Scottish Parliament Region: Glasgow

Case 201003976: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category

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

Overview

The complainants (Mr and Mrs C) raised a number of concerns about the treatment that Mrs C's mother (Mrs A) received when staying in the Southern General Hospital (the Hospital) between 6 October 2009 and 4 February 2010. They complained that staff of Greater Glasgow and Clyde NHS Board (the Board) failed to monitor Mrs A's condition properly or provide her with effective treatment. Mr and Mrs C raised further concerns about staff communication, record-keeping, a lack of patient dignity and a failure to provide stimulation for patients with dementia.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was a failure to provide the appropriate care and treatment to Mrs A between 6 October 2009 and 4 February 2010 (*upheld*);

(b) the nursing notes contained inaccurate and inconsistent information along with unprofessional language (*upheld*);

(c) there was poor communication between ward team members and the family (*upheld*); and

(d) the handling of the complaint was poor (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Mrs A's family for the issues highlighted in this report; and	14 March 2012
(ii) provide the Ombudsman with a report on the improvements made within the older people's unit as a result of their action plan, including details of how the National Dementia Strategy is being	18 May 2012

implemented by the Hospital.

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

Main Investigation Report

Introduction

1. The complainants (Mr and Mrs C) complained about the treatment Mrs C's mother (Mrs A) received from Greater Glasgow and Clyde NHS Board (the Board). At the time of the events complained about, Mrs A was 84-years-old. Mrs A was admitted to the Southern General Hospital (the Hospital) via the Accident and Emergency Department with a suspected urinary tract infection on 6 October 2009. She was discharged home on 27 November 2009 but was readmitted via Accident and Emergency on 7 December 2009. She stayed in the Hospital until 24 February 2010.

2. Mr and Mrs C complained about the treatment Mrs A received, particularly during her stay in Ward 55 at the Hospital. During her stay, she had a number of falls and Mr and Mrs C were dissatisfied with the way that these were handled and recorded by the Board's staff. A fall on 4 February 2010 resulted in Mrs A breaking her hip and Mr and Mrs C complained that this was not immediately picked up by medical staff. They raised a number of additional concerns about the nursing care at the Hospital and the staff's record-keeping and communication.

3. Mr and Mrs C raised their concerns with the Board. Dissatisfied with the Board's response, they brought their complaint to the Ombudsman in February 2011.

4. The complaints from Mr and Mrs C which I have investigated are that:

(a) there was a failure to provide the appropriate care and treatment to Mrs A between 6 October 2009 and 4 February 2010;
(b) the nursing notes contained inaccurate and inconsistent information along with unprofessional language;
(c) there was poor communication between ward team members and the family; and
(d) the handling of the complaint was poor.

Investigation

5. In order to investigate this complaint, my complaints reviewer reviewed Mrs A's clinical records as well as correspondence between Mr and Mrs C and the Board. He also obtained additional comments from the Board and sought the opinion of two of my professional medical advisers (Adviser 1 and

Adviser 2). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr and Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) There was a failure to provide the appropriate care and treatment to Mrs A between 6 October 2009 and 4 February 2010

6. Mrs A was referred to the Hospital's Accident and Emergency department by her GP on 6 October 2009. The GP provided an accompanying referral letter explaining that she had been acutely confused over the previous three days and was now unsteady on her feet. She was also noted as having urinary frequency (an increased need to urinate) and as having experienced significant weight-loss over a period of months. Her family had noticed memory loss over a similar period. The GP considered that Mrs A may have a urinary tract infection (UTI).

7. Mrs A's admission note, recorded after her initial examination at the Hospital, noted the symptoms described by the GP. It also noted that Mrs A was alert and undistressed, but significantly confused. She was hypertensive (high blood pressure) and there was some concern that she may not have been taking her medication regularly. There was no obvious infection and her C-reactive protein (CRP) levels were normal. (CRP is a protein found in the blood, raised levels of which are an indicator of infection.) Evidence was found of acute renal failure, reflecting a degree of dehydration. Mrs A was admitted to Ward 20 the same day for assessment.

8. The nursing records for 9 October 2009 show that Mrs A had become increasingly confused. Arrangements were made for her to be transferred to Ward 54. Shortly after a visit from family members, Mrs A was found kneeling at her bedside. She was examined on the assumption that she had had a fall. No apparent injuries were found. Mrs C was contacted to make her aware of the ward move and of Mrs A's fall.

9. Over the following days, Mrs A was noted as being unsteady on her feet and reluctant to drink sufficient fluids. Her food and fluid intake were monitored and she was ultimately put on intravenous fluids on 13 October 2009. Mrs A was also noted to be confused and prone to wandering around the ward.

10. On 17 October 2009, nursing staff found Mrs A sitting on the floor at the toilet door. Again, no injuries were found upon examination and Mrs C was

informed about the incident. Mrs A was referred to a falls co-ordinator on 19 October 2009.

11. Mrs A was diagnosed with vascular dementia and this was explained to Mr and Mrs C at a meeting with a doctor on 3 November 2009.

12. Occupational Therapy staff arranged a home visit to assess whether Mrs A could be discharged home. Arrangements were made for her to receive a full support package at home for a trial period before deciding whether she required residential care. Mrs A was discharged home on 27 November 2009.

13. Mrs A's GP referred her back to the Hospital on 7 December 2009, noting that she had not coped well following her return home. She was dehydrated again and was constantly agitated and confused. Mrs A attended the Accident and Emergency department at the Hospital that day and was again admitted to Ward 20. She was put on intravenous fluids.

14. On 8 December 2009, Mrs A was noted as being very confused and calling out for assistance. She was given 0.5 milligrams of haloperidol (an antipsychotic drug). Mrs A was reviewed by a consultant at 09:55 and was later transferred to Ward 57.

15. In their complaint to the Ombudsman, Mr and Mrs C explained that, during evening visiting time, the patient in the bed next to Mrs A's told them that Mrs A had slipped down several times and had grazed her knee. Mr and Mrs C noted that Mrs A's records had been marked 'Patient totally independent. Low risk of fall'. Mrs C spoke to nursing staff on 9 December 2009 and asked that a fall be noted in Mrs A's records.

16. On 10 December 2009, nursing staff found Mrs A sitting on the floor. Another patient advised that she had slipped from her chair. Staff were unable to enter details of the fall onto the Datix computer system due to a system error, but a doctor was advised. Mrs A was found to have no injuries upon examination. Mr and Mrs C said that they discussed Mrs A's falls with a senior staff nurse on 13 December 2009. The senior staff nurse reportedly suggested that Mrs A be moved closer to the nurses' station and that an alarm be fitted to her chair. The nursing records show that bed and chair alarms were in place by 14 December 2009. A review by the Falls Co-ordinator was also requested on 14 December 2009. The Falls Co-ordinator concluded that Mrs A was at risk of

falls and set out a 23-point plan of supervision and adjustments to minimise the risk.

17. Mrs A was transferred to Ward 55 on 14 December 2009. In their complaint to the Ombudsman, Mr and Mrs C said that they were advised by staff on the ward that Mrs A's bed and chair would be alarmed and that her food and fluid intake would be monitored. They were reportedly advised the following day that Mrs A's food and fluid intake was adequate.

18. Mrs A's clinical records for 19 December 2009 noted that she was wandering around the ward unsupervised and that she was argumentative with staff and other patients. She repeatedly set off the chair alarm and buzzer. Haloperidol was administered to settle her. When visiting Mrs A on 19 December 2009, Mr and Mrs C noticed that she had a bump on her head and a bruise on her hand. Mrs A told them that she had fallen. Mr and Mrs C raised this with nursing staff who were unaware of a fall that day.

19. Mrs A was reviewed by a member of the Falls Prevention Team on 21 December 2009. Her chair alarm was removed and close supervision of Mrs A recommended. Over the following days, Mrs A was regularly noted as being confused and agitated. Haloperidol was administered on a number of occasions to settle her.

20. During visiting time at around 18:30 on 1 January 2010, Mrs A told Mr and Mrs C that she had fallen in the bathroom. Mr and Mrs C said that nursing staff confirmed to them that Mrs A had fallen at 07:00, however, I note that the incident was recorded as having taken place at 04:30. Mr and Mrs C asked that they be contacted immediately, regardless of the time, should Mrs A suffer any further falls.

21. On 5 January 2010, Mrs A told Mr and Mrs C that she had fallen again and that someone had helped her up. However, the nurse on duty at the time advised that Mrs A had had no further falls.

22. Mr and Mrs C said that, when they were visiting Mrs A on 16 January 2010, one of the other patients removed her jumper. She had nothing on underneath and when a nurse was called, the nurse made comments which Mr and Mrs C did not consider appropriate. The nurse

reportedly pulled the screen around the patient's bed but returned to the nurse's station without covering her up.

23. Mr and Mrs C raised further concerns about patients being left to wander around the ward unsupervised. On 17 January 2010, they were presented with a bag of clothes and asked to establish which items belonged to Mrs A, as the patients had been swapping clothes. Other items belonging to Mrs A went missing at various times. It was suggested by ward staff that Mrs A also took other patients' belongings.

24. Mrs A told Mr and Mrs C on 20 January 2010 that she had fallen again. She said she fell in the bathroom and called for help but no help came. She got herself to her feet and a 'nice nurse' then arrived and helped her. Mr and Mrs C observed that Mrs A's eye was swollen, however, upon discussing the matter with the nurse on duty during visiting time, there was no record of the incident.

25. On 21 January 2010, nursing staff confirmed to Mr and Mrs C that Mrs A had fallen the previous day. She had been found by a physiotherapist. Mr and Mrs C asked why the incident had not been recorded in Mrs A's clinical records. The nurse said that she had now recorded the incident.

26. At 03:00 on 4 February 2010, Mr and Mrs C received a telephone call from staff on Ward 55. They explained that Mrs A had been found sitting at the door to the ward with a graze on her head. Staff did not know what had happened, but thought that she may have hit her head on a table. Mrs C telephoned Ward 55 around 07:30 for an update on Mrs A's condition. She said that she found the nurse who answered the telephone to be abrupt. She was told that Mrs A was asleep but that she had been examined by a doctor and he had concluded that Mrs A was quite lucid and did not require an x-ray. However, upon attending the Hospital for the evening visiting time, Mr and Mrs C were told that Mrs A had been taken for an x-ray.

27. Mrs A had not returned from her x-ray after some time so Mr and Mrs C went to the Accident and Emergency department to see her. They found that Mrs A's injuries were more serious than they had been told. She reportedly had a lump and swelling around her eye, blood on her ear and bruising on both arms. A doctor told Mr and Mrs C that Mrs A's hip was fractured.

28. The clinical records for 4 February 2010 showed that Mrs A was examined by a junior doctor (the Junior Doctor) at 05:10. The Junior Doctor noted that Mrs A had fallen and hit her head. He recorded that she was particularly lucid and that she complained of pain in her left hip. The hip was not tender, however, and she was able to weight-bear. 'Small lacerations and a couple of contusions' were noted on the left side of the rear of Mrs A's head. Her pupils responded to light appropriately and she did not want analgesia. Mrs A was seen by the Falls Co-ordinator at 16:00. She noted the provisions which were already in place to monitor Mrs A and encouraged the use of the bed alarm if Mrs A was unsettled overnight. The Falls Co-ordinator said that Mrs A's bed should be set at the lowest level, her buzzer should be to hand and she should be closely supervised. A trainee GP (the Trainee Doctor) examined Mrs A around 18:00. He noted the events of the previous night and recorded that nursing staff were concerned about Mrs A's reduced mobility. She had been complaining of pain in her left hip and was afraid to stand in case she fell. Nursing staff noted that Mrs A normally walked around the ward. The Trainee Doctor recorded that Mrs A had difficulty transferring from her chair to her bed, requiring the assistance of two people. She was unable to weight-bear and her left leg appeared short and externally rotated. He, therefore, arranged for an x-ray of her hip.

29. Mrs A was transferred to Ward 1 on 4 February 2010 and underwent hip-replacement surgery on 6 February 2010. Following the procedure, she developed a severe pneumonia. She was treated in Ward 1 until her discharge from the Hospital on 24 February 2010.

30. Mr and Mrs C complained to the Board about the treatment provided at the Hospital between 6 October 2009 and 4 February 2010. They were particularly concerned by the level of food and fluids provided at the Hospital and the treatment which Mrs A received in Ward 55. The Board told Mr and Mrs C that they had a nutrition policy in place to ensure that patients' individual nutritional needs were met. Mrs A's nutrition was monitored between 15 December 2009 and 10 January 2010, however, this ceased as there was no change to her daily intake. The Board noted that her weight was monitored weekly and that she gained 1.6 kilograms between admission and leaving Ward 55. Mrs A was recorded as only eating partial portions of the food that she was provided with, but it was noted that she preferred the food that Mr and Mrs C brought in for her each afternoon and evening. Mr and Mrs C questioned how the Board could know that Mrs A's nutritional intake was stable if they ceased monitoring. They

also noted that no details were recorded by staff as to what food was being brought in by family members and that Mrs A's clinical records indicated that her weight was not monitored weekly as suggested.

31. Mr and Mrs C highlighted that the Falls Co-ordinator had stated on 14 December 2009 that ward staff should 'monitor fluid intake – dehydration will heighten confusion and falls risk'. Mrs A was moved to Ward 55 on 14 December 2009. Only one fluid balance chart was commenced for the first week in that ward. No others were started. Mr and Mrs C noted that dehydration can heighten the risk of falls and raised concerns that Mrs A's fluid intake was not properly monitored in Ward 55.

32. With regard to Mrs A's risk of falls, the Board explained that their falls policy required staff to assess patients for the risk of falls; to put in place preventative measures; and to monitor and reassess as required. Where patients are identified as being at a high risk, or have repeated falls, the Falls Co-ordinator is involved. The Falls Co-ordinator became involved in Mrs A's case following her fall in Ward 57 on 10 December 2009. Advice from the Falls Co-ordinator led to chair and bed alarms being introduced when Mrs A moved to Ward 55, however, the Falls Co-ordinator suggested the chair alarm be removed on 21 December 2009 after Mrs A's mobility had improved and the alarm was found to be providing no benefit. They accepted that a traffic light system above the bed, used to highlight patients' risk of falls was not properly utilised during Mrs A's admission and assured Mr and Mrs C that this had been raised with staff on the ward. The Board also apologised to Mr and Mrs C that the doctor who examined Mrs A following her fall on 20 January did not record details of the incident. They explained that this was due to her finding no injuries, however, they again assured Mr and Mrs C that the staff member involved had since been told that details of such incidents should always be written up in the patient's records. It was noted that Mrs A continued to walk around the ward following the fall on 20 January 2010. The Board, therefore, considered that Mrs A's hip fracture would have been sustained as a result of her fall on 4 February 2010.

33. With regard to the events of 4 February 2010, the Board highlighted the Junior Doctor's findings and that he had asked for a further review of Mrs A later in the morning. They said that the Junior Doctor had been asked to reflect on his examination of Mrs A. Having done so, the Junior Doctor realised that he should have ordered an x-ray rather than mere observation of Mrs A's condition.

34. The Board acknowledged Mr and Mrs C's concern that Mrs A had had several falls over a short period. They said that, regrettably, it was not possible to prevent all falls, despite the measures put in place to minimise the risk to patients.

35. When investigating this complaint, my complaints reviewer sought the opinions of two of my professional medical advisers, Adviser 1 (a mental health specialist) and Adviser 2 (a nursing specialist).

36. Adviser 1 commented on the impact of dehydration on patients with dementia. He explained that older people generally tend to have a reduced sense of thirst and people with dementia often forget to drink adequate fluids. They may not feel thirsty or may not be able to effectively communicate that they are thirsty. Subsequently, it is very easy for the person with dementia to become dehydrated. The signs of dehydration can mimic the signs and symptoms of dementia. As the person's sodium levels gradually rise, they are likely to become increasingly confused - or more confused than usual. As a result, the signs of dehydration can be difficult to spot in a person with a diagnosis which has confusion as one of its primary signs. Adviser 1 also said that dehydration associated muscle weakness and dizziness can make older people prone to falls.

37. Adviser 2 noted that there was evidence that Mrs A's fluid intake and output was monitored during her admissions, using a fluid balance chart and a nutritional and diet wastage chart. Both charts combined would monitor the intake of fluid and food. Adviser 2 was generally satisfied that the fluid balance charts were completed to a reasonable standard. Intake of fluid and food and urine output was recorded consistently. However, she noted that Mrs A's fluid intake was very poor. For part of the admission Mrs A was given intravenous fluids and her intake was over 1 litre, however once the infusion was stopped, her oral intake was very poor. The clinical notes made reference to the poor intake and on 11 December 2009 the notes stated 'nursing staff report that she will not drink tea / juice unless helped / encouraged – I feel this needs to be done to improve renal function.' Adviser 2 also commented that people with dementia 'forget' to drink and she, therefore, considered that the plan of care should include regular opportunities to have a drink. The care plans should provide detailed information about strategies to improve fluid intake and, apart from a referral to the dietician, this was not carried out in Mrs A's case.

38. Adviser 2 highlighted the NHS Quality Improvement Scotland (now Healthcare Improvement Scotland) Clinical Standards. Standard 3 (2003) *Food, Fluid and Nutritional Care in Hospitals* states 'there are formalised structures and processes in place to plan the provision and delivery of food and fluid'. She was satisfied that staff made some effort to improve Mrs A's fluid intake by providing intravenous fluids initially, however, commented that this could not be a long term measure. Furthermore, due to confusion, Mrs A removed the infusion and staff, therefore, made the decision to encourage oral fluids. In the circumstances, Adviser 2 felt that this was reasonable.

39. Adviser 2 noted that food wastage charts were completed for a number of days. She explained that food charts are generally used to establish patterns in eating and to monitor the amount eaten at mealtimes. It is common practice to monitor food intake for a limited period and any food eaten should be included in the charts. Mrs A's charts demonstrated that about a quarter of meals were eaten, however, Adviser 2 said that the lack of detail in the charts meant that she could not comment on whether food was from relatives or not. Overall, Adviser 2 considered that Mrs A's food and fluid intake was monitored appropriately, taking due regard of the Quality Improvement Standards.

40. My complaints reviewer was provided with a copy of the Board's guidelines for the Prevention and Management of Falls (the Falls Guidance). Adviser 2 considered this to be a comprehensive document which followed national guidance and standards. Adviser 2 noted that the Falls Guidance required staff to do the following:

- complete a Cannard Falls Assessment chart and core care plan within 24 hours of admission and weekly thereafter;
- refer to the Falls Co-ordinator as per criteria; and
- following a fall, the patient should be assessed for injury, referred to a doctor, recorded by the Datix system and assessments should be reviewed.

41. Adviser 2 noted that Falls Assessment charts and core care plans were completed on the admission date for both of Mrs A's hospital admissions and on a further 16 occasions. Mrs A's case was referred to the Falls Co-ordinator appropriately and was reviewed on a number of occasions. For each witnessed fall, the Falls Guidance was followed, however, Adviser 2 felt that this was less

clear on occasions when falls were not witnessed by staff. Falls which were not witnessed were documented according to third party accounts.

42. Adviser 2 considered that staff generally followed the Falls Guidance. She commented that it is difficult to manage the care of older patients with dementia who are mobile and, therefore, at risk of falling. She felt that the Falls Co-ordinator provided excellent support and advice to staff including close supervision of Mrs A. However, she questioned whether there were enough staff on duty to maintain close observation.

43. Adviser 1 and Adviser 2 both expressed concerns regarding the Board's approach to the treatment of patients with dementia. They considered that scant regard was given to Mrs A's mental health needs or to treating her as an individual. They also considered that there was little evidence of a cohesive care plan being put in place for Mrs A. Both advisers felt that there was a general lack of understanding of how to manage the type of behaviour being displayed by patients on Ward 55 and that there was no effective strategy in place to manage those patients' behaviour. I comment on this in more detail under Complaint (b) of this report.

(a) Conclusion

44. I accept Adviser 2's comments regarding the use of food and fluid monitoring tools. However, Mrs A was noted as being dehydrated prior to both of her admissions to the Hospital and was disinclined to take on fluids without encouragement and supervision during her stays. I consider that it was important for staff at the Hospital to put in place a treatment plan which would ensure that adequate fluids were taken. Whilst there is evidence that Mrs A was put on intravenous fluids appropriately on more than one occasion, I found this and the monitoring of her fluid balance to be a reaction to the fact that she was already dehydrated. I consider that more could have been done by way of a proactive plan of oral hydration to prevent further dehydration.

45. I was generally satisfied that ward staff followed the Board's guidance on falls prevention and management. A detailed plan was put together by the Falls Co-ordinator to minimise Mrs A's risk of falling and the evidence that I have seen indicates that her recommendations were, on the whole, implemented in the ward. That said, I found reference to five falls and five possible falls. Whilst I acknowledge that ward staff cannot be with patients who are able to mobilise around the ward at all times, it is clear that Mrs A had a number of falls and was

at a high risk of falls. Closer supervision of Mrs A may have prevented some of her falls or may have led to other incidents being witnessed. As Adviser 2 mentioned, the Board may wish to consider the staffing levels on Ward 55.

46. The evidence that I have seen indicates that Mrs A fractured her hip as a result of her fall on 4 February 2010. I was concerned by the outcome of the Junior Doctor's examination shortly after her fall. There is no indication of any further falls or injuries between his examination and the Trainee Doctor's examination later the same day. I, therefore, consider that the Junior Doctor missed the fact that Mrs A's left leg was shortened and externally rotated, a common indicator of a hip fracture. I acknowledge that this matter has already been raised with the Junior Doctor and that he accepted he should have arranged for an x-ray as a matter of course following this examination. However, had the state of Mrs A's leg been noticed at that time, she would almost certainly have been sent for x-ray and could have avoided some of the pain and anxiety noted by the Trainee Doctor several hours later.

47. Bearing all of the above in mind, as well as my findings under complaints (b) and (c) of this report, I uphold this complaint.

(b) The nursing notes contained inaccurate and inconsistent information along with unprofessional language

48. In their complaint to the Board, Mr and Mrs C questioned the accuracy of Mrs A's clinical records. They complained that the records were incomplete and felt that some of the language used was inappropriate.

49. My complaints reviewer asked Adviser 1 and Adviser 2 to review Mrs A's clinical records. Both advisers subsequently raised concerns about the Board's general approach to the treatment of patients with dementia. Adviser 1 commented on the importance of issues such as the preservation of dignity; treating people with respect; upholding their rights as individual members of society; maintenance of a safe environment; and effective monitoring and supervision. He said that these are central to the caring process, regardless of diagnosis. With regard to Mrs A's care, he noted the following from the clinical records:

October 2009 admission:

- The Integrated Care Pathway assessment documentation prompts assessment of speech comprehension/expression, orientation and behaviour. These parts of the document were left blank. The parts

of the document which were completed relate primarily to physical care matters.

- In the biographical details section, which Adviser 1 commented are very important in the care of older people, the word ‘daughter’ was written and nothing else.
- The patient’s concerns and needs section was left blank.
- It was frequently recorded that Mrs A was at various times forgetful, disorientated, confused, unable to comprehend simple instructions, restless, unsettled and continually wandering. Despite this, Adviser 1 could find nothing in the records to demonstrate that planned interventions were put in place to address these aspects of her presentation.
- No jointly agreed relatives’ communication strategy was put in place to respond to Mr and Mrs C’s information needs or anxieties. Adviser 1 said that this should be standard practice for all patients with dementia. Staff should be proactive in their communication with relatives. The provision of information and regular updates, clarification of treatment plans and allaying of anxieties should be planned rather than demand-led.

December 2009 admission:

Adviser 1 considered that the Integrated Care Pathway assessment documentation was ineffectively completed.

- There were no records in relation to orientation, memory, mood or anxiety except to say that Mrs A was ‘settled on transfer’.
- The biographical details merely stated that Mrs A lived alone and had a home help. There were no records regarding family relationships and there was nothing to give a sense of who Mrs A was as a person, such as brief life story details, interests, likes/dislikes. Adviser 1 noted that all of these are important in the delivery of individualised holistic care.
- The section relating to patient concerns and needs simply stated ‘not discussed’.
- The section relating to personal care stated ‘requires assistance’. No comments were made as to what assistance was required, how much, or from whom.
- The tick boxes relating to whether or not a falls assessment had been completed were left blank.

- The relatives' communication documentation had approximately ten entries covering a seven week period. Most of those entries appeared to be in response to family queries, complaints and concerns. There was no evidence that staff took a proactive and supportive stance by seeking to develop a collaborative mutually beneficial relationship with the relatives or a communication plan to meet their needs.
- The 48 hour checklist completed on 8 December 2009 indicated that Mrs A was informed regarding the identity of her Named Nurse, was orientated to the ward and its routines and was provided with an explanation of the Integrated Care Pathway documentation. However, the nursing notes of the same day and the previous day indicate that she was very confused. Adviser 1, therefore, considered it extremely unlikely that she would have been able to comprehend, process or retain this information. He was critical of the fact that there was nothing in the comments column of the checklist to suggest that Mrs A's understanding of the information was assessed. He felt that this was strongly suggestive of the Integrated Care Pathway documentation being treated as a paperwork exercise rather than a clinical tool. Scant regard was given to Mrs A's psychological needs and cognitive deficits.
- The nursing notes do not refer to Mrs A by name. Either there is no reference to her identity at all or she is referred to as 'the patient'. Adviser 1 considered that this was not indicative of a person-centred approach to care.
- Adviser 1 could find no cohesive nursing care plan. Whilst he found a lot of assessment data on the various forms, mainly relating to physical needs, he could find no written interventions corresponding to the needs identified in the assessments apart from that compiled by the Falls Co-ordinator.
- Generally, Adviser 1 considered that the Board's staff took something of a 'fire-fighting' approach to Mrs A's psychological and cognitive deficit needs rather than developing a cohesive plan to address them.

50. Adviser 2 commented on the language used in the records. She said that she was 'particularly distressed' by negative language used in Mrs A's nursing notes on more than one occasion. She highlighted entries such as 'very

argumentative, annoying other patients – staff unable to work with other patients due to patient constantly setting chair alarm off or constantly buzzing' and the use of terms such as 'complaining of', 'refusing', 'accusing'. Adviser 2 noted that these references were made without any mention of strategies in place to manage such behaviour. She considered that Mrs A was displaying distressing behaviour but staff showed a disregard or lack of understanding of how to manage this type of behaviour.

51. Adviser 2 also highlighted the fact that haloperidol was administered on a number of occasions as a means of managing Mrs A's behaviour. Adviser 1 explained that the use of haloperidol was not inappropriate of itself. It is a widely used antipsychotic drug. However, it should be used as part of an overall plan for managing patient behaviour, rather than as a 'quick fix' reactive tool when an individual's behaviour becomes difficult.

52. Upon reviewing Mrs A's case, Adviser 2 contacted the Board to raise her concerns about the treatment of patients with dementia. The Board explained that they had arranged an independent review of the Hospital's older people's unit, following Mr and Mrs C's complaint and others. This represented a root and branch examination of the culture, leadership and behaviours within the unit, including Ward 55. The Board's review highlighted similar issues to those mentioned in this report, including the use of negative language and an apparent lack of knowledge about the care of people with distressed behaviours in dementia. My complaints reviewer was provided with a copy of a detailed action plan created by the Board as a result of the review.

(b) Conclusion

53. Mrs A's admission to the Hospital pre-dated the introduction of the National Dementia Strategy. However, dementia care has been a Scottish Government national priority since 2007 and I, therefore, consider that the Board and their staff should have been equipped with the appropriate skills, knowledge and managerial support to care for people with dementia.

54. The clinical records show that the Board provided their staff with appropriate tools to record relevant personal information about patients and to assess what level of care was required. I did not find that these tools were properly utilised and, as such, there was very little information available to staff telling them what Mrs A was like as a person. I consider this type of information

to be particularly important for patients with dementia, to help them settle in circumstances which they can find confusing and stressful.

55. I accept entirely the comments made by Adviser 1 and Adviser 2 and consider that the Board and their staff failed to demonstrate an understanding of the need to recognise and care for the individual underneath the dementia diagnosis. This lack of understanding is demonstrated through the failure to record essential background information in the records or to properly complete a comprehensive plan for treatment and for managing the difficult behaviour which can be associated with dementia. In this regard, I found Mrs A's clinical records to be incomplete. The lack of understanding is further evident in the negative language used within the records, as highlighted by Adviser 2. With all of the above in mind, I uphold this complaint.

(b) Recommendation

56. I recommend that the Board:	*Completion date*
(i) provide the Ombudsman with a report on the improvements made within the older people's unit as a result of their action plan, including details of how the National Dementia Strategy is being implemented by the Hospital.	18 May 2012

(c) There was poor communication between ward team members and the family

57. Mr and Mrs C raised a number of concerns regarding the communication from the Board's staff. On occasions they were not advised of falls and, as I mentioned under complaint (a) of this report, the severity of Mrs A's injuries was not explained to them.

58. Mrs A's records contained a number of entries relating to discussions between Mr and Mrs C and staff members. As well as specific relatives' communication sheets, there were contemporaneous records of conversations within the nursing and clinical records.

59. Mr and Mrs C complained to the Board about the level of communication generally. They also highlighted specific examples: they were not contacted following Mrs A's fall on 1 January 2010. Mrs A advised them of the fall during visiting hours and staff confirmed that they were aware of the incident when asked. Again, they were not contacted following Mrs A's fall on

20 January 2010. By this time they had asked to be contacted should Mrs A have any falls. When raising the issue with nursing staff at the time, they were told that the nurse on duty did not contact them, as they had a meeting scheduled with a consultant later that day and it was assumed the consultant would mention the incident. The consultant did not mention the fall.

60. In response to Mr and Mrs C's complaint, the Board explained that relatives' communication sheets were in use, but a review was to be carried out as to their effectiveness. To improve communication, information is now displayed at the entrance to each ward advising which nurse is in charge at the time and how they can be contacted (Mr and Mrs C noted that this was already in place at the time of Mrs A's admission). Information is also displayed to advise when the Senior Charge Nurse is available. A proactive approach has been reinforced with ward staff to ensure that they have a visible, accessible presence to visitors, especially at visiting times. The Board considered that these measures would improve the exchange of information between staff and relatives.

61. As I mentioned under complaint (b) of this report, Adviser 1 was critical of the documentation completed for Mrs A's admissions to the Hospital. He commented that most recorded discussions with Mr and Mrs C appeared to be in response to family queries, complaints and concerns. There was no evidence of a jointly agreed relative's communication strategy, which should be standard practice for all patients with dementia.

(c) Conclusion

62. I share Adviser 1's view that the communication between ward staff and Mr and Mrs C appears to have generally centred around concerns raised by them about Mrs A's treatment. I found very little evidence of contact being made to update them as to Mrs A's condition or the treatment that she was to receive. Whilst I acknowledge that Mr and Mrs C were regular visitors to the Hospital and appear to have been generally aware of the treatment being provided, I was concerned by the lack of a proactive scheme of regular, planned contact with Mrs A's family. The provision of information and regular updates, clarification of treatment plans and allaying of anxieties should be planned rather than demand-led.

63. With regard to Mr and Mrs C's complaints about the lack of information following Mrs A's falls, I found that the nursing staff were somewhat passive and

could have made them aware of the incidents, if not by telephone, then during Mr and Mrs C's next visit. Similarly, I did not consider there to be any need or reason to leave it to the consultant to pass on information about falls.

64. Overall, I found the level of communication from ward staff to be poor and largely instigated by Mr and Mrs C. I uphold this complaint.

(c) Recommendations

65. I acknowledge the action already taken by the Board to improve displayed information and to promote a proactive culture for communication. I have no further recommendations to make.

(d) The handling of the complaint was poor

66. In their complaint to the Ombudsman, Mr and Mrs C complained about the Board's complaint handling.

67. The Board's complaints procedure states that they will acknowledge complaints within three working days. A full response will be sent within 20 working days, however, if this is not possible the Board will write to the complainant to let them know and to explain why.

68. Mr and Mrs C raised a formal complaint with the Board on 3 March 2010. The Board sent a written acknowledgement on 10 March 2010 and issued their formal response to the complaint on 12 April 2010. On 1 May 2010, Mr and Mrs C wrote to the Board again. They noted that the Board had offered to arrange a meeting with their Head of Nursing and General Manager and advised that they would like to go ahead with the meeting after reviewing Mrs A's clinical records. A meeting was arranged for 24 August 2010.

69. On 8 September 2010, following their meeting with the Board, Mr and Mrs C wrote a further letter in response to the Board's letter of 12 April 2010. Their letter raised additional concerns as a result of having had the opportunity to review Mrs A's clinical records, as well as commenting in detail on the content of the Board's response to their initial complaint. Mrs C emailed the Board on 9 November 2010, noting that she had not yet received a response to her complaint. She also asked that a copy of the minutes for the 24 August 2010 meeting be sent to her and Mr C. The Board, in fact, responded to Mr and Mrs C's further complaint on 8 November 2010. They received the response on 11 November 2010.

70. Mrs C emailed the Board on 23 December 2010 and 9 January 2011, noting that she had not received a copy of the meeting minutes as requested.

71. Mr and Mrs C wrote to the Board on 13 January 2011 stating that they were unhappy with the Board's 8 November 2010 response to their complaints. They said that they would be taking the matter to the Ombudsman but requested clarification on a number of specific points. The Board acknowledged receipt of this further letter on 26 January 2011.

72. On 6 March 2011, Mrs C emailed the Board, noting that she had received no response to the 13 January 2011 letter and, as yet, no copy of the meeting minutes. The Board responded on 9 March 2011. They explained that their investigation into the points raised by Mr and Mrs C was ongoing and apologised for the delay to their response. With regard to the meeting minutes, they clarified that no formal minutes were taken at the meeting. Summary notes were taken, but as these were found to reflect Mrs C's own notes, Mrs C's comments were used as the basis for the Board's investigation and no formal minutes were taken. The note-taker subsequently destroyed his summary notes.

73. The Board issued their final response to Mr and Mrs C on 24 March 2011.

74. Mr and Mrs C were dissatisfied with the delays to responses from the Board. They also complained about the accuracy of the Board's responses and the fact that some of the points that they raised in their complaints were not responded to.

(d) Conclusion

75. Having reviewed all of the correspondence between Mr and Mrs C and the Board, although I found that the Board did not respond to every point raised, I was generally satisfied that their responses were thorough. It is good practice, however, to ensure that all points of complaint are addressed.

76. The Board did not meet any of their stated timescales when responding to Mr and Mrs C's complaints and I was particularly concerned by the lengthy delay to their final response. Whilst updates were provided, these were in response to contact from Mrs C.

77. I was not provided with evidence of a commitment from the Board to provide formal minutes for the 24 August 2010 meeting. That said, Mrs C requested these on a number of occasions before being told that no minutes were taken. Again, I would consider it good practice for minutes to be taken during meetings with patients and their relatives, as these often involve important issues which may have been missed out of the written correspondence.

78. Overall, I found the Board's handling of Mr and Mrs C's complaint to be poor and not in line with the standards set out in their complaint procedure. Accordingly, I uphold this complaint.

(d) Recommendations

79. I have no recommendations to make.

General recommendation

80. I recommend that the Board:	*Completion date*
(i) apologise to Mrs A's family for the issues highlighted in this report.	14 March 2012

81. 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 and Mrs C	The complainants
Mrs A	Mrs C's mother
The Board	Greater Glasgow and Clyde NHS Board
The Hospital	The Southern General Hospital
Adviser 1	A professional medical adviser to the Ombudsman
Adviser 2	A professional medical adviser to the Ombudsman
UTI	Urinary tract infection
CRP	C-reactive protein
The Junior Doctor	A junior doctor at the Hospital
The Trainee Doctor	A trainee GP at the Hospital
The Falls Guidance	The Board's guidelines for the prevention and management of falls

Annex 2

Glossary of terms

Haloperidol	An anti-psychotic drug
Hypertension	High blood pressure
Urinary frequency	An increased need to urinate

Annex 3

List of legislation and policies considered

Greater Glasgow and Clyde NHS Board's guidelines for the Prevention and Management of Falls

Scottish Government's National Dementia Strategy

NHS Quality Improvement Scotland: Up and About – Pathways for the prevention and management of falls and fragility fractures