memorial Hospital, Daedalus Ward on 29th May. She subsequently died on 2nd September 2001.

This report and the investigation upon which this is based were instigated as a consequence of a letter of complaint written to the Nursing and Midwifery Council in June 2002. This letter was sent to the Primary Care Trust requesting a response to the issues raised.

The investigation was commissioned by Fiona Cameron and was undertaken by Jane Williams, Nurse Consultant Stroke Care. Mrs Williams is an employee of East Hampshire Primary Care Trust and works primarily in Elderly Medicine Wards. Her speciality is in Elderly Stroke Care.

The following are the results of the investigation related to the specific issues raised by Code A in her letter.

1. **Nutrition and Hydration**

The investigation concluded that the nutritional screening form usually completed at the admission of a patient was absent from Mrs Middleton's notes. There were however daily summaries in the contact records referring to nutritional and fluid intake. Food and fluid charts commenced on 1st June were found not to be an accurate record of intake and output.

The Investigating Officer identified that towards the end of her stay in Royal Hospital Haslar, Mrs Middleton's recorded nutritional intake had significantly reduced prior to her transfer to Daedalus Ward.

Mrs Middleton's weight was recorded regularly and there was significant input from both Speech & Language Therapy and Dietetic departments. It was noted that despite written requests from the dietician within the notes, food and fluid charts were not accurately maintained. Subcutaneous fluids were prescribed to supplement oral fluid intake.

The Investigating Officer concluded that nursing documentation was inadequate in relation to the assessment, planning and evaluation of care provision with regard to nutrition and hydration. However, the Investigating Officer also concluded that from meetings with the staff, there was general concurrence between interviewees regarding the amount of input Mrs Middleton received and that there had been a genuine attempt to meet both Mrs Middleton and Code A needs.

It should also be noted that the Clinical Manager was addressing this issue with the development of a "user friendly " charting system.

2. Fluid Overload

At her meeting with Code A the Investigating Officer indicated that there was some confusion over the use of the words "fluid overload". It is believed that a review of Mrs Middleton's medical notes undertaken by an independent medical practitioner with Code A had alleviated her concerns regarding this.

3. Attitude of nurse in relation to nebuliser

The Investigating Officer could find no evidence to support or conclude this event and there was no record of it being reported to the nurse in charge. I am unable to offer any reasonable explanation for this. However, all the staff on the ward agree that this would have been an unacceptable comment.

4. Incident by patient's bed

The investigation confirmed that this event did take place and there is no reasonable explanation for the fact that Mrs Middleton was alone. She was subsequently examined by the doctor in the four-bedded room. This would be normal practice on this type of ward.

5. Sitting out of bed for long periods & wait for bed pan

At this time Daedalus Ward was a 24 bed rehabilitation ward. Mrs Middleton was admitted for active rehabilitation. It would be standard practice for patients to be dressed in their own clothes and sitting in the chair for the major part of any day. There is no reasonable explanation as to why Mrs Middleton had to wait for such a long period of time for a bed pan.

6 General attitude of nursing staff and lack of response to relative complaint

The Investigating Officer concluded that staff had failed to pick up Code A very serious concerns despite their remembering many interactions with Code A Code A

During her visit to Code A the Investigating Officer summarised her main issues of concern as being

the inadequacy of information and communication with Code A
nursing attitudes towards patients and relatives,
the nursing management of nutrition and fluids,
who is accountable for patient care,
concerns raised by Code A were not documented and followed through

Fiona Cameron
Operational Director
3 October, 2002