Scottish Parliament Region: South of Scotland

Case 200502839: Ayrshire and Arran NHS Board

Summary of Investigation

Category
Health: Hospital

Overview
The complainant Mrs C raised a number of concerns about the treatment that her late father (Mr A) received at Ailsa Hospital, Ayr. She complained that staff handled her father roughly; inappropriate oxygen therapy was provided; and staff failed to monitor Mr A's fluid intake.

Specific complaints and conclusions
The complaints which have been investigated are that:
(a) staff handled Mr A roughly *(not upheld*);
(b) Mr A received inappropriate oxygen therapy *(partially upheld)*; and
(c) there was inadequate monitoring of Mr A's fluid intake *(not upheld)*.

Redress and recommendations
The Ombudsman recommends that the Board share this report with Doctor 1 and encourage him to reflect on its findings.

The Board have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. On 18 January 2006 the Ombudsman received a complaint from Mrs C about the treatment that Mr A received at Ailsa Hospital, Ayr (the Hospital). She complained that staff handled Mr A roughly; inappropriate oxygen therapy was provided; and staff failed to monitor Mr A's fluid intake. Mrs C complained to Ayrshire and Arran NHS Board (the Board) but remained dissatisfied with the outcome and subsequently complained to the Ombudsman.

2. The complaints from Mrs C which I have investigated are that:

(a) staff handled Mr A roughly;

(b) Mr A received inappropriate oxygen therapy; and

(c) there was inadequate monitoring of Mr A's fluid intake.

Investigation

3. In writing this report I have had access to Mr A's clinical records and the complaints correspondence with the Board. I obtained advice from one of the Ombudsman's professional medical advisers (Adviser 1) and professional nursing advisers (Adviser 2) regarding the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A Glossary of the medical terms is at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Clinical history

5. Mr A was 71 years of age when a diagnosis of moderate vascular dementia was made in February 2003. Mr A's past medical history included widespread arteriosclerosis with at least three heart attacks with subsequent heart failure; several cerebral ischaemic episodes and peripheral vascular disease. On 8 September 2003 he was transferred to the Hospital after showing signs of anxiety and that he had developed a tendency to wander. While in the Hospital Mr A's physical condition remained stable for a few months but his dementia care needs increased. By November 2004 Mr A had become drowsier and less responsive and he needed assistance for double incontinence and occasional acts of aggression. Due to Mr A's deteriorating condition he was transferred to another hospital on 11 April 2005 where he

sadly died on 13 April 2005.

(a) Staff handled Mr A roughly

6. Mrs C said that Mr A had been a patient at the Hospital for 18 months and that during that time she and her family had cause to complain about the way staff handled Mr A. For example, she said that she saw Mr A being pulled from a low chair by a nurse who told her it was the only way to get people to their feet. Mrs C said there were also numerous unexplained bruises to the backs of Mr A's hands and forearms which could have been thumb or finger marks. When the family brought this to the staff's attention they were told a bruising chart had been set up but when the complaint had been raised they were told the form could not be found and staff denied knowledge of its existence. The family were also concerned that staff restrained Mr A inappropriately while he was being washed, dressed and when receiving medication as these were matters which he would resist.

7. Adviser 2 reviewed the clinical and nursing records and told me that she believed the Board had taken Mrs C's complaints seriously. She said Mrs C had raised numerous concerns about Mr A's treatment with the Board and they had conducted a thorough investigation which included interviews with relevant staff and had resulted in a report dated July 2005. The report was not specific to Mrs C's complaint but focussed on what was found overall; what issues needed addressed and what action was required. The report identified that some of the care which was provided was routine rather than patient specific and did not address all of the emotional, physical, psychological and spiritual needs of the patient and that the staff shift system which was in operation made communication difficult between teams. It was found that there was room for improvement in communication with relatives which recognised and took into account their emotional needs. While nursing staff attitude was on the whole patient focused more attention was needed in promoting patient choice. In response to the complaint and as a result of the report the Board developed a service improvement plan (which I have seen).

8. Adviser 2 continued that there was nothing in the documentation to support Mrs C's concerns about the way Mr A was handled by staff. There was an entry on 21 July 2004 that Mrs C had asked staff whether Mr A had been restrained recently as she had observed a thumb bruise on the inside of his right wrist. It was noted Mrs C was not making a formal complaint at the time. Staff completed the appropriate reporting form and passed it to the Co-ordinator

which was an indication the matter was being taken seriously. On 22 July 2004 it was noted that Mr A's skin was bruising easily and staff acted by commencing a recording chart and indicated the need to observe and note any further markings. It was recorded that staff noted no fresh marks on skin on 23 July 2004, 27 July 2004 and 1 August 2004. On 5 August 2004 it was recorded that Mr A was taking his aggression out on a radiator. Mr A was checked for any injury and the appropriate incident form was completed. Adviser 2 noted another of Mr A's daughters had reported dark bruising on Mr A's hands on 14 December 2004. Mr A fell on 17 December 2004 and sustained a badly swollen and bleeding nose which was assessed in the Accident and Emergency Department.

9. Adviser 2 said that Mr A was confused, aggressive and uncooperative at times which was to be expected from his condition. In addition his overall condition fluctuated from being quite ill to slightly better. Adviser 2 was confident that the bruising which was observed was related to this. Adviser 2 thought Mr A inadvertently self injured when he tried to be independent when this was not in line with his condition at the time. Adviser 2 added that as Mr A was bruising easily it was possible that when staff cared for him in line with good practice he sustained some bruising. An example was when Mrs C was upset to see blood on Mr A's chin when he was being shaved. Adviser 2 said shaving is quite a difficult task and more so when coupled with the mental state or behaviour of the patient and could easily lead to the nicking of skin. The fact that Mr A was cut during shaving would not, in itself, be an indication of inappropriate care.

(a) Conclusion

10. Mrs C had concerns about the way staff handled Mr A and that there were unexplained bruises to his hands and forearms. I have seen evidence that the staff recorded the family's concerns about the bruises and that appropriate action was taken to monitor the situation. The advice which I have received and accept is that Mr A's reluctance to perform actions would require staff to assist him and as a result he could have sustained bruising. There is no evidence to suggest that staff handled Mr A wrongly and as a result I do not uphold this complaint.

(a) Recommendation

11. The Ombudsman has no recommendation to make.

(b) Mr A received inappropriate oxygen therapy

12. Mrs C said that Mr A was very ill in the final days of his life but a doctor (Doctor 1) would not accept this and put his problems down to being deterioration in his mental health rather than being physically unwell. She said Doctor 1 did not want Mr A to receive oxygen even though he was cyanosed and distressed. When the duty doctor (Doctor 2) found Mr A to be in pain he commenced him on oxygen and morphine. Doctor 1 subsequently stopped the treatment and told the family that he had been informed by a consultant that Mr A did not require oxygen unless his oxygen saturation levels dropped below 60%. Mrs C said Doctor 1 accused the family of wanting to poison Mr A with morphine although it was Doctor 2 who decided on the dosage in conjunction with the pharmacist. Mrs C also felt that the monitoring of the oxygen by nursing staff was chaotic and staff did not seem to be confident in using the equipment.

13. Adviser 1 explained that the records showed that on 4 April 2005, Mr A's condition was poor with the development of a chest infection which was treated with antibiotics and oxygen. The following evening Mr A's temperature was noted to be up again, his lips and ears were blue and his oxygen saturation level was 85% and oxygen was provided. Doctor 2 increased the oxygen which improved Mr A's oxygen saturation level to 91%. The following day Mr A appeared to improve and nursing staff recorded Doctor 1's instructions about the use of morphine only for chest pain and oxygen therapy to be commenced if his oxygen saturation level fell to below 60%. On 9 April 2005 Doctor 2 changed the instructions in that oxygen was to be given continuously to Mr A with morphine for his apparent pain and agitation. Another doctor reviewed Mr A on 10 April 2005 and advised that he should have regular morphine for what appeared to be chest pain and asked that his oxygen levels be checked at half-hourly intervals. On 11 April 2005 it was recorded that Mr A was restless but did not appear to be in pain. Doctor 1 reviewed Mr A and felt that in view of his pinpoint pupils, flushing, sweating and drowsiness, it was likely that he had had too much morphine. Doctor 1 contacted a consultant who suggested a reduction in the amount of morphine which Mr A was to receive.

14. Adviser 1 felt that the decision by Doctor 1 to change Mr A's oxygen therapy to be commenced only if his oxygen saturation level fell to below 60% was a strange decision. The records and complaints correspondence contain no explanation for this decision. Adviser 1 felt the decision was out of step with the clinical findings especially as Mr A's oxygen saturation level improved from

85% to 91% when oxygen was administered. Adviser 1 felt that apart from Doctor 1's decision, staff gave appropriate oxygen therapy, recording oxygen saturation levels when requested and responding appropriately.

(b) Conclusion

15. Mrs C felt that Mr A received inappropriate oxygen therapy and this led to Mr A becoming distressed. Adviser 1 told me that staff acted appropriately in relation to Mr A's oxygen saturation levels and that action was taken to increase the oxygen therapy as required. The only concern which has not been addressed was the decision by Doctor 1 not to increase Mr A's oxygen unless the saturations fell below 60%. No reasonable explanation has been given by the Board for this decision. However, on two occasions Doctor 2 increased Mr A's oxygen therapy, once to obtain 91% saturation levels which resulted in an improvement in Mr A's condition and again later Doctor 2 ordered continuous oxygen therapy. In considering those actions and Adviser 1's comments I believe, on balance, the decision not to commence oxygen therapy until Mr A's saturations level fell below 60% was inappropriate. I have, therefore, decided to partially uphold this complaint to the extent that Doctor 1's decision in relation to oxygen therapy was inappropriate. However, Adviser 1 found that staff responded appropriately and gave appropriate oxygen therapy and I am of the view that, given Doctor 2's intervention, Mr A's care was not compromised.

(b) Recommendation

16. The Ombudsman recommends that the Board share this report with Doctor 1 and encourage him to reflect on its findings. The Board have accepted the recommendation and will act on it accordingly.

(c) There was inadequate monitoring of Mr A's fluid intake

17. Mrs C complained that although Mr A was obviously dehydrated nursing staff made no attempt to ensure that he had adequate fluids and the family were confident that no fluid intake was recorded.

18. Adviser 2 said that it would have been difficult to monitor Mr A's fluid output because he was inclined to go to the toilet himself or pass urine in inappropriate places. Adviser 2 noted entries in the nursing records during 2004 and up to April 2005 relating to Mr A's fluid and dietary intake. This is an indication that staff had noted this aspect of need. There is also evidence that IV antibiotics were not commenced on 5 April 2005 in view of Mr A's family wishes that he be kept comfortable at all costs. Adviser 2 thought this was

appropriate action and commented that to continue to encourage Mr A to take fluids could have increased his agitation and lack of well being. Adviser 2 felt that there was no requirement for staff to keep fluid balance charts in these circumstances.

(c) Conclusion

19. Mrs C had concerns that staff did not adequately monitor Mr A's fluid intake. There is evidence from the records during 2004 and 2005 which indicated that staff were aware of Mr A's fluid and dietary intake and took into account the family's wishes that Mr A should be kept comfortable. Sometimes it can be difficult for staff to balance the needs of the patient with those of relatives but in this instance I have not seen evidence that staff failed in this regard. There would not have been a need for staff to commence a fluid balance chart for Mr A as staff were fully aware of his needs and those of the family. Accordingly I do not uphold this complaint.

(c) Recommendation

20. The Ombudsman has no recommendations to make.

23 May 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	Mrs C's father
The Board	Ayrshire and Arran NHS Board
The Hospital	Ailsa Hospital, Ayr
Adviser 1	The Ombudsman's professional medical adviser
Adviser 2	The Ombudsman's professional nursing adviser
Doctor 1	A doctor who treated Mr A
Doctor 2	A duty doctor who treated Mr A

Annex 2

Glossary of terms

Arteriosclerosis	Thickening of the artery walls
Cerebral Ischaemic episodes	Interruptions to the blood supply to the brain
Cyanosed	Blue skin colour caused by lack of oxygen in the blood
IV antibiotics	Medication administered directly to the blood supply through a vein
Oxygen saturation levels	Measure of oxygen levels in the bloodstream
Peripheral Vascular Disease	Partial or total blockage of an artery