Scottish Parliament Region: Glasgow

Case 200501239: Greater Glasgow NHS Board – Acute Services Division[3]

Summary of Investigation

Category

Health: Hospital; care of the elderly

Overview

The complainant raised a number of concerns about the care and treatment of her 90-year-old father (Mr C) in hospital, which she considered had changed him from an active man, with a good quality of life, to a bruised, emaciated and broken man and which caused his death six weeks after admission to hospital.

Specific complaints and conclusions

The complaints which I have investigated are:

(a) Mr C's four falls were avoidable, and it was inappropriate to sedate and restrain him as a means of control *(not upheld)*;

(b) Mr C had no appropriate care plan and was given inadequate nutrition *(not upheld)*;

(c) Mr C caught pneumonia, probably from another patient *(not upheld)*;

(d) Mr C's and the family's wishes were not respected *(not upheld)*; and

(e) Staff falsified facts to protect themselves *(not upheld)*.

Redress and recommendation

The Ombudsman has no recommendation to make.

[33] On 1 April 2006 the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by Argyll and Clyde Health Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of Argyll and Clyde Health Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to Greater Glasgow and Clyde Health Board as its successor.

Main Investigation Report

Introduction

1. I shall refer to the complainant as Mrs C, her father as Mr C and her brother as Mr C Junior. On 10 August 2005 the Ombudsman received Mrs C's complaint about two of the Health Board's hospitals, which were involved in Mr C's care between 21 May 2004 and his death on 2 July 2004 in the second hospital. I refer to Greater Glasgow and Clyde NHS Board as the Board and to the hospitals respectively as Hospital 1 and Hospital 2.

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

(a) Mr C's four falls were avoidable, and it was inappropriate to sedate and restrain him as a means of control;
(b) Mr C had no appropriate care plan and was given inadequate nutrition;
(c) Mr C caught pneumonia, probably from another patient;
(d) Mr C's and the family's wishes were not respected; and
(e) Staff falsified facts to protect themselves.

3. I should say here that Mrs C had many other complaints. I have not investigated these for various reasons: I would not be able to prove the complaint about staff's attitude to Mr C because of the lack of independent evidence; the Board had already apologised and taken action on the complaint about lack of mental and physical stimulation (and in any case, the Ombudsman's adviser considers that it is unrealistic to expect nursing staff to provide such stimulation to a cognitively-impaired patient). Neither did I investigate the cleanliness of the ward furniture and floors. That is because Mr C did not catch any infection because of any shortcoming in cleanliness. Whilst important in itself, I did not consider that cleanliness was relevant to the real essence of this complaint, which was, to put it simply, whether Mr C's death was avoidable. It is part of a Complaint Investigator's role to identify and focus on the heart of the matter, and, therefore, I focused the investigation on complaints (a) to (d). I added complaint (e) because of the seriousness of Mrs C's allegation of staff as having lied about what happened, to protect themselves. Mrs C has asked for her view about the paramount importance of a hospital's general cleanliness to be recorded, which I do here.

Investigation

4. I was assisted in the investigation by two of the Ombudsman's advisers, a consultant geriatrician and a nurse. Their roles were to explain to me, and comment on, the clinical aspects of the complaint. We examined the papers provided by Mrs C, the Board's complaint file and Mr C's clinical records. To identify any gaps and discrepancies in the evidence, the content of relevant correspondence on file was checked against information in the clinical records and also compared with my own and the advisers' knowledge of the issues concerned. I am, therefore, satisfied that the evidence has been tested as robustly as possible. Bearing in mind that Mrs C considered that the paper evidence was false, I have used only evidence where the facts are not in dispute, as far as possible. In line with the practice of this office, the standard by which the events were judged was whether they were reasonable in the circumstances. By that, I mean whether the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical and nursing professions in terms of knowledge and practice at the time. 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 were given an opportunity to comment on a draft of this report.

(a) Mr C's four falls were avoidable, and it was inappropriate to sedate and restrain him as a means of control

5. On 20 May 2004 Mr C, a man of 90, was admitted to a hospital (not the subject of the complaint) because of a fall at home, which had caused cuts and bruising. On 21 May, Mr C was transferred to Hospital 1. He was seen by a consultant in Medicine for the Elderly, who noted that, amongst other things, he was very confused, with significant, advancing dementia. As the Board's letter of October 2004 to Mrs C explained the evidence for this dementia, I do not intend to state the detail here. The advisers say that references in the 2001 clinical records to falls and confusion suggest that Mr C had had dementia, to some extent, at least since then. During his admission, it became increasingly clear that Mr C's needs were now too great to allow him to return home to his family's care, despite their wish for this. On 18 June, therefore, he was transferred to Hospital 2, which is a NHS continuing care (in other words, for long term residence) hospital, where, sadly, he died on 2 July 2004.

6. Mr C had four falls at Hospital 1. The nursing care plan for 21 May records him as being unsteady on his feet and being able to walk with one person's help. On the evening and night of 21 May he failed to settle, despite two doses of sedative. During the early hours of the morning (22 May) he was found on the floor, with new bruising. Appropriately, an incident form was completed and proper observations were carried out and recorded. The advisers say that the sedation was reasonable and in an appropriate dosage. One-to-one nursing was given for a while (in other words, one nurse had only Mr C to look after), hip protectors were put on Mr C, and on various dates a restraining strap was applied while he was sitting in a chair. The one-to-one nursing was stopped on 24 May because Mr C's agitation had reduced. On 25 May, while nurses were attending to another patient, Mr C, who had constantly been trying to get out of bed, was found lying on the floor, but without injury.

7. While with Mr C Junior on 26 May, Mr C fell a third time, again without injury. In the evening of 1 June, Mr C is recorded as lashing out at staff, and the advisers consider that the decision to give more sedative was appropriate. On 15 June, Mr C had a further fall, causing surface head injury.

8. At paragraphs 8 to 10, I summarise the advisers' comments about the falls and their further comments about the sedation. The supervision of wandering, elderly, patients (such as Mr C) to prevent falls is notoriously challenging and cannot reasonably be expected to be provided at all times. In particular, one would not expect it to be provided while a patient's family are visiting. Falls are a very common accompaniment of even minor illness and confusion in older people. Indeed, studies have shown that around 60 per cent of deaths in elderly people were preceded by one or more falls within the previous month. Sedatives are a common cause of falls as they may worsen the confusion and unsteadiness. However, the sedatives given to Mr C do not appear to be related to any of his falls. Mrs C had asked that no sedative be given. This was an understandable, but unrealistic, wish, especially at night-time, which is when the sedatives from 1 to 23 June are recorded as having been given.

9. For each fall, the records show (in line with good nursing practice) clear documentation of the reasons and the action taken to try to reduce the risk of further falls. And there is clear evidence (again, in line with good practice) that

medical staff and senior management were kept informed. Nursing staff did their best to provide one-to-one nursing, which is very unusual in such cases and is likely to have resulted in far fewer falls than would otherwise have been the case. Hip protectors and a restraining strap were also appropriately used.

10. Overall, there is no evidence that Mr C was inappropriately sedated or that his safety was not properly considered.

(b) Mr C had no appropriate care plan and was given inadequate nutrition

11. I summarise here the advisers' comments about Mr C's care plan. The clinical records show appropriate assessments for a man with confusion and a history of falls. They show Mr C as having been assessed by a tool called *Activities of Daily Living,* which helps to identify a patient's needs against the 12 daily activities of normal everyday life, such as eating, drinking, sleeping and movement. The records show that, as a result, several care plans were drawn up and actioned to address the issues which had been identified as potential problems, including care plans for movement, handling, falls risk (for the provision of hip protectors) and a bed rail assessment. To summarise, the care plans in the clinical records were appropriate.

12. I turn now to Mr C's nutrition. According to the records, Mr C received much input from SALT (speech and language therapy/therapists) at Hospital 1. This was because of swallowing difficulties, which developed over the course of the admission, requiring SALT plans which changed in line with the changing swallowing difficulties.

13. A SALT recommendation at one point was for food which had the consistency of cream. The records state that this was explained to the family but that the family disagreed. In one of the papers sent to the Ombudsman, Mrs C said that the family provided sandwiches, ice cream and lemonade for Mr C while he was in Hospital 1 and that he was used to a drink with his meals but that staff had refused this. I return to this issue at complaint (c). The records say that the family also said that Mr C did not like the creamy consistency of the food that Hospital 1 were giving. And a SALT report said that, when Mr C was given a clear, thin, fluid in error by a nurse on one occasion, he was unable to cope with it. At other times, Mr C was given fluid by needles directly into the veins and directly into the skin.

14. The advisers say that there was a real difficulty in ensuring appropriate nutrition in a patient who was confused, often resistive (according to the records) and who had swallowing difficulties. There is evidence that staff tried hard to deal with this, and the assessments and recording of information at Hospitals 1 and 2 were appropriate.

(c) Mr C caught pneumonia, probably from another patient

15. On 8 June Mr C started to show signs of chest infection, which was confirmed by x-ray. (While suffering from this infection, he was taken for an appointment elsewhere in Hospital 1, on another matter. The advisers say that it would have been better to have postponed this appointment because of his condition, but that it had no adverse effect on Mr C.) The records state that he made a recovery from this infection.

16. The advisers consider that the most likely cause of the infection was fluid aspiration, caused by inappropriate food and/or drink from the family. The advisers have explained that dementia can lead to a weakness or lack of co-ordination in the throat muscles and to inadequate swallowing. This prevents the normal swallowing mechanism, which closes the wind pipe to stop food, liquid and stomach contents from getting into the lungs. The bacteria and acidity of these products in the lungs irritate them, causing inflammation and infection. The advisers say that it seems very unlikely that Mr C's chest infection was caught from another patient, as the family had thought.

(d) Mr C's and the family's wishes were not respected

17. The advisers consider that staff did try to meet the family's many requests. I have already covered the family's wish for Mr C not to be sedated and the family's disagreement with the creamy diet. The main complaint here concerns Hospital 1's statements that they would block Mr C's return home, which Mrs C believed was obstructive as the family wanted him at home. The advisers are very clear that Mr C's progressive dementia and various care needs were such that he needed to be cared for in hospital. If the family had removed Mr C from Hospital 1 against medical advice, there is no doubt that Hospital 1 would have been forced to report this to the Social Work Department of the Local Authority as a case of a vulnerable adult who needed protection.

(e) Staff falsified facts to protect themselves

18. I cover this at paragraph 20.

Advisers' overall views

19. The advisers say that the admission of an elderly family member to hospital is often extremely worrying for a family. In this case, they feel that the family misunderstood the rapid progress of Mr C's dementia, assuming (understandably, but wrongly) that his deterioration was the fault of inappropriate or inadequate care. The family's anxiety appears to have led to their unreasonable expectations of what could, or should, be done for Mr C. The challenges faced by medical and nursing staff to deliver safe and quality care to Mr C were, on a daily basis, immense and should not be under-estimated. The records give a clear picture of a great deal of time and effort as being given to caring for Mr C.

(a) to (e) Conclusions

20. As explained at paragraph 4, I have tried to use only evidence that is not disputed by the family and I am satisfied that the evidence used has been tested as robustly as possible. That includes the advisers' advice, which has been checked to ensure that it was clear and, where relevant, was clearly and logically based on the evidence. Therefore, I accept that advice. In respect of complaints (a) to (d), the advisers consider that the actions complained of fall within the bounds of reasonableness described at paragraph 4. Therefore, I do not uphold complaints (a) to (d). From the advisers' comments on those complaints, it should be apparent that I have found no evidence of falsification of facts by staff for the purpose of self-protection or covering up faults. Therefore, I do not uphold complaint (e).

(a) to (e) Recommendations

21. The Ombudsman has no recommendations to make.

29 August 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	The complainant's father
Mr C Junior	Mr C's son
Hospital 1	The hospital to which Mr C was transferred on 21 May 2004
Hospital 2	The hospital to which Mr C was transferred on 18 June 2004
The Hospitals	Hospital 1 and Hospital 2
SALT	Speech and language therapy / therapists