Scottish Parliament Region: Mid Scotland and Fife

Case 201004743: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; Psychiatry; clinical treatment; diagnosis; complaints handling

Overview

In February 2010, the complainant (Mrs C)'s late mother (Mrs A) was admitted to Drumcarrow Lodge of Stratheden Psychiatric Hospital (the Hospital). She was hearing voices and suffering from hallucinations and paranoia. Mrs A was discharged from the Hospital on 31 May 2010 after her mental health problems had been resolved. However, Mrs C alleged that the Hospital paid scant regard to Mrs A's physical condition and did not assess this properly before her release. Mrs A died from heart failure on 5 June 2010 after an emergency admission to Ninewells Hospital, Dundee, on 2 June 2010. Mrs C submitted a formal complaint about the way the Hospital dealt with Mrs A's physical care and treatment but she alleged that the responses she received were unreasonable.

Specific complaints and conclusions

The complaints which have been investigated are that Fife NHS Board (the Board)'s:

(a) physical care and treatment of Mrs A, while she was a patient at the Hospital, were unacceptable (*upheld*); and

(b) responses to Mrs C's complaints about Mrs A's physical care and treatment were unreasonable *(upheld).*

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) offer Mrs C a full and sincere apology for their failures with regard to Mrs A's treatment;	16 December 2011
(ii) share this report with the team involved and with the Consultant Psychiatrist and remind him of his overall responsibilities in such cases;	16 December 2011
(iii) look into the process of issuing referral letters, to	16 December 2011

	ensure that any failures to respond are chased up and into the fact that a letter appeared to have been signed by a trainee psychiatrist when she was on holiday;	
(iv)	apologise to Mrs C for their failures with regard to the investigation of her complaint; and	16 December 2011
(v)	review the rigour of their complaint handling process, with particular relevance to timescale and investigative thoroughness.	16 February 2012

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

Main Investigation Report

Introduction

1. On 28 February 2011, Mrs C wrote to this office concerning the death of her mother (Mrs A). She said that in February 2010, Mrs A was admitted to Stratheden Psychiatric Hospital (the Hospital) because she was experiencing hallucinations. She was hearing voices and suffering from paranoia. Mrs A was discharged later that month but was readmitted as an informal patient on 31 March 2010 when her symptoms had increased despite her medication. She was allowed home on pass on 31 May 2010 (with a view to fully discharge her) after her mental health problems were resolved. However, Mrs C alleged that while Mrs A was a patient, the Hospital paid scant regard to her physical condition and failed to assess this properly before her release. Mrs A died from heart failure on 5 June 2010 after an emergency admission to Ninewells Hospital, Dundee, on 2 June 2010.

2. The complainant said that Mrs A's sudden death caused the family much stress and sadness but that the attitude of the Hospital to the complaint she subsequently made, made the situation even more difficult to deal with.

3. The complaints from Mrs C which I have investigated are that Fife NHS Board (the Board)'s:

(a) physical care and treatment of Mrs A, while she was a patient at the Hospital, were unacceptable; and

(b) responses to Mrs C's complaints about Mrs A's physical care and treatment were unreasonable.

Investigation

4. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Mrs C and the Board. My complaints reviewer has had sight of the Board's complaints file, NHS Fife's Patient Feedback Policy (including complaints), the relevant clinical and nursing records, drug cardex and test results and copy correspondence between the Consultant Psychiatrist and Mrs A's GP practice. Independent advice was obtained from nursing and clinical sources.

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

(a) The Board's physical care and treatment of Mrs A, while she was a patient at the Hospital, were unacceptable

Mrs C's complaint

6. Mrs A was admitted to the Hospital in February 2010. She was experiencing hallucinations, suffering from paranoia and hearing voices. Mrs C said that before this, Mrs A had lived independently and had generally been physically well and alert. She said her main health problem to that point had been diabetes and her failing eyesight. She said Mrs A was initially admitted to the Hospital for ten days but on 31 March 2010, she required to be admitted again as her condition had become more extreme.

7. Mrs C said that Mrs A remained in the Hospital for a total of ten weeks but she said throughout that time she saw the Consultant Psychiatrist on only three occasions. She was prescribed Risperidone which, Mrs C said, had several side effects and came with a caution with regard to prescribing it to patients with cardiovascular concerns. Mrs C said that Mrs A had angina.

8. Mrs C said that Mrs A suffered a serious drop in blood pressure, with pains in her chest and back, dizziness and weakness. She said that a subsequent electrocardiogram (ECG) showed an erratic heart rate and the family were advised that a referral letter had been sent to the cardiology department. She alleged that this referral was never followed up. By this time, Mrs C said, Mrs A had become very tired, breathless and unable to walk any distance. She also began to suffer from fluid retention which ultimately affected her entire body. She said her shoes and clothes no longer fitted. While Mrs C said that the family expressed concern about this on many occasions, they were told not to worry and that her physical condition would improve.

9. Meanwhile, Mrs C said, Mrs A's mental condition had stabilised and it was considered that she could be discharged. She said that a formal discharge meeting was arranged for 24 May 2010. However, she complained that at the meeting no account was taken of Mrs A's physical condition, despite the fact that she had great difficulty walking, she could not dress herself and she had problems breathing. She said that the Community Nurse asked whether a care plan had been put in place for Mrs A's release but that it had not and that she also asked whether consideration had been given to keeping Mrs A in hospital until her physical condition improved. In response, the Consultant Psychiatrist, who chaired the meeting, confirmed that a doctor would assess Mrs A before

discharge and that a care plan would be put in place. Mrs C said that a doctor who did not know Mrs A carried out the assessment and deemed her fit for discharge. Mrs A was discharged home on 31 May 2010 but was taken into Ninewells Hospital, Dundee, as an emergency patient on 2 June 2010. Mrs A died of heart failure there on 5 June 2010.

10. Mrs C felt that the Hospital had not cared properly for Mrs A's physical health and that, as a consequence, this led to her death. Mrs C, therefore, wrote to the Board on 29 July 2010 complaining and said that there were a number of matters that needed to be clarified; that she did not want anyone else to have to endure the same and that she wanted procedures in the Hospital to be investigated.

The Board's response

11. The Board replied to Mrs C on 25 August 2010. They told her that during the time Mrs A had been a patient at the Hospital between 31 March and 31 May 2010, the Consultant Psychiatrist had been on leave for a period of three weeks. However, he held three formal interviews with her and spoke to her briefly at other times. They maintained that the Consultant Psychiatrist would not personally require to see the patient more frequently and that Mrs A was also seen by a Psychiatric Trainee on 'a number of occasions' and by duty doctors four times. It was their view that the Consultant Psychiatrist was aware of Mrs A's physical condition and of the medication she had been prescribed with the exception of the fact that after his return from holiday on 24 May 2010 (which was the same day that the Psychiatric Trainee went on leave) he was not brought up to date about the increase in Mrs A's oedema. The Board said he only became aware of this at the case conference on 24 May 2010, as a consequence of which the Consultant Psychiatrist requested that Mrs A have a physical review by the duty doctor (as the Psychiatric Trainee was now on holiday) adding that if there were any concerns highlighted to discuss these with the medical registrar. The duty doctor examined Mrs A and, while noting her oedema, nevertheless considered her fit for discharge home.

12. In the meantime, the Board said that Mrs A had had a cardiac review on 18 April 2010 and on 19 April the Psychiatric Trainee repeated her ECG (see paragraph 8) and discussed the findings with the on-call medical registrar at a nearby hospital. The Psychiatric Trainee said she was given advice to commence Mrs A on Digoxin and make a referral for a 24 hour tape and echo-cardiogram. The Board said that there was a letter dated 23 April 2010

requesting such investigation, together with a further follow-up letter of 26 May 2010.

13. It is the Board's view that the matter of Mrs A's fluid retention was taken seriously. She had repeat ECGs and her condition was discussed with a medical registrar (see paragraph 12). She was commenced on Digoxin and the dosage of her diuretic was increased. Two letters were sent to the cardiac investigations department. However, the Board did say that there had been an error in the minute of the discharge meeting, which had recorded that the Consultant Psychiatrist had said that Mrs A's oedema predated her admission to hospital. This should have read that her cardiac condition predated her admission to hospital and they apologised for this.

14. Mrs C was dissatisfied with the Board's response. She felt that there were further matters to be addressed and so she wrote again to the Board on 28 September 2010 and this letter was acknowledged the next day. The Board said they sent Mrs C a formal response on 26 January 2011 which said, amongst other things,

> 'I do feel that there are areas where your mother's care was less than we would wish to provide. I feel that our communications both internally and with you as a family were very poor. While your mother (sic) mental well being was being addressed, I believe that her physical needs were not always being met in full'.

The Board added that they would welcome the opportunity to discuss Mrs A's care with Mrs C and to share the learning they had taken. Mrs C, however, in commenting on a draft of this report said she did not receive this letter and, because of an apparent non reply, she made a complaint to this office at the end of February 2011.

15. In complaining to me, Mrs C said that Mrs A should not have been prescribed Risperidone particularly as she had an existing heart condition; she said that the Hospital did not treat her oedema properly and that she was told not to worry about it; she considered that in the circumstances Mrs A should not have been discharged from hospital on 31 May 2010. Mrs C also believed that the Board took little action on Mrs A's deteriorating heart condition and she felt, overall, that a lack of proper care contributed to Mrs A's death.

Independent advice received

16. My complaints reviewer discussed the care and treatment Mrs A received for her physical ailments with two clinical advisers (Adviser 1 and Adviser 2 who is a consultant geriatrician), and with a nursing adviser (Adviser 3). Overall, Adviser 3 said that from her reading of the nursing notes, there was no evidence to suggest that Mrs A's nursing care was poor. She said that she found the nursing records to be comprehensive and written sensitively

17. With regard to clinical matters and to the drug Risperidone which was given to Mrs A for her psychiatric problems, my complaints reviewer was directed by Adviser 1 to the British National Formulary (BNF, a medical and pharmaceutical reference) which stated that Risperidone was an 'Atypical Antipyschotic Drug' which should be used 'with caution in patients with cardiovascular disease or a history of epilepsy' and 'used with great caution in the elderly'. Adviser 1 said that known side effects included weight gain, low blood pressure and high blood sugar. With regard to Risperidone in particular, he said that the side effects mentioned were hyponatraemia (low sodium in the blood), oedema and urinary incontinence amongst others. Under dosage for the elderly the BNF suggested an initial dose of 500 micrograms twice daily, increased in steps of 500 micrograms twice daily to 1-2 milligrams twice daily (I milligram = 1000 micrograms).

18. Adviser 1 said that it would be incorrect to say that Risperidone should never be used in the elderly but the BNF advised caution and a gradual increase in dose. Adviser 2 agreed. He said that caution should be advised and that in some cases a decision would be made not to use such a medicine for risk of cardiovascular complications. Adviser 1 said Mrs A was commenced on Risperidone 2mg daily as a single dose on 13 April 2010 and this was increased to 4 milligrams on 19 April 2010 (this was given as 2 milligrams twice per day). Adviser 1 noted that the notes reported that Mrs A had previously been taking another atypical antipsychotic drug (350 milligrams).

19. The day before (12 April 2010) the decision was taken to change Mrs A's medication to Risperidone, Adviser 1 told my complaints reviewer that a duty doctor was called because Mrs A had experienced a period of hypotension (abnormally low blood pressure) but that it had not been possible to do a full examination because she was 'deeply asleep' although her pulse was noted to be 63 bpm (beats per minute) and her blood pressure 78/44. Adviser 1 said that no estimation of blood sugar, conscious level or oxygen saturation was

recorded. He also said this incident did not appear to have been referred to when the decision was taken to change Mrs A's antipsychotic medication. He continued that, while the decision to commence Risperidone could be regarded as reasonable and the high starting dose could be justified by her symptoms and the exposure to another similar antipsychotic drug, his view was that there should have been close monitoring of the change and such monitoring should have been specified. Adviser 2 added in his comments that the clinicians introducing Risperidone to Mrs A's prescribed medicines did not document a risk benefit analysis and decision in the clinical notes. Adviser 2 said he could not find any evidence of consideration of Mrs A's known cardiovascular disease before or during prescription

20. Mrs C maintained that Mrs A's physical condition declined so much and she retained so much fluid that her clothes no longer fitted. She contended that the Board failed to take proper cognisance of these facts. Adviser 1 was asked about this. He told my complaints reviewer that in February 2010, Mrs A's weight was recorded as 62.25 kilograms, on 31 March it was 62.95 kilograms but by 28 May 2010 it was 77.85 kilograms, representing an increase of almost 11 kilograms in four weeks, during which time the nursing notes recorded only a moderate food intake. He said it was his view that such rapid weight gain was most often caused by fluid retention with heart failure being a common cause, especially in patients with a history of known cardiovascular disease. Adviser 1 added that although Mrs A's diuretic was increased on 20 May 2010, in his view it was an inadequate response to her symptoms. Meanwhile, he said, Mrs A remained on a beta blocker, even when her blood pressure was noted to be causing concern. The drugs she was taking, he said, were used to lower blood pressure. It was Adviser 1's view overall that, with the increasing signs of oedema, weight gain, hyponatraemia, the liver functions abnormalities which were also noted and the concerns expressed in the nursing notes and by the family, urgent investigations and a referral should have been prompted. Adviser 2 commented that while there was a record of weight increase with regard to Mrs A, no cause was identified and noted other than fluid retention. He said that the clinical notes documented some of the changes that were occurring with regard to Mrs A but no action plan as to how to deal with them was noted.

21. Mrs C was concerned that Mrs A had not seen a cardiologist and Adviser 1 said that in his opinion a cardiological review would have been beneficial. He said this could have established the extent of heart failure

present and led to review of her medication. On 18 April 2010, Adviser 1 said that Mrs A had a prolonged episode of hypotension and had complained of chest pains in the previous two days. Two ECGs were recorded and he said they appeared to him to be materially different. He said this should have led to urgent action. Adviser 1 noted that in April 2010 (see paragraph 12) a referral was sent but that this was addressed to cardiac investigation and was not a request for a consultant opinion. Adviser 2 confirmed that no request for a medical review had been made for Mrs A. He went on to say that, independent of this lack of advice, the clinical team responsible for Mrs A should have been more proactive in trying to obtain physician or cardiology review. Adviser 2 said in his opinion it was hard to see how the organisation of the tests suggested would have been helpful without expert evaluation of the patient and any results. Adviser 2 said that the medical team responsible for Mrs A should have made more detailed notes about their consideration of her care and the changes in her physical condition after admission. The team should have gained physician or cardiology assessment during the admission, especially with Mrs A's increasing weight and blood test abnormalities.

22. Adviser 1 went on to say that the letters of 23 April and 26 May 2010 concerning the referral (see paragraph 12) were identical, even to the record of the pulse rate and medication. Adviser 2 emphasised that these letters did not request an appointment or review by a cardiologist. They were to request a 24 hour tape (ECG) and echo-cardiogram. Adviser 1 said that the second letter failed to make any reference to Mrs A's change of medication. Both letters were signed by the Psychiatric Trainee although the second letter appeared to have been written when she was on leave (see paragraph 11). Adviser 1 further stated that the letters were only present in the GP correspondence and not in the Hospital in-patient notes. Adviser 1 said that the fact that no word had been received as a result of the first letter caused him concern, he said there was no apparent action on this until the case discussion on 24 May 2010 which prompted the letter dated 26 May 2010. Adviser 2 said that a medical opinion should have been obtained before discharge.

23. Concerning the discharge meeting about which Mrs C expressed concern, Adviser 1 agreed. He said by then it was clear from the record that Mrs A's physical state was deteriorating. The notes reflected increasing oedema, confusion and faecal incontinence. After Mrs C asked about a care plan and expressed her concern (the district nurse also registered her concern), Mrs A was seen by a doctor (see paragraph 11, reference the duty doctor) who noted

the hyponatraemia but, in Adviser 1's opinion, did not recognise its significance. His view was that Mrs A was suffering from significant heart failure and low blood sodium when she went home on 31 May 2010 but, in his view, the significance of this was not recognised. Adviser 2 questioned why, during these health changes, the team did not reflect upon the appropriateness of the Risperidone prescription. He said that was a missed opportunity to consider a risk assessment. He also said that after the case conference on 24 May 2011, the Consultant Psychiatrist in charge of Mrs A's case should have had further documented discussion about the duty doctor's findings, with a care plan. The Consultant Psychiatrist could then have documented the care plan and, if relevant, a discharge plan.

24. Adviser 2 went on to explain that a medical team, with the Consultant Psychiatrist as lead, were responsible for the health needs of patients under their care. This included health problems outside their expertise. In a case where a patient had health problems outside their competence, they had the responsibility to request input from a colleague in the relevant discipline. Adviser 2 said that in his view no proactive measures were taken to find Mrs A medical expertise relevant to her problems. He said this was the responsibility of her Consultant Psychiatrist. If Mrs A was discharged without physician input, this was then his responsibility.

25. Mrs C believed that the way in which the Board treated Mrs A's physical ailments and the fact that she was discharged on 31 May 2010 when, she said, she was obviously very unwell, led to her death. Adviser 1 said that the act of discharging Mrs A was not, in itself, likely to have hastened her death. He said that it was not possible to say with any certainty whether the outcome would have been different for Mrs A but, in his opinion, her medication at the time of her discharge was not optimal and that insufficient action was taken to respond to Mrs A's physical condition.

(a) Conclusion

26. I have carefully considered all the information and evidence before me. I note the Board's response and in particular their recognition that Mrs A's care was less than they would have wished to provide (see paragraph 14). I have taken cognisance of the advice given by the advisers, particularly by both Adviser 1 and Adviser 2. They had concerns about Mrs A's change of medication to Risperidone (see paragraphs 18 and 19) and the response made to her oedema (see paragraphs 20 and 21). They considered that she should

have been seen by a cardiologist for review and Adviser 1 was concerned about the letters written in this regard and the fact that little was done to chase the initial letter (see paragraph 22). Both Adviser 1 and Adviser 2 were also concerned about Mrs A's discharge on 31 May 2010 (see paragraph 23). I cannot ignore this advice and I uphold the complaint.

27. In this connection, I consider that the Board should offer Mrs C a full and sincere apology for their failures in this matter. It was clear from the notes that Mrs A's physical condition was deteriorating even though her mental condition had improved. The Consultant Psychiatrist was responsible for Mrs A's overall care while she was a patient in the Hospital and it has been seen that this was not satisfactory. There were also anomalies in the referral letters and the Board should consider these.

(a) Recommendations

28. I recommend that the Board:	*Completion date*
(i) offer Mrs C a full and sincere apology for their failures with regard to Mrs A's treatment;	16 December 2011
(ii) share this report with the team involved and with Consultant Psychiatrist and remind him of his overall responsibilities in such cases; and	16 December 2011
(iii) look into the process of issuing referral letters, to ensure that any failures to respond are chased up and into the fact that a letter appeared to have been signed by a trainee psychiatrist when she was on holiday.	16 December 2011

(b) The Board's responses to Mrs C's complaints about Mrs A's physical care and treatment were unreasonable

29. Mrs C submitted her formal letter of complaint to the Board on 29 July 2010 and the Board provided their response on 25 August 2010 (see paragraph 11). Mrs C was not satisfied with this and, therefore, wrote again on 28 September 2010 (see paragraph 14). The Board's final reply was sent on 26 January 2011, some four months later which, Mrs C said, she did not receive. While I am aware that in the meantime the Board offered (on 26 November 2010) to meet with Mrs C, she should have been in receipt of a reply by then. Mrs C declined a meeting on the grounds that she wanted the Board's written response to her complaint and the Board wrote again, on

17 December 2010, referring to this fact and making their apologies for their delay in providing a response by citing the Christmas/New Year break.

30. My complaints reviewer has had sight of the Board's complaints policy and all the complaints correspondence, in particular to the Board's substantive letters of 25 August 2010 and 26 January 2011. There is a surprising shift between the content of these two letters and Mrs C was unaware of the contents of the second of these letters (see paragraph 14). The first does not provide any agreement with Mrs C's initial contentions about the care and treatment given to Mrs A and in reality appears to be an explanation of matters from their point of view and confirmation that they acted correctly. The second letter shows a considerable change, agreeing that Mrs A's care was less than the Board would have wished and that her physical needs were not always met. The Board then again invited Mrs C to meet to discuss Mrs A's care and allow them to tell her what they had done as a consequence of what they had learned from the entire matter. However, Mrs C did not receive this letter and, accordingly, made no further contact with the Board.

(b) Conclusion

31. It is clear to me that the Board took too long to respond to Mrs C's formal complaint. This is maladministration. It is also clear that the replies she received were contradictory; the second of which appears accepting of the complaint but without any explanation why. Their turn-around suggests to me that the Board's initial enquiries into Mrs C's complaint were inadequate and ill founded. Notwithstanding that Mrs C did not receive a copy of this second letter (and I make no comment upon the possible reasons for this), I recommend that the Board apologise to Mrs C as their initial investigations appear to have been inadequate. Also, that they review the rigour of their complaint handling process with particular relevance to timescale and investigative thoroughness.

(b) Recommendations

32. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C for their failures with regard to the investigation of her complaint; and	16 December 2011
(ii) review the rigour of their complaint handling process, with particular relevance to timescale and investigative thoroughness.	16 February 2012

33. 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

Mrs C	The complainant
Mrs A	The complainant's late mother
The Hospital	Drumcarrow Lodge, Stratheden Psychiatric Hospital
The Board	Fife NHS Board
ECG	Electrocardiogram
Adviser 1	A clinical adviser
Adviser 2	A consultant geriatrician adviser
Adviser 3	A nursing adviser
BNF	The British National Formulary

Annex 2

Glossary of terms

Hyponatraemia	Low sodium in the blood
Hypotension	Abnormally low blood pressure
Oedema	Swelling