Results of the Investigation regarding care of Mrs Dulcie Middleton (deceased) – complaint instigated by her daughter, Mrs Bulbeck

Investigation undertaken by:

Jane Williams MSc RGN RM, Consultant Nurse - Stroke Care

Process:

- Initial meeting with Fiona Cameron – commissioning manager
- Review of medical and nursing notes
- Planning meeting with Fiona Cameron – terms of reference discussed
- Meeting with Mrs Bulbeck (type notes)
- Arrange and conduct interviews with key staff (type notes)
- Write report
- Final meeting with Fiona Cameron to discuss report

Report:

This report follows the structure provided by the terms of reference.

1. **Was there a full assessment of Mrs Middleton's nutrition and hydration status?**

- It is customary practice (and Trust policy) for nurses to complete a nutritional screening on admission. This form could not be found in the notes. Mrs Middleton's intake was noted to be poor two days after admission. Weights were recorded.
- After three weeks on the ward, Mrs Middleton was referred to the dietitian as her intake continued to be poor.
- The nursing daily summaries record frequent (usually daily) entries regarding nutritional and fluid intake.
- Food and fluid charts were commenced on the 01/06/01 but do not appear to accurately record intake/output.
- Electrolyte imbalance was present on 31/5/01, two days after admission (Potassium low, urea high). Fluid regime adjusted and potassium supplement prescribed. U&Es continues to be monitored regularly and adjustments made accordingly throughout stay. Increasing problems with hydration/electrolyte balance noted throughout Mrs Middleton's inpatient stay. Prescriptions adjusted accordingly.

2. **Was a plan of care formulated as a result of the assessment?**

- A standardised care plan for dysphagia was commenced on the day of admission. A referral to the speech and language therapist (SLT) was made on the day of admission and Mrs Middleton was reviewed by the SLT on the same day and many times subsequently. The care plan records the outcome of that assessment and the management plan. Each visit and reassessment by the SLT are recorded in duplicate, both in the medical and nursing notes.
- Assessment carried out by the dietitian on the 20/06/01. The dietetic notes record that assessment in more depth than the medical or nursing notes.

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Following the assessment further recommendations are made regarding portion sizes and supplements. The dietitian requests recording of nutritional and fluid intake. Food and fluid charts are present but not complete with an accurate record of intake.

3. **Is there evidence of the plan of care being pursued?**

- Daily summaries record problems with dietary intake, but these tend to be reports from the staff on duty in the morning.
- Despite written requests from the dietitian within the notes, food and fluid charts are not accurately maintained.
- Weight is charted regularly
- Subcutaneous fluids prescribed to supplement oral fluid intake, but intake/output not recorded.
- Regular reviews recorded by SLT
- Regular reviews recorded by Dietitian

4. **Is there evidence of evaluation of the impact of the planned care?**

- SLT records demonstrate evaluation of planned care
- Dietetic notes record evidence of evaluation of planned care
- Nursing notes do not record evaluation of nursing interventions apart from subjective comments "small diet taken", "Very little food and fluid intake" etc.
- Medical records document on-going evaluation of planned and prescribed care.

5. **Is the above evidence sufficient to show a satisfactory level of documentation of care.**

- Nursing documentation is poor and inadequate in relation to assessment, planning, implementation and evaluation of care provision with regard to nutrition and hydration. (see below for further discussion)
- Speech and Language Therapy and Dietetic record keeping with regard to dysphagia, nutrition and hydration satisfactory.
- Medical documentation with regard to nutrition and hydration satisfactory.

6. **Identify the nurses involved in the care of Mrs Middleton**

- Interviews extended to other professionals involved in the care of Mrs Middleton
- Dr Althea Lord (Consultant Geriatrican) and Dr Joesph Yikono, staff grade physician, declined to be interviewed on advice from their representative.
- Interviews undertaken with Clinical Manager Philip Beed, Senior Staff Nurse Pat Wilkins, Staff Nurse Sally Webb and Dietitian Kathryn Fuente.
- Time constraints did not allow for further interviews to be undertaken. Mrs Middleton had complex needs and required a lot of nursing care. All staff were involved in her care at some point during her inpatient stay.

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Supporting information and evidence

- I have nine years of stroke experience and expertise to call upon in reviewing the care of Mrs Dulcie Middleton
- I have spent four and a half years researching the involvement of relatives in the ethical decision-making dilemma 'to feed or not to feed' with regard to the commencement of enteral feeding in patients following dysphagic stroke.

- I have spent many hours reviewing the notes. Following the meeting with Mrs Bulbeck in which she praised the care provided by Haslar and their level of record keeping in respect of nutrition and fluid intake, I re-reviewed the notes. Mrs Bulbeck reported that her mother did not have any problems with the functioning of her bowel prior to the stroke. As I reviewed the notes I became aware of the frequency of the documentation regarding the presence of diarrhoea or loose bowel motions. This commenced on the 17th May and continued for the duration of Mrs Middleton's inpatient stay in Haslar Hospital. Food and fluid charts were not commenced until 7 days after her admission. The records appear to accurately record her nutritional and fluid intake.
  Towards the end of Mrs Middleton's stay in Haslar Hospital her recorded nutritional intake declined significantly. Mrs Middleton's appetite and intake were reduced prior to transfer to Daedalus Ward, Gosport War Memorial Hospital.
- How significant is the onset of diarrhoea on the 17/5/02? No bacterial cause was isolated despite numerous specimens being collected and tested.
- The diarrhoea continued for the rest of Mrs Middleton's life. This problem was investigated by Dr Lord.
- Nursing record keeping with regard to nutrition and hydration is notoriously inaccurate nationally. C/M Philip Beed has attempted to address this issue with the development of a 'user friendly' charting system. On review of the notes these charts are not accurately maintained either.
- From the meeting undertaken with staff I found concurrence between interviewees regarding the amount of input Mrs Middelton and Mrs Bulbeck received. I felt that nursing staff had genuinely attempted to meet their needs. Unfortunately the nursing documentation does not record the multiple meetings/discussions/issues raised.
- Senior nursing staff or senior medical staff did not pick up the signs that Mrs Bulbeck was dissatisfied with the care and seek a way to resolve her concerns.
- Senior nursing staff could have called upon hospital managers for support/advice.
- The concept of 'named nurse' may require review. The philosophy of rehabilitation is alien to many patients and their families. The routine of the ward, amenities and introductions etc. should all be part of the admission process. Families of stroke patients require care and support too. Making use of specialist staff outside the immediate team (i.e. nurse specialists, consultant nurse, allied health professionals) can offer additional support.

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- Other factors, i.e. police investigation, impending CHI review, changing role of the ward, attendance at numerous meeting etc., had a detrimental effect on C/M Philip Beed and staff. Whilst care was provided Philip recognises that staff may have defensive in their communication with relatives due to the stresses listed above.
- Much of the substance of the complaint is subjective and cannot be answered as names, dates, times etc. are not available. Clear evidence therefore is limited but as is so in all review cases, there are lessons to be learned and actions to be recommended to improve the provision of care.

Conclusion
It is not within my remit to make recommendations, but as the investigating officer to review and report fact.

Mrs Middleton had suffered a major stroke as indicated by the prognostic indicators altered conscious level on admission; dysphagia; urinary incontinence/retention and the pre-existing ischaemic heart disease.

The issues outlined above represent the findings of many hours of reviewing notes, talking with staff and the patient's daughter and pulling those finding together into a meaningful report. I hope that staff may learn from the findings and that Mrs Bulbeck can finally, in her mind, lay her mother to rest.