Scottish Parliament Region: Glasgow

Case 201000373: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; care of the elderly

Overview

The complainant (Mr C) raised a number of concerns about the prescription of antipsychotic drugs to his mother (Mrs A), failures in record-keeping and failures in communication by Greater Glasgow and Clyde NHS Board (the Board) from late 2008 until February 2010.

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) wrongly prescribed Mrs A with antipsychotic drugs from late 2008 to February 2010 (*upheld*);

(b) failed to keep adequate medical records (*upheld*); and

(c) failed to communicate properly with Mrs A's family (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) undertake an external peer review in Hospitals 1 and 2, on the implementation of the Adults with Incapacity Act and SIGN Guideline 86 for patients with dementia with particular reference to assessment of capacity within 72 hours of admission wherever practicable and report back to the Ombudsman on the findings;	22 December 2011
(ii) carry out an audit of their: record-keeping to ensure it is in accordance with the national guidelines with particular reference to care planning practice; practice relating to the storage of patients' medical records to ensure it accords with the Scottish Government Records Management: NHS Code of Practice (Scotland);	22 September 2011

	and report back to the Ombudsman on the findings;	
(iii)	develop a policy on meeting the communication needs of patients with dementia which includes having an identifiable and agreed relatives' communication or participation strategy as a core aspect of the care plan; and	22 September 2011
(iv)	apologise to Mr C for the failures identified in this report.	22 July 2011

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

Main Investigation Report

Introduction

1. Mr C has complained about the care and treatment provided to his mother, (Mrs A) by Greater Glasgow and Clyde NHS Board (the Board). Mrs A suffers from vascular dementia and was prescribed antipsychotic medication from 2008 to 2010 both in the community by her GP and by the Board during her numerous admissions to hospital. Mr C said Mrs A had an adverse reaction to the antipsychotic drug, haloperidol, which was prescribed prior to and during Mrs A's first admission to the Vale of Leven Hospital (Hospital 1) on 14 November 2008 until 19 November 2008. Following her readmission to Hospital 1 on 18 December 2008, Mr C complained that hospital staff continued to prescribe the drug despite Mr C asking them not to because of Mrs A's adverse reaction. Mrs A was prescribed another antipsychotic drug, quetiapine, on 23 March 2009 until 26 April 2010. When the family became aware of this and made their objections known to the Board, the treatment was discontinued.

2. Mr C also complained about Mrs A's medical records because they failed to describe his mother's ill effects from the antipsychotic drugs and to note the family's strong opposition to her being prescribed such drugs. Finally, Mr C complained about the lack of communication from healthcare professionals about Mrs A's treatment and that they failed to seek the family's consent to treatment. As a result of the failures by the Board, Mr C said that his mother had been prescribed antipsychotic drugs without consent and had endured severe side-effects causing physical and mental suffering over a long period. Furthermore, he and the rest of the family had been caused a great deal of distress.

3. Mr C complained to the Board on 26 February 2010. On 15 April 2010, the Board responded to Mr C's letter of complaint. Mr C raised further issues with the Board and received the Board's final response on 19 July 2010. Mr C remained dissatisfied with the Board's responses and complained to my office.

4. The complaints from Mr C which I have investigated are that the Board:

(a) wrongly prescribed Mrs A with antipsychotic drugs from late 2008 to February 2010;
(b) failed to keep adequate medical records; and
(c) failed to communicate properly with Mrs A's family.

Investigation

5. During the course of the investigation into this complaint, my complaints reviewer obtained and examined Mrs A's clinical records and the complaint correspondence from the Board. She obtained advice from two of the Ombudsman's professional advisers; a consultant physician specialising in care of the elderly (Adviser 1) and a nursing adviser with extensive experience of psychiatric nursing (Adviser 2). My complaints reviewer also made enquiries of the Board.

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

Relevant legislation

7. Adults with Incapacity (Scotland) Act 2000 (the Act) provides a framework for safeguarding the welfare and managing the finances of adults who lack capacity due to a mental disorder or inability to communicate. The Act sets out the principles to be followed by everyone who is authorised to act on behalf of someone with incapacity (a 'proxy'). In relation to decisions about medical treatment, the Act allows treatment to be given to safeguard and promote the physical and mental health of an adult unable to consent. Where a welfare attorney or guardian has been appointed with healthcare decision-making powers, the doctor must seek their consent where it is practicable and reasonable to do so. If the adult has no proxy, a doctor is authorised to provide medical treatment subject to certain safeguards and exceptions (see paragraph 9).

8. The Act defines incapacity as being incapable of: acting on decisions; or making decisions; or communicating decisions; or understanding decisions; or retaining the memory of decisions. An adult may lack capacity because of mental disorder, such as dementia. In relation to medical treatment, in order to demonstrate capacity, an individual should be able to:

- understand broadly what the treatment is, its purpose and nature and why it is being proposed;
- understand its principal benefits, risks and alternatives and be able to make a choice;
- understand in broad terms what the consequences will be of not receiving the proposed treatment;

- retain the information long enough to use it and weigh it in the balance in order to arrive at a decision; and
- communicate that decision.

9. Healthcare professionals who provide medical treatment to patients who lack capacity to consent should do so with regard to the principles of the Act. This means that healthcare professionals are required to complete a certificate of incapacity and should consult those with an interest in the person's welfare, such as the person's primary carer, nearest relative etc, whenever practicable and reasonable. A flow chart showing the steps healthcare professionals should take is at Annex 4.

Relevant policy

10. SIGN Guidelines 86 state that conventional antipsychotic drugs including haloperidol have traditionally been used to treat behavioural problems associated with dementia. Sedation, movement disorder and increased confusion are all recognised side-effects. An analysis of the use of these drugs showed that they were very effective for treating behavioural disorders associated with dementia. Haloperidol is the most commonly assessed drug. Evidence suggested that it is useful in controlling aggression in people with dementia. The guideline advises that, if necessary, a conventional antipsychotic, such as haloperidol, may be used with caution (given their side-effects) to treat the associated symptoms of dementia. The guideline concluded that: an individualised approach to managing agitation in people with dementia was required; where antipsychotics are inappropriate, cholinesterase inhibitors may be considered; and antipsychotic withdrawal should be considered in stable patients. The guideline also clearly indicates that good communication between healthcare professionals and carers of patients with dementia was essential and that such communication should focus on the needs of both patients and carers.

Clinical background

11. From 2005 until 2008, Mrs A was a resident in a care home. During this period, Mrs A was prescribed a number of drugs, including the antipsychotic drugs haloperidol and quetiapine. In 2005, Mrs A's GP documented that she was on quetiapine for a while but that this 'seemed to make things worse' and it was stopped. Mrs A was prescribed rivastigmine (a drug used to limit the progression of dementia) regularly from 2006. Mirtazepine, an antidepressant, was also used in 2006 on two occasions with no apparent success. In 2007, a

consultant suggested stopping two drugs, betahistine (a drug used to treat vertigo) and mirtazepine because Mrs A was sleepy and falling. Mrs A's GP prescribed a small dose of a sleeping tablet on 1 February 2008 because Mrs A was not sleeping. On 30 September 2008, Mrs A's GP prescribed haloperidol in response to reports of agitation including minor physical aggression by care home staff and stopped the antidepressants and sleeping tablet. On 26 October 2008, Mrs A was seen by healthcare professionals at the accident and emergency department of Hospital 1 because of concerns of increased confusion. A nurse from Hospital 1 raised the possibility with care home staff that the haloperidol may be worsening agitation. On 27 October 2008, on the basis of this opinion and the views of the care home staff, Mrs A's GP discontinued the haloperidol in case it was worsening confusion and referred her to a community psychiatric nurse. At this point, Mrs A was still on rivastigmine. Mrs A became increasingly agitated and an out-of-hours service GP prescribed a single dose of diazepam (a sedative drug used to treat anxiety) on 11 November 2008.

12. On 14 November 2008, Mrs A was admitted to a medical assessment ward in Hospital 1 and transferred to a medical ward (Ward 2) on 15 November 2008 because of oedema of her legs. The GP's referral note stated that haloperidol and mirtazepine had recently been stopped, but did not suggest that Mrs A had had any adverse reaction to these drugs. The nursing admission note suggested that Mrs A was still on haloperidol, but Mrs A's medical records documented that care home staff informed healthcare professionals at the hospital that haloperidol had recently been discontinued and a nurse noted 'please review'. There was no medical documentation of a review or why the haloperidol had been stopped in the community. A haloperidol dose of 0.5 mg was prescribed to be given to Mrs A twice daily from 14 November until 18 November 2008, but it is recorded in the medical records that the first dose was withheld. Mrs A was also prescribed 10 mg of temazepam (a sedative drug used to treat anxiety) from 14 November until 18 November. The records also showed that Mrs A was given lorazepam (a drug used to treat anxiety) on 17 and 18 November 2008. Mrs A was discharged on 19 November 2008 on 0.5 mg haloperidol and regular rivastigmine. Mrs A's medical records documented that she was over sedated on discharge, but there was no evidence of any significant change of blood pressure or blood oxygen saturation at any point. A psychiatrist reviewed Mrs A on 27 November 2008, and recommended using haloperidol as required in addition to trazodone (a sedating antidepressant) and temazepam. The

psychiatrist also suggested that Mrs A's diagnosis was vascular dementia with depression.

13. On 18 December 2008, Mrs A was admitted to Ward 3 (a psychiatric admissions unit for older patients specialising in the care of patients with dementia) at Hospital 1. She was transferred to Ward 4 (a long stay psychiatric ward) at Joint Hospital (Hospital 2) on 27 March 2009 where she stayed until her discharge on 1 December 2009. A certificate of incapacity and a treatment plan in line with the Act was completed for Mrs A by the doctor responsible for her care at the time (the Doctor) in consultation with Mr C's brother on 26 February 2009 whilst a patient in Ward 3. The treatment plan lists a number of drugs prescribed to Mrs A, which does not include any antipsychotic drugs. The medical records did not contain drug prescribing cardexes from 18 December 2008 until 1 March 2009, but a transfer document dated 27 May 2010 showed that Mrs A was on a regular painkiller (fentanyl), regular quetiapine, regular temazepam and, as required, haloperidol. The document did not refer to rivastigmine. Drug prescribing cardexes from 1 March 2009 onwards, showed that Mrs A was prescribed a variety of drugs for pain and agitation on a regular basis including fentanyl, sodium valproate, citalopram, quetiapine, temazepam and haloperidol, as required. The records also documented that Mrs A was sensitive to aricept (the same class of drug as rivastigmine used in dementia - a different class of drug to antipsychotics).

14. The discharge summary for this admission was dated 27 May 2010 (which was six months after discharge from Hospital 2). It noted that mirtazepine was changed to trazodone, and that because Mrs A's mental state did not improve, quetiapine was added but this 'did not have the desired improvement on her mental state'. It also noted that following transfer to Ward 4 on 27 March 2009, trazodone was changed to citalopram (another antidepressant) and that mood and agitation improved after sodium valproate was added.

15. Mrs A was admitted to a nursing home on 1 December 2009. A psychiatrist (Psychiatrist 1) noted on 20 January 2010 that Mrs A was 'fine' on quetiapine. Following a telephone call from Mr C, Psychiatrist 1 recorded Mr C's concern about quetiapine being prescribed to Mrs A and said that they would discontinue if possible. On 22 March 2010, Psychiatrist 1 reviewed Mrs A and suggested reducing quetiapine. On 26 April 2010, Psychiatrist 1 advised that the quetiapine should be stopped because 'since the reduction in her quetiapine there has been very little in the way of behavioural problems.

[Mrs A] has not been at all aggressive and only occasionally shouts out for her sister [name]'.

(a) Wrongly prescribed Mrs A with antipsychotic drugs from late 2008 to February 2010

16. Mr C complained that the Board had wrongly prescribed his mother with antipsychotic drugs from late 2008 until February 2010. Mr C said that his mother had suffered from severe side-effects from being prescribed haloperidol by both her GP and hospital staff during November 2008, which had caused physical and mental suffering. Mr C said his mother's condition when she returned to the care home from Hospital 1 on 19 November 2008 was very serious; she had reacted severely to the antipsychotic drugs. When Mrs A was readmitted to Hospital 1 on 18 December 2008, Mr C telephoned the deputy ward manager about the drugs his mother had been prescribed during her previous admission. Mr C asked her not to prescribe his mother with an antipsychotic telling her that the previous prescription had nearly killed her and he would take them to court if they prescribed them again. Mr C and his brother met the Doctor on 26 February 2009 to discuss his mother's care and treatment, including her medication, but he was thrown off balance during the meeting because the doctor had asked unexpectedly for his permission not to resuscitate Mrs A. However, he left the meeting believing he had been given an assurance by the Doctor that Mrs A would not be given antipsychotic drugs. Despite this assurance, Mr C discovered on 25 February 2010 that Mrs A was being treated with the antipsychotic drug, quetiapine, and had been since 2009. Until then, Mr C had been happy with the care his mother had received whilst a patient at Ward 4 because she had improved and he was unaware that she was being treated with quetiapine. Mr C complained that at no time had the Board taken into account the severe side effects he believed Mrs A had suffered from or sought his or his brother's consent to administer antipsychotic drugs to their mother. Furthermore, Mrs A's condition had improved significantly when the antipsychotic had finally been withdrawn in April 2010.

Board's response to Mr C's complaint

17. The Board said there was a record showing that Mrs A was given 1 mg of lorazepam and 1 mg of haloperidol twice on 18 November 2008, and there was nothing recorded to state how she responded to the treatment or to suggest any ill effects when she was discharged back to the care home. However, on her return both staff and family were worried about the state Mrs A was in. Referring to Mr C's telephone call to the deputy ward manager on

18 December 2008, the Board said the record of this conversation showed that Mr C had said there was a specific drug Mr C did not want Mrs A to receive because it had made her very ill when she received it previously in a medical ward in Hospital 1. However, Mr C was unable to provide the name or type and no reference was made to it being an antipsychotic drug. Mr C went on to say that if it was prescribed, Mr C would sue the hospital. The deputy ward manager contacted the care home for further information, but they were unable to help. Referring to the meeting with the Doctor, the Board said he could not recall offering an assurance that no antipsychotic treatment would be prescribed. The only medication that was recorded as an 'alert' on Mrs A's medication chart was Aricept, which is not an antipsychotic drug. The Board said if this was not the drug Mr C had referred to, then it was difficult to explain how such a misunderstanding occurred and they apologised.

18. The Board said the causes and symptoms of Mrs A's depression and anxiety were first noted by staff at the care home who observed dramatic changes in Mrs A's behaviour. In particular, they were concerned by Mrs A's deterioration in mobility, her increasing anxiety and that she was not sleeping. The cause of the change in behaviour and apparent increase in agitation leading up to the admission on 14 November 2008 was not clear, but can often be a feature of dementia as it progresses. Adapting to a changing environment would also contribute to increasing the level of agitation. In the period leading up to her admission to Hospital 1 to Ward 3 on 18 December 2008, Mrs A's agitation worsened and the Board suggested that there were some contributing factors including severe oedema (now thought to be cellulitis) with associated pain and hypothyroidism in addition to her dementia.

19. In relation to the prescription of haloperidol during her admission from 14 November 2008 to 19 November 2008, the Board said the medical notes showed that Mrs A was being prescribed haloperidol when she was admitted (presumably by her GP) and during this admission lorazepam was added. There was no record in Mrs A's medical notes that she had experienced a bad reaction to an antipsychotic drug and her GP stated that haloperidol was stopped as he did not think it was helping, but again, there was no mention of a severe reaction.

20. The Board went on to say the decision to treat Mrs A with quetiapine was made by a psychiatrist (Psychiatrist 2) on clinical grounds including current best evidence and practice guidelines for Mrs A's condition. Mrs A had dementia

and a depressive illness which was associated with agitation. Mrs A had been admitted for her depression and agitation, which was treated with an antidepressant, but she did not improve on the antidepressant alone. The decision to prescribe quetiapine followed a ward multi-disciplinary review of Mrs A's care on 23 March 2009 in Ward 3. Psychiatrist 2 decided that since Mrs A's predominant symptom was anxiety with agitation, a combination of an antidepressant and an antipsychotic medication would be the most appropriate treatment and there was no record of Mrs A responding badly to the drug. The Board continued that agitation can be extremely distressing and disabling and Psychiatrist 2 could not leave Mrs A untreated. He was unaware at this point of the family's views on prescribing an antipsychotic treatment. Mrs A was transferred to Ward 4 on 27 March 2009 and discharged from there to a nursing home on 1 December 2009. Psychiatrist 1 then reviewed Mrs A's treatment, but the case notes were not available and Psychiatrist 1 was not aware of any concerns and considered it appropriate to continue Mrs A's treatment. After reviewing Mrs A on 25 January and 22 March 2010, quetiapine was reduced and finally discontinued by Psychiatrist 1 as there had been no deterioration.

21. In response to my complaints reviewer's enquiries, the Board said that Mrs A was admitted to Ward 3, a dementia assessment ward, on 18 December 2008. They advised that a period of assessment can take months and many patients remained there for a significant period of time before diagnosis was made. In Mrs A's case, she was assessed as being incapacitated and section 47 [of the Act] was implemented on 22 February 2009, approximately two months following her admission. The Board said this was common practice, indeed good practice to ensure that people's capacity was properly assessed and their wealthy and finances properly protected.

Advice received

22. My complaints reviewer asked Adviser 1 to assess Mrs A's medical condition in late 2008 and the evidence that she reacted adversely to the antipsychotic medication administered. Adviser 1 said major adverse effects of haloperidol included over sedation, paradoxical agitation, low blood pressure and involuntary movements. In his view, that was no evidence of any definite adverse reaction by Mrs A of these kinds to haloperidol at any time. This was largely because the behavioural and psychological symptoms of dementia seen in Mrs A fluctuated, both within and between days. As such, any observed increase or decrease in agitation could not be said with certainty to relate to the

use of any drug rather than to the fluctuations in the disease process. The clinical impression of nursing staff on at least two occasions was that Mrs A's behaviour was not consistently improved by haloperidol, and some clearly felt it made her worse. However, this was not documented by medical or psychiatric staff and was simply transmitted informally. Mrs A's GP appeared to base his judgement to stop haloperidol on this message and on the observations of nursing staff. Adviser 1 said this did not comprise evidence of a definite adverse reaction to haloperidol. Furthermore, Mrs A was clearly very sleepy on the discharge from the hospital on 19 November 2008, but this could not be said to be due to haloperidol alone as she had been prescribed a variety of drugs with sedating side-effects. It was Adviser 1's view that the temazepam and lorazepam prescribed to Mrs A caused her sleepiness on discharge. There was no evidence of any other side-effects such as changes in blood pressure or involuntary movements.

23. Referring to Mrs A's medical condition, Adviser 1 said her condition was dominated by behavioural and psychological symptoms of dementia which ultimately required an admission to a specific psychiatric unit. That Mrs A then spent one year in hospital care was evidence of the severity of the problems. At the time of her discharge from Hospital 1 on 19 November 2008, Adviser 1 said in his view she was over sedated for a short time but there was no specific evidence that other illness was present and overlooked or that there were persistent side-effects from any prescribed drug. Attaining a balance between agitation and sedation is extremely difficult and, although undesirable, relative over sedation can occur and was not in itself a sign of poor care. Adviser 1 concluded that the drugs used in the hospital were all appropriate in type and dose and use of these drugs was not at all extraordinary in acute hospital care in this situation.

24. On whether there was clear information suggesting that haloperidol should not be prescribed by the Board in late 2008, Adviser 1 said that it was not possible to conclusively determine the quality or accuracy of the information sent by the community to hospital regarding the use of haloperidol (namely whether they had said the haloperidol had no effect or an adverse effect, see paragraph 21). However, neither was it possible to ascertain whether subsequent decisions by the Board to prescribe haloperidol were appropriately informed by that information.

25. On whether there was clear information suggesting quetiapine should not be prescribed by the Board from 2008-2010, Adviser 1 said medical entries during the long psychiatric admission (18 December 2008 to 1 December 2009) appeared infrequent and were difficult to identify. Adviser 1 said it was not possible to establish evidence of any specific or clear deterioration in Mrs A's physical or cognitive condition that could be secondary to the prescribed drugs during this time, but the available evidence suggested there was not.

26. Adviser 1 said it was not reasonable to prescribe antipsychotic drugs if there was no clinical indication for their use or clear evidence of a specific adverse reaction to them. They should not be prescribed to a competent patient who refuses them or to an incompetent patient without a consideration of the risks and benefits and involvement of proxy decision-makers. However, doubts about previous efficacy of the drug would not represent an absolute contraindication to their use, provided it is supervised and effects monitored. On medical grounds alone, it was Adviser 1's view that the Board's prescription of antipsychotic drugs was reasonable. Adviser 1 said that the use of antipsychotic drugs can be of great value to selected patients. However, Adviser 1 said there was no evidence that healthcare professionals had taken account of the Act in their treatment of Mrs A, including full communication with and involvement of the family in treatment decisions.

27. In view of Adviser 1's comments about the Act, my complaints reviewer asked Adviser 2 to assess the evidence of Mrs A's capacity when she was admitted to Hospital 1 on 14 November and 18 December 2008. Turning first to the admission on 14 November 2008, Adviser 2 said that her GP had recorded evidence of confusion, agitation, distress and disorientation by Mrs A by 27 October 2008. On Mrs A's admission to Hospital 1 on 14 November 2008, medical staff noted that she had dementia and that she 'seems quite confused'. Adviser 2 said the evidence in the records showed that it was likely Mrs A lacked the capacity to provide informed consent to treatment or participate in treatment decision-making. There was nothing in the records to indicate that her capacity was ever considered during the 14 November to 19 November 2008 admission. There was sufficient evidence to alert the medical team to the fact that Mrs A may have lacked capacity and a proper assessment of her capacity should then have taken place. Adviser 2 said that in certain circumstances, specialist assessment may be required, but in general the assessment consists of conveying information to the patient, discussing it with them to gauge their understanding and then asking questions about the

salient points to see if they have grasped them. In line with the Act, where a lack of capacity is confirmed, a certificate of incapacity should have been completed.

28. Turning to the admission to Ward 3 on 18 December 2008, Adviser 2 said that Mrs A's presentation on admission showed that she was in cognitive decline, disorientated for time and place, confused, anxious, showing evidence of dramatic changes in behaviour over a short period of time and having difficulty comprehending and retaining information. There was no evidence in the records that Mrs A's capacity to consent to treatment was assessed on her admission. A certificate of incapacity and relevant care plan under the legislation had been completed on 26 February 2009, but Adviser 2 said it was not clear what triggered the completion of the paperwork at that point when Mrs A had been a patient on the ward since 18 December 2008. Adviser 2 said a formal assessment of Mrs A's capacity under the Act should have taken place as part of the admission process or as part of an initial 72 hour assessment given that Ward 3 was a facility for the admission and assessment of older people with organic illnesses, especially dementia. The routine assessment of capacity should be an integral aspect of the first 72 hours of care for all new admissions in this type of ward.

29. Adviser 2 said a routine assessment of capacity can be carried out by a relevant professional, for example, a community psychiatric nurse, GP, hospital doctor, hospital or social worker. This initial assessment only needs to conclude that it is likely that the person lacks capacity to make informed decisions about their welfare and/or financial affairs for the procedure to be invoked. If the initial assessment concludes that the adult apparently lacks capacity, a multi-disciplinary case discussion can then be convened. This meeting is often best combined with a pre-existing hospital weekly review meeting or discharge planning meeting. All relevant professionals, the person, his or her relatives, carers and others having an interest in the person's property, finance or welfare should be invited to attend. A certificate of incapacity should be completed. Following the general principles underpinning the Act, a treatment plan should have been drawn up which detailed the conditions in which treatment was required and the healthcare procedures agreed to address these conditions and bring benefit.

(a) Conclusion

30. Mr C has complained that the Board wrongly prescribed antipsychotic drugs to his mother, Mrs A. There are two elements to Mr C's complaint: whether the Board was reasonable in prescribing antipsychotic drugs and whether they had consent to do so. Turning to the first element, I note that antipsychotic drugs can be beneficial to selected patients and that they are useful in controlling aggression in people with dementia. The guidelines also clearly indicate that antipsychotic drugs should be used with caution, and they should be prescribed only where there is a clear clinical reason to do so and there is no evidence of a specific adverse reaction to them. I have decided that in this case it was not reasonable for the Board to prescribe antipsychotic drugs in the absence of evidence that they had fully assessed the risks. In reaching my decision, I have taken into account the advice which I accept that there was no evidence of any definitive adverse reaction by Mrs A to antipsychotic drugs. This is because the psychological symptoms of dementia fluctuated in Mrs A and any increase or decrease in agitation could not be said to relate the drug rather than the disease process itself. Mrs A was over sedated on her discharge from Hospital 1 on 19 November 2008, but this was probably due to other medication that was prescribed at the same time. I am not, therefore, reaching a conclusion on the decision itself to prescribe haloperidol. However, there was no evidence that the Board's decision to prescribe haloperidol from late 2008 onwards had been informed appropriately by information from the community regarding the efficacy of the use of haloperidol (see paragraphs 10 and 11). Moreover, on admission to Hospital 1 on 14 November 2008, there was no evidence that hospital staff had taken into account the decision by Mrs A's GP to stop haloperidol despite the fact that responsibility for treating Mrs A with antipsychotic drugs during this admission (and subsequent admissions) lay with hospital staff and not her GP. In these circumstances, I am not convinced that the Board's decision to recommence haloperidol without the review as requested by the nurse (see paragraph 12) was reasonable.

31. Turning now to the second element to Mr C's complaint, I have decided the Board did not obtain consent to prescribe Mrs A with antipsychotic drugs. The advice I have accepted is that it was likely Mrs A lacked capacity to provide informed consent to treatment or participate in treatment decision-making on her admission to Hospital 1 on 14 November 2008. The Board failed to assess her capacity, which is of concern. Had they done so and found, as the evidence suggested, that Mrs A lacked capacity to consent to treatment, then they should

have completed a certificate of incapacity and consulted Mr C and his brother about treatment.

32. The Board also failed to assess Mrs A's capacity when she was admitted to Ward 3 on her admission on 18 December 2008 until 26 February 2009. I am particularly critical of the Board's failure to do so in this instance because Ward 3 is an admissions and assessment ward for patients with dementia and as such should be well aware of the need to assess capacity on admission. I am extremely concerned about the Board's statement that waiting two months from admission to assess a patient's capacity was good practice as my investigation has shown this not to be the case.

33. When the Board eventually completed a certificate of incapacity and relevant care plan including treatment under the Act on 26 February 2009, this was discussed with Mr C and his brother. However, the care plan did not include antipsychotic drugs even though quetiapine was being prescribed regularly and haloperidol as required at that time (see paragraph 13). Mr C was vehemently opposed to his mother being prescribed with antipsychotic drugs and had the Board acted in accordance with the Act and guidelines relating to communication, his views would have been known and informed treatment. When Mr C found out about the prescription of quetiapine in February 2010 and made his concerns known to Psychiatrist 1, the Board appropriately and properly decided to withdraw the antipsychotic. Good communication with carers is an underpinning principle of the Act and integral to obtaining consent to treatment for patients who lack capacity. I am very concerned that despite the fact that an antipsychotic drug had been prescribed on a regular or as required basis from December 2008 until 2010, Mr C was unaware of this until 2010. I go on to discuss the communication between the Board and Mr C further, including the phone call to the deputy ward manager and the meeting with the Doctor, in paragraphs 45 to 54.

34. In conclusion, there were serious failings by Board in the treatment they provided to Mrs A. I have not found evidence that Mrs A suffered a definitive adverse reaction to the antipsychotic drugs she had been prescribed, but the Board failed to: carry out a review of the prescription of haloperidol on Mrs A's first admission to Hospital 1; make an informed decision about the prescription; and obtain consent to treatment. As a result of these failings, Mr C and the family have been caused a great deal of distress. I uphold the complaint. Ward 3 and Ward 4, which specialise in the care of patients with dementia need

to be beacons of good practice to ensure public confidence in the care and treatment they provide. I have, therefore, made the following recommendation.

(a) Recommendation

35. I recommend that the Board:	*Completion date*
(i) undertake an external peer review in Hospitals 1 and 2, on the implementation of the Adults with Incapacity Act and SIGN Guideline 86 for patients with dementia with particular reference to assessment of capacity within 72 hours of admission wherever practicable and report back to the Ombudsman on the findings.	22 December 2011

(b) Failed to keep adequate medical records

36. Mr C complained about the Board's failures in record-keeping, describing them as chaotic. In particular, Mr C complained that the Board failed to record Mrs A's reaction to the antipsychotic drugs administered to her in late 2008 and throughout 2009 in her medical records. Moreover, the records failed to record the family's opposition to such drugs being administered to Mrs A, which had been made known to the Board on 18 December 2008 (Mr C's telephone call to the deputy ward manager) and 26 February 2009 (meeting between the Doctor, Mr C and his brother).

Board's response to Mr C's complaint

37. The Board said they could only report to Mr C what was recorded in Mrs A's notes and there was no record that she had experienced a bad reaction to an antipsychotic drug. Referring to Mr C's telephone call to the deputy ward manager on 18 December 2008, the Board said the records documented the conversation and that she had attempted to find out what drugs Mr C was objecting to, but to no avail (see paragraph 17). As to the meeting with the Doctor on 26 February 2009, the Board said he did not recall giving an assurance that an antipsychotic drug would not be prescribed.[1]

38. In response to my complaints reviewer's enquiries, the Board said they had been unable to locate Volume 1 of Mrs A's mental health notes. These

[1] Please note there is no record of this conversation in the medical records, but there is a record of the treatment plan listing the drugs administered to Mrs A which was discussed with Mr C and his brother at the same meeting (see paragraph 13).

included medical records pertaining to Mrs A's admission to Ward 2 from 18 December 2008 to 29 March 2009. The Board pointed out that the Mental Welfare Commission had said in 2007 that the patient files at Hospital 1 should be used as a good example for services elsewhere to examine and that Ward 3 was not identified as an example of poor documentation.

Advice received

39. On record-keeping, Adviser 1 said the case notes were voluminous and disorganised. The notes relating approximately from 20 December 2008 to 1 March 2009 were missing and the nursing and medical records in Ward 3 were incomplete. Medical entries during the long psychiatric admission (18 December 2008 to 1 December 2009) appeared infrequent and were difficult to identify.

40. Adviser 2 said the records were not in chronological order, which made following them difficult. He noted that the Ward 3 records were incomplete because the nursing reports related only to the short period 22 March to 26 March 2009. This is despite the fact that Mrs A was admitted to Ward 3 from 18 December 2008 and stayed until 27 March 2009. Adviser 2 would have expected, at the very least, daily entries covering Mrs A's entire time on the ward. It was, therefore, conceivable that other elements of the clinical record were also missing. On the evidence available, there was a significant difference in the quality of record-keeping between Ward 3 and Ward 4 with the latter being far superior. In Ward 3, a number of assessments were carried out which highlighted care needs relating to: existing wounds, on going skin integrity issues, disturbed sleep, washing and dressing, accidental harm, mobility and falls, wandering, cognitive function, personal hygiene, unfavourable reactions of other patients to some of Mrs A's behaviours, eating and drinking, incontinence, communication, periodic anxiety and agitation. Despite this extensive catalogue of needs, there was only evidence of plans of care for social and therapeutic intervention and tissue viability (although this was not evaluated). No specific plans were available which dealt with the range of Mrs A's needs which were identified by the assessments carried out. Adviser 2 said if these care plans had not been completed, then this was extremely poor record-keeping and care planning practice. However, it was possible that some of these plans were missing from the record. In contrast, in Ward 4, a care plan index was compiled and care plans were documented for a number of needs identified by a range of assessments carried out by staff. There was clear evidence of the evaluation

and review of all aspects of the overall care plan. Adviser 2 concluded that the quality of record-keeping and care planning in Ward 4 was of a high standard.

(b) Conclusion

41. Mr C complained that the Board failed to keep Mrs A's medical records properly. I have decided there were failures in record-keeping by the Board. In reaching my decision, I have taken into account that some of Mrs A's medical records are missing. However, I can only make a judgement on the evidence available to me. Even with some of the records missing, it is clear they are disorganised and difficult to follow. Adviser 2 has said there is no evidence that the Board met the extensive range of care needs of Mrs A identified by healthcare professionals in Ward 3 when she was a patient there, but that some of these care plans may have been completed and were missing from the record. Either way, the Board's practice in relation to record-keeping and care planning in Ward 3 fell far below a standard that was reasonable.

42. Turning now to Mr C's concerns about the Board's failure to record Mrs A's severe reaction to the antipsychotic drugs, it is clear there is little or no written record of Mrs A's reaction to the drugs. Whilst this raises questions over the accuracy and thoroughness of the Board's record-keeping, as I said above, it was not possible to establish that the prescribed drugs caused the deterioration in Mrs A's physical or cognitive condition. Even so, I share Mr C's concerns about the Board's record-keeping and I have criticised the Board for prescribing Mrs A with antipsychotic drugs because there was no evidence of the rationale of their decision (see paragraph 30). It is essential that healthcare professionals record the rationale for treatment decisions in patients' medical records. I am also critical of the failure of the Doctor to record the discussion he had with Mr C and his brother on 26 February 2009.

43. In all the circumstances, I uphold the complaint and I make the following recommendation.

(b) Recommendation

44. I recommend that the Board:	*Completion date*
(i) carry out an audit of their: nursing and medical record-keeping to ensure it is in accordance with the national guidelines with particular reference to care planning practice; practice relating to the	22 September 2011

storage of patients' medical records to ensure it accords with the Scottish Government Records Management: NHS Code of Practice (Scotland); and report back to the Ombudsman on the outcome of the findings.

(c) Failed to communicate properly with Mrs A's family

45. Mr C complained that given the inadequacy of Mrs A's medical records, communication with the family was all the more important and that healthcare professionals should have consulted with and fully informed the family at all times about the care and treatment provided to Mrs A.

Board's response to Mr C's complaint

46. In response to Mr C's complaint about communication failures by the Board, the Board said ward staff were disappointed that the family felt this way. They felt that they had tried to keep the family informed and involved in Mrs A's care as much as possible and that Mr C and his brother had spent days at a time in the ward visiting and talking with staff. Ward staff had reported the only concern raised by the family throughout Mrs A's stay in the wards was when her discharge was being discussed. The family did not wish her to be discharged expressing a concern that her health may deteriorate again.

47. In response to my complaints reviewer's enquiries, the Board said the records showed that Mrs A received regular visits from both her sons whilst a patient in Ward 4 and that staff had always made them welcome. In addition, there were numerous examples of clear communication between ward staff and members of the family. On 26 March 2009, the records showed that Mr C's brother had commented on his appreciation of his mother's care. On 12 May 2009, Mr C was kept fully informed about Mrs A's physiotherapy treatment regarding her painful legs. On 4 June 2009, Mr C was updated on information about his mother's hearing aid. At that time, staff were communicating regularly with the family and keeping them up to date with Mrs A's treatment. Mr C's brother was invited to a meeting with Mrs A's psychiatrist and social worker to discuss the type of care that Mrs A required on 13 August 2009.

48. In relation to the decision to prescribe quetiapine in 2009, the Board said a decision was taken by Mrs A's psychiatrist at a multi-disciplinary team meeting

(see paragraph 20). The family was invited to attend these meetings and would be fully consulted on the treatment that was being considered.

Advice received

49. My complaints reviewer asked Adviser 2 to consider the communication between the Board and Mrs A's family, particularly in relation to the Act and guidelines. Adviser 2 said effective assessment of people with dementia who do not have the capacity to fully participate in their care for reasons of mental disorder requires the involvement of relatives and carers. Strategies to effectively manage communication with relatives should be a core aspect of the care plan of all people with dementia. Such a plan should document and detail a jointly agreed approach to communication between staff and relatives.

50. Adviser 2 said there was little written evidence relating to the interaction with the family during Mrs A's time on Ward 3, although it was recorded in the notes on 26 March 2009 that Mr C 'expressed appreciation of the care given to his mother' during her time there. However, it was recorded on 24 December 2008 that a named nurse planned to make contact with Mrs A's next of kin as part of the assessment process, but there was no evidence that this was carried out. Furthermore, there was no evidence that relatives were asked to help complete a life story book as outlined in the social and therapeutic intervention plan. Overall, there was a lack of a formal documented plan for involving the family in accordance with the Nursing and Midwifery Council's record-keeping guidance. Such a plan should detail the aims, degree, nature and frequency of relatives' involvement, their views and concerns, who would be involved from the relative's side and how that involvement will happen and be evaluated.

51. Adviser 2 said care in Ward 4 was much more transparent because of the quality of the available documentation. It showed a lot of communication with the family via informal interactions and other more formal meetings. It was recorded that Mr C was 'convinced that [Ward 4] was the best possible place for his mother'. However, as in Ward 3, there was a lack of a formal documented plan for involving the family in accordance with the guidance.

(c) Conclusion

52. Mr C has complained that healthcare professionals failed to communicate about the care and treatment provided to Mrs A. The advice which I have accepted is that communication fell far below a standard that was reasonable

and was contrary to the guidelines and the principles underpinning the Act. I am extremely concerned about this, particularly the practice in Ward 3, given the importance of communication with the family in meeting the needs of patients with dementia.

53. In addition, on 18 December 2008, Mr C contacted the deputy ward manager about a drug he did not want prescribed to his mother and she attempted to find out what drug this was (see paragraphs 15, 34 and 35). I am surprised that she did not establish from the care home or the medical records that there had been concerns about the discharge from Hospital 1 and Mr C is sure that he referred to an antipsychotic drug. Even so, Mr C's phone call should have prompted healthcare professionals to have a full and proper discussion with the family about treatment decisions. This would have given healthcare professionals an opportunity to explain the risks and benefits of the use of a variety of drugs to control Mrs A's agitation. The Board missed another opportunity to communicate fully with Mr C and his brother during a meeting with the Doctor on 26 February 2009 and find out their views on treating their mother with antipsychotic drugs (see paragraphs 16, 32, 36, 37 and 42).

54. As to the practice in Ward 4, there was evidence of a high level of communication. However, as in Ward 3, there was no formal plan outlining a communication strategy as part of the care plan. I am also concerned that given the level of communication with Mr C and his brother by healthcare professionals in Ward 4, they remained unaware of the prescription of an antipsychotic drug to Mrs A until a few months after her discharge in December 2009. It appeared that they did not use communication to seek and take account of the family's views relating to treatment decisions, as they should have.

55. In all the circumstances, I uphold the complaint and I make the following recommendation.

(c) Recommendations

56.	I recommend that the Board:	*Completion date*
(i)	develop a policy on meeting the communication needs of patients with dementia which includes having an identifiable and agreed relatives' communication or participation strategy as a core	22 September 2011

aspect of the care plan; and

(ii) apologise to Mr C for the failures identified in this report. — 22 July 2011

57. 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

Mr C	The complainant
Mrs A	The complainant's mother
Hospital 1	Vale of Leven Hospital
Hospital 2	Joint Hospital
Adviser 1	The Ombudsman's medical adviser in care of the elderly
Adviser 2	The Ombudsman's clinical nursing adviser in mental health
The Act	Adults with Incapacity (Scotland) Act 2000
Ward 1	Ward 6 - a medical assessment ward in the Vale of Leven Hospital
Ward 2	Lomond Ward - a medical ward in the Vale of Leven Hospital
Ward 3	Fruin Ward – a psychiatric assessment ward in the Vale of Leven Hospital
Ward 4	Glenarn Ward - a long stay psychiatric ward in Joint Hospital
The Doctor	The doctor primarily responsible for the medical treatment of Mrs A during her admission to Ward 3
Psychiatrist 1	A psychiatrist at the Board

Psychiatrist 2	A psychiatrist at the Board
SIGN	Scottish Intercollegiate Guidelines Network

Annex 2

Glossary of terms

Aricept (donepezil)	A drug used in dementia
Betahistine	An anti-vertigo drug
Cellulits	Common skin infection
Cholinesterase inhibitors	A drug used to treat symptoms related to memory
Citalopram	An antidepressant drug
Community	Community healthcare services
Diazepam	A sedative drug used to treat anxiety
Fentanyl	A painkiller
Haloperidol	An antipsychotic drug
Hypothyroidism	A condition in which the thyroid gland does not make enough of the hormone thyroid
Lorazepam	A drug used to treat anxiety
Mirtazepine	An antidepressant drug
Oedema	A build up of excess fluid in body tissues
Paradoxical effect	When medical treatment (usually a drug) has the opposite effect to that which is normally expected
Quetiapine	An antipsychotic drug

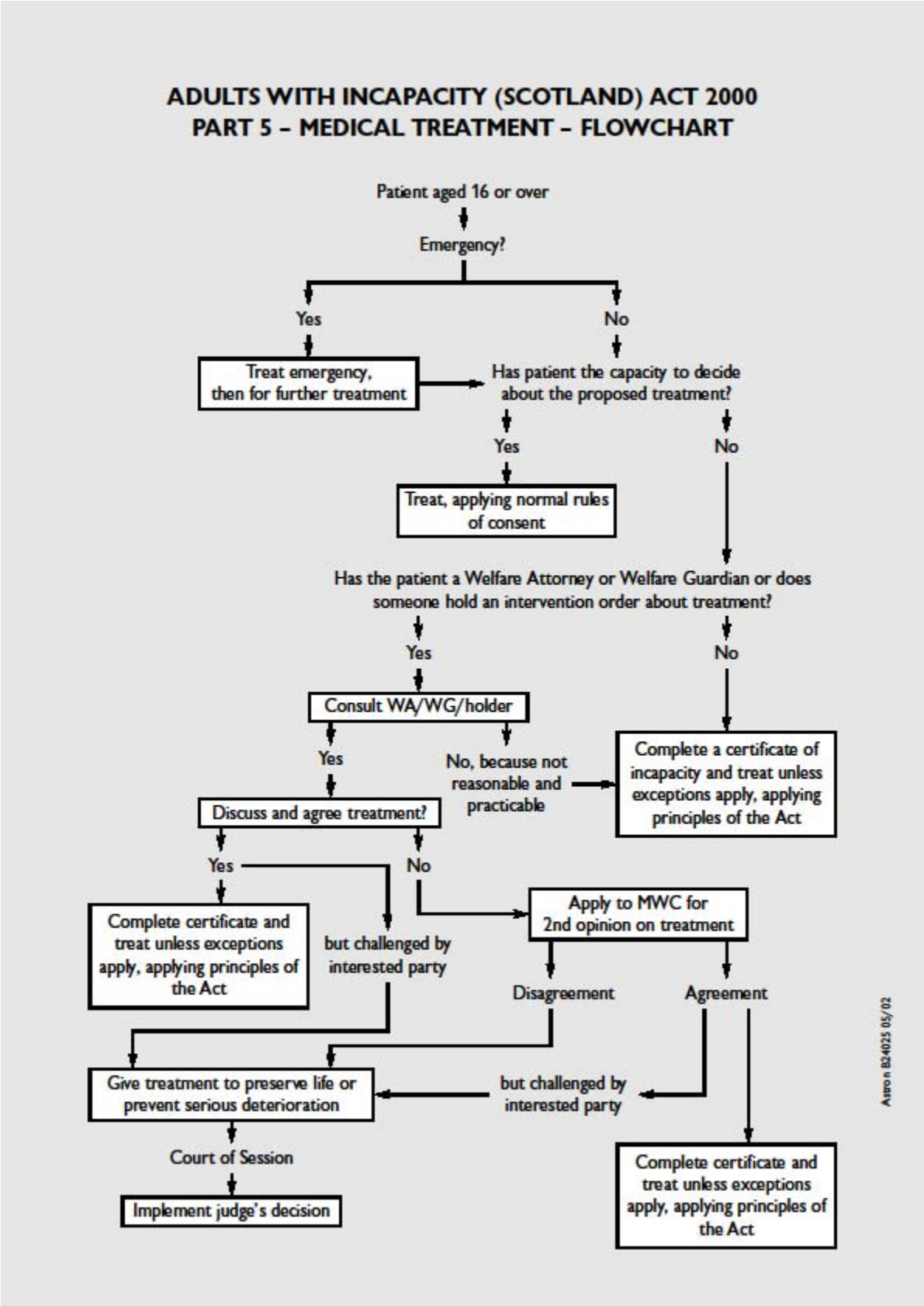
Rivastigmine	A drug used to limit the progression of dementia
Sodium valproate	An anticonvulsant drug used to treat epilepsy and mania
Temazepam	A sedative drug used to treat anxiety
Trazodone	A sedating antidepressant drug

Annex 3

List of legislation and policies considered

Adults with Incapacity (Scotland) Act 2000

SIGN Guidelines 86 *Management of patients with dementia*


ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000
PART 5 – MEDICAL TREATMENT – FLOWCHART
Patient aged 16 or over
Emergency?
Yes
No
Treat emergency, then for further treatment
Has patient the capacity to decide about the proposed treatment?
Yes
No
Treat, applying normal rules of consent
Has the patient a Welfare Attorney or Welfare Guardian or does someone hold an intervention order about treatment?
Yes
No
Consult WA/WG/holder
Yes
No, because not reasonable and practicable
Complete a certificate of incapacity and treat unless exceptions apply, applying principles of the Act
Discuss and agree treatment?
Yes
No
Complete certificate and treat unless exceptions apply, applying principles of the Act
but challenged by interested party
Apply to MWC for 2nd opinion on treatment
Disagreement
Agreement
Give treatment to preserve life or prevent serious deterioration
but challenged by interested party
Court of Session
Implement judge's decision
Complete certificate and treat unless exceptions apply, applying principles of the Act
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