Scottish Parliament Region: North East Scotland

Case 200500810: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; Old Age Psychiatry

Overview

Ms C complained about the care and treatment provided to her brother (Mr A) by the Royal Cornhill Hospital, Aberdeen (the Hospital).

Specific complaints and conclusions

The complaints which have been investigated are about:

(a) Mr A's loss of weight was not dealt with appropriately *(upheld)*;

(b) the response to Mr A's falls was poor *(upheld)*;

(c) poor communication between staff and relatives *(not upheld)*; and

(d) poor hygiene *(no finding)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) review how eating and drinking/weight problems are dealt with in the Hospital and take action to ensure that a plan is drawn up and implemented in each relevant case;

(ii) review care planning in the Hospital;

(iii) implement their new policy on patient falls if they have not already done so;

(iv) develop and implement a policy on the use of restraints at the Hospital in line with Mental Welfare Commission Guidelines; and

(v) take steps to ensure that the guidelines on pressure ulcer prevention are followed in the Hospital.

The Board have accepted the recommendations and are acting on them accordingly.

Main Investigation Report

Introduction

1. Mr A has a long history of manic depressive illness. After his wife became ill and was admitted to hospital Mr A also became unwell. He was admitted to the Royal Cornhill Hospital (the Hospital), which specialises in the care and treatment of people with mental health problems, in terms of section 24 of the Mental Health (Scotland) Act 1984 and was a detained patient under various sections of the Act throughout his stay there.

2. Ms C complained to Grampian NHS Board (the Board) on 14 January 2005 about Mr A's care and treatment during his admission to the Hospital between 4 December 2004 and 9 January 2005 (when he required to be admitted to a general hospital). Mr A was re-admitted to the Hospital on 21 January 2005 but again required to be admitted to a general hospital on 15 February 2005. On 16 February 2005 Ms C sent a further letter of complaint to the Board regarding Mr A's second period of admission to the Hospital.

3. The Chief Operating Officer responded to Ms C's complaints on 1 March 2005. He offered Ms C a meeting with the Acting Clinical Director for Old Age Psychiatry (who investigated Ms C's complaints) and the Ward Manager.

4. Before meeting, Ms C asked for further details of the investigation and the Chief Operating Officer wrote to her again on 20 April 2005. He provided further information and said that the Consultant Psychiatrist and the Staff Grade Psychiatrist responsible for Mr A on a day-to-day basis would also attend the proposed meeting.

5. Ms C supplied dates when the family would be available to attend the meeting but the complaints officer wrote on 19 May 2005 to say that the Consultant Psychiatrist had been out of the country and they were having difficulty confirming his availability.

6. Ms C wrote that she was unhappy with the delays and on 18 June 2005 she complained to the Ombudsman.

7. The meeting did take place on 22 June 2005 but Ms C remained dissatisfied and pursued her complaint with the Ombudsman's office.

8. The complaints from Ms C which I have investigated are about:
(a) Mr A's loss of weight was not dealt with appropriately;
(b) the response to Mr A's falls was poor;
(c) poor communication between staff and relatives; and
(d) poor hygiene.

9. Ms C also complained about the way her complaint was handled particularly the delays. The NHS complaints procedure has since changed,[1] however, to allow complainants the option of complaining to the Ombudsman if their complaint is not resolved within 20 days. I have decided, therefore, not to investigate this specific matter as it has already been resolved by the change in the process.

Investigation

10. In order to investigate this complaint I have had access to Mr A's clinical notes for the relevant period and the NHS complaint file. I have corresponded with Ms C and with the Board. I have obtained clinical advice from two professional advisers to the Ombudsman, one a Consultant Psychiatrist (Adviser 1) and the other a Psychiatric Nurse (Adviser 2). My report is based on the advice I have received.

11. In line with the practice of the Ombudsman's office, the standard by which the actions of the Hospital were judged was whether they were reasonable. 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 profession in terms of knowledge and practice at the time.

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

(a) Mr A's loss of weight was not dealt with appropriately

13. Ms C complained that on 22 December 2004 Mr A choked on his food. This incident made him reluctant to eat and he lost a lot of weight. The staff did not provide appropriate food for him or assist him at mealtimes. He was unable to drink on his own and he became severely dehydrated. After Mr A's family

[1] The procedure changed in April 2005.

complained, a drip was set up on 5 February 2005 but it was removed the following day. At the time of his second admission to the general hospital he was described as dehydrated and emaciated.

14. The clinical notes show that Mr A weighed 49 kg on admission to the Hospital on 4 December 2004. That was the same weight as he had been in September 2004. He was noted at admission to be thin and had a history of poor self care. His blood results showed some renal (kidney) impairment and he also had angina and thyroid problems.

15. The serious choking fit which Mr A suffered on 22 December left him cyanosed (a sign of oxygen depletion) and unresponsive and he required suction, abdominal compression and oxygen. Medical assistance was provided by the doctor on the ward.

16. On 29 December 2004 Mr A was reviewed by the Consultant Geriatrician from the Department of Medicine for the Elderly who noted that he was dehydrated and recommended 2-3 litres of fluid daily and keeping a record of his intake and output. Mr A was also noted to have lost weight. From 30 December 2004 intake charts were kept daily apart from 1 February 2005. Mr A's weight was 45Kg on 3 January 2005, 40 Kg on 28 January, 37 Kg on 1 February and 38 Kg on 5 February.

17. In response to my enquiries the Chief Executive of the Board vigorously refuted the claim that Mr A was deprived of food. He said that Mr A's erratic eating behaviour was identified by nursing staff on his admission. The nurses on the ward which Mr A was in were very used to persuading elderly patients with altered mood to eat. It was not normal practice to record all foodstuffs offered and refused within and outwith mealtimes. He considered that the total intake charts for the period 30 December 2004 to 6 January 2005 showed that Mr A took a wide range of milky and sugary drinks and semi-solid foodstuffs including soup, porridge, yoghurt, pureed main course and sweets.

18. Adviser 1, however, was not satisfied that Mr A's intake charts demonstrated appropriate dietary intake. In his view they generally showed very poor dietary intake. He noted that from 4 February 2005 Mr A's intake was supplemented with prescribed supplements and intravenous dextrose. The Adviser said that Mr A's poor dietary intake as documented in the first week in January should have been a cause for concern. There are no

recommendations about Mr A's dietary intake in the records although there are recommendations about his fluid intake. The dietician should have been consulted at an early stage but there is no evidence in the case notes that this happened until 28 January 2005.

19. Adviser 2 said that Mr A's fluid intake was variable as was the quality of the charting. The Adviser said that on some days the charts suggest that Mr A was not offered adequate food or drink. Mr A was also known to refuse these at times. There is evidence that staff were attending to Mr A's fluid intake but there was little consistency or planning in this respect. Because Mr A was frequently incontinent it was impossible to be clear about his fluid balance other than from blood tests which continued to show evidence of dehydration. The Adviser said he gained the impression that staff seemed to be of the opinion that Mr A was deteriorating and was going to die. (He was determined to be 'not for resuscitation' on 9 February 2005.) Eventually Mr A's fluid intake required to be restricted due to renal failure.

20. The Adviser said that given the seriousness of the choking incident it would have been advisable to get a swallowing assessment from a speech therapist and to consider the causes of the incident more widely. The Adviser noted that Mr A was not referred to a speech therapist until 9 January 2005 when staff noticed swallowing problems. The Adviser said that it was understandable that the incident made Mr A afraid to eat in case he choked again and a nursing care plan should have been drawn up to address Mr A's problems with eating.

(a) Conclusion

21. I am concerned that although Mr A's weight loss was documented no plan was instigated to deal with it. Although staff responded correctly to the choking incident there was a lack of investigation into the causes. There was inadequate speech therapy and dietetic input and there is evidence that Mr A was not offered adequate amounts of food or drink. Although the nursing staff are described as being used to dealing with this situation the continued decline in Mr A's weight was evidence of their lack of success in this case. This should have been a cause for concern. The lack of a plan contributed to the failure to address the issue of Mr A's falling weight. I uphold this complaint.

(a) Recommendation

22. The Ombudsman recommends that the Board review how eating and drinking/weight problems are dealt with in the Hospital and take action to ensure that a plan is drawn up and implemented in each relevant case.

(b) The response to Mr A's falls was poor

23. Ms C said that Mr A suffered several falls during his time in the Hospital which caused him injury, and that he received no treatment for his injuries. Staff eventually sought permission from his niece to strap him to a chair. On 10 January 2005 family members, including Ms C, had a meeting with the staff grade psychiatrist. Mr A was present, heavily sedated and strapped to a chair by the window. After the meeting the family members told staff that they were going for coffee. When they returned they found Mr A alone, lying on the floor with his head sticking out into the corridor. The chair remained strapped to him and was on top of him. An ambulance was called and Mr A was transferred to a general hospital.

24. From the records Mr A was noted to have a number of bruises on the day following his admission to the Hospital. It is not clear what caused these. There are a number of incidents documented while he was in the Hospital as follows:

> '9 December 2004: slipped and fell – abrasion to forehead
> 3 January 2005: large bruise noted on right thigh, not clear how this occurred
> 5 January 2005: slipped from chair, graze on back
> 6 January 2005: dragging himself along the floor – sustained friction burns and bruises
> 7 January 2005: found on the floor 4 times – niece agreed for a lap restraint to be used for his safety; fell when got up to the toilet at night. Graze to right shoulder and cut to right hand; trying to bang head on wall – bruise on right forehead
> 8 January 2005: restrained in chair as refusing to stay in bed
> 10 January 2005: found lying on floor with a chair on top of him
> 27 January 2005: fell out of bed – grazed right elbow
> 10 February 2005: fall
> 12 February 2005: lying on floor beside bed, apparently slipped from a chair'

25. Adviser 1 said that the falls were recorded on incident forms and staff appear to have taken appropriate action each time. There is no treatment for bruising although painkillers may provide some relief from discomfort. The Adviser was concerned that there was no attempt to assess the cause of the falls and no plans for how to address the risk of Mr A falling, which he said is both a very common occurrence and a significant cause of disability and death in older people. The Adviser would have expected physiotherapy input but there is no record of referral to physiotherapy until 14 February 2005 by which time Mr A was unable to walk. The Adviser was also concerned that a restraint was instituted without any evidence of team discussion and without a risk assessment. Restraining people in this way is contentious and it may have been possible to use a less restrictive option, for example, increasing observation levels or determining the cause of the falls. The Adviser would be concerned if using restraints in this way was routine or normal practice in the Hospital.

26. The Adviser also noted that on 22 January 2005 an injury was observed on Mr A's heel. The Adviser said that being underweight, dehydrated and with poor skin condition Mr A would have been considered as high risk for pressure sores. The Adviser said that there was no evidence of assessment or monitoring of this injury or of Mr A's skin condition more generally.

27. In response to my further enquiries the Chief Executive said that consideration of risk is fundamental to the provision of psychiatric care and the medical and nursing notes record the attention given to Mr A's care. He said no specific risk assessment tools were used but staff in the ward were familiar with the concepts of 'likelihood' and 'severity' of risks.

28. The Chief Executive said that the Hospital used the guidelines on the use of restraint in hospitals issued by the Mental Welfare Commission for Scotland in April 1998 and the subsequent good practice guidance. I have checked these guidelines and they state that:

- use of restraint should be based on multi-disciplinary discussion which should be fully documented in the care plan together with the decisions taken and the arrangements for regular reviews;
- each episode of restraint must be recorded;
- all restless residents and those with difficulty walking should have full physical examination to look for causes and identify effective treatment if possible;

- in all cases alternatives to physical restraint should be considered first;
- the tying of a person's body into a chair will inevitably feel very restrictive and should in almost no circumstances be considered. There will always be alternatives to consider. The risks that may be caused by using restraints should also be considered. People may injure themselves in trying to escape from restraints and this is unacceptable;
- a person who is the subject of any mechanical restraint should never be left unobserved.

29. The hospital did not have a policy on patient falls at the time of Mr A's admission but the Chief Executive sent me a copy of a draft document which he said was at the consultation stage. On page 6 it states:

> 'It should be remembered that the most important element is that the true cause of the fall is investigated.'

30. In response to my further enquiries the Board sent me the NHS Scotland booklet 'Pressure Ulcer Prevention' although the Chief Executive said that he was not sure of the relevance of this document because damage to Mr A's skin was in the form of bruising. This document states that 'All patients at risk of pressure sore development should have their skin assessed'. There is no evidence in the records that an assessment was done.

(b) Conclusion

31. The Chief Executive told me that the Hospital followed the guidelines. The evidence above shows some of the information that is set out in the guidelines. I am concerned that there was no attempt to discover why Mr A was falling and there was no plan to minimise the risk. There is no evidence of multi-disciplinary discussion or regular reviews before the use of the restraint. The incidents of restraint are not recorded. Mr A was able to move from the window to the doorway unobserved before falling with the chair on top of him. There is no evidence that Mr A's skin was assessed even although he was at high risk of developing a pressure sore. Despite the Chief Executive's assertion, all of these are in breach of the guidelines. The falls and the use of the restraint must have been at the least very distressing for both Mr A and his family, and it is a matter of concern to me that the evidence shows that significant elements of the guidelines were not followed in his case. I uphold the complaint.

(b) Recommendations

32. The Ombudsman recommends that the Board:

(i) review care planning in the Hospital;
(ii) implement their new policy on patient falls if they have not already done so;
(iii) develop and implement a policy on the use of restraints at the Hospital in line with Mental Welfare Commission guidelines; and
(iv) take steps to ensure that the guidelines on pressure ulcer prevention are followed in the Hospital.

(c) Poor communication between staff and relatives

33. Ms C said that varied and inaccurate information was given to Mr A's relatives. For example, following the choking incident Mr A's relatives asked that he be transferred to a medical unit. They were told that no bed was available. When they asked again they were told that no hospital would accept Mr A because of his mental state. A further example is that on 3 January 2004 the family were told that Mr A would be given his drugs by injection. On 5 January 2005 Ms C was told that was what was happening. It later transpired that Mr A was given no drugs by injection.

34. In response to Ms C's complaint the Chief Operating Officer said that there was evidence in both the medical and nursing notes that there was active consideration of Mr A's mental and physical health with input from several medical practitioners. It was possible that the number of staff involved and the absence of some key staff during the holiday period may have made communication appear more difficult or complex.

35. In response to my enquiries the Board provided me with a copy of the medical and nursing staffing profiles for the periods of Mr A's admission. The profiles show that in addition to the Consultant Psychiatrist there was a Locum Consultant, a Staff Grade Consultant, a Senior House Officer and a Medical Officer on the in-house staff. There were additionally ten visiting doctors. The nursing staff on the ward comprised the ward manager and between three and seven nurses depending on how many patients were on the ward and the time of the day or night.

36. Adviser 2 said that from the records it is difficult to be absolutely clear about the communication issues with relatives as there is not much information about this. Mr A's next of kin is clearly noted to be his niece and there is evidence that staff spoke with her and she visited frequently. There is also clear evidence that Mr A's family were concerned about aspects of his care,

particularly in the light of his deterioration. From the limited evidence available it would seem that staff did try to speak with them although the details of the communication are not in the records.

(c) Conclusion

37. It is clear from the clinical records that Mr A's niece was recorded as his next of kin and there is evidence that she was communicated with. Ms C was clearly concerned about her brother but felt that communication with her was not satisfactory. I note, however, that she was not recorded as joint next of kin and, therefore, would not have been the staff's first port of call in communicating with the family. It is also clear that many different members of staff were involved in caring for the patients on the ward during the Christmas holiday period. This may have led to some disruption of continuity of care. Communication may not have been ideal but there is evidence that, despite the fact that she was not named as next of kin, staff did make reasonable attempts to communicate with Ms C. I, therefore, do not uphold this complaint.

(d) Poor hygiene

38. Mrs C said that there was blood on Mr A's bedhead from 30 December 2004 to 10 January 2005. Ms C said that the windowsill of Mr A's room and the floor under Mr A's bed were covered with dust during the same period.

39. The Chief Operating Officer said that the issue had been discussed with the ward manager who had been asked to liaise with domestic staff to ensure that satisfactory standards of cleanliness were maintained throughout the ward. (The Chief Operating Officer of the Acute Division was then appointed as the Chief Executive of the NHS Board).

40. In response to my further enquiries the Chief Executive sent me a copy of the cleaning schedule for the ward. This shows that the floor should be damp mopped and the window sills damp dusted every morning. The bed frame should be cleaned weekly. There is also a requirement to deal with any ad-hoc requests made by the nurse in charge or the supervisor. The Chief Executive said that the ward manager had made contact with the domestic supervisor following receipt of the complaint to ensure that the cleaning schedule was followed. A subsequent visual inspection of the room by the ward manager found it to be clean. The Chief Executive said that it was normal practice for nurses on the ward to identify areas for cleaning and take appropriate action.

The hospital had no record of Ms C raising any concerns at the time and the Chief Executive considered it unlikely that the nurses would not have taken action had she done so.

(d) Conclusion

41. Ms C clearly was not satisfied regarding the cleanliness of Mr A's room but there is no written evidence that Ms C raised the matter with staff during Mr A's admission although Ms C said she did mention it. I am satisfied that there is provision in the cleaning schedule to deal with requests from nursing staff to clean particular areas. There is no clear evidence, however, that the staff were aware of the defects in hygiene. In the circumstances, therefore, I am unable to make a finding in relation to this complaint.

42. The Board have accepted the recommendations and are acting on them accordingly.

22 August 2007

Annex 1

Explanation of abbreviations used

Mr A	The complainant's brother
The Hospital	Royal Cornhill Hospital, Aberdeen
Ms C	The complainant
The Board	Grampian NHS Board
Adviser 1	Professional adviser to the Ombudsman - a Consultant Psychiatrist
Adviser 2	Professional adviser to the Ombudsman – a Psychiatric Nurse