**Parliament Region: Lothian**

**Case 200904074: Lothian NHS Board**

**Summary of Investigation**

***Category***

Health: Hospital; care of the elderly; clinical treatment; diagnosis

***Overview***

On 2 February 2010, I received a complaint from the complainant (Ms C) against Lothian NHS Board (the Board). The complaint concerned the care and treatment her grandfather (Mr A) received in the Maple Villa Care Home, Livingston (the Care Home) prior to his death. Mr A suffered from Alzheimer's disease and the Care Home is a specialist dementia unit catering for patients with particularly challenging aspects of that condition. Mr A resided there from 2004 until July 2009. On 24 July 2009 he was admitted to St John's Hospital, Livingston, where he died three days later. Ms C said that on his admission he was severely dehydrated, had a urinary tract infection and bedsores.

***Specific complaints and conclusions***

The complaints which have been investigated are that the Board failed to:

(a) provide Mr A with proper nutrition *(upheld);*
(b) provide Mr A with general personal care *(upheld);*
(c) take action to prevent bedsores *(not upheld);*
(d) provide any form of stimulus to Mr A as a patient suffering from Alzheimer's disease *(upheld);* and,
(e) communicate adequately with the family *(upheld).*

***Redress and recommendations***

| The Ombudsman recommends that the Board: | *Completion date* |
|---|---|
| (i) make a written apology to Ms C for their failures with regard to Mr A and for the misinformation given; | 28 January 2011 |
| (ii) emphasise to staff in the Care Home the necessity of following adopted procedures and the proper completion of standardised forms; | 28 January 2011 |

| | | |
|---|---|---|
| (iii) | monitor procedures in the Care Home for a period of four months; | 15 April 2011 |
| (iv) | provide evidence to the Ombudsman of the range of structured recreational or diversional activity now available to residents in the Care Home and emphasise to staff the importance of such; | 28 January 2011 |
| (v) | emphasise to their staff the benefit to all parties of clear communication; and | 28 January 2011 |
| (vi) | ensure that, on each new admission, the Care Home take steps to discuss and record the level and means of communication required with families; and provide evidence to the Ombudsman that this is happening. | 15 April 2011 |

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

## Main Investigation Report

### Introduction

1. The complainant (Ms C)'s elderly grandfather (Mr A) became a resident of Maple Villa Care Home, Livingston (the Care Home) in 2004 and he stayed there until just before his death in July 2009. Mr A suffered from Alzheimer's disease and, on occasion, his behaviour could be extremely challenging. However, the Care Home was a specialist, residential unit catering particularly for people like Mr A. Over the years, Mr A's condition deteriorated and on 24 July 2009 he was admitted as an emergency to St John's Hospital, Livingston, where he died on 27 July 2009. After his death, Ms C and her family felt they had reason to complain about the care and treatment he had received while resident in the Care Home and on 23 September 2009 raised their concerns with Lothian NHS Board (the Board). Ms C was not satisfied with the response she received and complained to me on 2 February 2010.

2. The complaints from Ms C which I have investigated are that the Board failed to:

(a) provide Mr A with proper nutrition;
(b) provide Mr A with general personal care;
(c) take action to prevent bedsores;
(d) provide any form of stimulus to Mr A as a patient suffering from Alzheimer's disease; and
(e) communicate adequately with the family.

### Investigation

3. Detailed enquiries have been made of the Board in relation to this matter and my complaints reviewer has had sight of Mr A's clinical records and records from the Care Home. She has also seen relevant haematological and biochemical reports. My complaints reviewer sought independent medical advice. This information, together with that provided by Ms C, has been taken into careful consideration when reaching decisions on the complaints.

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 both given an opportunity to comment on a draft of this report.

**(a) The Board failed to provide Mr A with proper nutrition**

5. Ms C was aggrieved and upset by what she considered to be the Board's failure to care for Mr A's nutritional requirements. She said that Mr A always enjoyed his food and that the family regularly took meals to him, which he always welcomed. However, while he was resident in the Care Home his meals were exceptionally small and Ms C provided examples of meals Mr A had been given when she was present. Routine visiting was not generally allowed at meal times so the family could not assist or ensure that Mr A was taking enough food. Similarly, no-one ensured that he took regular drinks. So much so, Ms C said, that when he was admitted to hospital on 24 July 2009, he was severely dehydrated.

6. In responding to representations after Mr A's death, the Board said that all patients in the Care Home had a Nutrition Care Plan in place; that family members would be asked what the patient would normally like to eat and drink; and that patients regularly underwent regular nutritional screening and their care plan was adjusted accordingly. The Board said that all patients were monitored at meal times and if someone was noted not to be eating or drinking, action would be taken. They said that family were always welcomed to assist with a patient at meal times. With regard to the availability of drinks, it was the Board's opinion that drinks being openly available could be a risk to some patients but that there were set times throughout the day when residents were offered drinks. If there was any concern about a resident's intake, the Board maintained that they would be encouraged to drink more. Drinks were always available when asked for.

7. From the Care Home records, it was seen that there were frequent entries relating to the adequacy or otherwise of Mr A's dietary and fluid intake. However, there was no evidence to show that his intake was being charted. Further, the Nutrition Care Plan (referred to above) had the appearance of being a standardised proforma where the resident's name was inserted. It made reference to the fact that food and fluid intake should be monitored and food likes and dislikes identified and noted but there was no evidence of charting food or fluid intake against any agreed daily targets. There was no record that staff had contacted relatives about Mr A's dietary preferences. In this regard the independent adviser (the Adviser) was critical, in so far as the nationally adopted Malnutrition Universal Screening Tool, which was in use in the Care Home and which indicated weekly screening for someone in routine care like Mr A, was used sporadically. This fell well below the standard of

weekly screening. The Adviser added that, even if the Care Home was following the Care Home standard of monthly screening, the Board failed to meet their obligations, in that months went by without this occurring.

*(a) Conclusion*

8. My complaints reviewer has had sight of the relevant records and has noted what the Board have said in this regard. However, while it appeared clear that processes and procedures were in place in the Care Home for monitoring residents' food and fluid intake, it appeared that they were followed less than assiduously. The forms were there, the processes were in place but they were not used as they were intended. There was no evidence to show that Mr A was eating and drinking agreed amounts and the Board cannot, therefore, be satisfied that Mr A, as their patient, was properly cared for in this regard. Accordingly, I uphold this aspect of the complaint.

9. In the circumstances, I recommend that the Board apologise to Ms C for their failure. They should also emphasise to staff the necessity of following adopted procedures and the proper completion of standardised forms available for their use. Procedures in the Care Home should be monitored by the Board over a period of four months thereafter and the results should be reported to the Ombudsman.

*(a) Recommendations*

| 10. I recommend that the Board: | *Completion date* |
|---|---|
| (i) make a written apology to Ms C for their failures with regard to Mr A and for the misinformation given; | 28 January 2011 |
| (ii) emphasise to staff in the Care Home the necessity of following adopted procedures and the proper completion of standardised forms; and | 28 January 2011 |
| (iii) monitor procedures in the Care Home for a period of four months. | 15 April 2011 |

**(b) The Board failed to provide Mr A with general personal care**

11. Ms C said that she and her family were saddened and distressed to see the decline in Mr A's physical appearance. She said she accepted that his behaviour could be extremely challenging but she did not think enough was done for him to allow him to retain his dignity in the face of his illness. She complained that there was a lack of general personal care; he was given

infrequent baths and showers; his finger and toe nails were neglected; and his teeth were not cleaned.

12. In replying to Ms C's concerns on this matter, the Board said that Mr A did become 'very aggressive during interventions' and was normally assisted by three staff for his personal hygiene. They also said that a podiatrist saw him on seven occasions in the last two years of his stay in the Care Home and on later occasions two podiatrists attended. His finger nails were cut and cleaned when he allowed staff to do so. Similarly, he was bathed and showered when possible, otherwise he was washed thoroughly but, again, this was when he allowed staff to do so.

13. Mr A's Personal Hygiene Care Plan was contained within the available records and it was commenced on 30 January 2009. This took the form of a standardised plan with gaps included for entering the resident's name. There was no evidence that it had been individualised or updated to address the changes required to address the decline in Mr A's physical health from this period of time, particularly when he became incontinent. In this regard, the Adviser said that he would have expected greater attention to Mr A's physical hygiene at this time and that a daily shower/bath/bed bath would have been the minimum he would have expected.

14. The records confirmed that Mr A was often resistive to assistance with his personal hygiene requirements and this would have caused staff significant difficulty in assisting him. However, they also showed that on some occasions he was more amenable than others but it was unclear from the notes how often offers to help were repeated over the course of a day. There was nothing to indicate that repeated attempts were made to persuade him to have a daily shower or bath if he refused the initial offer.

15. An oral hygiene record was available covering the period from 23 June 2009 until Mr A's admission to hospital on 24 July 2009. The chart was not completed each day and, in the view of the Adviser, it was often completed retrospectively with arrows covering days at a time. Mr A's Nutritional Care Plan indicated that it was planned for him to see a dentist at least every three months but when the information was recorded, it appeared that he refused every time. All attempts in this regard were made in the morning but there was no evidence that Mr A was approached later in the day, or at all, to persuade him to clean his teeth.

16. The records showed that between 23 February 2007 and 10 March 2009, Mr A had had seven appointments to see a podiatrist. On one occasion the podiatrist was assisted by five members of staff, on another, two podiatrists attended. Treatment was not always successful. The records also noted that a Core Foot Health Plan was agreed between staff of the Care Home and that Mr A's nails should have been filed weekly by care staff. There was no evidence of this being carried out or offered.

*(b) Conclusion*

17. From the incomplete information available to me, it appeared that Care Home staff observed the requirements of providing personal care to Mr A only in a very limited way. The level of care was significantly lower than one would have expected. Mr A was in the care provided of a specialist residential facility which claimed to cater for those who suffered from the more challenging effects of Alzheimer's disease and dementia. It was, therefore, expected that the behaviour he presented was not unknown. Families and society expect that patients in this type of facility will be treated and cared for in such a way as to allow them their dignity. This does not appear to have happened in Mr A's case. With the exception of the podiatry service, staff do not appear to have gone back to Mr A after his first refusal of care to make the offer again. The records were silent on this point but it appeared to me that staff had a mechanical approach to care, not seeing the individual behind it. I uphold this complaint.

**(c) The Board failed to take action to prevent bedsores**

18. Ms C said that when Mr A was admitted to hospital on 24 July 2009 he had bedsores and that the hospital required to use a special mattress for him. She and her family were of the view that the poor condition of his skin was a contributory factor to his death (his death certificate recorded that he suffered from Enterococcus coli septicaemia). She believed that this could have been avoided.

19. The Board maintained that on arrival in hospital Mr A's skin was noted to be red but intact and it was for this reason that a therapeutic mattress was recommended. At the time of his admission, they said that there was no record of him having open sores nor did he require any wounds to be dressed. They said he was treated for a fungal skin infection, the most prominent site being behind his ear.

20. The Personal Hygiene Plan indicated that Mr A's skin integrity should have been checked every day, however there were no specific skin care records from the Care Home. However, the hospital record of his admission to Accident and Emergency on 24 July 2010 noted that his skin was intact and unbroken; it was dry and there was only a moderate risk of his skin breaking down. Taking this into account, I am of the view that the skin care provided to Mr A was adequate.

*(c) Conclusion*

21. I do not uphold this complaint.

**(d) The Board failed to provide any form of stimulus to Mr A as a patient suffering from Alzheimer's disease**

22. Ms C was unhappy because she said that in all the time Mr A was in the Care Home neither she nor her family saw any evidence that he was being distracted by any activity and that there was rarely even one to one interaction between him and a member of staff.

23. In responding to this complaint, the Board said that the Care Home had a dedicated activities nurse, who took advice from the Occupational Therapy Department and from the Stirling Dementia Centre about those activities which were appropriate for patients with dementia. They said that the activities nurse involved Mr A in group activities but that he would wander away after about five minutes. They maintained that he was continually offered to be involved.

24. A review of the available records did not show that any attempts were made to engage Mr A in any recreational or diversional activities. Neither was this activity mentioned in any of his care plans. It was ultimately confirmed by the Board during the process of this investigation that, despite the information given to Ms C, the Care Home did not have a dedicated activities nurse/ coordinator. (At draft report stage this information was amended by the Board to show that the post concerned had been affected by periods of long term sick leave.) I uphold this complaint.

*(d) Conclusion*

25. I uphold this complaint and, in light of the information above, I recommend that the Board proffer an apology to Ms C, taking into account that they failed to offer Mr A stimulation and also to reflect the misinformation they gave. Furthermore, they should provide evidence to the Ombudsman of the range of

structured recreational or diversional activity now available to residents in the Care Home and emphasise to staff the importance of such.

*(d) Recommendation*

| 26. I recommend that the Board: | *Completion date* |
|---|---|
| (i) proffer an apology to Ms C, taking into account that thye failed to offer Mr A stimulation and also to reflect the misinformation they gave; and | 28 January 2011 |
| (ii) provide evidence to the Ombudsman of the range of structured recreational or diversional activity now available to residents in the Care Home and emphasise to staff the importance of such. | 28 January 2011 |

**(e) The Board failed to communicate adequately with the family**

27. Ms C maintained that while Mr A was in care she received little information about his condition. She had particular concerns about the lack of communication with the family about a fall, blood tests and 24 hour observation.

28. In a letter to Ms C's mother, the Board said that Mr A was found lying on the floor on 22 June 2009 and that it was documented that the family were informed. A further letter to Ms C's mother of 22 December 2009 referred to a fall, after which 'his son-in-law was telephoned on 22 June 2009'. Ms C disputed this and said that no family member was contacted and that her mother only became aware that there had been a fall after staff were questioned because Mr A appeared to be in some discomfort.

29. A review of the records showed that on 19 June 2009, Mr A was found on the floor. There was no reference in the notes of any member of the family being informed at that time. The notes suggested that, in fact, the family were informed when they visited on 22 June 2009 and it was observed that Mr A was holding his chest. The Board have advised as part of this investigation that no incident form was completed at the time because Mr A 'appeared to have placed himself on the floor and not fallen'. Given that there were no witnesses to the event, it was difficult to see how the Board could be so conclusive. Nevertheless, regardless of the cause of Mr A being on the floor, the Adviser told my complaints reviewer that he would have expected an incident form to be completed because a fall could have been the explanation. He said that good practice should have dictated that the family be informed of the situation.

30. Ms C said that the situation around the question of blood tests was a 'shambles' and that, although her parents asked for information, it was not forthcoming. It was her belief that if blood tests had been completed earlier, steps could have been taken to mitigate any deleterious effects (that is, the effects of blood poisoning would not have contributed to Mr A's death). In response to this, the Board advised Ms C that as Mr A's physical condition deteriorated, the benefits of any investigation, including blood tests, were weighed against the level of distress they caused him. They confirmed that one set of results had, in fact, been lost and they apologised. They said that arrangements were now in place so that nursing staff in the Care Home could access results on a computer system.

31. Records show that blood tests were done on 30 June 2009 and 22 July 2009. Although both haematology and biochemistry results were requested for the first of these tests, only biochemistry were available. The advice my complaints reviewer received was that these were essentially normal. While the haematology result was not available, the Adviser believed, according to his experience, that it would most likely have been normal too. By the time of the second blood test (on 22 July 2009), the Adviser said that there were signs of dehydration and early renal failure. The haematology result at that time suggested infection and that Mr A's general condition was deteriorating. Given this information and the advice received about the first of these blood tests, my complaints reviewer has been told that it would have been unlikely to have caused a change in the management of Mr A's condition.

32. While Ms C also raised concerns that the family was not advised of the outcome of the blood tests, the advice my complaints reviewer was given was that it would not have been usual practice to inform relatives every time blood was taken for analysis. However, I believe that it would have been good practice to keep the family apprised, particularly if they had made a specific request for information.

33. Ms C was concerned that Mr A had been placed under special observation. She said that her family had not known this had happened or what it meant. Ms C believed that if it had involved the giving of oxygen and that Mr A's health was deteriorating, the family should have been told.

34. When Ms C complained to the Board about this she was told that special observation meant that one member of staff was continually with the patient. In

Mr A's case, this meant that someone was with him from 22 July 2009. The following day, 23 July 2009, the GP recommended that he commence oxygen therapy and the Board said that the family were informed then.

35. The records indicated that special observation (that is, nurse(s) in close proximity at all times) was initiated on 22 July 2009 to prevent injury. However, on 23 July 2009, observation was reduced to 'constant' (that is, nurse(s) within sight and/or sound). Special observation was not reinstated until Mr A was transferred to hospital on 24 July 2009. In reality, it appeared that Mr A was on special observation for less than 24 hours. Ms C was upset that the family was not advised of the situation with regard to Mr A and the advice my complaints reviewer has received was that to do so would have been both good practice and courteous, particularly as it appeared to reflect Mr A's deteriorating condition.

36. On discussing this point with the Adviser, it was his view that it was always good practice at the outset of a patient's care to establish the level of communication each family wished or required, and how they wanted this to happen. There was no evidence in the records to indicate the presence of a strategy with regard to the family or evidence that it was ever discussed.

37. I take the view that, overall, communication between the Board and Ms C's family was at best unplanned and ineffective. Accordingly, I uphold the complaint.

*(e) Conclusion*

38. I uphold this part of the complaint and recommend that the Board offer their apologies for their shortcomings in this regard. I also recommend to the Board that they emphasise to their staff the benefit to all parties of clear communication and that on each new admission the Care Home take steps to discuss, and record, the level and means of communication required.

*(e) Recommendations*

| 39. I recommend that the Board: | *Completion date* |
|---|---|
| (i) emphasise to their staff the benefit to all parties of clear communication; and | 28 January 2011 |
| (ii) ensure that, on each new admission, the Care Home take steps to discuss and record the level | 15 April 2011 |

and means of communication required with families; and provide evidence to the Ombudsman that this is happening.

40. 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 complainant's grandfather |
| The Care Home | Maple Villa Care Home, Livingston |
| The Hospital | St John's Hospital, Livingston |
| The Adviser | An independent specialist medical adviser |