Scottish Parliament Region: South of Scotland

Case 200501596: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; Care of the Elderly; Clinical Treatment

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment of her father (Mr A) during the final months of his life while he was a patient of Ayrshire and Arran NHS Board (the Board). She was particularly concerned with the administration of drugs to her father and the palliative care he received.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board's administration of Amisulpride to Mr A was not appropriate (*not upheld*); and

(b) the Board did not provide adequate palliative care to Mr A (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board apologise to Mr A's family for the inadequacy of the palliative care afforded to Mr A to the extent that the use of syringe drivers would have been a more appropriate method of pain management than fentanyl patches.

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

Main Investigation Report

Introduction

1. On 12 September 2005 the Ombudsman received a complaint from a lady, referred to in this report as Mrs C, concerning the care and treatment of her father, referred to in this report as Mr A, by Ayrshire and Arran NHS Board (the Board). She was particularly concerned about the administration of the drug Amisulpride to Mr A, which she felt had over-sedated her father and had a detrimental effect on his condition. She was also concerned about the standard of palliative care given to Mr A.

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

(a) the Board's administration of Amisulpride to Mr A was not appropriate; and

(b) the Board did not provide adequate palliative care to Mr A.

Investigation

3. The investigation of this complaint involved obtaining and examining all the relevant medical and correspondence files from the Board. I also sought the opinion of a number of medical advisers to the Ombudsman, with specialist pharmacological (the Pharmacy Adviser) and nursing (the Nursing Adviser) knowledge. I have not included in this report every detail investigated but 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.

4. Mr A was diagnosed with Alzheimer's Disease in 1999. In early 2003 he took up residence in a nursing home. In August 2003 his behaviour became more challenging and the records show he exhibited symptoms of aggression, disinhibition, hallucination and agitation. On 27 August 2003 he was admitted to Ailsa Hospital (the Hospital). On 2 September he was detained at the Hospital under section 25 of the Mental Health (Scotland) Act 1984 and on 5 September he was detained under section 26 of the Act. Mr A's wife, Mrs A, agreed that detention was necessary.

5. It had been hoped that Mr A's condition would improve and he would be able to return to the nursing home but, unfortunately, no improvement occurred and he was transferred to a long stay ward at the Hospital in December 2003. In early May 2004 his condition deteriorated and by mid-June he was taking fluids only. On 25 June 2004 he was commenced on a palliative care package. This package was discontinued on 22 July 2004.

6. A doctor met with Mr A's family on 13 July 2004 and discussed Mr A's condition with them. He explained that, although Mr A's condition had stabilised and slightly improved in the previous few days, it was likely to deteriorate over time at an unpredictable rate.

7. A further palliative care package for Mr A was commenced on 22 August 2004. On 26 August 2004 the family raised concerns about the level of care Mr A was receiving. They requested that anaesthetic levels of morphine be prescribed to Mr A. Staff attempted to contact a consultant, but no consultant was available. Mr A died later that day.

(a) The Board's administration of Amisulpride to Mr A was not appropriate

8. On 10 December 2004 Mrs C wrote to the Board to complain about the care and treatment her father had received. In relation to the administration of Amisulpride she complained that prior to his admission to the Hospital, her father could walk without aid, feed himself at a table and was continent. She complained that the withdrawal of the medicines he had previously been prescribed (Galantamine and Citalopram), the prescription of Amisulpride and the dosage he was prescribed concerned her as her father had seemed extremely over-sedated during this prescription.

9. The Chief Executive responded to Mrs C on 3 February 2005. He explained to Mrs C that the medicines Mr A had previously been prescribed were associated with anxiety, confusion, secondary aggression, hallucinations, hypomania and mania. These had been reviewed and discontinued because of Mr A's agitation and aggression in the Hospital. Amisulpride had been prescribed on Mr A's admission to the Hospital in order to calm him. The maximum prescription was 50 mgs as required up to four times per day and the Chief Executive told Mrs C that this was within British National Formulary therapeutic limits. The Chief Executive said that from mid-September 2003 the dosage was gradually reduced and ceased completely on 6 October 2003. The medicines Mr A had previously been receiving were gradually reintroduced at the same time.

10. Mrs C responded to the Chief Executive on 22 February 2005. She told the Chief Executive that she was not satisfied with his response. She felt her father had suffered a direct drug-induced deterioration and that over-sedation

had resulted in permanent and serious physical and mental effects. She understood that sedation of the elderly with Amisulpride was recognised as a problem and that special precautions should be taken when prescribing it to patients such as her father. She felt that her father being unable to speak, walk or function went beyond the description 'calm'. Mrs C explained that the medicines Mr A had been prescribed previously had been in place for some time and that a trial withdrawal of one of them in summer 2003 had resulted in adverse effects. She also said that if the staff had felt the previous medicines had been detrimental to Mr A's conditions it was illogical to reintroduce them as had happened.

11. The Chief Executive wrote to Mrs C on 23 March 2005. He gave more details of the potential side-effects of the medicines Mr A had been prescribed prior to his admission to the Hospital and explained that the progression of Alzheimer's Disease was such that the side-effects experienced by a patient could alter over time. He said that the Acting Associate Medical Director had advised him that it was acceptable that different medications be prescribed at different times in an attempt to help a patient and that the prescription of medication to Mr A as noted was within normal and acceptable practice.

12. Mrs C responded to the Chief Executive on 14 April 2005. She said that she was unhappy that the Chief Executive seemed to have misinterpreted her views and had not mentioned Amisulpride at all in the letter. She asked the Chief Executive to escalate her complaint through the Board's formal complaint procedure.

13. The Chief Executive wrote to Mrs C on 22 April 2005. In his letter he explained that she could request an Independent Review Panel be convened to examine the handling of her complaint or she could make her complaint directly to the Ombudsman.

14. Mrs C asked that a request for an Independent Review Panel be made. In response to this the Independent Lay Convener decided not to convene an Independent Review Panel as she felt that Mrs C's complaints had been addressed in the Chief Executive's letters. Mrs C raised her complaint with the Ombudsman on 12 September 2005.

15. I sought the opinion of the Pharmacy Adviser on this complaint.

16. I asked the Pharmacy Adviser for his views on the withdrawal of medicines Mr A had been prescribed prior to his admission to the Hospital. He told me that Mr A had been prescribed the Galantamine at the top end of the range for a maintenance dose. He said that given this and the fact that Mr A was suffering from periodic episodes of verbal and physical aggression, it was reasonable to consider discontinuing the prescription of Galantamine. In addition to this a mini mental-state examination made on 27 August 2003 had resulted in a score of ten points while the range of suitability for Galantamine is 12 points and above.

17. The Pharmacy Adviser told me that Mr A's prescription of Citalopram on his admission to the Hospital was first reduced and then removed altogether within days of his admission. Against the background of increased agitation and significant behaviour change over a short period of time the use of another medication, such as Amisulpride, was not unreasonable.

18. I asked the Pharmacy Adviser for his views on the prescription and dosage of Amisulpride to Mr A. He told me that Mr A's medical notes indicated that he was unco-operative, violently aggressive both verbally and physically, had refused medication and spoke disjointedly in this period. In these circumstances, the prescription of Amisulpride was reasonable. The dosage of Amisulpride prescribed was not high and it was adjusted sensitively in relation to emerging symptoms, such as the observation of a degree of over-sedation on 17 September 2003. He commented that the reducing dosage administered while Galantamine was reintroduced was also appropriate.

19. I asked the Pharmacy Adviser whether there had been a direct drug-induced deterioration in Mr A's condition with resultant permanent and serious physical and mental effects, as Mrs C had suggested in her letter of 22 February 2005 (see paragraph 10). He told me that, in his opinion, there would have been no permanent and serious physical and mental effects and that the deterioration of Mr A's condition was not directly drug-induced. He felt that the deterioration in Mr A's condition was the result of the continuing progression of his Alzheimer's Disease. I asked the Pharmacy Adviser if the responses given to Mrs C by the Board on this issue were accurate. He told me that they were.

20. The Pharmacy Adviser also commented on the other medicines prescribed to Mr A during this period, which had not been specifically complained about by Mrs C. These were Lorazepam, used to address

insomnia and anxiety, and Chlormethiazole (also known as Clomethiazole), an anxiolytic and night-time hypnotic. He commented that the prescription and dosage of these medicines was reasonable and could have contributed to some of the drowsiness and apparent over-sedation that Mrs C felt her father experienced.

(a) Conclusion

21. I agree with the Pharmacy Adviser that the Board's administration of medicines to Mr A was appropriate both in general terms and with specific reference to the administration of Amisulpride and, therefore, I do not uphold the complaint.

(b) The Board did not provide adequate palliative care to Mr A

22. In her letter of 10 December 2004, Mrs C complained that she had been alarmed at her father's condition when she visited him on 25 August 2004. She had felt that he was distressed. She raised concerns about a number of aspects of his palliative care during the last few days of his life. She felt that the option of transferring Mr A to another ward or another hospital had not been properly addressed. She had asked for oxygen to be provided to her father and, while this request had been acceded to, she had been told that this would be of no particular benefit. Mrs C felt that measurement of Mr A's blood saturation levels should have been undertaken to allow a fully-informed decision to be taken. She also felt that other options were neither suggested nor discussed, such as the administration of analgesia via a morphine pump rather than fentanyl patches and whether it would have been in Mr A's best interests to have been given an intravenous drip of fluid.

23. The Chief Executive responded to this in his letter of 3 February 2005. He explained that, as it had been agreed following discussion with Mr A's family that aggressive resuscitation was not to be attempted should there be a potentially terminal event, the medical staff considered that Mr A's needs could be best met by remaining in the ward in the Hospital where he was known to the staff and where continuity of care in familiar surroundings could be provided. He also explained that oxygen saturation measurement was not normally undertaken for patients who were known to be terminally ill. He told Mrs C that staff felt that Mr A was experiencing pain only when moved during nursing procedures. As a result of this, fentanyl patches were prescribed from 20 August 2004. On 25 August 2004 it was felt that subcutaneous injections of morphine would provide greater control of Mr A's pain relief and this was

prescribed from then on. The Chief Executive told Mrs C that because Mr A's pain was felt to be related to specific times when he was being moved, a morphine pump was not considered necessary. He also explained that a senior clinician had agreed with this treatment plan, that the Hospital did not normally administer intravenous fluids and that there was no indication that Mr A had been clinically dehydrated.

24. Mrs C responded on 22 February 2005. She told the Chief Executive that she was not satisfied with his response. She said that she was concerned that the medical staff had had no clear opinion about whether or not the provision of oxygen to Mr A would be beneficial. She felt the Chief Executive's suggestion that remaining in the Hospital during the final days of his life, because he was familiar with the surroundings and staff, did not stand up to scrutiny and that, since no fluids of any significance had been received for around four days, it was a physiological certainty that Mr A had been dehydrated.

25. The Chief Executive wrote to Mrs C on 23 March 2005. In this letter he told Mrs C that he had passed her letter to the Nurse Manager who had assured him that patients requiring palliative care were nursed in the Hospital's wards and that they and their families were treated with dignity. The Hospital had a comprehensive Palliative Care Manual that covered all aspects of such care. The nursing staff were confident that they delivered compassionate palliative care which, though it may not have met the same standard as a specialist or dedicated unit, prioritised the maintenance of as dignified an environment as possible.

26. Mrs C wrote again to the Chief Executive on 14 April 2005. She told him that she was concerned that his letter had indicated that mental health patients in the Hospital did not receive an equity of palliative care with patients in other units. As noted in paragraph 12 above, Mrs C requested that her complaint be escalated. She was advised about the possibility of requesting an Independent Review Panel as noted in paragraph 13 above.

27. While the Independent Lay Convener felt that the Chief Executive had largely addressed Mrs C's complaints, she did refer the issue of the right of mental health patients to receive equity in palliative care back to the Chief Executive.

28. On 25 July 2005 the Chief Executive wrote again to Mrs C. He clarified that the Board always aimed to deliver comprehensive and appropriate palliative care to all patients requiring it. Clinical areas of the Hospital had a palliative care link nurse who was supported by the Board's adviser in cancer care and that all nursing staff had access to continuing professional development, support and supervision.

29. Mrs C raised her complaint with the Ombudsman on 12 September 2005. She felt that the alternative options that she had complained to the Board about and that were not taken would have minimised her father's distress.

30. As well as the Pharmacy Adviser, I sought the opinion of the Nursing Adviser in relation to this complaint. I asked the Pharmacy Adviser and the Nursing Adviser whether the alternative options Mrs C suggested would have minimised the distress to Mr A. The Nursing Adviser told me that Mr A's decline in the terminal stage of his illness was quite rapid and to have moved him to another ward, even within the same hospital, would have been likely to be quite stressful physically and mentally for him.

31. The Nursing Adviser told me that there was no evidence to support or criticise the use of oxygen.

32. In relation to the administration of analgesia via a morphine pump rather than fentanyl patches, the Nursing Adviser told me that there was obvious difficulty in managing Mr A's pain. She suggested that it may have been more beneficial to Mr A if his pain relief had been given via a syringe driver as this would have provided more consistent effects than fentanyl patches. The Pharmacy Adviser expanded upon this and explained that when fentanyl patches are used there is a delay of some hours after a patch is applied to the skin before sufficient morphine has entered the system for it to have a full effect. He also told me that the three-day duration of a fentanyl patch means it is difficult to manage fluctuating requirements for analgesia in this period. His opinion was that fentanyl patches are not, therefore, usually appropriate during the initiation of palliative care unless there are significant over-riding circumstances. He could not see any such circumstances in Mr A's case. He too, suggested that a syringe driver would have been a more appropriate method of pain management for Mr A.

33. I asked the Board whether the use of a syringe driver as a method of managing Mr A's pain had been considered. The Board told me that, at the time of Mr A's residence in the ward, neither the medical nor nursing staff had been trained in the use of syringe drivers and, therefore, it was not considered. The use of syringe drivers is rare in the care of the elderly with mental health issues and that it is now the Board's practice when syringe drivers are used that they are implemented, supported and monitored by specialist palliative care nurses.

34. With regard to Mrs C's suggestion that fluid be administered to Mr A via an intravenous drip, the Nursing Adviser commented that the rehydration of those in the terminal stages of an illness is controversial because as the body's organs and systems begin to shut down they are less able to deal with any sudden increase in workload and to begin rehydration would overload the kidneys and circulatory system. This would lead to fluid pooling in the tissues and cause the patient more distress. She also said that often intravenous rehydration is undertaken solely to comfort the family that something is being done.

35. I asked the Nursing Adviser whether Mrs C's contention that it would have been a physiological certainty that Mr A was dehydrated was accurate. She told me that there was no evidence to indicate exactly how much diet or fluid Mr A had taken in the last days of his life, nor was there any record of the volume of urinary output. I sought clarification from another Adviser with specialist nursing knowledge. She said that, in her view, Mr A's care in this respect was as good as it could have been in the circumstances. The extent to which hydration should be pushed in the terminal stages of an illness is always a difficult issue and that the significant deciding factor must be what is in the best interest of the patient. She felt that in Mr A's case, a serious consideration would be to ensure that any action that would agitate him was minimised. She gave her opinion that the staff gave Mr A appropriate care in the circumstances.

36. I asked the Pharmacy Adviser and the Nursing Adviser for their general comments on Mr A's palliative care. The Pharmacy Adviser said that, in his opinion, Mr A's palliative care had not been adequate because of the use of fentanyl patches rather than syringe drivers. The Nursing Adviser also identified the use of fentanyl patches as the only area of concern regarding Mr A's palliative care.

(b) Conclusion

37. I agree with the Pharmacy Adviser and the Nursing Adviser that most of the issues Mrs C raised were not indicative of an inadequacy of palliative care. However, I also agree that the use of fentanyl patches was not appropriate in Mr A's circumstances and that, consequently, the pain management aspect of Mr A's palliative care was inadequate to the extent that the use of syringe drivers would have been a more appropriate method of pain management. Given the importance of pain management to palliative care, I uphold the complaint.

(b) Recommendation

38. It is reassuring that the Board do now consider the use of syringe drivers when formulating palliative care packages and have access to properly trained staff to implement and monitor them. The Ombudsman recommends that the Board apologise to Mr A's family for the inadequacy of the palliative care afforded to Mr A to the extent that the use of syringe drivers would have been a more appropriate method of pain management than fentanyl patches.

39. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant; Mr A's daughter
Mr A	The aggrieved; Mrs C's father
The Board	Ayrshire and Arran NHS Board
The Nursing Adviser	A medical adviser to the Ombudsman with specialist knowledge of nursing
The Pharmacy Adviser	A medical adviser to the Ombudsman with specialist knowledge of pharmacology
The Hospital	Ailsa Hospital
Mrs A	Mr A's wife and Mrs C's mother

Annex 2

Glossary of terms

Alzheimer's Disease	A neurodegenerative disease; a type of dementia
Amisulpride	An drug used in cases of psychosis and schizophrenia
Anxiolytic	A drug prescribed for the treatment of symptoms of anxiety
Chlormethiazole (also known as Clomenthiazole)	A drug frequently used as an anxiolytic and night-time hypnotic in the treatment of the elderly
Citalopram	A drug prescribed for the control of symptoms of depression and panic attacks
Fentanyl	An analgesic
Galantamine	An inhibitor used for treatment of mild to moderate dementia
Lorazepam	A drug used for insomnia or anxiety
Mini mental-state examination	A brief questionnaire used to assess cognition
Morphine	An analgesic
Subcutaneous injections	An injection through the skin

Annex 3

List of legislation and policies considered

The Mental Health (Scotland) Act 1984