Scottish Parliament Region: South of Scotland

Case 200602521: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; Care of the Elderly/Clinical treatment/Diagnosis

Overview

The complainant (Mrs C) complained about the care her late husband (Mr C) received in Ayrshire Central Hospital (the Hospital). In particular, she was concerned about the rapid deterioration in Mr C's condition during his stay.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the care Mr C received was unsatisfactory (*upheld*);

(b) communication from senior medical staff was inadequate (*not upheld*); and

(c) the follow-up to Mrs C's complaint was poorly handled (*upheld*).

Redress and recommendations

The Ombudsman recommends that Ayrshire and Arran NHS Board:

(i) undertake training in the recognition of acute physical illness in patients on mental health wards using a well-recognised scoring system such as MEWS (medical early warning score);

(ii) apologise to Mrs C for the failings in the care of Mr C identified in this report;

(iii) apologise to Mrs C for failing to provide an explanation for the deterioration in Mr C's physical health during his stay in the Hospital; and

(iv) take steps to ensure that the findings of critical incident reviews are fully incorporated in their responses to complainants.

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

Main Investigation Report

Introduction

1. Mrs C's complaint concerns the treatment her late husband (Mr C) received at Ayrshire Central Hospital (the Hospital). Mr C suffered from dementia and was admitted to the Hospital on 2 December 2005 for assessment. His condition worsened over the next few weeks and he was transferred to another hospital in the area on 31 December 2005 for rehydration. Mr C's condition continued to deteriorate and he died on 10 March 2006.

2. Mrs C had complained to the Hospital about Mr C's treatment on 14 February 2006 and the Board's response was sent on 27 March 2006. Mrs C remained dissatisfied with the explanation of Mr C's deterioration and had further contact with the Board culminating in a meeting on 15 June 2006. Mrs C continued to be dissatisfied and made a complaint to the Ombudsman's office on 6 November 2006.

3. The complaints from Mrs C which I have investigated are that:
(a) the care Mr C received was unsatisfactory;
(b) communication from senior medical staff was inadequate; and
(c) the follow-up to Mrs C's complaint was poorly handled.

Investigation

4. To investigate this complaint, I reviewed Mr C's medical records and documentation relating to the complaint Mrs C made to Ayrshire and Arran NHS Board (the Board). In response to my inquiry of 21 February 2007, the Board sent evidence relating to an improvement plan put in place to address issues raised in their investigation of Mrs C's complaint. I sought advice from Independent Professional Advisers on nursing matters (Adviser 1) and on the care of older people (Adviser 2).

5. 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.

Background

6. Mr C was diagnosed as having early stage Alzheimer's disease on 26 April 2004 and began to receive treatment of his symptoms with donepezil

(see Annex 2). By December 2005, his condition had deteriorated and his behaviour was causing difficulty to his family. He was, therefore, reviewed at a memory clinic on 2 December 2005 and a consultant in old age psychiatry (the Consultant) admitted him for assessment to the Hospital. On admission, all medication was stopped so that Mr C's condition could be assessed accurately.

(a) The care Mr C received was unsatisfactory

7. In the course of Mr C's stay in the Hospital, Mrs C observed a rapid and significant deterioration in his physical health. In particular, she noticed a decline in his ability to walk unaided, she was concerned that his hands felt cold, his fingernails were discoloured and his face looked grey. In addition, she thought that he was suffering from weight loss. Mrs C raised these concerns with nursing staff on a number of occasions and nursing notes confirm that the advice she received was that Mr C's deterioration was consistent with his dementia. Mrs C was told that there was no other observable physical cause for his deteriorating condition.

8. Mrs C had noted that Mr C had been having difficulties in eating and this is confirmed by entries in his clinical notes. Nursing staff explained that people whose cognitive functions were impaired by dementia often encounter difficulties in eating. Mrs C had wondered whether these difficulties were contributing to his deteriorating condition and noticed a weight loss during Mr C's stay in the Hospital. Adviser 2 noted that a small weight loss of 3lbs had occurred, and that this was not unexpected in the circumstances. He said that a 'lack of comprehension of what was expected … in feeding' including difficulty in swallowing contributed to this. Adviser 2 said that Mr C's nutritional needs were adequately assessed and re-evaluated appropriately in the course of his stay in the Hospital.

9. However, Adviser 2's review of the records suggested that there was a significant physical cause for the deterioration in Mr C's condition. By 31 December 2005, it was recognised that Mr C's physical state was related to dehydration and constipation. The constipation had been noticed before that date and, on 28 December 2005, the cause of this was considered to be 'lack of awareness'. Adviser 2 found that there were signs, most significantly including results of blood tests, that Mr C was 'already significantly dehydrated, with a degree of kidney impairment by 6 December 2005, some four days after admission' but this was not picked up at the time. Adviser 2 considered this to be a 'serious gap in clinical judgement'. In addition, he highlighted the fact that,

in a critical incident review on 23 May 2006, the Board acknowledged that Mr C was dehydrated at the beginning of his stay in the Hospital, and also that there was a delay in requesting blood tests after admission. Furthermore, Adviser 2 said that there was an apparent lack of fluid monitoring between 13 and 31 December 2005, which may have led to an underestimation of Mr C's fluid intake.

10. The Hospital responded to Mr C's dehydration on 31 December 2005 by sending him to another hospital to be rehydrated. By that time, in Adviser 2's judgement, 'the physical damage [caused by dehydration] was almost irreversible'.

(a) Conclusion

11. Adviser 2 commented that the records 'demonstrate careful assessments and evaluations with appropriate actions in response to these from nursing and medical staff'. However, the failure to respond early to indications of Mr C's dehydration represents a significant deficiency in his care. Therefore, I uphold this complaint.

12. Adviser 1 underlined 'the importance of medical and nursing staff being competent in recognising changes to the physical health of patients in mental health wards'. The Board alluded to this in their response to Mrs C's complaint of 13 March 2006 saying that the Patient Services Manager had been asked to consider whether there were training needs for staff in this area. A service improvement plan drawn up in response to Mrs C's complaint attends to some of these training needs for nursing and non-training grade medical staff. This includes action to address the need to take blood samples on the day of admission, better communication of the results of such tests and the introduction of fluid balance charts for patients at risk from dehydration.

(a) Recommendations

13. I commend the Board for the action taken in response to this complaint. In addition to the measures put in place to remedy shortcomings in some aspects of Mr C's care, Adviser 1 and Adviser 2 have both identified the need for training in the recognition of acute physical illness in patients on mental health wards. I, therefore, recommend that the Board undertake such training using a well-recognised scoring system such as MEWS (medical early warning score).

14. I have concluded that there were failings in the Hospital's care of Mr C. On 20 June 2006, the Board sent a letter to Mrs C following a meeting with her and her sons. In that letter, they included a copy of the improvement plan mentioned in paragraph 23. They also offered an 'unequivocal apology for the inattentiveness of certain aspects of care' received by Mr C. The guidance from the Ombudsman's office on making an apology advises that apologies should be specific in naming the mistakes for which the apology is made. Therefore, I recommend that the Board apologise to Mrs C for the failings in the care of Mr C identified in this report.

(b) Communication from senior medical staff was inadequate

15. Mrs C complained about inadequacies in communication with her during Mr C's stay in the Hospital. She felt that she was not given clear advice on the likely progression of his illness and his future care needs. She also felt that staff did not communicate an accurate picture of Mr C's condition when she saw a deterioration in his physical health and that some responses to her concerns were dismissive.

16. Mr C's nursing records contain a number of detailed notes of conversations between senior nursing staff and Mrs C. These conversations addressed, among other things, issues around Mr C's future care needs, explanations of medical interventions being made, concerns about Mr C's nutrition and explanations of the effects of dementia. In addition, there were full notes of two conversations with Mrs C after Mr C had been transferred to another hospital, one by telephone and another at Mrs C's home. These conversations focussed mainly on the deterioration of Mr C's condition. Mrs C remained unhappy with the explanations given.

17. From the evidence I have seen, it does not appear that Mrs C was fully aware of the reasons for Mr C's admission and the connection between the assessment of his condition and his future care needs. In particular, Mrs C was not happy with the way that the issue of Mr C's need for 24 hour care was raised with her.

(b) Conclusion

18. Adviser 2 noted how difficult it is to break the bad news to someone of a loved one's condition, especially when it concerns a condition as distressing as dementia. In their letter to Mrs C of 13 March 2006, the Board acknowledged that communications from health professionals could have been more

informative and sensitive. The Board apologised for these shortcomings before Mrs C brought her complaint to the Ombudsman's office and there are significant actions in the service improvement plan which address the need for better communications, including multi-disciplinary reviews and communications with relatives at every stage of the process from diagnosis onwards. In all of these circumstances, I do not uphold this complaint.

(c) The follow-up to Mrs C's complaint was poorly handled

19. Mrs C complained to the Hospital about Mr C's treatment on 14 February 2006. A response letter was prepared by the Board and was dated 13 March 2006. However, Mr C died on 10 March 2006, so the Board sent a letter explaining that a response had been prepared and would be sent to Mrs C when she felt able to receive it. The letter responding to Mrs C's complaint was sent on 27 March 2006.

20. On 23 May 2006, the Board held a critical incident review of the issues surrounding Mr C's care as raised by Mrs C's complaint. This review identified a number of actions surrounding aspects of care and communications and these were incorporated into a service improvement plan, as referred to above in paragraphs 12, 14 and 18.

21. Mrs C remained dissatisfied with the explanation of Mr C's deterioration and had further correspondence with the Board culminating in a meeting on 15 June 2006. Following this meeting, the Board sent a further letter on 20 June 2006 including a copy of the service improvement plan. After further telephone contact with the Board, Mrs C referred her complaint to the Ombudsman's office on 6 November 2006.

(c) Conclusion

22. The documentary evidence of the Board's handling of Mrs C's complaint shows that care was taken in the investigation and response. In her complaint to the Ombudsman's office, Mrs C acknowledged the attentiveness of the staff who responded to her complaint.

23. The actions which were included in the service improvement plan directly address many of the issues raised in Mrs C's complaint and the Board has provided me with evidence to demonstrate that the progress of these actions is good.

24. However, Adviser 2 raised a serious concern about the Board's response to Mrs C's central concern, which was an explanation for the rapid deterioration in Mr C's physical condition during his stay in the Hospital. Although the critical incident review acknowledged the issue of Mr C's dehydration and the failures in identifying this condition, the Board's letters to Mrs C did not provide an explanation of how this contributed to the deterioration in Mr C's physical health. Therefore, the findings of the critical incident review were not fully incorporated in the response to Mrs C's central complaint. I acknowledge the care and thoroughness of much of the Board's handling of Mrs C's complaint. However, the Board's response did not address a central concern of Mrs C's complaint, which was to obtain an explanation for the deterioration of Mr C's physical condition while in the care of the Hospital. For all of these reasons, I uphold this complaint.

(c) Recommendations

25. I recommend that the Board apologise to Mrs C for failing to provide an explanation for the deterioration Mr C's physical health during his stay in the Hospital. I also recommend that the Board take steps to ensure that the findings of critical incident reviews are fully incorporated in their responses to complainants.

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

27. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

21 November 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	Mrs C's late husband, a patient at Ayrshire Central Hospital
The Hospital	Ayrshire Central Hospital
The Board	NHS Ayrshire and Arran
Adviser 1	An Independent Professional Adviser on nursing matters
Adviser 2	An Independent Professional Adviser on the care of older people
The Consultant	A consultant in old age psychiatry at the Hospital
MEWS	Medical early warning score

Annex 2

Glossary of terms

Alzheimer's Disease	A progressive degenerative disease of the brain which is a major cause of dementia
Donepezil	A drug used for the symptomatic treatment of people with mild to moderately severe Alzheimer's dementia