**Scottish Parliament Region: North East Scotland**

**Case 200502959: Tayside NHS Board**

**Summary of Investigation**

***Category***

Health: Hospital; care and treatment

***Overview***

The complainant (Ms C) raised a number of concerns about her mother (Mrs A)'s care and treatment following her admission to Ninewells Hospital (the Hospital) on 3 October 2004. Mrs A was elderly, frail and suffered from dementia. Sadly, Mrs A died on 9 October 2004.

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) drugs were administered to Mrs A inappropriately (*not upheld*);
(b) Mrs A was not provided with adequate nutrition (*not upheld*);
(c) nursing care provided to Mrs A was inappropriate (*not upheld*);
(d) Mrs A was not provided with appropriate medical care (*not upheld*); and
(e) communication with Mrs A's family was inadequate (*not upheld*).

***Redress and recommendations***

The Ombudsman has no recommendations to make.

## Main Investigation Report

### Introduction

1. Mrs A was an extremely frail 82-year-old woman who suffered from osteoporosis and dementia and who had previously been treated at Ninewells Hospital (the Hospital) after falling. Mrs A was re-admitted to the Hospital on 3 October 2004 with increasing agitation, after several falls and a soft tissue injury to her right shin. Mrs A was initially admitted to Ward 15 and was transferred to Ward 6 the following day (4 October 2004). There did not appear to be any acute medical problems and, in view of Mrs A's continued agitation and frequent falls, nursing home placement was considered. However, Mrs A died in her sleep on the morning of 9 October 2004. The cause of death was certified as '1 a. Pneumonia 11. Cerebrovascular disease'.

2. On 8 April 2005 Ms C complained to the Hospital about her mother (Mrs A)'s care and treatment. On 21 June 2005 Ms C met with medical and nursing staff who had been responsible for her mother's care. Ms C wrote clarifying her concerns in a letter dated 25 June 2005, to which the Medical Director responded on 26 August 2005. Ms C remained dissatisfied and wrote again on 3 September 2005. The Chief Executive wrote to Ms C on 15 November 2005 and on 26 January 2006 Ms C complained to the Ombudsman.

3. The complaints from Ms C which I have investigated are that:

(a) drugs were administered to Mrs A inappropriately;
(b) Mrs A was not provided with adequate nutrition;
(c) nursing care provided to Mrs A was inappropriate;
(d) Mrs A was not provided with appropriate medical care; and
(e) communication with Mrs A's family was inadequate.

### Investigation

4. In order to investigate this complaint I have had access to Mrs A's medical records, including the original prescription charts and medicine recording sheets, and the correspondence relating to the complaint. I have received advice from three advisers: a pharmacy adviser (Adviser 1), a nursing adviser (Adviser 2) and an adviser who is a Consultant Physician in the Care of the Elderly (Adviser 3). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and Tayside NHS Board (the Board) were given an opportunity to comment on a draft of this report.

**(a) Drugs were administered to Mrs A inappropriately**

5. Ms C raised several concerns about the medication administered to her mother, including the type, dosage and combination of medications, which she considered were inappropriate and caused her mother to be unnecessarily drowsy.

6. In response to the complaint, the Medical Director outlined the medicines given to Mrs A. He said that it would never be the intention of the staff to over-sedate a patient and a balance is struck, given the condition of the patient, which is continually assessed by both nursing and medical staff. On 15 November 2005 the Chief Executive provided further details of the drugs given to Mrs A.

7. Ms C said that her mother was not taking sedation medication before she was admitted to the Hospital but the Chief Executive said that the letter from her GP, which accompanied Mrs A to hospital, stated that she was taking quetiapine 25mg twice daily and diazepam 2mg three times daily. This sedation medication was reviewed throughout Mrs A's admission and was stopped on 5 October 2004. Mrs A was then prescribed risperidone twice daily, at one eighth of the standard dose for elderly patients. Mrs A received this medication on three occasions over 6 and 7 October 2004.

8. Adviser 1 said that he looked at the charts relative to Mrs A's admission between 3 October and 9 October 2004. First, he carefully examined the prescriptions, comparing them with the clinical record and nursing record. Then he compared the prescriptions with the record of medicine actually administered. Of the prescriptions written for Mrs A, three would not cause drowsiness: digoxin, aspirin and calcichew forte and he made no further comment on them. There were no antibiotics or diamorphine on any of the charts. Adviser 1 said that there was nothing to indicate that any medicines at all were given to Mrs A on either 8 or 9 October 2004.

9. Adviser 1 said Mrs A's prescribed dose of quietipine at the time of her admission was 25mg twice daily. Her GP had recently prescribed diazepam but that had rendered her more aggressive. Prescriptions for quetiapine and diazepam were in line with the medicines already prescribed by Mrs A's GP, as outlined in the out-of-hours GP's referral letter to the Hospital. Adviser 1 said that the intention of this prescription was to provide a reduction in Mrs A's

agitation but it appeared, from the correspondence between Ms C and the Hospital, that the family had taken a prior decision not to give these medicines to Mrs A, possibly without informing her GP. Adviser 1 said that only two doses of quetiapine were actually given to Mrs A, on the evening of 5 October and the morning of 6 October 2004. Risperidone was substituted for quetiapine on 6 October 2004, with Mrs A receiving two doses on that day. Adviser 1 said that this substitution and the way it was undertaken was acceptable. Diazepam was prescribed at a low dose (2mg, three times daily). All three doses were given to Mrs A on 4 October and two out of the three doses given to Mrs A on 5 October 2004. Adviser 1 said that he would not expect this amount of diazepam, taking into account her other medicines, to produce an undue level of drowsiness.

10. Adviser 1 said that, at times, Mrs A also received other medicines which are chemically related to diazepam (lorazepam and lormetazepam), the main difference being their relative duration of action. Adviser 1 said that these were also administered in modest doses, with reasonable gaps between doses. Adviser 1 said this was reasonable. In addition, on 3 October 2004 two doses of haloperidol were administered to Mrs A: 2mg at 16:45 and 4mg at 20:50. There is an entry in the clinical record on that afternoon stating that Mrs A's family said she did not tolerate haloperidol well. The combined dose of 6mg of haloperidol over a four hour period is in the range of medium to high for a patient who is suspected of being particularly sensitive to this medicine and Adviser 1 said that it could, therefore, have caused a noticeable degree of sedation. Adviser 1 said that Mrs A had become very agitated, however, and her agitation had to be reduced quickly. Haloperidol was a suitable medicine to choose for this purpose as it is reliable and effective and was administered at times when the chance of interaction with other medicines to produce an unacceptable degree of sedation was reduced.

11. Adviser 1 said that, in conclusion, the prescribing and administration of medicines to Mrs A were both reasonable and appropriate in the care and treatment of her agitation. The medical team required to reduce and then control Mrs A's agitation and they attempted to do so by adjustments both to the medicines being administered and their doses at different times. Adviser 1 said that a degree of sedation was inevitable but the adjustments were made in relation to clinical need and in line with commonly accepted practice.

*(a) Conclusion*

12. Ms C was concerned that medicine was administered to her mother inappropriately. I note that when Mrs A was admitted to the Hospital on 3 October 2004, one of the reasons was that her degree of agitation had increased. The advice I have received is that the medication prescribed for Mrs A was intended to decrease her agitation. Adviser 1 said that a degree of sedation was inevitable and he did not have concerns about the medication or the dosage or timing. I have to be guided by the advice I receive and, in the circumstances, I do not uphold this complaint.

**(b) Mrs A was not provided with adequate nutrition**

13. Ms C said that her mother was not given adequate food or liquids during her admission. In particular, on Thursday 7 October 2004, when Mrs A was recovering from a chest infection, she was given solid food, on which she choked. Ms C considered that it would have been more appropriate to feed her mother intravenously. Ms C complained to the Ombudsman about the level of nutritional care her mother had been given.

14. In response to the complaint, the Medical Director wrote to Ms C on 26 August 2005. He said that there was documented evidence in the form of food and fluid charts that Mrs A did take some fluids and food, although very little. Given Mrs A's confusion, the use of intravenous fluids would have been problematic to maintain. Mrs A's condition was monitored, however, and whenever she was able, food and fluids were offered to her throughout her time in the Hospital.

15. As part of her consideration of this complaint, Adviser 2 reviewed Mrs A's previous hospital records and noted good evidence that, during her admission to the Hospital in 2003, Mrs A was eating well. Mrs A was seen by the dietician who prescribed 'build up' and extra snacks, resulting in positive comments about intake during August and September 2003. During Mrs A's admission in June and July 2004, the dietician was again involved and there is evidence from the records that, on the whole, Mrs A's intake was reasonable. Adviser 2 said that the situation during Mrs A's final admission was quite different from her previous admissions. She was noted in the records to have no appetite and to be refusing food. Her intake was very poor indeed according to the records, although it is clear that Mrs A was offered food and drink. Adviser 2 said that by the time of this admission Mrs A's condition had changed and decline to her death on 9 October 2004 was rapid. The priority at that stage was to keep

Mrs A comfortable and give her palliative care. Adviser 2 said that patients with dementia tend to pull out intravenous tubes. They are, therefore, ineffective and the patients hurt themselves. In Adviser 2's view, the decision not to feed Mrs A via intravenous tube was appropriate at this stage, as it would have been likely to cause Mrs A distress and agitation.

*(b) Conclusion*

16. It must have been very distressing for Ms C to see her mother eating and drinking so little but I am satisfied that Mrs A was offered food and drink. Ms C considers that food and drink should have been administered to her mother either directly or intravenously but I accept Adviser 2's view that the priority was to try to keep Mrs A comfortable and it would, therefore, have been inappropriate to take any action likely to cause Mrs A pain or distress. I do not uphold this complaint.

**(c) Nursing care provided to Mrs A was inappropriate**

17. Ms C complained that her mother was nursed inappropriately. In particular: she was left alone in a side room, where she fell out of bed; she was allowed to sustain a fall and hurt her head and this was not properly investigated; she was left in a lying position for long periods; and her mattress was put on the floor, which left her at risk of dirt, disease, accident and draughts.

18. In his response to Ms C the Medical Director said that when Mrs A was admitted to Ward 15 she was very agitated and shouting out. She was, therefore, placed in a side room with one side of the bed against the wall facing the door. This allowed nursing staff to observe her while allowing the other patients to rest. The Medical Director said that it is extremely unfortunate when patients fall while in hospital but it is not an uncommon occurrence. It is difficult to predict the actions of all patients and that is especially true of those who are confused, for whatever reason. The staff identified that Mrs A was at risk of falling and took precautions, which were to have cot sides in place with one side of the bed against the wall. The position of the bed ensured that she could be easily observed by nursing staff and she was nursed on a one-to-one basis on occasion. When Mrs A was more settled she had been left alone but, on one of these occasions, she had managed to make her way to the bottom of the bed and had shuffled onto the floor. On that occasion no injury was noted but the Medical Director appreciated that Ms C had been caused distress and apologised for that. The Medical Director said that, unfortunately, Mrs A fell

again in Ward 6 and sustained injury to her forehead and knee. A neurological assessment was completed and found to be within normal limits and, therefore, no further investigation was indicated.

19. The Medical Director said that there were times when Mrs A was encouraged to stay in bed, as it was felt that was the safer option for her in terms of her confusion and agitation and given that she had already had some falls. Mrs A was able to sit up in a chair at her bedside when her condition and mental state allowed this. He said that Mrs A's condition was continually assessed, as there was a balance to be struck between the complications of reducing the patient's mobility with safety. Staff try to do all in their power to ensure the patient's safety. The Medical Director said that the placing of the mattress on the floor is not a usual course of action but is a last resort for staff who feel that they have exhausted all other means of fall prevention. He said that he appreciated that was distressing for Ms C and Mrs A but the decision was taken with Mrs A's best interests in mind.

20. Adviser 2 said that there is evidence in the nursing notes that attempts were made to manage Mrs A's safety in the light of her agitation and attempts to get out of bed. Staff moved the position of the bed and enabled her to sit out of bed when possible. Adviser 2 said that the steps taken by staff in Ward 15 and Ward 6 were reasonable but unfortunately failed to prevent Mrs A from falling. Adviser 2 said that when Mrs A sustained injury to her forehead and knee a neurological assessment was carried out and found to be within normal limits. No further investigation was done, which Adviser 2 said was in line with reasonable practice, especially given Mrs A's state of agitation which staff would not wish to provoke further by investigations which would add no value to the package of care already in place. In Adviser 2's view, no specific treatment was indicated. Adviser 2 noted that the Hospital had a low bed but it was already in use. Adviser 2 said that she agreed that, in those circumstances, placing the mattress on the floor was the best option.

21. The Mental Welfare Commission in its Principles of Good Practice Guidance - Rights, Risks and Limits of Freedom (June 2006) states 'The alternative of putting the mattress on the floor may be perfectly reasonable'. Adviser 3 agreed that nursing Mrs A on the floor was reasonable (and common) in the circumstances. Adviser 2 said that a falls prevention tool has been introduced by NHS Tayside and they also now had a small number of low beds, with the facility to rent more from the manufacturer when required. The Board

commissioned a review of relevant policies in July 2007 to eradicate the practice of having mattresses on the floor and this review is currently nearing the end of the draft process. I have seen a copy of the proposed draft policy, which proposes that low-level beds of non-variable height adjustment and mattresses on the floor will not be employed. Only low-level beds of variable height will be used in the future.

*(c) Conclusion*

22. It is very unfortunate that the measures taken by staff failed to prevent Mrs A from falling and from injuring herself on one occasion. Adviser 2, however, having carefully considered all of the clinical records and the relevant guidelines, is clear that the steps taken to try to safeguard Mrs A were reasonable, as was the action taken when Mrs A injured herself. The Medical Director recognised that having the mattress on the floor was distressing and apologised for that. I note the steps taken by the Board subsequently to try to eradicate the practice of putting mattresses on the floor. In the circumstances, and taking into account the advice I have received, I do not uphold this complaint. I realise that Ms C might wonder why this is not an upheld complaint, given that the Board have changed their policy on nursing patients on a mattress on the floor since she made her complaint. However, the advice I have received is that this was reasonable in the circumstances at the time and I have taken this into account in reaching my finding.

**(d) Mrs A was not provided with appropriate medical care**

23. Ms C complained that her mother was not provided with appropriate medical care after she had developed pneumonia, despite having no previous history of chest infections. Ms C asked why her mother was not given antibiotics if she had a chest infection.

24. In his letter to Ms C on 15 November 2005 the Chief Executive said that Mrs A did have some chest symptoms on admission but they were mild and did not indicate a chest infection. The symptoms worsened over the following 72 hours and it was at that time that a diagnosis of pneumonia was made. The Medical Director said that pneumonia is a common occurrence in elderly patients who suffer from dementia and can often occur in patients with no previous respiratory problems.

25. Adviser 3 said that, on admission to Ward 15 on 3 October 2004, the doctor who examined Mrs A found only 'few crackles r[ight] base, normal

temperature 36.7 and blood tests showed normal white cell count and CRP level, indicating the absence of infection'. Adviser 3 said that the registrar who reviewed Mrs A the following morning did not record any examination of the chest or any suspicion that she might be harbouring a chest infection. On 5 October 2004 Adviser 3 said that Mrs A was reviewed by two SHOs, who described her as 'medically stable' and 'medically no issues'. On 6 October 2004, however, the registrar said he had a long discussion with Mrs A's daughters about the reasons for her admission, mentioning 'non-correctable problems and possible pneumonia', although he gave no indication of how he came to make the latter diagnosis. Adviser 3 said that the registrar said that it had been agreed not to treat this (presumably the pneumonia) due to her quality of life. On the morning of 7 October 2006 the nurses recorded that Mrs A was coughing up 'lots of sputum'. Adviser 3 said that Mrs A died in her sleep on the morning of 9 October 2004 and the cause of death was certified as '1 a Pneumonia 11 Cerebrovascular disease'. Adviser 3 said that the diagnosis of pneumonia was very likely (a combination of symptoms: frailty, lying in bed and coughing up sputum) and, while there is no evidence that it had been arrived at by the usual methods of examining the lungs, a chest x-ray would not have been warranted as Mrs A's condition was so poor and treatment was, in any case, agreed by the registrar and Mrs A's daughters, not to be appropriate. Adviser 3 said that, in his opinion, the care and treatment provided to Mrs A was reasonable.

*(d) Conclusion*

26. I can understand why Ms C considers that if her mother had been treated for a chest infection at an earlier stage she might not have developed pneumonia. There is no evidence in the clinical records, however, that her mother had any symptoms which might suggest that she had a chest infection before 6 October 2004. At that stage the registrar said that she was already suffering from pneumonia. Adviser 3 noted the agreement not to treat Mrs A's pneumonia and said that was reasonable in the circumstances. I, therefore, do not uphold this complaint.

**(d) Communication with Mrs A's family was inadequate**

27. Ms C complained that communication with Mrs A's family was inadequate and a decision not to resuscitate her was made without any prior consultation with her family.

28. In response to her complaint the Medical Director wrote to Ms C. He said that it was documented that Ms C asked to discuss her mother's case with medical staff and she spoke with a junior member of the team. The Medical Director said he was sorry that this doctor had not been able to address all of the concerns which Ms C had at that time. The need to give clear, detailed and timely information to relatives had been brought to the attention of all members of the medical team. The Medical Director apologised for the distress Ms C had suffered. He noted that Ms C had been able to discuss her mother's care with the registrar on 6 October 2004 and her mother's condition and poor prognosis was outlined at that meeting. In view of that, it was decided that Mrs A should not receive treatment for her pneumonia and, in the event of cardiorespiratory arrest, it would be futile to perform resuscitation. The Medical Director said that this decision was taken after discussions with all staff caring for Mrs A.

29. Adviser 2 said that, in her view, there is evidence in both the nursing and medical notes that staff did communicate with Mrs A's family in a reasonable manner. Adviser 2 said that the family, and especially Ms C, were close to Mrs A and very concerned and it may be that she needed and expected a different level of communication, which is not always possible. In Adviser 2's opinion, the general level and quality of communication with the family was reasonable. Adviser 3 said that it was documented in the clinical records that at a meeting with Mrs A's daughters, including Ms C, on 6 October 2004 they agreed that Mrs A was 'not for resuscitation in the event of an arrest'. Adviser 3 said that would appear to answer Ms C's concern that the family had not been able to discuss Mrs A's status.

*(d) Conclusion*

30. I note that the Medical Director apologised to Ms C that the member of staff she first spoke to had not been able to answer all of her concerns when Ms C approached him. Ms C said that she had to wait to attend a meeting with the registrar on 6 October 2004. The evidence is that at that meeting Mrs A's medical condition, her treatment options and the decision not to resuscitate were discussed. Both Adviser 2 and Adviser 3 considered the decisions and communication with the family about the decisions was reasonable in the circumstances. I, therefore, do not uphold this complaint.

**Annex 1**

## Explanation of abbreviations used

| | |
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| Mrs A | The complainant's mother |
| The Hospital | Ninewells Hospital |
| Ms C | The complainant |
| Adviser 1 | The pharmacy adviser |
| Adviser 2 | The nursing adviser |
| Adviser 3 | The adviser who is a Consultant Physician in the Care of the Elderly |
| The Board | Tayside NHS Board |

**Annex 2**

## Glossary of terms

| | |
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| Aspirin | A common pain killer, in this case used as a blood thinning agent, in conjunction with Digoxin, to prevent strokes |
| Calcichew forte | A calcium supplement |
| Diazepam | A type of medicine called a benzodiazepine. Benzodiazepines are used for their sedative and anxiety-relieving effects. |
| Digoxin | A cardiac glycoside extracted from foxglove leaves. It increases the pumping force of the heart muscles and slows down the heart rate. |
| Haloperidol | An anti-psychotic drug used to reduce agitation |
| Intravenous | Into a vein |
| Lorazepam and lormetazepam | Medicines which are chemically related to diazepam |
| Pneumonia | Inflammatory disease of the lung |
| Quetiapine | An anti-psychotic drug used to reduce agitation |
| Risperidone | A sedative medication used for treating agitation in dementia, because of its better side-effect profile compared with phenothiazines (eg, Sparine) or benzodiazepines (eg, diazepam) |

**Annex 3**

## List of legislation and policies considered

The Mental Welfare Commission in its Principles of Good Practice Guidance - Rights, Risks and Limits of Freedom (June 2006)

Draft NHS Tayside Policy 3.1 Low-level Beds and Caring for Patients on Mattresses on the Floor