Scottish Parliament Region: Mid Scotland and Fife

Case 201100109: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; Accident and Emergency; Care of the Elderly

Overview

The complainant (Mrs C) raised a number of concerns about the care, treatment and subsequent discharge of her husband (Mr C), who has dementia, following his admittance to the Accident and Emergency Department (the Department) of Victoria Hospital (the Hospital) on 6 January 2011.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the care and treatment of Mr C in the Department on 6 January 2011 was not reasonable (*upheld*);

(b) the arrangements for Mrs C to deal with Mr C's personal hygiene in the Department were unreasonable (*upheld*);

(c) the time taken to admit Mr C to a ward from the Department was unreasonable (*upheld*);

(d) the responses to Mrs C's telephone calls to the Department for information about Mr C were unreasonable (*upheld*);

(e) the arrangements for Mr C's discharge on 7 January 2011 were unreasonable (*upheld*);

(f) Mrs C was not provided with reasonable information upon Mr C's discharge (*upheld*); and

(g) Mr C's mental health condition and Mrs C's role as his carer, next of kin and holder of power of attorney over him were not reasonably taken into account during his admission (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) remind nursing staff within the Department of their responsibilities with regards to patients' personal hygiene and that it is not appropriate to rely on	2 May 2012

	visitors to undertake this for them;	
(ii)	provide evidence to the Ombudsman that staff within the Department have undergone training in relation to the importance of good communication with patients and their families;	16 May 2012
(iii)	review their policy in relation to ensuring appropriate discharge arrangements for patients, taking into account any vulnerabilities and risk factors;	16 May 2012
(iv)	remind nursing staff of the importance of treating patients with dignity at all times;	2 May 2012
(v)	review their policy in relation to providing discharge information to patients with dementia and their relatives and carers as part of the implementation of Scotland's National Dementia Strategy;	30 May 2012
(vi)	provide evidence that, as part of the implementation of Scotland's National Dementia Strategy, staff within the Department and the Ward are given ongoing training in relation to the importance of acknowledging dementia and recognising the role of carers and next of kin; and	30 May 2012
(vii)	provide a full formal apology to Mr and Mrs C for all of the failings identified within this report.	16 May 2012

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

Main Investigation Report

Introduction

1. Mr C is 73 years old and has dementia. He is cared for at home by his wife, Mrs C. Mr C was admitted to the Accident and Emergency Department (the Department) at the Victoria Hospital (the Hospital) at 07:25 on 6 January 2011, with symptoms including increasing head pain and disturbed vision. He had initially been attended to at home by paramedics, who deemed it appropriate to admit Mr C to the Department given his medical history of strokes. Following Mr C's examination, he was assessed as suitable for admittance to a ward, and was moved to a corridor of the Department to wait for a bed in a ward to become available.

2. Apart from one occasion when Mr C was transferred back into a bay for examination because Mrs C had raised concerns about his condition to staff, Mr C remained in the corridor until 22:00 that evening, when he was transferred to Ward 14 (the Ward). Mrs C had had to leave the Department in the afternoon in order to take her own medication. She telephoned the Department on a number of occasions to enquire about Mr C and to check whether he had been admitted to a ward. Mrs C eventually telephoned Fife Police (the Police) when she was unable to get information from staff answering the telephone at the Department. Meantime, staff at the Department also contacted the Police to ask them to visit Mrs C at home to ask her to refrain from calling the Department. The Police were in fact able to provide Mrs C with information over the telephone about Mr C's condition, having obtained this from the Hospital.

3. Mr C was ready for discharge from the Ward on the morning of 7 January 2011. The Hospital called Mrs C to ask her to collect Mr C, and she asked if she could collect him in the afternoon as she had to attend a doctor's appointment. Instead, the Hospital sent Mr C home in a taxi that morning. Mr C did not have outdoor clothing with him so was sent home in pyjamas and a housecoat, with a quantity of medication.

4. Mrs C complained to Fife NHS Board (the Board) on 7 January 2011 about a number of aspects of Mr C's care. She was concerned about the length of time Mr C spent in the corridor of the Department, and that none of the staff seemed to be paying attention to the symptoms he was displaying. She was also concerned that she had had to enter the sluice room to empty Mr C's urine

bottle without appropriate protection. She was distressed by the situation regarding her telephone calls to the Department, and the staff decision to contact the Police about her calling. She was also concerned by the manner in which Mr C was discharged from the Hospital; she felt his dress was inappropriate for the winter weather, and she was concerned that she was not given details of what medication he had had or any changes to his medication. She felt it was important this information was passed to her as Mr C's carer, particularly given he had dementia. Mrs C felt that the way she and her husband had been treated overall was unacceptable.

5. The Board responded to Mrs C's complaints on 7 February 2011. Mrs C raised further complaints on 12 February 2011, and the Board responded to these on 1 April 2011. On 6 April 2011 Mrs C wrote again regarding the fact she had power of attorney in relation to Mr C, and felt on that basis she should be involved in decisions about his care and advised of changes to medication. The Board wrote a further letter responding to outstanding issues on 5 July 2011, and offered Mr and Mrs C a meeting; however, they were unable to attend due to health difficulties until 15 August 2011, at which time Mrs C met with the Patient Relations Manager (the Manager) of the Hospital to discuss how Mr and Mrs C might be supported in the event of a future admission. In the meantime, Mrs C had brought her complaints to my office on 27 July 2011. She remained dissatisfied following the meeting and requested that we investigate her complaints.

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

(a) the care and treatment of Mr C in the Department on 6 January 2011 was not reasonable;
(b) the arrangements for Mrs C to deal with Mr C's personal hygiene in the Department were unreasonable;
(c) the time taken to admit Mr C to a ward from the Department was unreasonable;
(d) the responses to Mrs C's telephone calls to the Department for information about Mr C were unreasonable;
(e) the arrangements for Mr C's discharge on 7 January 2011 were unreasonable;
(f) Mrs C was not provided with reasonable information upon Mr C's discharge; and

(g) Mr C's mental health condition and Mrs C's role as his carer, next of kin and holder of power of attorney over him were not reasonably taken into account during his admission.

Investigation

7. In order to investigate Mrs C's complaints, my complaints reviewer has reviewed Mr C's medical records and the complaints correspondence between Mrs C and the Board. She also obtained advice from my nursing adviser (the Adviser).

8. 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.

(a) The care and treatment of Mr C in the Department on 6 January 2011 was not reasonable

9. When Mr C was admitted to the Department on 6 January 2011 at 07:25, a number of blood tests and a computed tomography (CT) scan were carried out initially. Given his presenting symptoms (see paragraph 1) it was felt appropriate to admit him to the Hospital for further observation. He was moved to the corridor to await a bed in a ward. Mrs C stated the corridor was draughty. She stated that shortly after 14:00, Mr C began to hold his head and complain of extreme pain. He also developed a pain in his arm and across his chest. She was very concerned for his well being and sought assistance from a member of staff. She stated Mr C had been in pain in full view of staff in the Department but nobody came to his aid voluntarily. Mr C was moved into a cubicle for examination and was administered with pain killers. He was then moved back into the corridor where he remained until approximately 22:00 that evening. Mrs C was concerned that staff did not appear to take notice of Mr C's increasing symptoms of pain, and stated the fact that he was moved between the corridor and the cubicle with fluctuating temperatures significantly increased his discomfort.

The Board's response

10. In their letter of 7 February 2011, the Board explained the Hospital had been experiencing a period of severe pressure due to the bad winter weather. This meant over 100 beds were unavailable due to patients being unable to move back home or on to nursing home care. This had in turn impacted upon the ability to move patients on from the Department to wards, which had

resulted in Mr C having to remain in the corridor. The Board explained pressure had also been added to their services by the community acquired winter vomiting noro-virus, which had resulted in an increased number of people attending the Hospital. They explained that Mr C was kept in the corridor as the bays were required for other patients arriving into the Department at short notice.

11. The Board apologised for any distress caused to Mr and Mrs C during Mr C's time in the Department. They explained they had reflected on Mrs C's comments about a lack of consideration being shown to Mr C, and stated that the Department by its nature as an emergency department is a busy and constantly changing environment. They explained priority had to be given to patients with life threatening conditions.

Advice obtained

12. The Adviser noted that the medical assessment documentation in relation to Mr C's admittance was comprehensive and the reasoning behind the decision to admit was documented. However, the only record in relation to care from nursing staff within the Department was at 17:30 – 'sandwich box and tea given.' She said there was no record of any medicines given or observations taken at the time at which Mr C had been re-examined in the afternoon. There was also no record of any personal care having been given. The Adviser summarised that the documented evidence of the care given in the Department was very poor, and that she was therefore critical of the care and treatment Mr C received. The Adviser stated that, regardless of the exceptional circumstances at that time, waiting in a corridor was undignified and provided no privacy for patients or relatives.

(a) Conclusion

13. Mrs C was concerned about the standard of care provided to Mr C whilst in the Department. Whilst acknowledging the Board's position that this was an exceptionally busy and difficult period for the Hospital, I find that Mr C received a standard of care which fell well below an acceptable level. I appreciate that staff within the Department were very busy, but I would still expect compassion to be shown to an elderly and vulnerable patient who was experiencing pain. There is no evidence from the nursing records of any personal care being given to Mr C nor is there any record of any medications or observations of Mr C during the extended time he was in the Department. I regard this as a failing in care. For the reasons given I uphold this complaint.

(b) The arrangements for Mrs C to deal with Mr C's personal hygiene in the Department were unreasonable

14. In her letter to the Board of 12 February 2011, Mrs C explained she had had to empty Mr C's urine bottle in the sluice rooms. She stated she was not provided with protection to undertake this task, and had not been given access to sanitation facilities. She stated both she and Mr C later contracted the winter vomiting noro-virus, and was concerned that this may have been acquired as a result of her having to undertake this task.

The Board's response

15. In their letter to Mrs C of 1 April 2011, the Board stated that they appreciated the assistance Mrs C had provided to the Nursing Team at that time by attending to Mr C's personal care. They explained there was a hand washing point in the trolley bay area within the Department as well as alcohol gel decontamination facilities.

Advice obtained

16. As noted within complaint (a), there were no records of personal care having been given to Mr C by nursing staff within the Department at any point during his time there. The Adviser said she found it unacceptable for a relative to empty a patient's urine bottle as there are hazards associated with this; this task should only be undertaken by someone who has had appropriate training. She stated it was likely this situation would be contrary to the Board's own policies in relation to standards of hygiene.

(b) Conclusion

17. Whilst again recognising the fact staff were very busy during Mr C's time within the Department, I find that the Board failed to provide assistance with his personal care. This is a basic aspect of care that I would not expect to be omitted. I also find the Board placed Mrs C at potential risk by allowing her to undertake the task she did. For the reasons given I uphold this complaint and have one recommendation to make.

(b) Recommendation

18. I recommend that the Board:	*Completion date*
(i) remind nursing staff within the Department of their responsibilities with regards to patients' personal	2 May 2012

hygiene and that it is not appropriate to rely on visitors to undertake this for them.

(c) The time taken to admit Mr C to a ward from the Department was unreasonable

19. As stated within complaint (a), Mr C remained in the Department from his admittance at 07:25 until approximately 22:00 when he was transferred to the Ward. Mrs C was worried about the length of time Mr C had to wait for a bed; given he has dementia, she was concerned he would become disorientated and distressed, particularly given she was unable to remain with him during the evening of his stay due to her own health difficulties. Mrs C stated in her complaint to my office that she found Mr C's sixteen hour wait in a corridor for a bed to be completely unacceptable.

The Board's response

20. As stated within complaint (a), the Board provided details of why the Hospital had been so busy on that particular day. They explained that the Bed Management Team had continued to attempt to transfer Mr C to a ward, and that the circumstances had been out with staff control at that time. They said the number of patients requiring emergency admission exceeded the number of beds available. They explained the Bed Management Team were constantly working to improve their admission and discharge arrangements, including exploring alternatives to inpatient admission.

Advice obtained

21. The Adviser was critical of the time period Mr C spent on a bed in the corridor. She stated that, despite the busy conditions within the Department, it was totally unacceptable for a patient to be kept in a hospital corridor for hours on end. The Adviser stated that, regardless of the exceptional circumstances at that time, waiting in a corridor was undignified and provided no privacy for patients or relatives. She noted the Board's position about the pressure on services but stated that the Government had introduced four hour waiting targets for accident and emergency departments[1] to prevent this kind of incident.

[1] This target was introduced in 2004 stipulating that by 2007 at least 98 percent of patients attending at an Accident and Emergency department should be seen within four hours ie admitted, discharged or transferred elsewhere.

(c) Conclusion

22. I have considered the matter of the wait Mr C experienced for a bed in isolation from the care and treatment he received whilst in the Department (complaint (a)). I find that the decision to keep Mr C in this location for such a prolonged period was unacceptable, and the Government's target on Accident and Emergency waiting times was clearly not met on this occasion. Alternative arrangements should have been made until a bed in a ward became available, particularly in order to allow Mr C some comfort and dignity. I uphold this complaint.

(d) The responses to Mrs C's telephone calls to the Department for information about Mr C were unreasonable

23. Mrs C left the Hospital at around 15:30. She telephoned the Department at around 19:00 to find out how Mr C was doing and whether he had been transferred to a ward. She explained that she telephoned several times, and whoever she spoke to told her they had not had dealings with Mr C directly and could not tell her anything about him except he was still waiting for a bed. Mrs C explained she continued to make calls as 'her mind could not be put at rest' until someone could tell her how her husband was. Mrs C stated eventually she was asked to stop calling the Department, and her calls thereafter were cut off.

24. Mrs C said she then telephoned the Police for advice, as at that stage Mr C had been in the Hospital for around twelve hours and she did not know what was happening in relation to his care. Meantime, staff at the Department had also made a call to the Police asking them to attend at Mrs C's house to ask her to refrain from making calls into the Department. A police officer contacted Mrs C, and thereafter assisted her in obtaining information about Mr C's condition from the Department by contacting them himself.

25. Mrs C said she felt she had been 'wrongly labelled as a trouble maker', and felt it was reasonable for her to have enquired about her husband's condition by telephone. She stated the Police had helped her, advised her she had not done anything wrong, and that she was entitled to get up to date information about Mr C.

The Board's response

26. The Board explained they understood Mrs C had been anxious about Mr C, and they were sorry that their contact with the Police had been

necessary, but, given there was only one dedicated telephone line to the Department, her calls had left other people unable to call in or out of the Department, which potentially put other patients at risk. They also stated her calling had affected the running of the Department as staff had to continually answer the telephone.

27. In their further letter of 1 April 2011, the Board stated Mrs C had been given assurances that Mr C was settled and his needs were being attended to. They also stated staff had advised they would contact her if there was a change in his condition or if he was transferred to a ward, and that they had done this. Mrs C wrote back on 6 April 2011 advising this did not happen, and the only information or assurance she received was from the Police.

Advice obtained

28. The Adviser stated there was no documentary evidence that Mrs C had ever been given information about Mr C's condition by staff in the Department. She said the only record in relation to communication was written by a staff nurse which stated Mrs C had been 'irate and verbally aggressive' on the telephone when asking for information about Mr C, and that they had contacted the Police to intervene as staff were unable to continue with their work. The Adviser said Mrs C was entitled to be kept fully informed about Mr C's care, and that it was quite right that she had expected to be given up to date information. The Adviser said it was understandable Mrs C was anxious and distressed given the circumstances in which she had had to leave Mr C, and particularly given his dementia.

29. The Adviser stated there was no evidence staff had been proactive in obtaining or providing up to date information, and she was critical of this. She stated this demonstrated a lack of engagement with Mrs C and a lack of compassion. She said that any concerns about Mrs C blocking the telephone line should have been raised with a more senior member of staff or a hospital manager. She acknowledged the Department was busy and the staff nurse concerned may have been under pressure to take action; however, the decision to disconnect Mrs C and contact the Police was totally unreasonable and unprofessional, and provided additional distress to Mrs C. The Adviser also commented she was dismayed the Board had not considered this decision to be unreasonable in their responses to Mrs C. She referred to the Nursing and Midwifery Code which states:

'The people in your care must be able to trust you with their health and wellbeing. To justify that trust, you must: work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community.'

The Adviser said the decisions taken on that evening were contrary to the Code.

(d) Conclusion

30. I am very concerned by the situation described within this aspect of Mrs C's complaint. It was not handled well by staff within the Department, and concerns should have been escalated to a more senior member of staff, rather than contact being made with the Police. I am critical that, even in retrospect, the Board did not deem this situation to have been handled inappropriately, and I draw this to their attention.

31. It appears that this upsetting aspect of Mrs C's complaint could have been avoided if a member of staff had taken the time to obtain information about Mr C and called Mrs C back to update her. Mrs C was within her rights to insist she be advised on Mr C's condition and whereabouts. This would not have taken long, and would have meant the avoidance of the unnecessary additional upset caused to Mrs C, and prevented the lengthy debate on this issue in the subsequent complaints correspondence. I uphold this complaint and have one recommendation to make.

(d) Recommendation

32. I recommend that the Board:	*Completion date*
(i) provide evidence to the Ombudsman that staff within the Department have undergone training in relation to the importance of good communication with patients and their families.	16 May 2012

(e) The arrangements for Mr C's discharge on 7 January 2011 were unreasonable

33. Mr C was approved for discharge from the Ward on the morning of 7 January 2011. Mrs C was telephoned at home and asked if she could come to collect him. Mrs C asked if she could collect Mr C in the afternoon, as she had an appointment with her Councillor who was in her home at that time, and

she had a doctor's appointment immediately afterwards. She was called back a short time later and advised Mr C would be sent home that morning in a taxi.

34. Mrs C stated that when Mr C arrived home, he was wearing only thin pyjamas and a housecoat. Given the winter temperatures she found this to be unacceptable. She stated that when she had been called earlier that morning, she had advised she would be able to bring appropriate winter clothing for Mr C later that day, but that this had been declined.

The Board's response

35. In their first letter to Mrs C, the Board said Mr C had been offered a blanket for the journey home but that he had declined it. They stated the taxi's heating had been checked prior to departure and had been found to be warm. In their second letter, the Board addressed the issue further and stated that due to the excessive demand on their services at that time as previously described, there was a requirement to discharge patients as soon as possible in order to accommodate new admissions. They then stated that they accepted that the manner in which Mr C had been sent home was not acceptable.

Advice obtained

36. The Adviser said that the discharge was not in keeping with the Board's policy which should have ensured that Mrs C, as Mr C's main carer, was involved in the discharge arrangements. She noted she understood the Hospital was under pressure to find beds; however, she found it would have been reasonable for Mr C to be kept in the Hospital until the afternoon as suggested by Mrs C, in order that she could bring more suitable clothing for him. The Adviser went on to say that most hospitals have a discharge lounge or waiting area where a patient can wait until transport arrives.

(e) Conclusion

37. Whilst considering this complaint, I note that it is evident the Hospital was experiencing serious issues in relation to bed capacity. Nonetheless, the way in which Mr C was sent home was not appropriate given he is an elderly and frail man with dementia. Sending a patient home in these circumstances shows a lack of nursing care and due regard for the dignity of the patient which is a fundamental aspect of nursing care. The Board should have recognised their responsibilities in relation to Mr C's care extended to the manner in which he was discharged home. On balance I uphold this complaint, making the following recommendations.

(e) Recommendations

38. I recommend that the Board:	*Completion date*
(i) review their policy in relation to ensuring appropriate discharge arrangements for patients, taking into account any vulnerabilities and risk factors; and	16 May 2012
(ii) remind nursing staff of the importance of treating patients with dignity at all times.	2 May 2012

(f) Mrs C was not provided with reasonable information upon Mr C's discharge

39. Mrs C complained she had not been advised of Mr C's International Normalised Ratio (INR) results upon his discharge. She also stated Mr C had arrived home with a bag of pills, but she had not been advised of any medication he had been given whilst in the Hospital nor of any changes to his current medication. She stated it was important she was given such information directly, and felt that it should be given on discharge, especially to relatives or carers in relation to a dementia patient such as Mr C.

40. Mrs C also stated that Mr C's Warfarin booklet was not completed whilst he was in the Hospital. Mrs C stated it was vital this be done as she required up to date information as Mr C's main carer, in order to care for him safely. She stated the failure of the Hospital to provide any discharge information had created additional stress for both her and Mr C.

The Board's response

41. In their first letter to Mrs C, the Board stated there had been no change to Mr C's blood clotting level, and he was to continue on the same Warfarin dose as already prescribed by his GP. They apologised for the breakdown in communication in this regard, and advised Mrs C she should have been given discharge information over the telephone when she was contacted that morning.

42. In a further letter to Mrs C of 5 July 2011 clarifying their response, the Board stated Mr C's Warfarin booklet had not accompanied him to the Hospital given he was an emergency admission. They explained the INR results would have been documented on Mr C's immediate discharge letter. They stated it is normal practice for this letter to be given to the patient, but they were unable to

determine if this had happened in Mr C's case. They apologised if there had been an omission on the part of the nursing staff in this regard.

43. The Board went on to change their previous position and stated that Mrs C had been given information over the telephone, in that she had been advised there was no change in medication, although they accepted she had not been explicitly informed of the INR results or the Warfarin dosage, and they apologised for this.

44. Mrs C responded to the Board on 9 July 2011 that she had taken the Warfarin booklet with her to the Hospital and left it with Mr C, and it had been returned with Mr C having not been completed.

Advice obtained

45. The Adviser stated that, as his welfare guardian, Mrs C should have been involved in any communication relevant to Mr C, including discharge information. She said the Board's position was that, as Mr C's medications and dosages were unchanged, they did not think they had to inform Mrs C of this – this was not the case. She examined the medical records in relation to Mr C's time on the Ward and stated they were very poor with limited information about the care Mr C required.

46. In relation to the Warfarin booklet, the Adviser stated there was no recorded evidence to demonstrate whether the booklet was present or not with Mr C at the Hospital.

47. The Adviser explained national standards in relation to the care of people with dementia had been launched since Mr C's attendance at the Hospital[2], and that the failure of staff at the Hospital to provide discharge information to Mrs C as Mr C's carer was an issue which should be addressed by the Board as part of their implementation of these national standards.

(f) Conclusion

48. Providing appropriate care for dementia sufferers is an increasingly relevant and fundamental aspect of health care, and a challenge that NHS Boards across Scotland must meet. This is recognised in the Government's introduction of a national strategy to ensure good standards of care for

[2] Scotland's National Dementia Strategy, launched in April 2011.

dementia patients. This includes ensuring those responsible for the care of a dementia sufferer are given full and clear information upon their discharge from a hospital. I find that Mrs C was not given full or clear information following the discharge of Mr C.

49. I acknowledge that it cannot be properly established what in fact occurred regarding Mr C's Warfarin booklet. However, I note the Board have apologised overall for the failure in communication in relation to providing Mrs C with information relevant to Mr C's ongoing care upon his discharge. As Mrs C rightly asserts, such information is crucial to her as Mr C's main carer, and should be passed to her directly. The Board did not do this, and on that basis I uphold this complaint. I have one recommendation to make.

(f) Recommendation

50. I recommend that the Board:	*Completion date*
(i) review their policy in relation to providing discharge information to patients with dementia and their relatives and carers, as part of the implementation of Scotland's National Dementia Strategy.	30 May 2012

(g) Mr C's mental health condition and Mrs C's role as his carer, next of kin and holder of power of attorney over him were not reasonably taken into account during his admission

51. Mrs C felt that, throughout Mr C's time in the Department, the Ward and upon his discharge, she was not appropriately recognised, involved or consulted with in relation to his care, treatment and ongoing requirements. She stated she had been treated in an 'off hand' manner within the Department. As described within complaint (d), she was unable to obtain information about her husband's condition over the telephone. In her letter to the Board of 6 April 2011, Mrs C stated she had pointed out to staff at the Hospital that she was Mr C's full time carer as well as his next of kin with power of attorney, and she required to be communicated with in order to provide safe and continuing care to Mr C. She also stated she had requested to be present when Mr C was examined or spoken with especially when it involved decision-making, as Mr C may not be able to remember all that was said during such discussions. She said the issue had not been addressed satisfactorily, and she continued to be concerned about this should Mr C have to use the services of the Hospital in the future.

The Board's response

52. In their letter of 1 April 2011, the Board stated they regretted that, during that exceptionally challenging time, their communications with Mr and Mrs C did not meet their needs. They apologised that they had been unable to find a way to resolve this. They stated they intended to use elements of Mrs C's complaints to inform ongoing communication training for staff.

53. During the meeting between Mrs C and the Manager on 15 August 2011, the Manager offered to act as a temporary intermediary when possible during any future admissions of Mr C to the Hospital, whom Mrs C could telephone if she felt she was not being included in or involved with discussions about Mr C's care and treatment. The Manager could thereafter contact staff and either obtain information for Mrs C, or advise staff Mrs C required further involvement. It was felt this could help to alleviate Mrs C's concerns about not being kept informed, and of Mr C being relied upon to acknowledge and remember important information.

Advice obtained

54. The Adviser stated there was minimal evidence to suggest Mrs C had been communicated with during Mr C's admission and upon his discharge. As stated within complaint (f), she said the notes from the Ward were poor; the only reference to Mr C's dementia was 'mild cognitive impairment'. There was no record of Mr C's individual needs, activities, or any mention that Mrs C has power of attorney. The Adviser stated that in essence the power of attorney meant Mrs C was acting on behalf of Mr C, and should, therefore, be involved in any process involving consent. This included discharge planning. There was no evidence that staff were aware of this or took this into account.

55. The Adviser concluded the lack of awareness about Mr C's condition and the lack of reference to Mrs C being power of attorney was unacceptable. She reiterated she found this to be so even when taking account of the exceptionally busy period being experienced by the Hospital.

(g) Conclusion

56. I find that Mrs C's role as Mr C's power of attorney was not appropriately recognised at any stage during Mr C's time within the Hospital. This case has identified some serious shortcomings within the Hospital in relation to care for patients with dementia, and the fundamental requirement for those with

guardianship of a patient with dementia to be involved in care. I uphold this complaint.

57. I acknowledge that the Board have apologised for this aspect of Mr and Mrs C's experiences, and that they have taken steps to find a solution by suggesting a system of contact with a manager at the Hospital. However, given that the significance of the problems identified by this report, it is important the Board can demonstrate improvements in this area on a service-wide basis. I have two recommendations to make.

(g) Recommendation

58. I recommend that the Board:	*Completion date*
(i) provide evidence that, as part of the implementation of Scotland's National Dementia Strategy, staff within the Department and the Ward are given ongoing training in relation to the importance of acknowledging dementia and recognising the role of carers and next of kin; and	30 May 2012

General recommendation

59. I recommend that the Board:	*Completion date*
(i) provide a full formal apology to Mr and Mrs C for all of the failings identified within this report.	16 May 2012

60. 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.

Annex 1

Explanation of abbreviations used

Mr C	The aggrieved, Mrs C's husband
The Department	The Accident and Emergency Department within Victoria Hospital
The Hospital	Victoria Hospital in Kirkcaldy
Mrs C	The complainant
The Ward	Ward 14 within Victoria Hospital
The Police	Fife Police
The Board	Fife NHS Board
The Manager	The Patient Relations Manager at Victoria Hospital
The Adviser	The Ombudsman's nursing adviser

Annex 2

Glossary of terms

International Normalised Ratio (INR) results	A system established by the World health Organisation for reporting the results of blood coagulation tests, which is relevant to the measure of warfarin dosage given to a patient
Warfarin	An anticoagulant used to prevent and treat the formulation of harmful blood clots within the body

Annex 3

List of legislation and policies considered

The Nursing and Midwifery Code