Scottish Parliament Region: Glasgow

Case 200500878: Argyll and Clyde NHS Board[2]

Summary of Investigation

Category

Health: Hospitals; Clinical treatment

Overview

The complainant (Mrs C) raised a complaint in respect of the treatment and care provided to her husband (Mr C), a dementia sufferer, when he was admitted to hospital with chest pains. She further believed that the hospital used unnecessary restraint techniques during his stay. Mrs C pursued her complaint through the NHS complaints system and, as she remained unsatisfied with the outcome, asked the Ombudsman to consider her complaint on 28 June 2005.

Specific complaints and conclusions

(a) That the level of care provided by the hospital was not of an acceptable standard *(not upheld)*.

(b) That the level of observation provided to Mr D was not satisfactory *(not upheld)*.

(c) That hospital staff did not properly deal with Mr D's dementia related problems and used unnecessary physical restraint *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board should:

(i) review training for staff dealing with dementia sufferers;

(ii) review training on the production of care plans; and

(iii) review training on communication with dementia patient's families.

The Board has considered this report and accepted these recommendations.

[2] Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to the former Board or Greater Glasgow and Clyde Health Board as its successor. However, the recommendations within this report are directed towards Greater Glasgow and Clyde Health Board.

Main Investigation Report

Introduction

1. On 28 June 2005 the Ombudsman received a complaint from a member of the public (referred to in this report as Mrs C) that Argyll and Clyde NHS Board had failed to provide an acceptable level of care for her father (Mr D) who suffered from dementia.

2. In addition, it was alleged that staff in the hospital failed to provide appropriate observation to Mr D which led to him suffering a fall. After the fall, she claims that they restrained Mr D by securing a table in front of his chair rather than providing appropriate observation.

3. The complaints raised by Mrs C which I have investigated are:

(a) that the level of care provided by the hospital was not of an acceptable standard;
(b) that the level of observation provided to Mr D was not satisfactory*;* and
(c) that hospital staff did not properly deal with Mr D's dementia related problems and used unnecessary physical restraint.

Investigation

4. Mrs C initially raised her complaint with the Board. They carried out a review in line with the standard NHS Complaints Procedure. Once the final response had been issued by the Board, Mrs C requested a review by our office.

5. I have reviewed correspondence from the complainant and the Board. I have obtained the clinical records and complaints file from the Board and have sought professional advice from an Independent Clinical Adviser (the Adviser). The points in particular which I have asked the Adviser to review relate to whether the clinical care provided was appropriate and whether improvements could be made in the way Mr D was cared for in view of his dementia. I have set out, for each of the three main headings of Mrs C's complaint, my findings of fact, and conclusions. The Board and Mrs C have both had the opportunity to comment on a draft of this report.

(a) The level of care provided by the hospital was not of an acceptable standard

6. Mr D was admitted to hospital on 5 January 2005 after a fall. On 25 January 2005 Mr D was re-admitted to hospital suffering from chest pains. On admission he was transferred to Ward 30 and then on to Ward 14. On 26 January 2005 he was transferred to Ward 8.

7. As a result of his dementia, aspects of Mr D's behaviour proved to be challenging for nursing staff. In particular, and possibly as a result of a change in environment, he was prone to getting out of bed and wandering through the ward. On 27 January 2005 Mr D fell over and required stitches to a head wound. Following the fall, the nursing staff placed him on a 15 minute observation cycle.

(a) Conclusion

8. On 1 February 2005 Mr D was discharged back to the nursing home where he was resident. Mrs C advised that, on arrival, the nursing home staff were very concerned about the deterioration in his condition. The Adviser reviewed the medical records in respect of Mr D's stay at the hospital. These included the admission documentation, clinical notes and full nursing records. It is the Adviser's opinion that the medical care provided to Mr D during his stay was satisfactory. As a result, I do not uphold this aspect of the complaint. Although the medical care provided to Mr D was of an acceptable standard, the care specifically associated with his dementia was less successful. I have considered these issues separately in section (c).

(b) The level of observation provided to Mr D was not satisfactory

9. Mrs C complained that when she visited her father on 26 January 2005 she found him alone by the side of his bed, swaying and disorientated, trying to make his bed. She gave details of his fall the next day and of her visits on the 29 and 30 January when she arrived to see him suffering discomfort as a result of him being placed in his chair with a table in front of him and with his feet tucked under the table legs.

10. It is clear from Mr D's medical notes that he was at times very confused and disorientated as a result of his dementia. This was likely to have been exacerbated by both the unfamiliar surroundings and nursing staff. The fact that there were

multiple ward changes may not have helped settle him. There is no evidence from the nursing notes that Mr D was inappropriately observed. Prior to his fall he was observed on a regular basis. After his fall on 27 January, staff initiated a 15 minute behaviour observation chart. Mr D was also moved nearer to the nurses' station to allow for closer observation at times when there were fewer staff on duty.

(b) Conclusion

11. It is not possible in a busy hospital ward such as this to have constant observation of patients. Although Mrs C did find Mr D by himself and in a distressed state on occasion, this is almost inevitable given his confusion and his attempts to get out of bed. A programme of 15 minute observation in circumstances such as these is an appropriate system of monitoring. I believe, having reviewed the evidence, that Mr D was appropriately observed during the period of his stay. I do not uphold this aspect of the complaint.

(c) That hospital staff did not properly deal with Mr D's dementia related problems and used unnecessary physical restraint

12. The main aspect of the complaint brought to our office related to the way hospital staff dealt with Mr D's problems associated with his dementia. Whilst there is no evidence that he received sub-standard medical care, this case has highlighted a number of important issues concerning care for people with dementia.

13. From the medical records there is no indication that any Care Plan was produced to deal with his dementia associated problems. His symptoms clearly posed problems for nursing staff. It is accepted that in a busy hospital, staff can find it difficult to find time to deal with both the patient's problems and the family's needs.

(c) Conclusion

14. When dealing with patients with dementia it is important to ensure that potential issues arising from their condition are identified at an early stage. One of the most useful ways of addressing these issues is through the production of a Care Plan. A Care Plan can be agreed between members of staff, the patient, if appropriate, and importantly, the family. Placing the family of an individual who is suffering from dementia at the centre of the planning for their care, will greatly

assist the family's understanding of the problems and limits to the care which can be provided. This is especially important as these patients can present with very upsetting behaviour at family visits.

15. The issue of restraint is highly emotive. Medical, and in particular nursing staff, must be ready to deal with people presenting with difficult, confused and sometimes aggressive behaviour. Past practices in respect of the use of restraint are no longer acceptable. Much greater consideration must now be given to the patient's human rights, even in extreme cases. The Mental Welfare Commission has produced publications in respect of the management of patients with mental health problems including dementia.

16. There is no direct mention of staff using restraint to control Mr D's difficult behaviour during his stay in hospital. There is, however, a specific mention in the nursing notes that Mr D was seated beside his bed in a chair: 'with a table in front'. It would seem that this reference to the table could indicate that this was being used as an indirect form of restraint. There is no evidence other than this statement and Mr D's family's mention of the table being jammed in front of his legs, to imply restraint. However, I believe that this was, on the balance of probabilities, a technique being employed to assist staff to restrain Mr D.

17. I have sympathy for the difficulties the staff encountered when providing care for Mr D. I do not, however, believe that this was an acceptable technique to employ in an attempt to control Mr D's behaviour. There are situations where restraint may be an acceptable tool in the handling of difficult patients, however, staff must be very aware of the guidance on offer by the relevant professional bodies before employing such techniques.

18. As a result of the above, I consider that staff did employ inappropriate restraint on Mr D. Had an effective Care Plan been produced, full and proper consideration of how best to manage Mr D's challenging behaviour could have been given. This may have included the possible use of some form of restraint if necessary. The Care Plan could also be used as a basis for discussing Mr D's behaviour and the possible methods used to best manage his behaviour with his family. These discussions may have helped to reduce the level of worry which this caused to his family. In these circumstances, I uphold this aspect of the complaint.

(c) Recommendation

19. The Ombudsman recommends that the Board review staff training in light of the current guidance provided by the Mental Welfare Commission for Scotland on problems associated with patients with dementia. These publications include: *'Safe to Wander?'* and *'Rights, Risks and Limits of Freedom'*.

Contribution to Mr D's Death

20. Although not put forward as a formal complaint, Mrs C was concerned that the care provided to Mr D may have contributed to his death. From our investigation of this case and the clinical advice I have received, I can see no evidence whatsoever to suggest this possibility. I can, therefore, reassure her on that point.

29 August 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr D	The patient
The Adviser	Independent Clinical Adviser