Parliament Region: South of Scotland

Case 200901416: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; care of the elderly

Overview

The complainant, Ms C, raised a number of concerns about the care and treatment that her late father (Mr A) received at Crosshouse Hospital Kilmarnock (the Hospital), in the area of Ayrshire and Arran NHS Board (the Board). Ms C considered that poor standards of care had led to Mr A's premature death.

Specific complaint and conclusion

The complaint which has been investigated is that the care and treatment which Mr A received at the Hospital was inadequate and brought about his death prematurely (*I upheld the complaint that the care and treatment were inadequate. However, I did not find that poor standards of care had led to Mr A's premature death).*

Redress and recommendations

The Ombudsman recommends that the Board	*Completion date*
(i) provide the Ombudsman's office with a specimen copy of the new in-patient admissions booklet;	18 November 2010
(ii) provide the Ombudsman's office with a report on the findings of the audit of the Abbreviated Mental Test section of the patient medical admission form;	18 November 2010
(iii) remind staff of the importance of fully completing all significant documentation, paying particular attention to the omissions identified in this report;	18 November 2010
(iv) reflect on the comments of the specialist Advisers in paragraphs 15 and 22 of this report; and	18 November 2010
(v) issue an apology to Ms C and her family for the failings identified in this report.	15 September 2010

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

Main Investigation Report

Introduction

1. On 30 June 2008 Ms C's father, Mr A, who was 85 years of age at the time, was admitted to Ward 3E of Crosshouse Hospital, Kilmarnock (the Hospital). He was suffering with dehydration, acute diarrhoea with a history of vomiting, malnutrition and weight loss. He also had Acute Macular Degeneration (AMD). Initially Mr A made good progress and his family were optimistic that he would make a full recovery. However, when he was moved from Ward 3E to Ward 3B (the Ward) on 2 July 2008 his condition deteriorated. Mr A died on 8 July 2008. Ms C thereafter complained to Ayrshire and Arran NHS Board (the Board) about Mr A's care and treatment. She was dissatisfied with their response and complained to this office.

2. The complaint from Ms C which I have investigated is that the care and treatment which Mr A received at the Hospital was inadequate and brought about his death prematurely.

Investigation

3. In writing this report my complaints reviewer has had access to Mr A's medical records and Ms C's complaints correspondence with the Board. In addition, my complaints reviewer sought advice from two of my medical advisers, a hospital consultant (Adviser 1) and a nursing adviser (Adviser 2).

4. 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.

Complaint: The care and treatment which Mr A received at the Hospital was inadequate and brought about his death prematurely

Ms C's complaint to the Board

5. Ms C, in a letter dated 31 December 2008, complained to the Board about her father's care and treatment by nursing and medical staff. In her letter Ms C said that she and her family considered the treatment which Mr A received in Ward 3E to be 'superb' and saw an improvement in his condition. After Mr A's move from Ward 3E to Ward 3B they had discussions with the Ward doctor about his needs to allow him to return home. However, Mr A's condition deteriorated shortly thereafter. According to Ms C, on one particular day, a Sunday, the Ward appeared to be short staffed, nursing staff failed to clean

Mr A's eyes and to ensure that he had something to eat and drink. Mr A subsequently suffered a fall and developed pneumonia. Mr A became confused. Furthermore, nursing staff failed to make allowances for his poor eyesight, caused by AMD, and to use the first name he was familiarly known by. Mr A died on 8 July 2010, six days after he was admitted to the Ward.

The Board's response to Ms C's complaint

6. The Board's Nurse Director (the Nurse Director) wrote to Ms C in response to her complaint. The Nurse Director accepted that the cleaning of Mr A's eyes had appeared to have been overlooked. However, nursing staff had noticed Mr A was not eating or drinking on the Sunday and had tried to encourage him to do so. A nutritional assessment had been carried out on Mr A's admission but the dieticians had not received the initial written referral report until almost a week later, when a further referral was sent. The Nurse Director apologised for a failure in the referral system, which would be drawn to the attention of staff and the referral process reviewed. Training was about to start for nursing staff on the implementation of a new nutritional screening tool and there were plans to further audit the provision of nutritional care in wards. The Nurse Director said that she wished to reassure Ms C that the Ward was fully staffed in line with professional nursing guidelines at the time. She said she was sorry if Ms C had the impression that staff did not have time to attend to Mr A or to discuss his care and treatment with her and her family.

7. The Nurse Director confirmed that Mr A did appear to have fallen in the toilet area on 5 July 2010. He was reviewed by a doctor and an Advanced Nurse practitioner who noted no injury and he was observed for any neurological abnormalities. The Nurse Director accepted that Mr A's family should have been notified, for which she apologised, and that it had been documented as a clinical incident to be reviewed for future learning by staff.

8. The Nurse Director said that the issue which Ms C had raised about Mr A's AMD was understandable. The condition had been documented on Mr A's admission to the Hospital's Accident and Emergency Department but unfortunately this had not been communicated between ward staff when Mr A had been transferred. Ms C's suggestion of staff training about AMD was something they intended to take forward. She also apologised that Mr A's preferred first name was not used although they had been advised of this.

9. The Nurse Director then addressed the medical aspects of Mr A's care. She said that initially it was considered that Mr A would be fit for discharge from the Hospital and he had embarked on rehabilitation to improve his mobility to allow for this. However, unfortunately there was an acute deterioration in Mr A's condition that was due to the onset either of a chest or urinary tract infection for which treatment was started. Mr A continued to deteriorate and it was concluded that a urinary infection was the cause of this. There was no indication of pneumonia. The Ward doctor treating Mr A apologised if he had not made it clear that both diagnoses were suspected.

Adviser 1's comments

10. My complaints reviewer asked Adviser 1 to comment on the records of Mr A's care and treatment. Adviser 1 said that Mr A had been losing weight for several months before admission and may have been suffering from malignant disease. He had a poor appetite. A nutritional screening tool was completed on admission, which suggested he was at high risk of problems relating to sub nutrition. Adviser 1 could not see evidence of fluid or intake charts being completed and the eating and drinking care plan had only one entry. The freehand nursing notes made only occasional reference to oral intake. Mr A was dehydrated on admission but this had greatly improved by 4 July 2008, suggesting he was well hydrated by then. However, when Mr A's condition subsequently deteriorated he suffered markedly impaired kidney function, which may in part have been due to dehydration, but could also have been related to sepsis and urinary retention.

11. Overall Adviser 1 considered the standard of documentation of Mr A's fluid and food intake, given the recognition of his feeding needs on the initial screening, to be below an acceptable standard. However, even if Mr A had been offered oral nutritional supplementation that would not, in his opinion, have materially altered the outcome. It would have been clinically inappropriate to feed Mr A artificially and he and the family had apparently declined further investigations for his weight loss (see paragraph 13).

12. Adviser 1 considered whether there was any evidence that Mr A had pneumonia. A sputum sample sent on 4 July 2008 grew no organisms but was described as mucopurulent (possibly indicating infection). On the day before Mr A died 'thick purulent sputum' was documented suggesting infection. Mr A's admission chest x ray showed no features of pneumonia, but one of the doctors examining him on the day of death found clinical signs on the right side of his

chest to suggest aspiration pneumonia. There were changes in the lungs compatible with heart failure, chronic lung disease or bilateral lung infection. His blood tests on this day suggested he had an infection as his white blood cell count had risen and the amount of oxygen in his blood had fallen. Mr A was also retaining urine and had blood in his urine, both of which possibly suggested a urinary infection. Antibiotic treatment for both possibilities was given. On balance, Adviser 1 suspected Mr A did have pneumonia but, in his view, this was a terminal event in an extremely frail man that was not preventable and in whom more aggressive or earlier treatment would have been of highly debatable value.

13. Adviser 1 said that it was clearly documented on several occasions in Mr A's records that he did not apparently wish treatment or investigation. The decision appeared to have been discussed with his family who had agreed that he was competent to make this decision. This had to be taken into account in any subsequent analysis of Mr A's care as he believed the medical team were acting in good faith in accepting Mr A's view. It may be that the family had not appreciated the implications of this decision, which was that uncertainty would remain about the cause of Mr A's pre-admission decline, that subsequent decline was likely and that he could quite possibly have malignant disease and a short life expectancy. Adviser 1 did not consider there was any evidence to suggest that Mr A's treatment was compromised by his decision not to have further investigation, aside from the fact that specific treatment cannot be given for any underlying specific problem if it is not in the first instance diagnosed following investigation.

14. Having said that, Adviser 1 was of the view that Mr A and his family should still have expected that his basic care needs were properly addressed. In that regard, it appeared that Mr A's nutritional and fluid needs were not well documented and perhaps not met. His terminal event, whether it was sepsis secondary to urine infection or chest infection, was not, in his opinion, an indicator of poor medical treatment but of Mr A's very poor general condition and probable underlying disease. Although critical of the fact that Mr A's nutritional and fluid intake was not well documented, he did not believe that those problems arose specifically because Mr A had decided against investigation.

15. Adviser 1 said the nursing assessment and care planning documentation were voluminous and must have been very challenging for care staff to

complete. The documentation failed to identify or manage Mr A's visual impairment and his nutritional and feeding requirements. Adviser 1 considered the Board could usefully reflect on whether this indicated a problem with the documentation itself or the time nursing staff have to complete it and the associated assessments.

16. Adviser 1 said that he suspected that Mr A had significant cognitive impairment. This could have been due to a dementia (developing over time) or a delirium (acute and relating to his then current illnesses and potentially correctible). However, this was not formally documented or assessed but merely commented on by the admitting doctor. The admitting medical proforma had a section for AMT (Abbreviated Mental Test) but this had not been completed. The admitting doctor suggested a formal Mini Mental State Examination (MMSE) of Mr A but this was never done. The admission care plan only asked 'known dementia' but had no other prompts for nursing staff to formally consider or evaluate cognitive impairment.

17. Adviser 1 considered that some of Mr A's subsequent care problems (falling which perhaps related to impaired safety awareness and judgement as well as visual impairment), wanting to go home in the face of severe symptoms and functional impairment (possibly indicating impaired judgement, reasoning and insight), poor interest in feeding (again poor insight) may well have related to this cognitive impairment. In addition, although a doctor judged Mr A to be competent to decide that he should go home this decision would have been better informed if formal assessment of Mr A's mental state had taken place. The family's points about Mr A's visual impairment and confusion meaning he needed assistance with feeding were reasonable. The failure to evaluate Mr A's confusion indicated care of a standard below that which can be reasonably expected. This criticism would, in his view, apply equally to the two wards Mr A occupied, irrespective of their specialty, as both would deal with large numbers of frail older patients.

18. On the occurrence of Mr A's fall, staff including at least one physiotherapist had identified that Mr A was unsafe when alone due to a combination of physical frailty and visual and cognitive impairment. A moving and handling risk assessment was carried out and a mobilising care plan completed. The risk assessment suggested that Mr A had been classified as moderate risk (requiring one or more 'handlers' to transfer) although another part of the same document suggested he had been capable of mobilising

independently. The physiotherapist recommended that Mr A mobilise with one person assisting. Nursing staff subsequently documented that they mobilised him with one member of staff to the toilet but on the day of the fall he was found on the floor by the toilet. Adviser 1 said that he suspected that Mr A decided to mobilise to the toilet without buzzing for help because he may not have understood, remembered, or appreciated the need to do so and fell whilst mobilising alone. Adviser 1 said that it is not possible for all patients to be directly observed at all times and considered that the assessment and documentation of Mr A's mobility and safety issues was of an acceptable standard, with the exception of the documentation of his cognitive function referred to in paragraphs 16 and 17.

Adviser 2's comments

19. My complaints reviewer also asked Adviser 2 to review and comment on the records of Mr A's care and treatment. Adviser 2 firstly addressed how the Hospital had dealt with Mr A's nutritional needs. She said that a number of the standards expected were not met and she was critical of this. Mr A was not weighed on admission and, therefore, an estimate was made. A nutritional assessment was done which demonstrated Mr A was at high risk of sub nutrition and he should, therefore, have been referred to the dietetic team. However, a referral made on the day Mr A was admitted was lost. Although there was a second referral on 6 July 2008, she could find no record of Mr A being seen by a member of the dietetic team.

20. Adviser 2 said that the nursing assessment and care planning documentation were very long and she found it difficult to find the appropriate information. The level of detail about Mr A was minimal. There was no food chart. There was no record of what Mr A liked or disliked to eat or drink, no mention of supplementary high calorie drinks or any other suggestions to tempt his appetite. There was no record of his personal needs for assistance with eating due to his poor eyesight. The records mentioned 'only eating and drinking small amounts', however, no fluid balance chart was completed until the day of his death. Although there are methods to identify patients that require help with eating and drinking it was unclear what Mr A drank or ate. He was clearly at risk of becoming dehydrated. She would have expected more detail in relation to individualised care for an elderly man, such as Mr A, who required assistance with eating and drinking, mobility and washing. The assessment and care planning record-keeping was, therefore, unacceptable

and, in her view, Mr A had received poor nutritional care both from the nursing and dietetic staff.

21. Adviser 2, however, considered the standard of the nursing notes was generally very good and there were reasonable efforts at recording communication between Mr A's family and the medical staff and arrangements for his discharge home. The nursing records also well documented the wishes of Mr A and his family to restrict any further treatment.

22. Adviser 2 said there was no evidence that anyone in the Hospital had apologised to Mr A's family for the delay in the issue of his death certificate at such a distressing time. There was also no evidence that anyone spent time talking and listening to their concerns about the care Mr A received and arranging for a senior member of staff to speak to the family or offer a meeting. The tone of the entry in the notes demonstrated a lack of compassion and may well have escalated the family's emotions.

The Board's response to my complaint reviewer's enquiries

23. The Board in response to my complaint's reviewer's enquiries accepted that Mr A should have seen a dietician and although a referral was made, this did not happen. The failure to follow up the referral should have been escalated to the Dietetic Department via the named nurse. A further referral was then made but this was not followed up either. The Board accepted this was a serious failing as it represented a gap in care.

24. The Nurse Director said the Board also accepted that although care planning documentation was started on admission, later documentation was poor. While nutritional screening was carried out on the basis of an estimate of Mr A's weight and his weight was subsequently measured for accuracy the following day after his admission, they accepted that subsequent planning was poor. To address this issue a new in-patient admissions booklet incorporating all the new standards from the Food Fluid and Nutritional Care in Hospitals guidance was shortly to be implemented. Training for nurses took place in March and April 2010 where it was emphasised that patients' nutritional needs are the responsibility of nursing staff and that trained nursing staff should demonstrate leadership in this key area. The Board now provide annual training days for all staff nurses and nursing assistants that cover nutritional care and its importance for patients. Nutritional care also features in nurse induction.

25. In October 2009 monitoring of nutritional care for patients was started. Individual wards audit their practice weekly, which information is then reported throughout the organisation. Audit results from the Ward demonstrate solid progress with improvements being sustained on an ongoing basis. The Ward now has a dedicated nutritional link nurse who liaises with the Board's nutritional care leader over any identified issues or planned changes. The link nurse attends all relevant fluid/nutritional educational events and then passes the information learned to the Ward staff.

26. A protected meal times policy, although not in place at the time of Mr A's admission to the Ward, has now been implemented in another hospital within the Board area with other areas following on. Ahead of this, the Ward had informally implemented such a policy and nursing staff were very aware of this. To allow focus on food and nutrition no staff breaks are scheduled during patient meal times. NHS Quality Improvement Scotland had recently reviewed the organisation as to how they were implementing the standards for food fluid and nutritional care and the draft report commends the new documentation.

27. The Board recognised the particular difficulties which Mr A experienced with regard to his sight needs and the needs of similarly disabled patients. As a practical response they had purchased red coloured trays to indicate that a patient needs particular help with feeding. Furthermore, staff numbers had now been reviewed and increased in order to provide better care. These changes are being led by a newly appointed Charge Nurse who has been tasked with improving quality and the over all service and experience for patients in the Ward.

28. The Hospital's Clinical Director for Medical Specialities (the Clinical Director) accepted that a lack of clarity around the diagnosis of pneumonia and poor communication with Mr A's family caused the family to be confused as to the cause of Mr A's death and better communication would have made matters easier for his family at a very difficult time.

29. The Clinical Director also agreed with Adviser 1 that failure to evaluate Mr A's confusion represented poor care. In response to this clear failing discussions were being held with colleagues in Geriatrics and Psycho-geriatrics to produce an audit tool in order to examine the quality of documentation in the AMT section of the medical admission form and whether the AMT tool was

being properly used where it is needed. It was the Board's intention to conclude and report on this audit by the end of summer 2010. Any relevant findings will be used to inform future training and practice development.

Conclusion

30. I am satisfied that, based on the evidence I have seen and the clinical advice received from Adviser 1 and Adviser 2, whose advice I accept, that there were serious failings in the care and treatment of Mr A.

31. There were failings in identifying, documenting and managing Mr A's nutritional and feeding requirements, particularly as Mr A was at high risk of sub nutrition. The standard of Mr A's nursing assessment and care planning documentation was below an acceptable standard, containing minimal information. All of this led to Mr A receiving poor nutritional care both from the nursing and dietetic staff.

32. Mr A had significant cognitive impairment but there was a failure to carry out a formal assessment of and formally document his mental state, which in the opinion of Adviser 1 indicated care of a standard below that which can be reasonably expected. Furthermore, there was also a failure to identify and manage Mr A's visual impairment.

33. For these reasons I uphold Ms C's complaint.

34. However, I have seen no evidence which would enable me to conclude that these failings brought about Mr A's death prematurely. The clinical advice I have received and which I accept is that Mr A's death was not due to poor medical treatment or because his nutritional and fluid intake was not well managed or documented but was due to his very poor general condition and probable underlying disease.

35. The Board have accepted there were failings in the care and treatment that Mr A received. I welcome the remedial action that the Board have already taken to address failings identified in this report. The further action required by the Board is in relation to the recommendations below.

Recommendations

36. I recommend that the Board: *Completion date*

(i)	provide my office with a specimen copy of the new in-patient admissions booklet;	18 November 2010
(ii)	provide my office with a report on the findings of the audit of the Abbreviated Mental Test section of the patient medical admission form;	18 November 2010
(iii)	remind staff of the importance of fully completing all significant documentation, paying particular attention to the omissions identified in this report;	18 November 2010
(iv)	reflect on the comments of the specialist Advisers in paragraphs 15 and 22 of this report; and	18 November 2010
(v)	issue an apology to Ms C and her family for the failings identified in this report.	15 September 2010

37. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mr A	The late father of Ms C and the subject of this report
The Hospital	Crosshouse Hospital, Kilmarnock
The Board	Ayrshire and Arran NHS Board
The Nurse Director	The Board's Nurse Director who dealt with Ms C's complaint
The Ward	Ward 3B of Crosshouse Hospital, Kilmarnock
Adviser 1	One of the Ombudsman's hospital advisers
Adviser 2	One of the Ombudsman's nursing advisers
The Clinical Director	The Hospital's Clinical Director for Medical Specialities
AMD	Acute Macular Degeneration
AMT	Abbreviated Mental Test
MMSE	Mini Mental State Examination

Annex 2

Glossary of terms

Acute Macular Degeneration (AMD)	Acute Macular Degeneration, a medical condition that causes visual impairment in older adults
Food Fluid and Nutritional Care in Hospitals guidance	NHS Quality Improvement Scotland Food Fluid and Nutritional Care in Hospitals report (April 2010)
Sub nutrition	Being in a poor nutritional state