Scottish Parliament Region: Central Scotland

Case 201004658: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; Care of the Elderly; nursing and clinical care

Overview

The complainant (Mrs C) raised a number of concerns about the treatment her late husband (Mr C) received whilst a patient at Hairmyres Hospital (the Hospital) in March 2010, after he was admitted on 10 March 2010 with shortness of breath. He developed pneumonia and MRSA, and Mrs C felt the Hospital were not caring for him adequately, in particular that staff did not properly recognise his needs (Mr C suffered from dementia). Mr C discharged himself against medical advice on 23 March 2010 and died at home on 2 April 2010.

Specific complaint and conclusion

The complaint which has been investigated is that during Mr C's admission to hospital in March 2010, there were unreasonable failings in his medical and nursing care and treatment in relation to pneumonia and medication (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Lanarkshire NHS Board (the Board):	*Completion date*
(i) provide evidence on the implementation of Scotland's National Dementia Strategy[1] and the Dementia Resource folder, including relevant action plans, in order to ensure: ongoing education and training for staff in the Hospital; and good communication with dementia patients and their families, involving family members in care when appropriate; and	16 May 2012
(i) carry out a ward audit to ensure compliance with the Nursing and Midwifery Council's Standards for	16 May 2012

[1] An initiative introduced by the Scottish government in April 2010 for national implementation.

medicine management and record-keeping.

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

Main Investigation Report

Introduction

1. Mr C was 72 years old. He had Alzheimer's dementia and chronic obstructive pulmonary disease (COPD), and was cared for at home by Mrs C. Mr C fell ill on 10 March 2010 and was admitted to Hairmyres Hospital (the Hospital) suffering a cough and shortness of breath. He was initially treated with antibiotics. Mr C was diagnosed with pneumonia and was also screened for methicillian-resistant staphylococcus aureus (MRSA) infection. He was suffering weight loss and appeared malnourished. His condition was monitored and his course of treatment was reviewed – more details can be found at paragraphs 8 to 10.

2. Mrs C was unhappy about a number of aspects of Mr C's care. On some occasions she found his dementia medication among his bed sheets and on the floor. She was concerned staff were not supervising him taking this medication appropriately. On two occasions she and her son had found the window in Mr C's room open. She said Mr C's winter pyjamas had gone missing, he was wearing unsuitably thin pyjamas instead, and sometimes he did not have blankets on his bed, all resulting in him being very cold. Mrs C also felt Mr C was not being appropriately supervised at mealtimes, which was resulting in his weight loss and malnourishment. Mrs C decided to take Mr C home, and Mr C discharged himself against medical advice on 23 March 2010. He was cared for at home by Mrs C and a community nurse and carers. Mr C died at home on 2 April 2010.

3. Mrs C first complained to my office on 4 March 2011, however, her case was closed until Lanarkshire NHS Board's (the Board's) complaints procedure had been completed. Mrs C subsequently met with the Board on 28 March 2011. She remained dissatisfied with the Board's response, and her case was re-opened by my office on 24 May 2011.

4. Mrs C felt her husband had received a poor standard of care from the Board. She was deeply concerned that his dementia was not appropriately recognised or managed by staff at the Hospital. She wanted the Board to learn from Mr C's experiences, and to take action to prevent similar occurrences in the future.

5. The complaint from Mrs C which I have investigated is that during Mr C's admission to hospital in March 2010, there were unreasonable failings in his medical and nursing care and treatment in relation to pneumonia and medication.

Investigation

6. In order to investigate this complaint, my complaints reviewer considered Mr C's medical records, the complaints correspondence between Mrs C and the Board, as well as correspondence between the Procurator Fiscal (the PF), the Board and Mrs C. She also considered the minutes of a meeting which took place between Mrs C and the Board in March 2011. Finally, she obtained clinical advice from one of my clinical advisers, a consultant physician (Adviser 1), and nursing advice from my nursing adviser (Adviser 2). She also considered the Board's existing policies in relation to dementia, and the Nursing and Midwifery Council's Standards for Medicine Management.

7. 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.

Complaint: During Mr C's admission to hospital in March 2010, there were unreasonable failings in his medical and nursing care and treatment in relation to pneumonia and medication

8. Mr C was taken ill on 10 March 2010 whilst attending a day centre. He was experiencing a shortness of breath and a cough. Mr C was taken to his GP, who arranged for him to be taken to the Hospital. He was assessed by a member of the Medicine for the Elderly medical team, who documented that Mr C was suitable for an acute elderly assessment ward (the Ward). He was admitted to the Ward, which, although primarily a Stroke Unit, also admitted patients for acute elderly assessment. A chest x-ray showed evidence of mild pneumonia. Mr C was treated with nebulisers and antibiotics. It was noted in Mr C's medical records that he had dementia. It was noted on 12 March and 15 March 2010 that Mr C had walked out of the Ward and was 'wandering in the ward' respectively, despite being breathless.

9. On 18 March 2010 Mr C was noted to be coughing up sputum with pus in it. His treatment plan was discussed with a microbiologist to decide whether Mr C's antibiotics should be continued. Advice was given to discontinue the current course of antibiotics and undertake tests on Mr C's urine and sputum for

bacteria. On 22 March 2010 results came back with Mr C's sputum testing positive for MRSA, which was causing a chest infection. A different course of antibiotics was prescribed for a week; it was acknowledged that it would take a few days before it could be assessed whether they were working or not.

10. On 23 March 2010, a ward multi-disciplinary team meeting was held. It was noted there was slight deterioration and inflammation in Mr C's chest, and a computed tomography (CT) scan was recommended to investigate this further. It was noted there were concerns about Mr C's oral intake, and a dietary plan was discussed. Mrs C came to the Ward later that day and explained she was unhappy with Mr C's treatment. She was concerned staff had complained that Mr C was 'wandering around' – she felt this was not appropriate and demonstrated they did not recognise Mr C's dementia adequately. Mrs C felt Mr C had not been getting adequate nutrition, and that the nursing staff had not been assisting him appropriately at mealtimes. She was concerned he was being given food he did not like or could not tolerate given he had had stomach bypass surgery some years ago. Mrs C also explained she had found tablets in his bed sheets and on the floor. The nursing staff had stated they were encouraging Mr C to take his tablets but he had been spitting them out. She was also worried that Mr C had been left in his room with an open window, a thin blanket and no sheets – she felt this could have contributed to his pneumonia. Mrs C was also concerned that the focus on the MRSA investigations had detracted from the treatment of Mr C's pneumonia. The clinical staff explained they were currently treating Mr C for a chest infection, and that they needed to take daily blood tests and monitor the effectiveness of the antibiotics. Mrs C decided she would rather care for Mr C at home. Mr C discharged himself the same day and was cared for at home by Mrs C and a community care team until his death on 2 April 2010.

11. Mr C's death had been reported to the PF[2], and the Board wrote to the PF in relation to their investigation on 2 December 2010 and 18 January 2011, the former being a medical report (which explained the treatment Mr C had received as detailed within this report at paragraphs 8 to 10), and the latter being a letter addressing the nursing issues raised. In their letter of 18 January 2011, the Board explained Mr C had been admitted to a suitable ward, given it accepted patients for acute elderly assessment, and apologised that Mrs C's perception had been that the staff on the Ward did not understand the effects of dementia.

[2] Following an investigation, the PF decided to take no further action in relation to Mr C's death.

They stated any comment made about Mr C 'wandering around' was entirely unacceptable and apologised for this. They said most staff on the Ward had worked in elderly care for several years and worked with patients suffering from dementia on a daily basis. The Board said it was committed to improving care for patients with dementia and had made significant improvement in dementia awareness in the past year.

12. The Board apologised that Mrs C had found tablets in Mr C's bed sheets and on the floor. They said this was unacceptable and they would have expected nursing staff to have supervised Mr C in taking his medication. They also apologised for the distress caused by the fact Mr C did not have blankets or adequate bedding – they described this lack of care and compassion as unacceptable. In relation to dietary care, the Board explained Mr C was placed on a food record chart on 13 March 2010, and was referred to a dietician on 14 March 2010, and was prescribed supplement drinks. They noted Mr C had sometimes refused meals and drinks, and accepted it would have been good practice to request assistance from family members with whom Mr C was obviously more familiar. Finally, the Board explained all patients over the age of 65 were routinely swabbed for MRSA on admission to hospital, and apologised if this was not communicated to Mr C or his family. They explained the Ward now utilises a MRSA care plan which prompts staff to inform families of MRSA screening.

13. Mrs C raised her concerns with the Board formally following the conclusion of the PF's investigation. She and other family members attended a meeting with staff from the Board on 28 March 2011. She raised the issues previously mentioned, and also stated she felt the staff on the Ward had not communicated adequately with her or her family to let them know what the treatment plan was for Mr C. During the meeting, Mrs C was advised by the Associate Director of Nursing (the ADN) at the Hospital that there had been definite omissions in the nursing care of Mr C, and apologised for these. She explained changes had been implemented on the Ward, one of these being that nurses must ensure patients who require to be are supervised whilst taking their medication. She also advised the number of beds in the Ward had reduced from 24 to 20, which allowed nurses to provide more focussed care. In relation to the food provided in the Ward and dietary care of Mr C, Mrs C was advised a lot of work had been carried out to ensure the food served was of a high standard and there was a choice. The ADN stated that it was sometimes the case that food often appeared less appealing to those who were ill and had a

poor appetite. In relation to the MRSA screening, the ADN apologised on behalf of the Board the family were not advised why this was taking place. It was noted it was helpful to hold the meeting in order for the Board to have the opportunity to listen to a patient's relatives, and identify ways in which the nursing care provided could be improved.

Clinical and nursing advice received

14. Adviser 1 considered whether any failings in care had caused Mr C to contract pneumonia. He stated that there was no evidence of this; he explained that aspirating of food and drink caused by swallowing difficulties can be a cause of pneumonia, and that there was no evidence Mr C had swallowing difficulties. Both Adviser 1 and Adviser 2 said there is also no evidence that exposure to cold air or wearing inadequate clothing would contribute to a person developing pneumonia. Adviser 1 also considered whether the focus on the MRSA investigations had been detrimental to Mr C's treatment for pneumonia. Adviser 1 stated the British National Formulary emphasised the importance of using specific antibiotics for pneumonia after attempts to decide the cause – unless a patient is severely ill. In Mr C's case, the medical team had noted some deterioration at that time, but no severe illness except low oxygen. Adviser 1 explained signs of severe illness would include a raised respiratory rate, fever, or the patient not having enough breath to speak. He said it was, therefore, appropriate that the medical team waited to find a specific organism causing the pneumonia before treating. Adviser 1 explained the MRSA screening was also in fact helping to test to find the cause of the pneumonia, and that Mr C had also been tested for other causes of pneumonia, such as Legionnaire's Disease.

15. Adviser 2 considered the issue regarding the supervision of Mr C's medication. She explained that nursing staff have a responsibility to ensure that medication which is prescribed is given or, if unable to be given, that the reasons are documented as well as any actions taken. She explained the Nursing and Midwifery Council's Standards for Medicine Management state:

> 'You must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible.'

In addition:

> 'Where medication is not given, the reason for doing so must be recorded.'

Adviser 2 said Mr C's medical records describe tablets being found in the bed and on the floor as Mr C had spat them out. She could find no record in the nursing notes that described Mr C being unable or refusing to take his medicines; she said this was unacceptable. She noted the Board were correct in saying Mr C could not be forced to take tablets, but she would have expected nursing staff to look at alternative methods and to document any actions taken, for example the family could have been asked to assist with the medication or alternative routes considered such as liquid format. Adviser 2 concluded the nursing staff did not take reasonable steps to ensure Mr C's medication was administered competently.

16. In relation to Mr C's nutritional care, Adviser 2 noted the assessment documentation was poor and there was very little information provided about Mr C's ability to eat and drink, his preferred food and any dislikes. She noted the Board's own Dementia Resource Folder (implemented from April 2010) provides excellent information about ensuring people with dementia have a full assessment using a personal profile or assessment tool. Adviser 2 commented that in Mr C's notes, there was no sense of who he was, his usual activities at home or indeed any information that would allow staff to compare his presentation (including any delirium or confusion) as part of a baseline assessment. Adviser 2 noted there was no suggestion from the medical notes that personal information had been obtained from family members. She commented that the family could have been asked to attend at mealtimes to assist with eating and drinking.

17. Adviser 2 noted Mr C was recorded as frail and thin, but his weight was not recorded, therefore, again there was no baseline comparison. She acknowledged that the nursing staff had referred Mr C to a dietician given his poor appetite and reluctance to eat. Adviser 2 stated that the note from the dietician was comprehensive, and that high calorie drinks and food charts were commenced. Adviser 2 said these charts should contain all foods and drinks taken, however, they were incomplete and if accurate, suggested that on one day, 22 March 2010, Mr C only had a half cup of tea all day. Adviser 2 said there should have been a system in place to ensure Mr C was prompted to eat and drink regularly, and that from the records she could not be confident this occurred. She concluded that aspects of Mr C's nutritional care were poor.

18. Adviser 2 also considered the standard of communication with Mr C's family, in relation to the overall standard of care Mr C received. She considered

the communication needs of the family were not met. She found that on the day of admission, there was a record of Mrs C having raised her concerns that Mr C was not being looked after, and that the family had been described as aggressive. Adviser 2 explained the emotions of aggression, frustration and concern can be difficult to distinguish. Adviser 2 said she would have expected a senior nurse in the Ward to have been advised of the situation, and to be proactive in managing it and speaking to Mrs C about her concerns.

19. Adviser 2 said the notes indicated that the family were given updates on 14, 16 and 18 March 2010, but the detail of these discussions were unclear. She explained that nursing staff have a responsibility to be proactive in sharing information with the family of a patient. She reiterated in this case, a senior member of staff should have acted as the primary contact with the family, or escalated concerns to a more senior member of staff if required. Adviser 2 concluded although there was evidence of ongoing communication with the family, it had not met the needs of the family.

Conclusion

20. Mrs C complained to my office because she was concerned about the standard of care Mr C had received whilst in the Hospital. I conclude from my investigation that a number of aspects of Mr C's care, all in relation to nursing care, fell well below an acceptable standard. The areas of particular concern in this case are the supervision of medication, nutritional and dietary care, the recognition of dementia and incorporation of this recognition into patient care, and standards of communication. Most of these are basic aspects of nursing care and I am critical that the Board demonstrated failings in these areas.

21. Mrs C's concerns about the standard of care were so great, and she was given no reassurance, to the point that she decided Mr C would be better cared for at home. This lack of confidence in the Board's standard of care should not have been allowed to develop in the first place.

22. I note the Board have offered apologies to Mrs C and her family for the failings identified. I also note the Board have taken significant steps since Mr C's case to implement a range of initiatives[3] to inform and support nursing staff in the care of older people and people with dementia. These recognise

[3] The Dementia Resource Folder implemented in April 2010, and advice for Caring for People with Dementia implemented in June 2011.

that family and carers have 'expert knowledge' of the person with dementia and should have a significant degree of involvement in their care where appropriate. They also recognise the importance of good nutritional assessment, the need to help a patient orientate and feel as comfortable and safe as possible in the hospital environment, as well as of good communication and rapport building. It is very unfortunate that Mr C and his family were not able to benefit from these improvements, but I would expect that the Board learn from their failings in Mr C's care to help inform the development of these resources. I uphold this complaint and have two recommendations to make.

Recommendations

23.	I recommend that the Board:	*Completion date*
(i)	provide evidence on the implementation of Scotland's National Dementia Strategy[4] and the Dementia Resource folder, including relevant action plans, in order to ensure: ongoing education and training for staff in the Hospital; and good communication with dementia patients and their families, involving family members in care when appropriate; and	16 May 2012
(ii)	carry out a ward audit to ensure compliance with the Nursing and Midwifery Council's Standards for medicine management and record-keeping.	16 May 2012

24. 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.

[4] An initiative introduced by the Scottish government in April 2010 for national implementation.

Annex 1

Explanation of abbreviations used

Mr C	The aggrieved, Mrs C's husband
COPD	Chronic obstructive pulmonary disease
Mrs C	The complainant
The Hospital	A Hospital within NHS Lanarkshire
The Board	Lanarkshire NHS Board
The PF	The Procurator Fiscal for the Lanarkshire area
Adviser 1	A Consultant Physician, one of the Ombudsman's clinical advisers
Adviser 2	The Ombudsman's nursing adviser
The Ward	The Ward in the Hospital into which Mr C was admitted
CT scan	Computed tomography scan
The ADN	The Associate Director of Nursing at the Hospital

Annex 2

Glossary of terms

British National Formulary	A medical and pharmaceutical reference book that contains information and advice about prescribing and pharmacology
MRSA	Methicillian-resistant staphylococcus aureus, a bacteria resistant to certain antibiotics

Annex 3

List of legislation and policies considered

Nursing and Midwifery Council's Standards for Medicine Management

NHS Lanarkshire's Dementia Resource Folder

Top Tips in Caring for People with Dementia