Scottish Parliament Region: Central Scotland

Case 201104966: Lanarkshire NHS Board

Summary of Investigation

Category

Health: hospital; artificial feeding, DNACPR decisions, adults with incapacity, carer involvement

Overview

The complainant (Ms C), acting as Independent Advocate for Miss A, raised a concern about the decisions taken by staff about artificial feeding by nasogastric (NG) tube for Miss A during a hospital admission from 25 June 2011 and 8 September 2011. Ms C also raised a concern about a lack of consultation with her about a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in September 2011. Ms C also had concerns about the accuracy of Lanarkshire NHS Board (the Board)'s response to her complaint in October 2011.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) during a hospital admission from 25 June 2011 to 8 September 2011, a flawed decision was taken to remove an NG tube (*upheld*);

(b) a DNACPR decision was taken without appropriate consultation with Ms C as Miss A's advocacy worker (*upheld*); and

(c) Lanarkshire NHS Board's complaint reply of 1 December 2011 inaccurately stated that a particular clinician had known Miss A since 2004 (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) use the circumstances of Miss A's case to review their practice in respect of patients with learning difficulties and/or suspected dementia, with particular focus on a review of the quality of decision making, the recording of decision making and the quality of record-keeping on admission and	30 October 2013

concerning DNACPR decisions; and

(ii) review their procedures for investigating complaints to ensure that responses are both accurate and can be justified. 25 September 2013

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

Main Investigation Report

Introduction

1. Miss A was a 55 year old woman with Down's syndrome and a learning disability, who was also formally diagnosed with severe dementia on 25 August 2011. She required assistance with all aspects of daily life and her day to day care was arranged by the Local Authority and provided by a national charity. She had no family. Miss A had no Welfare Guardian registered with the Office of the Public Guardian. Ms C was appointed as her advocacy worker on 19 July 2011. Ms C works for an Independent Advocacy charity funded in part by the Local Authority. Her role was to help ensure Miss A's rights were enforced and protected. Miss A also had a Social Worker, Ms D, employed by her Local Authority.

2. Miss A had a number of hospital admissions throughout 2011 for a number of infections and breathing problems, some of which were caused by difficulty Miss A had in feeding; causing her to choke and inhale food into her respiratory tract (aspiration). Miss A was discharged on 24 June 2011 but readmitted to Monklands Hospital (Hospital 1) on 25 June 2011 with signs of acute renal failure and infection. She was discharged on 8 September 2011. During this admission she was under the care of Consultant 1 and Consultant 2 on alternate months.

3. Miss A was transferred from Hospital 1 to Hospital 2[1] on 8 July 2011 for surgical treatment and returned to Hospital 1 on 29 July 2011. Following Miss A's return to Hospital 1, Ms D raised concerns about apparent inconsistencies between the artificial feeding treatment by nasogastric tube (NG) offered by Hospital 1 and Hospital 2. She wrote to Consultant 1 with her concerns. Consultant 2 responded on 5 September 2011.

4. Miss A's clinical records for May to September 2011 indicate that decisions were taken not to attempt cardiopulmonary resuscitation (DNACPR) in May 2011, June 2011 and again in September 2011. There is no record of any of these decisions being discussed with Ms D, Miss A's carers or Ms C as her advocate, either in advance of the decision or once the decision was taken. In her complaint to Lanarkshire NHS Board (the Board), Ms C said that she,

[1] Hospital 2 is out with Lanarkshire NHS Board (the Board)'s area.

Miss A's carers, and Ms D only became aware a decision had been taken following Miss A's discharge on 8 September 2011.

5. Ms C raised a number of concerns about the feeding regime and the DNACPR with the Board on 19 October 2011 and received a response from them on 1 December 2011. Ms C was dissatisfied with the response and complained to this office on 9 March 2012. Sadly, Miss A had died on 30 December 2011 following a further illness. As Miss A had no family and no registered legal guardian my office accepted Ms C's complaint as she acts in Miss A's interests.

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

(a) during the hospital admission from 25 June 2011 to 8 September 2011, a flawed decision was taken to remove a NG tube;

(b) a DNACPR decision was taken without appropriate consultation with Ms C as Miss A's advocacy worker; and

(c) Lanarkshire NHS Board's complaint reply of 1 December 2011 inaccurately stated that a particular clinician had known Miss A since 2004.

7. Ms C also raised concerns with this office about a lack of appropriate consultation with Miss A's carers about the decision to remove an NG tube. As this matter had not yet been raised directly with the Board by Ms C, this office advised she would need to raise this first with the Board, therefore, this matter is not considered in this report.

Investigation

8. During the investigation of these complaints, my complaints reviewer spoke with both Ms C and the Board. She reviewed the Board's complaints file which included comments obtained from clinicians involved in Miss A's care, and read Miss A's clinical records from April to December 2011. A number of aspects of this complaint included issues of clinical judgement and my complaints reviewer asked the view of one of my clinical advisers (the Medical Adviser), a hospital consultant physician.

9. 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 the Board were given an opportunity to comment on a draft of this report.

(a) During the hospital admission from 25 June 2011 to 8 September 2011, a flawed decision was taken to remove a NG tube

Information from the clinical records

10. Between her admission on 25 June 2011 and 5 July 2011, there were a number of discussions by doctors and dieticians regarding a suitable artificial feeding regime for Miss A. Both NG tube feeding and percutaneous endoscopic gastrostomy (PEG) feeding (feeding through a tube directly into the stomach) were considered. There were concerns about the management of PEG feeding. The dietician noted on 5 July 2011 that NG feeding was required. The clinical records do not specifically record when an NG tube was inserted but NG feeding had commenced by 6 July 2011 and was planned to provide 50 percent of Miss A's nutritional needs. Miss A would also be encouraged to eat a suitable diet.

11. Miss A was transferred to Hospital 2 on 8 July 2011 and returned on 29 July 2011 with NG feeding still in place. On 2 August 2011 she was reviewed by a dietician who commented that it appeared Miss A had lost a third of her body weight in the last five months and now weighed 53 kilograms (this is marginally higher than the recommended range for Miss A's age and height). The dietician did not have a record of the feeding regime in place during Miss A's stay at Hospital 1 and noted that NG feeding should be used for all Miss A's nutritional needs until her ability to eat independently had been assessed. A further note on 3 August 2011 states that Miss A had been struggling to tolerate any texture in independent feeding. The plan was to continue to provide full nutritional requirements through NG feeding but to also try to reduce this by introducing a suitable alternative diet for independent feeding.

12. Miss A's feeding regime was reviewed by the dietician services over the next few days. On 10 August 2011 nursing services requested a further review to see if the NG feeding could be reduced. The dietician advised she could not recommend this at this time as independent feeding would not meet Miss A's nutritional needs. On 11 August 2011 an entry made by Consultant 1 included these comments 'slow progress, oral intake adequate, stop/remove NG'. The NG tube was removed on 11 August 2011. An entry by the dietician later that day notes a concern about fluid levels, as NG feeding had had a significant contribution to this.

13. On 19 August 2011 Miss A was reviewed by a nurse from the Adults with Learning Difficulties Service. It was noted that in light of Miss A's learning disabilities, an Adults with Incapacity Certificate (Section 47 notice), under the terms of Section 47 of Part 5 of the Adults with Incapacity (Scotland) Act 2000, should be in place for all care, treatment and investigations.

14. A multi-disciplinary case conference was held on 22 August 2011.

15. On 25 August 2011 Miss A was reviewed by a consultant in the Learning Difficulties Psychiatric Services (Consultant 3) who concluded Miss A had Learning Difficulties secondary to Down's syndrome and advanced dementia. A Section 47 Notice was completed on 5 September 2011 by Consultant 1 although the space for indicating next-of-kin, guardian or carer was not completed.

16. Ms D raised concerns on a number of occasions with hospital staff about the decision to discontinue NG feeding and in particular the difference in view between the two hospitals. She also put these concerns in writing to Consultant 1 on 31 August 2011 and Consultant 2 on 13 September 2011. Ms C then continued to raise these concerns with the Board through the complaints process.

17. The clinical records between April and September 2011 include two references to an NG tube being dislodged by Miss A on 24 May 2011 and 31 July 2011.

Consultant 2's response and the Board's complaint response

18. Consultant 2 wrote to Ms D on 5 September 2011. He declined to arrange any further case conference and indicated he did not consider PEG feeding or intravenous antibiotics would be advantageous for Miss A – in particular he considered them unduly invasive procedures in light of Miss A's condition and warned against the risk of prolonging death rather than life in Miss A's case.

19. In their response to Ms C the Board commented that Miss A did have an NG tube in place at several times during her admission when she was unable to take adequate nutrition orally. The Board stated that NG tubes can induce aspiration pneumonia (caused by choking and inhaling substances into the lungs) particularly if the tube is dislodged and that at times Miss A dislodged a

number of NG tubes. The Board also stated that Miss A had managed to put on weight without NG feeding.

20. I note that the Board response also discusses the unsuitability of PEG feeding for Miss A. This was not an issue raised by Ms C in her complaint to the Board or to this office.

The Medical Adviser's Comments

21. My Medical Adviser noted that there are several entries in the clinical records indicating that Miss A suffered repeatedly from aspiration pneumonia. The Medical Adviser told me that while there is a risk of aspiration pneumonia from NG feeding it is a reduced risk compared to the difficulties Miss A was having with feeding herself.

22. The Medical Adviser expressed considerable concern that there were a number of entries in the clinical records from dieticians noting that Miss A's oral fluid and nutritional intake from direct feeding was inadequate, but despite this Consultant 1 had taken a decision to remove the NG tube on 11 August 2011 in direct opposition to the dietician's advice at that time. He also questioned the Board's comment that Miss A had put on weight while NG feeding was not in place, as there is no evidence for this in the clinical records.

23. The Medical Adviser noted that all these decisions were taken before Miss A's dementia status had been formally assessed on 5 September 2011. The Medical Adviser concluded the decision not to feed Miss A by NG tube was not reasonable.

Additional comments from the Board

24. In commenting on a draft of this report, the Board explained that, since the time of Miss A's treatment, significant progress had been made in terms of implementing the Scottish Government's National Dementia Strategy, and in developing its policy and resources regarding the assessment of cognitive impairment. They said the Standards of Care for Dementia were launched by the Scottish Government in June 2011, with the Board's three acute hospitals having been inspected and working through improvement outcomes at present.

25. The Board further explained they have a multi-agency Dementia Strategy Implementation Group which includes representations from various public

bodies and other organisations, with the 'transformation of dementia services a major part of the wider shared health and social care agenda'.

26. Finally, the Board provided details of on-going work relating to their acute hospital services, which mainly concerned the recent development of its Policy on the Assessment of Cognitive Impairment in Adults; Impact on Capacity to Consent to Care and Treatment.

Relevant legislation, policy and guidance - Adults with Incapacity (Scotland) Act 2000

27. Part 5 Section 47 - certification is required for any clinical treatment to take place where an adult lacks the mental capacity to make a competent decision about their own treatment.

(a) Conclusion

28. I note that Miss A's treatment by NG feeding may have required a Section 47 Notice under Part 5 of the Adults with Incapacity (Scotland) Act 2000. This notice was not completed until 5 September 2011.

29. The clinical advice I have received is that the decision not to feed Miss A by NG tube was not reasonable. I note too that the clinical records do not support several of the statements made by the Board namely Miss A's repeatedly removing the NG tube, putting on weight without NG feeding and the relative risk of aspiration pneumonia for Miss A.

30. Based on the clinical advice I have received and the evidence contained in the clinical records and Board responses, I have concluded that the decision to discontinue NG feeding for Miss A was not reasonable, and I uphold this complaint.

31. My conclusion on this complaint demonstrates an injustice suffered by Miss A. This complaint and complaint (b) both raise serious concerns about the quality of decision making, consideration of capacity issues and recording of these issues with respect to a most vulnerable member of society, namely an adult with life-long learning difficulties and dementia. There are a number of legal safeguards which should have been in place for Miss A precisely because of her degree of vulnerability, and it is of considerable concern that there were significant delays in enacting these.

32. I note the Scottish Government's Standards of Care for Dementia were launched around the time of Miss A's stay in hospital. Whilst I am pleased to note from the Board's response to a draft of this report that, since the time of Miss A's care, a significant range of improvements and strategies have been implemented to address the care and treatment of patients with dementia, I remain concerned about the treatment given to a patient with such a high level of vulnerability. I have made one recommendation, which is detailed at the conclusion of complaint (b), as it relates to issues and concerns raised in both of these complaints. The recommendation seeks to address these bigger issues; particularly as I cannot now remedy the injustice to Miss A. I understand that the Board's procedures will be updated again following the publication of the updated National Dementia Strategy; I would expect compliance with the recommendation to include details of the steps currently being taken towards this.

(b) A DNACPR decision was taken without appropriate consultation with Ms C as Miss A's advocacy worker

Information from the clinical records

33. There are several entries relating to DNACPR decisions in the clinical records from April 2011 to September 2011 as follows:

24 May 2011	'patient should NOT be resuscitated in event of cardiac arrest. DNAR form implemented'
26 June 2011	'In view of comorbidities DNACPR seems appropriate'
27 June 2011	'[Miss A] has no power of attorney. Presently DNAR enacted'
30 June 2011	'DNAR status still in force'
19 August 2011	'Patient has a DNACPR on the front of notes, not evident that it has been discussed with relatives, or significant others'

34. There are no copies of the DNACPR completed forms for this time period contained in the clinical records supplied to my office by the Board. On 19 August 2011 Miss A was reviewed by a nurse from the Adults with Learning Difficulties Service. It was noted that there was a DNACPR document in Miss A's file but that there was no evidence that this had been discussed with relatives or significant others.

35. The admission records used by Hospital 1 include space to indicate whether a patient has a learning disability – this was completed on

25 June 2011 and not on 14 June 2011. On neither occasion was the supplementary information sheet indicated on the admission forms completed. There are numerous mentions throughout the clinical records of Miss A's learning difficulties and dementia. The record also contains a box to indicate whether or not resuscitation status has been discussed; this box was not completed for any of Miss A's hospital admissions between May and September 2011.

36. The clinical records do contain a copy of a later DNACPR form dated 31 October 2011 and the admission records indicate that this decision was discussed with Miss A's carer.

37. The DNACPR form used by the Board includes a provision that where a patient is discharged home with a DNACPR in place then this must be discussed with relevant others.

Consultant 2's response and the Board's complaint response

38. The Board's response noted that the fact that a DNACPR form had been completed and was to continue was communicated to Miss A's GP on 7 September 2011. It was the clinical view that the continuation of the DNACPR status was appropriate. The response did not refer to whether or not there should have been consultation with Ms C or Miss A's carers.

The Medical Adviser's comments

39. The Medical Adviser commented that he would have expected that there would be consultation with those involved in Miss A's care, including Ms C, about a DNACPR decision.

Relevant legislation, policy and guidance

40. There are several relevant sets of guidance in this area, a number of these are listed in Annex 3. Of particular relevance here are:

> *'1) Decisions relating to Cardiopulmonary Resuscitation - A Joint Statement from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing October 2007, updated November 2007*
>
> 9.2 Adults who lack capacity, have neither an attorney nor an advance decision but do have family or friends:
>
> Where a patient has not appointed a welfare attorney or made an advance decision, the treatment decision rests with the most senior clinician in

charge of the patient's care. The Adults with Incapacity (Scotland) Act requires doctors to take account, so far as is reasonable and practicable, of the views of patients' nearest relatives and their primary carers.

If a senior clinician believes that CPR [cardiopulmonary resuscitation] should be attempted, any person claiming an interest in the patient's welfare may appeal that decision to the Sheriff. A DNAR decision could also be challenged in the Court of Session.

In these circumstances, it should be made clear to those close to the patient that their role is not to take decisions on behalf of the patient, but to help the healthcare team to make an appropriate decision in the patient's best interests. Relatives and others close to the patient should be assured that their views on what the patient would want will be taken into account in decision-making but that they cannot insist on treatment or non-treatment.'

'2) Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy Decision Making and Communication. NHS Scotland May 2010

If the patient does not have capacity, then the principles of the Adults with Incapacity (Scotland) Act 2000 apply. Intervention with CPR should be considered if it is likely to be of overall benefit for the patient. If the clinical opinion is that there would be no benefit, then a DNACPR decision is appropriate. The past and current views of the patient, if known, must be taken into account and there is a duty to consult relevant others and ask if there is any valid advance directive which should be assessed to see if it is applicable to the current situation.

Where a patient lacks capacity for involvement in advance decisions and has no legally appointed welfare attorney/ welfare guardian /person appointed under an intervention order

- the responsibility for deciding if resuscitation is in the patient's best interests lies with the lead clinician with clinical responsibility for the patient
- family/carers/next of kin do not have decision-making rights or responsibilities in this circumstance. Discussion with the family has the primary aim of trying to clarify the patient's views, prior to incapacity.

3) Standards of Care for People with Dementia. The Scottish Government, May 2011.
These Standards incorporate The Charter of Rights for People with Dementia in Scotland and Their Carers 2009 and have several relevant provisions to Miss A's care but of most direct relevance is the provision that:

The anticipatory care plan and any other advance planning made will be recorded in the primary care record and shared with those providing care.'

(b) Conclusion

41. It is not within the scope of this complaint to consider whether or not a DNACPR decision was appropriate for Miss A in September 2011. The complaint I am considering is only whether such a decision should have been discussed with Ms C.

42. The view of the Medical Adviser is that Ms C should have been consulted. The NHS Scotland Policy indicates advocates and carers should be consulted where practical to ascertain the views of the patient and also made aware of a DNACPR which remains in place on discharge to the community. Advocates and carers do not have decision-making rights which remain with the clinician in charge of care.

43. The lack of relevant DNACPR forms in the clinical records means I cannot ascertain the reasons for the DNACPR decision or any reason for not discussing Miss A's wishes with Ms C or indeed any of Miss A's carers. I note that the DNACPR decision appears to have been made at least as early as May 2011 and was revisited several times with no discussion with any of Miss A's carers or latterly with Ms C. There is no apparent consideration of such a discussion, although a later decision in October 2011 was discussed with Miss A's carer. I also note Miss A's GP was not advised of any of the previous DNACPR decisions before September 2011.

44. While Ms C had no right to be consulted on the actual DNACPR decision or to refuse consent on Miss A's behalf, I conclude there was a duty on the clinical team to ascertain, if possible, Miss A's prior wishes through either her carers or advocate, and this did not happen. There was also a requirement on the DNACPR form to discuss the decision at the time of discharge; this did not happen. I, therefore, uphold this complaint. I make one recommendation,

which as explained above applies to the issues and concerns identified in relation to both complaints (a) and (b). Whilst I note the steps the Board has since taken to improve their care of patients with dementia as outlined at paragraphs 23 to 25, this recommendation seeks to address the specific issues and concerns identified in Miss A's care.

(b) Recommendation

45.	I recommend that the Board:	*Completion date*
(i)	use the circumstances of Miss A's case to review their practice in respect of patients with learning difficulties and/or suspected dementia, with particular focus on a review of the quality of decision making, the recording of decision making and the quality of record keeping on admission and concerning DNACPR decisions.	30 October 2013

(c) NHS Lanarkshire's complaint reply of 1 December 2011 inaccurately stated that a particular clinician had known Miss A since 2004

46. In the Board's response they noted that Miss A had been known to the Learning Difficulties Psychiatrist (Consultant 3) who assessed her on 25 August 2011 since 2004. Ms C complained that this was inaccurate as this was the first time Miss A had been seen by Consultant 3. Ms C was concerned at the overall lack of accuracy in the Board response that this error indicated.

47. In response to enquiries from this office the Board noted this was an error and that what should have been written was that Miss A was known to the Learning Difficulties Psychiatry service since 2004. The Board apologised that this unfortunate misrepresentation of the notes had occurred.

48. I note that there were a number of other inaccuracies in the complaints response, which are already referred to in paragraph 29 of this report.

49. In their response to a draft of this report, the Board said that in January 2012, the Acute Division Management Team had approved a paper on the Clinical Review of Formal Complaints, which 'consolidated and formalised' previous arrangements. The Board explained this was widely available for staff to refer to and was in the process of being updated. They said that investigating and responding to complaints was part of the senior medical staff induction programme and the Charge Nurse development programme.

(c) Conclusion

50. The Board have accepted the error and apologised for this. I uphold this complaint. I am concerned that my investigation has shown a worrying number of other inaccuracies in the complaint response which suggests to me an insufficiently robust investigation of this complaint by the Board. Whilst I am pleased to note the steps the Board has taken since the time of these events to update and improve their complaints handling processes, I make the following recommendation to ensure these are fully updated and fit for purpose.

(c) Recommendation

51. I recommend that the Board:	*Completion date*
(i) review their procedures for investigating complaints to ensure that responses are both accurate and can be justified.	25 September 2013

52. 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.

Further Action

53. This complaint has raised a number of concerns that the Adults With Incapacity (Scotland) Act was not properly applied in Miss A's case. A number of these issues go beyond the scope of this complaint. I have decided to refer this case to the Mental Welfare Commission for Scotland who have an oversight role in this area.

Annex 1

Explanation of abbreviations used

Miss A	The Aggrieved
Ms C	The Complainant, Miss A's Independent Advocate
Ms D	The social worker responsible for Miss A's care at the local authority
Hospital 1	The Hospital where Miss A was treated during the events of this complaint
Consultant 1 and Consultant 2	The Consultants responsible for Miss A's care on a rotational basis at Hospital 1
Hospital 2	The hospital Miss A was transferred to between 8 and 29 July 2011
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
The Medical Adviser	A hospital consultant physician who provides independent clinical advice to the Ombudsman
Consultant 3	The Learning Difficulties Psychiatrist who assessed Miss A in August 2011

Annex 2

Glossary of terms

Aspirational Pneumonia	Infection caused by breathing in a foreign substance (often food) into the lungs
DNACPR decision	A decision taken in advance that in the event of a cardiac arrest, no attempt should be made to restart the heart
Nasogastric tube (NG) tube	a tube used to provide fluids and nutrition through the nose directly to the stomach
Percutaneous endoscopic gastrostomy (PEG) Feeding	A tube used to provide fluids and nutrition directly into the stomach

Annex 3

List of relevant legislation and policies

Legislation

The Adults With Incapacity (Scotland) Act 2000
The general principles of the Act include ensuring that the present and past wishes of the adult (so far as they can be ascertained by any means of communication) are taken into account when determining if an intervention under the Act should be made.

Part 5. Some people with dementia may not always be able to give a valid consent for any proposed treatment. The law in Scotland recognizes this and has put in place procedures and safeguards to protect people. People with dementia, as with everyone else, must have their capacity to consent to medical treatment assessed by anyone proposing to prescribe medication or carry out any other medical treatment or intervention. If they have capacity to consent then it is up to the person with dementia to either give their consent or not. If the person with dementia cannot give valid consent then the view of any proxy decision maker (a welfare power of attorney or welfare guardian) should be sought. A certificate of incapacity must be completed under Section 47 of the Adults with Incapacity Act (Scotland) Act 2000 when someone lacks capacity to consent. This certificate authorises treatment and ensures treatment is given lawfully.

The Human Rights Act 1998 affects the way that public bodies such as hospitals and local authorities treat people when carrying out their functions. It adopts the articles of the European Convention of Human Rights giving them a legal basis in the UK.

The Mental Health (Care and Treatment) (Scotland) Act 2003 Section 259 states that every person with a mental disorder (this includes people with dementia) shall have a right of access to independent advocacy.

The NHS and Community Care Act 1990 gives local authorities the lead responsibility for planning and coordination of community care services and duties for community care assessments.

Existing Standards and Best Practice Guidance

SIGN 86 management of patients with dementia. A national clinical guideline. Scottish Intercollegiate Guidelines Network (2006 reviewed 2009). http://www.sign.ac.uk/guidelines/fulltext/86/index.html

Working with independent advocates. The Mental Welfare Commission for Scotland (2009). www.mwcscot.org.uk

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) - Integrated Adult Policy. NHS Scotland (2010).
http://www.scotland.gov.ukPublications/2010/05/24095633/0

Decisions relating to cardiopulmonary resuscitation. British Medical Association, Resuscitation Council (UK) and Royal College of Nursing (2007). http://www.resus.org.uk/pages/dnar.pdf

Standards of Care for People with Dementia. The Scottish Government, May 2011. These Standards incorporate The Charter of Rights for People with Dementia in Scotland and their Carers 2009
http://www.scotland.gov.uk/Publications/2011/05/31085414/10