SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Lothian

Case ref: 201403146, Lothian NHS Board
Sector: Health
Subject: Hospitals; clinical treatment; diagnosis

Summary
Mr A was elderly and had several serious health problems, including a form of dementia. He was admitted to the Royal Edinburgh Hospital from his nursing home due to worsening behavioural problems, including agitation and aggression. His mental health assessment showed that he lacked awareness and insight into his problems, and had trouble with communication. This, plus his aggression, meant that he was a risk to himself and other people.

Mr A was mobile with the help of a walking stick when he was admitted to hospital. He fell two days later and suffered bruising, then fell again a few days later, and broke his hip. He was transferred for surgery but died two days after the operation.

His daughter (Mrs C) believed that Mr A's fall risk had been poorly assessed when he was admitted, and that he was not properly cared for after the first fall so the second fall was not prevented. She was concerned that he was over-sedated and not eating or drinking enough, and that the management of his diabetes was inadequate. She also felt Mr A's aggression had not been handled well and that he was blamed for his behaviour, when it was actually the result of his illness.

I obtained independent advice from a nursing adviser, who noted that the board's policy is to complete a falls risk assessment for all elderly patients and to review the patient's falls care plan if they fall. The board's complaint investigation report said that this was all done, but my adviser found no evidence to support this and considered that the standard of record-keeping and falls prevention practice was poor overall. I agreed with this view and, therefore, upheld the complaint and made recommendations.

Regarding Mrs C's complaint about sedation, my adviser said that the appropriate medication and dosage was prescribed and that quick action was taken when adverse effects were noted. My adviser also considered that the board's response letter was balanced and did not blame Mr A for his behaviour.

However, the advice I received was critical overall of the standard of nursing provided to Mr A. The record-keeping was inadequate and did not include care plans for Mr A's personal care or communication difficulties. There was also a significant failure to monitor Mr A's blood glucose levels appropriately and a failure to adequately monitor his nutritional intake. I noted that the board's complaint response states that blood glucose levels were not monitored following Mr A's admission and I was critical of their failure to act on this. I upheld the complaint and made several recommendations.

Redress and recommendations

The Ombudsman recommends that Lothian NHS Board:	*Completion date*
(i) remind all staff that a falls risk assessment is a requirement on admission of an elderly patient;	2 December 2015
(ii) review the complaint investigation to establish why statements about Mr A's care not supported by the clinical record, were included in their formal response;	2 December 2015
(iii) review their admission procedures for elderly patients to ensure that a Malnutrition Universal Screening Tool assessment is recorded;	16 December 2015
(iv) remind all staff involved in Mr A's care of the importance of regular and accurate blood glucose monitoring for diabetic patients;	2 December 2015
(v) remind all staff involved in Mr A's care of the importance of accurate and comprehensive care plans, which meet all a patient's needs; and	2 December 2015
(vi) apologise to Mr A's family for the failures identified in this report.	2 December 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial

and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained about the care and treatment provided to her father (Mr A) during an admission to the Royal Edinburgh Hospital (the Hospital). The complaints from Mrs C I have investigated are that the Hospital's:

(a) falls management during the admission of 5 to 13 August 2013 was inadequate (*upheld*); and

(b) standard of nursing care during the admission of 5 to 13 August 2013 was unreasonable (*upheld*).

Investigation

2. In order to investigate Mrs C's complaint, my complaints reviewer considered all the information provided by Mrs C and by Lothian NHS Board (the Board). Independent advice was also provided from an nursing adviser (the Adviser). In this case, we have decided to issue a public report on Mrs C's complaint because of the significant failings identified by the Adviser and the significant personal injustice experienced by Mr A and his family as a result.

3. 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.

Background

4. Mr A was an elderly man with a number of serious health problems. He suffered from ischaemic heart disease, an acute myocardial infarction in 2010, vertebrobasilar insufficiency, chronic kidney disease, Barrett's oesophagus, pulmonary embolism and type II diabetes. He also had a diagnosis of advanced vascular dementia.

5. Mr A was an in-patient in the Hospital between 5 August 2013 and 13 August 2013. His admission to the Hospital had been precipitated by escalating behavioural problems. These included agitation, wandering during both day and night, and significantly aggressive behaviour towards his wife and others. These behaviours became acute during May 2013, whilst Mr A and his wife were resident in a nursing home.

6. Mr A's mental health assessment showed he was significantly disorientated as to time and place. He was also suffering from cognitive impairment as well as expressive and receptive dysphasia, which made communication difficult for him. He lacked awareness and insight into his

problems and was unable to effectively self-care consistently. This, coupled with his aggressive behaviour, meant that he posed a risk both to himself and others. He was mobile with the aid of a walking stick at the point of admission to the Hospital.

7. Mr A's son (Mr B) held welfare power of attorney for him. Mr B supported the Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR), decision taken on Mr A. He also expressed the wish that Mr A should not be transferred for acute medical care should he become physically unwell, but that any care should concentrate on keeping him comfortable.

8. Mr A was unsettled following his admission on 5 August 2013. Intermittent periods of aggression were recorded. He did not seem to be benefiting from the medication prescribed to moderate his behavioural problems.

9. Mr A suffered an un-witnessed fall on 7 August 2013. Despite this, he was unable to co-operate with physiotherapy reviews, due to his illness. Mr A fell again on 13 August 2013, whilst on the ward. He fractured his hip and although transferred for surgery, Mr A died two days after it had been carried out.

(a) The Hospital's falls management during the admission of 5 to 13 August 2013 was inadequate

Concerns raised by Mrs C

10. Mrs C said that Mr A had suffered falls in the nursing home prior to his admission and required the assistance of a stick to walk. Mrs C said Mr A fell whilst in the Hospital and sustained substantial facial and head bruising. Mrs C said she had been told that he had been assessed as 'no falls risk'.

11. Mr A had been referred for physiotherapy and it had been established that he required two walking aids. Mrs C said she did not believe Mr A was capable of complying with this requirement. Mrs C said she felt this had left Mr A at a very high risk of falling, as he was likely, due to his agitation to attempt to walk around the Hospital.

12. Mrs C believed there had been a poor identification of Mr A's fall risk on his first admission to the Hospital. She also felt that following the first fall, Mr A had not received an appropriate level of care, which meant the second fall was not prevented.

Key Events

13. Mrs C said the family had been told that Mr A had been standing at the French doors in the day room, on 13 August 2013 when he had attempted to turn and had fallen. The fall had broken his hip and although Mr A had been transferred for surgery, he had died two days later.

14. Following the fall Mrs C had met with staff from the Hospital. They had confirmed that one-to-one supervision could be provided. Mrs C did not feel the Board had provided a satisfactory answer as to why this level of supervision was not in place.

The Board's response

15. The Board's response to the family was sent on 8 January 2014. It stated that a full investigation had been carried out by the Consultant Psychiatrist and the Nurse Manager. The Board set out the circumstances of Mr A's admission, noting that Mr A had become increasingly disturbed whilst in his nursing home, with a history of aggression. The Board said that on admission, Mr A was identified as having a significant risk of self-harm, due to his diminished capacity and insight.

16. The Board said Mr A's initial nursing observations noted he was independently mobile with one walking stick. On 7 August 2013 Mr A was found on the floor of his dormitory, with a laceration to the bridge of his nose, the fall was un-witnessed by staff, although they did report hearing a loud noise immediately prior to Mr A's discovery. Nursing staff did not consider his injuries severe and he was assisted back into bed.

17. On 8 August 2013, Mr A was noted to be unsteady on his feet. Nursing staff spoke to a family member, who expressed concerns that he may have been over sedated. It was agreed his medication would be reviewed by medical staff. On the 9 August 2013, however, Mr A refused initially to co-operate with his physiotherapy assessment, although this was completed later that day. Mr A was offered a zimmer frame at this point, but was unable to understand the instructions on how to use it.

18. Mr A was felt to be over sedated on the evening of 9 August 2013 and his regular evening sedative was withheld. Mr A was reviewed again by a physiotherapist on 10 August 2013, but he refused to participate with their assessment. It was recommended Mr A attempt to mobilise with two walking

sticks. Mr A did manage to mobilise with two sticks and the support of a member of staff. It was noted, however that he continued to be aggressive towards staff, kicking out at them when they attempted to assist him.

19. On 13 August 2013, Mr A was reported to be unsteady on his feet, requiring the assistance of a member of staff to walk. A physiotherapist was called to assess him and noted Mr A was confused, with a poor sense of direction and an unsteady gait. Following this review, it was again recommended that Mr A mobilise with the aid of two walking sticks.

20. At 13:40 Mr A was found in a communal area of the ward, having suffered a fall. He was reviewed by a junior doctor, who noted symptoms consistent with a fractured hip and further clinical assessment was arranged.

21. The Board then responded to Mrs C's specific concerns about falls assessment

Falls Assessment

22. The Board said that on admission Mr A was assessed as '1' on the falls risk chart, which equated to no risk of fall. On 8 August 2013 he had a suspected fall and was found on the floor next to his bed. Over the weekend that followed, Mr A's mobility was variable, which had been his presentation previously. On 10 August 2013, however, his mobility was slower, although his Diazepam had not been administered the previous evening. He was able to walk with his stick and the assistance of one nurse.

23. The Board said there was no documented evidence that Mr A had needed to see the duty doctor or that he was in pain. He had been visited by family members, who expressed no concern that Mr A was experiencing pain, or that he should be seen by a medical doctor. It was noted that Mr A appeared sedated and this was addressed through a review of his medication. Over the weekend, Mr A was bright at times, interspersed with periods of confusion and irritability.

Physiotherapy

24. Mr A was referred and seen by the physiotherapist on 9 August 2013 but was unable to engage fully in an assessment using a walking frame. He was reviewed again on 12 August 2013, but remained unwilling to engage with physiotherapy.

25. A further assessment was carried out on 13 August 2013 and the physiotherapist was due to provide Mr A with two walking sticks, however, Mr A fell before this could be done. At all handovers between staff, Mr A's fall risk was made clear and staff ensured he was in the main area of the ward so Mr A could be observed. Mr A had an enhanced falls care plan, which alerted staff to the actions required to reduce the risks to Mr A from his environment.

26. At the time of Mr A's fall, there were five staff members present on the ward. Two were assisting another patient, one was in the dining area and two were in the main seating area where Mr A was. Mr A had been seated after being assisted back from the dining room. At the precise moment of the fall, a member of staff had been called to answer the telephone and the other member of staff was speaking to another patient. The Board said there were twenty patients on the ward at that time.

Nursing advice

27. The Adviser said it was recorded that Mr A was vulnerable to falls on 5 August 2013, when he was admitted to the Hospital. Adviser 1 noted the contemporaneous notes contained a record of Mr A's un-witnessed fall on 7 August 2013. Between then and 13 August 2013, there were repeated references to Mr A's problems with gait and balance and that he was unsteady and unsafe transferring to and from chairs.

28. The Adviser said that although the Board's complaint investigation report stated a falls assessment was completed on admission and Mr A was assessed as no fall risk; he could find no evidence of this assessment in the records provided by the Board. The Adviser said that as previously noted, he was recorded on admission as a falls risk and then repeatedly noted to be unsteady over the ensuing days.

29. On 10 August 2013, there was a completed falls risk assessment, which gave Mr A a score of 3 and the Adviser noted any score over 2, required a specific falls care plan. An enhanced falls care plan was included with the notes, but the Adviser concluded that although it was unsigned and undated, it could only have been related to the assessment of 10 August 2013, five days after Mr A was admitted.

30. The Adviser noted the Board's falls management policy clearly stated that a falls care plan should be completed for patients, especially elderly ones. In the event of a fall, the care plan should be reviewed.

31. The Adviser's conclusion was that there was no evidence to support the Board's statement a falls assessment was carried out at the point of admission. It was clearly recorded Mr A was considered a falls risk on admission. Mr A had an un-witnessed fall on 7 August 2013, which under Board policy should have prompted an immediate review of his falls risk, but there was no evidence this was carried out. The failure to evidence a falls assessment on admission and following Mr A's fall, were in breach of the Board's policies on falls risk management.

32. Although there were numerous entries in the nursing notes recording Mr A as unsteady, possibly over-sedated and exhibiting poor mobility, the first evidence of a falls assessment was on 10 August 2013, five days after his admission and three days after his un-witnessed fall. The Adviser said that although the care plan in place was described as 'enhanced' by the Board, he considered it limited as it consisted primarily of de-cluttering his immediate environment and lowering his bed. There was no record of enhanced observation or other measures, such as moving him to more observable areas of the ward, although these were referred to in the Board response.

33. The Adviser's view was that the standard of record-keeping and practice in relation to falls prevention was unreasonable.

(a) Decision

34. Mrs C complained the Hospital's standard of falls management was inadequate. The Board have stated Mr A was properly assessed on admission and that measures were taken to address on-going issues with his balance and mobility. The Advice I have received is that the Board have failed to evidence Mr A's assessment on admission and that the available evidence suggests he was considered a falls risk, directly contradicting the Board's response to Mrs C's complaint. The failure to document a falls risk assessment on admission, represents a breach of the Board's own policy, as does the failure to document a reassessment of Mr A's falls risk, following his un-witnessed fall.

35. Although a falls risk assessment is documented on 10 August 2013, the accompanying care plan is unsigned and undated and does not record a

number of the actions which the Board subsequently stated were taken to reduce Mr A's falls risk, such as enhanced levels of observation.

36. On the basis of the advice I have received and the available evidence I consider the falls management provided to Mr A fell below a reasonable standard and I uphold this complaint.

(a) Recommendations

37. I recommend that the Board:	*Completion date*
(i) remind all staff that a falls risk assessment is a requirement on admission of an elderly patient; and	2 December 2015
(ii) review the complaint investigation to establish why statements about Mr A's care not supported by the clinical record, were included in their formal response.	2 December 2015

(b) The Hospital's standard of nursing care during the admission of 5 to 13 August 2013 was unreasonable

38. Mrs C raised a number of concerns about the standard of the nursing care provided to Mr A. She said he had no false teeth in place when she visited him and was, therefore, unable to eat properly. Mrs C also felt he was over-sedated, to the point where he was unable to function independently. She was concerned Mr A had not been adequately nourished or hydrated.

39. Mrs C did not feel Mr A's diabetic management was adequate either. Although his treatment remained the same, his dietary intake had been severely reduced, due to the problems with a lack of false teeth and sedation. Mrs C believed the treatment should have been reviewed more regularly.

40. Mrs C also felt that although the family had met with staff members, inadequate answers had been provided about the standard of nursing care. Mrs C felt Mr A's aggression had not been handled well and that the Board's response had insensitively implied his non-compliance with treatment and staff was his fault, rather than a result of his illness. Mrs C felt the Board had failed to acknowledge their duty of care towards Mr A.

The Board's Response

41. The Board's response was set out in the form of a general comment on Mr A's admission to the Hospital followed by answers under a series of separate

headings. For clarity, I have summarised their general comments, before setting out the specific responses under the headings used by the Board.

42. The Board said Mr A showed significant confusion on admission and review. He believed the year to be 1954 and was unable to accurately describe his age or current location. The initial nursing observations were that Mr A was unable to eat or drink independently and required assistance with personal care. On 6 August 2013, it was reported Mr A had been very agitated, displaying verbal and physical aggression towards staff and patients. He had overturned furniture in the day room and had violently twisted a member of nursing staff's wrist. Mr A had been given oral medication to reduce these symptoms, but had thrown it at staff members. He had then been given intra-muscular medication, during which he had demonstrated extreme resistance to nursing support.

43. Later that day Mr A again became very aggressive, threatening staff with physical violence. This included striking another patient and although Mr A did take his prescribed medication, he obtained little benefit from it. On 7 August 2013, Mr A was again irritable and verbally aggressive, spitting out his medication and threatening staff with violence. The Board said he continued to eat well during this period, however, even though he was unsettled.

44. Mr A fell on 7 August 2013 but no serious injury was noted. On 8 August 2013, staff spoke with Mrs C's sister, who had concerns about Mr A's level of sedation and asked that it could be reviewed. The Board said they confirmed that Mr A's blood glucose was being regularly reviewed and his medication would be reviewed. Mr A continued to eat well, but remained abusive towards staff.

45. On 9 August 2013 Mr A was unable to participate effectively in a physiotherapy session. Nursing staff felt he may be over-sedated and reduced his evening medication. They continued this reduced medication on 10 August 2013. By 11 August 2013, however, his mobility had continued to decline and he was described as confused, irritable and tearful.

46. On 12 August 2013, although uncooperative with physiotherapy, Mr A did manage some personal care independently. He continued to be resistant to assistance from nursing staff. As previously noted, Mr A was found on the floor by nursing staff on 13 August 2013. At that time there were five staff on the

ward, looking after twenty patients and two members of staff were in the direct vicinity of Mr A.

Blood Glucose

47. The Board said Blood Glucose levels were checked on admission to the Hospital and found to be satisfactory. There was no evidence the levels were checked regularly, although the expectation was they would be checked every week.

Food Chart

48. Mr A was thought to have eaten well during his admission. Staff did not consider there was any need for a food chart.

Advice Received

49. The Adviser provided his comments under separate headings, to reflect the individual strands of Mrs C's complaint.

Allegation of over-sedation

50. The Adviser said on admission Mr A was prescribed Diazepam (a sedative) at 18:00 and 22:00 on a relatively low dose. He was also prescribed medication for agitation on an 'as required' basis.

51. The Adviser said when it was noted Mr A appeared over-sedated, his diazepam was withheld. The Adviser note that although the Board's investigation report referred to Mr A's restlessness escalating following this medication being withheld, this was not supported by the contemporaneous record, which suggested he was no more challenging than previously and that at times he was brighter and described as 'charming'.

52. The Adviser said overall, he felt the clinical team had prescribed an appropriate dosage for Mr A, noting that this was always a delicate balance between efficacy and over-sedation. When adverse effects were noted, prompt action was taken to address the problems.

Nutritional and Fluid Intake

53. The Adviser said Mr A was weighed on admission and his Body Mass Index (BMI) recorded. There was no record of the Malnutrition Universal Screening Tool (MUST) being used. A MUST screening was completed on 10 August 2013, when Mr A was found to be at medium risk of malnutrition.

The Adviser said whilst there were references in the notes to Mr A's food and fluid intake, these were not consistent. Whilst the Board's response stated charting was not carried out because it was not indicated, the admission care plan highlighted the need to observe, assess and document fluid and dietary intake.

54. The Adviser also noted Mr A's dietary preferences and requirements had not been recorded appropriately. The Adviser said he considered this a failing, since Mr A suffered from type II diabetes and national guidance was clear that consistency in the carbohydrate content of meals had to be included in meal planning systems. Mr A's records did not show a consistent approach to nutritional care from the point of admission.

55. Overall the Adviser felt the standard of care in this respect was inadequate. Although Mr A's BMI was not underweight on admission, national guidance and standards point to a requirement for full nutritional screening on admission to hospital. No charts were maintained of his intake and no acceptable minimum level identified. When Mr A's type-II diabetes was taken into consideration, accurate recording of his nutritional intake would have been important. The Adviser also noted the admission care plan required the observation and assessment of Mr A's intake and this would not have been possible without accurate and consistent charting. The Adviser felt the standard of record-keeping and practice fell below an acceptable standard.

Diabetic Management

56. The Adviser said diabetes required management and remained a constant treatment goal, whatever the circumstances of a patient's admission to hospital. Mr A's history of non-insulin dependent diabetes was recorded on admission. A blood sugar level was recorded on 6 August 2013. The Adviser found no further reference to Mr A's blood sugar levels in the clinical records, or evidence they were monitored or charted. There was also no evidence of an individualised blood sugar target being set for Mr A.

57. The Adviser said high blood sugar levels would have caused dizziness, amongst other symptoms. Mr A's diet and blood sugar levels should have been monitored as an integral part of his care. The management of Mr A's diabetes had fallen significantly below national standards and accepted good practice.

Ineffective Support with self-care

58. The Adviser said it was clear Mrs C was dissatisfied with Mr A's appearance whilst in hospital. At the point of admission, he was described as being smart and well-presented. The Adviser said the clinical records showed clear evidence of self-care deficits and required assistance. There was no care plan in the records setting out how these deficits were to be managed.

59. The Adviser said it was not possible to ascertain whether Mr A's appearance in the Hospital was acceptable or not. Mr A should, however, have had a personalised plan of support to address personal care activities. This should have been designed to maintain his safety, but also to preserve his dignity and maximise his independence. No personal care plan was evident in the notes, which the Adviser considered unreasonable.

Inappropriate and Unreasonable emphasis on Mr A's behaviour

60. The Adviser said Mrs C felt Mr A was blamed by the Board for his behaviours. In his view, however, the letter of response from the Board was reasonable both in terms of its tone and content. He noted they stated early in their letter that the details of Mr A's case were likely to be difficult to read. The Adviser felt the Board had stated the facts of Mr A's case but he did not find the language used judgemental or pejorative. He added that the Board had an obligation to provide a realistic presentation of Mr A's behaviours and seriousness of his impairment, but he acknowledged this would have been difficult for Mrs C to read.

61. The Adviser's view was the Board had presented an accurate picture of Mr A's condition and behaviour, whilst acknowledging this was a difficult subject for the family. The Adviser felt the letter of response was balanced in tone and content and reflected Mr A's situation and condition.

Communication

62. The Adviser said Mr A's communication ability was recorded as confused in the nursing notes following his admission and prior to admission he was assessed as having significant communication difficulties. The Adviser said there was no care plan in the record which addressed Mr A's communication difficulties. The Adviser noted the admission assessment document recorded Mr A's communication abilities as 'normal'.

63. The Adviser said he considered this discrepancy significant, since accurate assessment was the basis on which useful, person centred care plans were constructed. Conflicting information and poor record-keeping led to ineffective identification of need and compromised the care-planning process. The evidence showed a clear misunderstanding by the professionals involved in Mr A's care of his level of communication and an absence of any care plan designed to address his communication difficulties. This aspect of his care and treatment fell below a reasonable standard.

(b) Decision

64. Mrs C raised a number of concerns about Mr A's nursing care. Some aspects of his care were reasonable, such as the use of sedation, where the evidence shows the Board acted proportionately in dealing with a challenging patient and were responsive to the family's concerns. Additionally the Adviser did not feel the Board's response letter blamed Mr A for his behaviours, or demonstrated a lack of sensitivity towards Mr A's family.

65. The Advice I have received is critical overall of the standard of nursing provided to Mr A. The record-keeping was inadequate and failed to include care plans for Mr A's personal care or communication difficulties. There was also a significant failure to monitor Mr A's blood glucose levels appropriately and a failure to adequately monitor his nutritional intake. I note that the Board's complaint response states that blood glucose levels were not monitored following Mr A's admission and I am critical of the Board's failure to act on this finding.

66. In light of the failures in nursing care identified by the Adviser, I uphold this complaint.

(b) Recommendations

67. I recommend that the Board:	*Completion date*
(i) review their admission procedures for elderly patients to ensure that a Malnutrition Universal Screening Tool assessment is recorded;	2 December 2015
(ii) remind all staff involved in Mr A's care of the importance of regular and accurate blood glucose monitoring for diabetic patients; and	2 December 2015
(iii) remind all staff involved in Mr A's care of the	2 December 2015

importance of accurate and comprehensive care plans, which meet all a patient's needs.

General Recommendation

68.	I recommend that the Board:	*Completion date*
(i)	apologise to Mr A's family for the failures identified in this report.	2 December 2015

69. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mr A	the complainant's father
the Hospital	the Royal Edinburgh Hospital
the Board	Lothian NHS Board
the Adviser	a mental health nursing adviser
Mr B	Mr A's son, who held power of attorney for him
BMI	Body Mass Index
MUST	Malnutrition Universal Screening Tool

Annex 2

Glossary of terms

acute myocardial infarction	a heart attack
Barrett's oesophagus	an abnormal change to the lower part of the food pipe, may be a pre-cursor of cancer
expressive and receptive dysphasia	a deficiency in the generation of speech and its comprehension due to brain disease or damage.
ischaemic heart disease	narrowing of the blood vessels supplying the heart
pulmonary embolism	a blockage in the blood vessel between the heart and lungs
vascular dementia	dementia caused by impaired blood supply to the brain.
vertebrobasilar insufficiency	poor blood flow to the back of the brain due to blocked arteries

Annex 3

List of legislation and policies considered

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

Adults With Incapacity (Scotland) Act 2000

The Scottish Executive, National Nursing, Midwifery and Health Visiting Advisory Committee, Promoting Nutrition for Older Adult In-Patients In NHS Hospitals in Scotland. Edinburgh. 2002

NHS Quality Improvement Scotland, Food, Fluid and Nutritional Care in Hospital. Clinical Standards. Edinburgh 2003

National Institute for Health and care Excellence (NICE). The Management of Type II Diabetes. Clinical Guideline no. 87. London 2009