SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Tel **0800 377 7330**
SPSO Information **www.spso.org.uk**
SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: North East Scotland

Case ref: 201508033, Grampian NHS Board
Sector: Health
Subject: Hospitals / Nurses / Nursing Care

Summary
Mr A, who had Alzheimer's disease (the most common cause of dementia), was admitted to a specialist ward at Royal Cornhill Hospital for assessment and treatment. He had been displaying very challenging behaviour, and was no longer safe to be looked after at home. He was sectioned under the Mental Health (Scotland) Act, and he remained in this hospital for the next ten months. During this time his behaviour became more stable and he was transferred to a dementia assessment ward at Glen O'Dee Hospital. This move was against the wishes of Mr A's partner and welfare power of attorney, Ms C. Mr A died six weeks after being transferred, following a rapid deterioration in his physical condition.

Ms C raised concerns about a range of aspects of the nursing care that Mr A received in both hospitals. In relation to his time at Royal Cornhill Hospital, she was concerned about Mr A's risk of falls and the staff response to this, his skin care, his oral health care, and provision of social activities for Mr A. She also raised concerns about communication with Mr A's relatives, particularly with Ms C, given her position as his welfare power of attorney and his Named Person under the Mental Health (Scotland) Act.

In relation to the care and treatment Mr A had in Glen O'Dee Hospital, Ms C complained about the forms of restraint used to keep Mr A safe from falls, the lack of sufficient encouragement and assistance to mobilise him, and the impact of this on his skin care. In relation to Mr A's medical care, she was concerned that Mr A developed a sore throat that was not properly assessed, and this led him to stop eating and drinking.

When Ms C complained to the board, they identified no significant failings with the care and treatment given to Mr A, either in Royal Cornhill Hospital or Glen O'Dee Hospital.

During my investigation I sought advice from a psychiatric nursing adviser and a psychiatric adviser, who both identified failings in Mr A's care and treatment.

This case has raised significant failings, particularly in the most standard elements of nursing care: effective care planning; keeping a patient safe; monitoring their condition; providing appropriate food and nutrition; record-keeping; and communication with relatives. Caring for Mr A was not always made easy by Mr A's challenging behaviour, but the planning and communication around his care were all the more necessary because of his behaviour and incapacities. I am also particularly critical of the way the board handled this complaint and their lack of focus on their failings and ways to improve their services. I upheld all Ms C's complaints and made several recommendations.

Redress and recommendations

The Ombudsman recommends that the board:	*Completion date*
(i) conduct a Significant Event Analysis, aimed at exploring and understanding the causes of the care failures for Mr A, in order to identify appropriate improvements in clinical practice, and explore how complaint handling failed to identify these issues;	9 January 2017
(ii) provide an action plan setting out improvements identified in the above Significant Event Analysis, with explanation of how they would be met, along with changes that have already taken place since these events;	6 February 2017
(iii) remind staff of the need to ensure that changes to visiting hours are mutually agreeable to staff, patients and relatives, and are recorded wider staff awareness;	28 November 2016
(iv) conduct a nursing audit in the appropriate ward to assess the current practices in relation to record-keeping, food, fluid and nutrition and vital signs monitoring;	28 November 2016
(v) provide evidence that any actions identified from the nursing audit are implemented in full;	6 February 2017
(vi) conduct a Significant Event Analysis, aimed at exploring and understanding the causes of the care failures for Mr A, in order to identify appropriate improvements in clinical practice, and explore how	9 January 2017

	complaints handling failed to identify these issues;	
(vii)	draw together the findings from both Significant Event Analyses to identify any shared issues on the continuum of care and in complaints handling, to be addressed by the Board; and	6 February 2017
(viii)	apologise to Ms C for the failings identified in this report, both in relation to Mr A's care and treatment and in relation to the responses Ms C received to her complaints.	28 October 2016

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 Ms C, and her late partner is Mr A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to the Ombudsman about the care and treatment her late partner (Mr A) had while he was in two different hospitals, in the eleven months before his death.

2. Mr A had Alzheimer's Dementia, and was admitted to a specialist ward for people with dementia who exhibit extremely challenging behaviours, at the Royal Cornhill Hospital (Hospital 1), on 20 April 2013. He was treated there until 3 February 2014. Over this time his condition became significantly more stable, and it was agreed that he no longer needed to be in such a specialist, restrictive environment. He was therefore transferred to a dementia assessment ward at Glen O'Dee Hospital (Hospital 2), against Ms C's wishes.

3. Ms C raised a range of concerns about Mr A's care at Hospital 1, including his risk of falls and their response to this; skin care; oral health care; provision of social activities; and communication with Mr A's relatives.

4. Ms C also raised concerns about the nursing care Mr A received while he was in Hospital 2. In particular, she complained about the forms of restraint used to keep Mr A safe from falls; encouragement and assistance he was given to mobilise, and the impact of this on his skin care; provision of appropriate food and fluids; and lack of privacy during visits.

5. Ms C was also concerned that Mr A became isolated in Hospital 2. She also said that when he developed a sore throat, it was not adequately assessed. She said that he stopped eating and drinking enough because of his throat and that his dehydration and malnutrition contributed to a rapid, ultimately terminal, decline in his condition.

6. Mr A died in Hospital 2, on 16 March 2014.

7. Ms C complained to Grampian NHS Board (the Board) about her concerns relating to Mr A's care in Hospital 1 after his transfer to Hospital 2. She met with staff, and subsequently received a response to these complaints shortly before Mr A's death. They responded to the concerns Ms C raised, but did not identify any significant concerns in his care. She was not satisfied and wrote to them again about Hospital 1 in April 2014, (though the Board have no record of this letter) and shortly afterwards wrote to complain about Mr A's care and treatment in Hospital 2. The Board responded to the complaints about Hospital 2 in

July 2014, and again did not identify any significant concerns about his care and treatment. Ms C also met with staff in November 2014 and January 2015 to discuss her on-going concerns. In a subsequent letter to Ms C on 13 March 2015, the Board confirmed that they had investigated Ms C's concerns thoroughly and had not been able to find any evidence which supported her concerns about Mr A's care and treatment.

8. Ms C was dissatisfied with the responses she had from the Board and complained to my office.

9. The complaints from Ms C I have investigated are that during:

(a) an admission to Hospital 1, nursing staff failed to provide Mr A with an appropriate level of nursing care (*upheld*);

(b) the admission to Hospital 2, staff failed to provide Mr A with an appropriate level of nursing care (*upheld*); and

(c) an admission to Hospital 2, staff failed to provide Mr A with an appropriate level of clinical treatment (*upheld*).

Investigation

10. In order to investigate Ms C's complaint, my complaints reviewer examined all the information provided by Ms C, a copy of Mr A's clinical records and the Board's complaint file. They also obtained independent advice from a psychiatric nursing adviser (Adviser 1) and a psychiatric adviser specialising in psychiatry of old age (Adviser 2). In this case, we have decided to issue a public report on Ms C's complaint because of the systematic nature of the failings we have identified in Mr A's care and treatment, and because the Board's own investigation failed to identify any of these systematic failures.

11. 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.

Background

12. When Mr A was admitted to Hospital 1 on 20 April 2013 he was under a Short-Term Detention Certificate, which was later changed to a hospital-based Compulsory Treatment Order. This was renewed and remained in place until 13 March 2014, three days before Mr A's death. Ms C had financial and welfare power of attorney (a legal document appointing someone to act or make decisions for another person) for Mr A, and she was his Named Person while he

was the subject of compulsory measures under the Mental Health (Scotland) Act 2003 (the person who has to be informed and consulted about aspects of care when a patient is considered not to have capacity for their own decisions). While he was there, he displayed a range of challenging behaviours.

13. When he was initially admitted to Hospital 1, Mr A was unwell and he needed intensive support. Ms C has suggested that this was due to the change in his surroundings. She visited him every day for most of his stay in Hospital 1 and after several months he gradually became more stable. It was agreed that he would be more appropriately placed in a less restrictive environment than the specialist ward in Hospital 1.

14. When Mr A was transferred to Hospital 2, Ms C was unhappy with the decision, because its location would restrict her ability to visit. She was concerned that continuity of contact with Mr A was critical for his wellbeing and she wanted him placed in a care home nearer to her. However, the transfer went ahead on the basis that it would be in Mr A's long-term best interests for him to be transferred to a step-down facility for further assessment, prior to seeking a placement in a nursing home.

15. At the time of Mr A's discharge from Hospital 1, Mr A was much more settled than when he was first admitted. The expectation was that he would have a period of assessment of his needs in Hospital 2 and would then be transferred to a nursing home, if this was still considered to be appropriate.

16. Mr A was transferred to a dementia assessment ward at Hospital 2 on 3 February 2014. While he was there, his condition deteriorated. This was first noted by the Board on 5 March 2014 and, until this point, they said that Mr A had been eating and drinking normally. Ms C has reported that Mr A developed a sore throat. She has said that this contributed to his reluctance to eat and drink and that he became dehydrated, which contributed to a marked deterioration in his health. Mr A died on 16 March 2014.

(a) During an admission to Hospital 1, nursing staff failed to provide Mr A with an appropriate level of nursing care

Concerns raised by Ms C

17. Ms C has raised a range of concerns about the nursing care given to Mr A while he was at Hospital 1. She raised concerns that Mr A was not given

access to the programme of activities that were meant to be available to patients in the ward.

18. While on the ward, Mr A was prone to walking a lot and had limited insight into his own safety in this regard. Ms C raised a range of concerns about the risks that Mr A posed to himself. She was concerned that insufficient action was taken in relation to his falls risk and this led to him falling on several occasions.

19. In particular, she complained that insufficient action was taken to provide Mr A with a helmet and hip protectors, to keep him safe. Mr A was fitted with a helmet to prevent head injuries in January 2014. Ms C has reported that there were also discussions around the potential use of hip protectors for Mr A, and that she provided them for him in January 2014.

20. Ms C also raised concerns that Mr A had tripped and hurt his toes on bed wheels but she said staff did not take action to reduce this risk once they were alerted to it.

21. In May 2013 Ms C raised concerns about Mr A's oral hygiene, as she was concerned that his mouth was becoming sore.

22. Ms C also complained about the level of nursing care Mr A received in relation to a rash he developed. Ms C reported that Mr A had suffered from eczema prior to admission and this was exacerbated by stress. In October 2014 he develop a rash, which started on his feet. She was concerned that the treatment being provided was inadequate. So she sought assistance from a private dermatologist, who considered that Mr A had Discoid Eczema (a long-term skin condition that causes skin to be red, itchy, swollen and cracked, in circular or oval patches), and recommended steroid treatment.

23. Ms C also complained about Mr A's skin care in relation to Mr A's feet, because he had developed sore skin on his heels, which she felt was not properly attended to.

24. Ms C also raised concerns about the level of communication and involvement she was given in his care, given her position as his financial and welfare power of attorney and his Named Person. In particular, she complained

that she was not informed about possible infections Mr A developed and the planned treatment for them.

The Board's response

25. Ms C wrote to the Board to complain about Mr A's care in Hospital 1 on 28 January 2014. The Board responded in a letter dated 11 March 2014, covering each of the issues which Ms C had raised. 13 March 2015, the Board confirmed that they had investigated Ms C's concerns thoroughly and had not been able to find any evidence which supported her concerns about Mr A's care and treatment.

26. In relation to Mr A being offered activities on the ward, they noted that not all patients are able or wish to participate in such activities, and that an occupational therapy assessment had found that Mr A had great difficulty in participating in group activities. However, they said that there was evidence he had taken part in some activities and that he had 'normal chats and interactions with nursing staff'. They noted that recording of his involvement in these activities declined after Mr A had been on the ward for about three months. They said they would expect staff to note down any offer or involvement in such activities and that a senior charge nurse would ensure that this was being done.

27. In relation to Mr A's falls risk, the Board noted that Mr A had actual or suspected falls on 17 occasions between 22 April 2013 and 3 February 2014. They noted that around half of these were at Mr A's bed and that checks on patients had to be balanced against disrupting a patient's sleep. They also said that Mr A's falls may have been made worse by seizures he was having and by his medication, which was reduced as soon as was practicable. They also noted that Mr A had a falls care plan in place and regular fall risk assessments. The Board commented that Mr A often ran in the ward, which put him at risk and was difficult for staff to manage safely. They noted that there was a balance to be struck between keeping a person safe and allowing them freedom, which could involve some risk.

28. In relation to Mr A wearing a helmet, the Board noted that there had been some miscommunication as to whether this was appropriate or not and that when a formal physiotherapy assessment had recommended the use of a helmet, this was initiated.

29. In relation to the provision and use of hip protectors, the Board noted that these had been 'sent for labelling' but that this had not been properly passed to all nursing staff. They noted that this was unreasonable and said that staff had been reminded to the importance of timely and accurate communication.

30. The Board noted that Mr A had suffered from bruising to his toes, but they considered that this was not due to hurting himself on bed wheels, but rather that it was the result of him kicking out at objects, walls or doors. However, they acknowledged that Ms C had raised a legitimate and helpful concern and said staff would be more vigilant in relation to this risk in all the Board's Older Adult Mental Health wards.

31. In relation to Mr A's oral hygiene, the Board noted that Mr A had difficulty eating and drinking for much of his time in Hospital 1. However, they said that there was evidence that nursing staff consistently attempted to clean Mr A's mouth and provide oral care, both before and after Ms C first raised these concerns. However, they noted that they had to approach this very gradually, as Mr A found it very distressing, and he frequently resisted it. They also noted that ward staff had completed further oral hygiene training, beyond their basic nurse training.

32. In relation to Mr A's skin care, the Board noted that nursing staff administered all the prescribed medications at the appropriate times, including creams for his skin. They said that medical staff treated Mr A's eczema appropriately and that steroid creams had been appropriately avoided, due to the potential side effects on Mr A's mental state. They noted that when this treatment started after his private consultation, Mr A's levels of distress did increase.

33. The Board's response to Ms C's concerns about Mr A's feet said the 'hacks' on his heels had been appropriately treated with moisturisers and had healed. They said there was no sign of any infection. They also noted that, due to footwear and the movement of his feet even while in bed, it was difficult to ensure that this skin remained moisturised at all times.

34. The Board also responded to Ms C's concerns about communication, specifically in relation to suspected infections that Mr A had at various times. They noted that Mr A was treated for infections on two occasions. In April 2013 blood tests indicated that he had a potential infection and he was treated

accordingly. In August 2013 Mr A was put on antibiotics for a chest infection. They said that staff should have informed Ms C if they thought Mr A had an infection and should have informed her of any such test results. They apologised if this did not happen. In comments on a draft of this report, the Board noted that they had communicated with Ms C on one occasion in April 2013.

35. Then Board ended their letter in relation to Mr A's care in Hospital 1 by commenting that they were pleased that his condition had improved so he could be in a more mainstream health care setting. This letter was sent five days before Mr C passed away.

36. In their comments on a draft of this report, the Board noted that Mr A received Speech and Language Therapy twice during his time in Hospital 1, in relation to management of his eating and swallowing, and he was seen at least five times by a specialist mental health dietician. They noted that further documentation on Mr A's care had gone missing, including documents relating to his nutritional and dietary needs and falls assessments. They also stated that falls prevention measures had been taken, including the use of a mat beside his bed, using a low rise bed, and encouraging him to wear appropriate footwear.

37. They went on to conclude that the records indicated that 'the quality of the nursing records could not confirm that the quality of the nursing care was adequate'. In their defence, the Board also noted that Mr A displayed particularly challenging behaviours, which required intensive support and supervision away from other patients. The noted that this made it difficult, and at times inappropriate, for them to provide normal levels of care and care planning. In particular, they pointed to difficulties in applying nutritional screening procedures on admittance, and providing oral hygiene on an ongoing basis.

Guidance

38. Nursing staff should have been acting in line with a range of guidance during their care for Mr A. In particular, the Essence of Care; benchmarks for the fundamental aspects of care (Department of Health, 2010) include oral hygiene as an indicator of the standard of patient care.

39. The Nursing and Midwifery Council (NMC) Code sets out professional standards for nurses and includes guidance on effective practice. This included the requirement for nurses to keep clear and accurate records relevant to their practice.

40. The Adults with Incapacity Act (Scotland) Act 2000 stated that doctors responsible for the care of a person who has lost capacity must obtain consent from that person's welfare power of attorney, where it is reasonable and practicable to do so.

41. Healthcare Improvement Scotland have produced guidance on Food Fluid and Nutritional Care Standards (2014, which replaced similar standards from 2003), which specified that all patients should have their nutrition assessed within the first 24 hours of admission to hospital, using the Malnutrition Universal Screening Tool (MUST).

Psychiatric nursing advice

42. Adviser 1 provided detailed advice in relation to the issues which Ms C complained about. They noted that Mr A's very challenging behaviour made the provision of care more difficult, and noted that these behaviours (resulting from his deteriorating Alzheimer's Dementia) included physically aggressive behaviour to staff, resisting interventions, agitation and aggression.

43. In relation to the care provided to Mr A, Adviser 2 noted a range of concerns.

Social activities

44. In relation to concerns about lack of social activities, Adviser 1 noted that the level of clinical activity on most wards normally fluctuates in line with the level and complexity of patient need. They noted that clinical plans may need to be amended to reflect clinical priorities and, at such times, less essential activities can occasionally be deferred. However, he also noted that if this happened frequently, then staffing levels or clinical activities should be reviewed.

45. Adviser 1 went on to note that Mr A's records indicated that he quite frequently resisted staff interventions and it would have been inappropriate to compel him to take part. However, they said that Mr A should have been offered activities on an on-going basis and efforts should have been made to

persuade him to participate, despite any pattern of declining such offers, and that this should have been recorded. They concluded that either the standard of record-keeping was inadequate, or the consistent delivery of the ward activity programme was ineffectual. He considered that either of these circumstances was unreasonable.

Falls assessment and prevention

46. In relation to Mr A's falls risks, Adviser 1 provided detailed advice. He reviewed the files and noted that falls risk assessments for Mr A were completed on 20 April, 21 June and 19 July 2013. In the first of these, Mr A was considered to be in the low risk category and in the latter two assessments he was considered to be at medium risk of falls.

47. However, Adviser 1 noted that none of these assessments took account of Mr A's history of myoclonic jerks (brief, shock-like jerks of a muscle or a group of muscles), his history of seizures and seizures that he had while in Hospital 1. They also considered that the first risk assessment was wrong, in that the scores within the assessment were incorrectly added up, while on another occasion the score was inaccurately considered to reflect a low risk rather than a medium risk.

48. Adviser 1 went on to review the falls prevention measures in place for Mr A. They noted that the falls assessments did not make clear which potential measures (listed on the back of the assessment form) would be appropriate for him. They also reviewed the falls prevention plans developed for Mr A (dated 12 July and 24 August 2013 and 20 January 2014). Adviser 1 noted that when a falls prevention measure was identified in the clinical notes (use of a bed sensor to reduce his risk of falls at night), this was not referred to in any of the prevention plans.

49. In relation to the falls prevention plan dated 20 January 2014, Adviser 1 noted that this identified Mr A as having a low risk of falls, despite scoring 10, which was within the 'medium' category according to the Board's falls prevention documents. The Board were unable to provide a falls risk assessment linked to this score of 10. However, Adviser 1 noted that when Mr A was transferred to Hospital 2, two weeks later, he was considered to have a falls risk of 19, which put him in the high risk category.

50. Adviser 1's review of Mr A's file identified formal records for 17 falls while Mr A was in Hospital 1, though the nursing records refer to another fall on 6 September 2013 and a falls assessment chart refers to another fall on 9 December 2013, neither of which were formally recorded. Adviser 1 also noted that seven falls took place on consecutive days in November 2013.

51. In addition to the assessments and plans, Adviser 1 noted that Mr A's bed was lowered to floor level, to prevent further falls, but that this did not happen until 29 November 2013, after he had fallen ten times in hospital. They noted that this was contrary to the falls assessment documentation, which said that this intervention was to be considered for all patients.

52. In relation to Ms C's request for a helmet for Mr A in January 2014, the Board were unable to provide any nursing notes for the whole of January 2014. Adviser 1 therefore did not feel able to comment on Ms C's concerns in this regard.

53. In relation to Ms C's concerns about hip protectors, Adviser 1 noted that there was reference to family having been asked to provide hip protectors on falls prevention plans dated 12 July and 24 August 2013. They noted that there was no further information in Mr A's records in relation to hip protectors and no documentation of any discussion about this with Ms C. They found that, while hip protectors were identified as being needed, there was no evidence of their use until 20 January 2015. They considered this delay to have been unreasonable and also found that record-keeping was weak and ineffective.

54. In conclusion, Adviser 1 noted that the falls assessments and preventions during Mr A's time in Hospital 1 were unsystematic, incoherent and ineffective. They found the falls assessments to be incorrect or inaccurate in a range of ways and were inconsistent in their consideration of Mr A's risks. In relation to the falls prevention plans, Adviser 1 concluded that they lacked detail and had not been subject to consistent and systematic review. Overall, they considered practice in this area had been unreasonable.

55. Adviser 1 was particularly critical that there were no falls risk assessments after 19 July 2013, despite clear evidence that Mr A was still having falls with significant and concerning regularity. Furthermore, they noted that Mr A had fallen seven times on consecutive days in November 2013 alone, yet Mr A's falls risk was never assessed as being high at any point in his stay in Hospital 1.

Adviser 1 said it was 'extremely concerning' that Mr A was considered to have a low risk of falls on 20 January 2014, after falling at least 17 times in hospital.

Risk assessment of bed wheels

56. Adviser 1 noted concerns that the Board had not taken reasonable actions in relation to the risk of Mr A hurting his toes on bed wheels. However, they found clear evidence of Mr A's physical aggression, which frequently included kicking out at other people and furniture. They considered it reasonable for staff to have been made aware of the potential risks in relation to bed wheels and for them to take steps to minimise this risk. Adviser 1 therefore considered the Board's actions to be reasonable in relation to this issue.

Oral hygiene

57. Adviser 1 highlighted the importance of maintaining good oral hygiene, as set out in the guidance 'The Essence of Care'. They noted that, while oral hygiene was mentioned in his Personal Hygiene Careplan, this merely stated that Mr A should have been offered assistance with oral hygiene; it did not provide any detail about how much assistance was required. They noted a lack of any information in relation to how, when and how frequently oral care was to be carried out. They considered that this was not in line with NMC Guidelines on record-keeping: it did not provide a clear prescription of nursing care and fell short of professional standards.

58. Adviser 1 went on to review the evidence in relation to provision of oral hygiene for Mr A. In the period from May to July 2013, they identified 25 references to oral hygiene being carried out. However, they noted that during this time, Mr A was also noted to be resistive to care and reacting aggressively towards staff trying to deliver care. They noted that this lack of co-operation was likely to have led to staff being unable to consistently provide effective oral hygiene, particularly as there may have been risks relating to him biting staff or the implements used for oral hygiene. However, they also noted that there were no records which specify these risks, or describe his resistance as a reason for oral care not being carried out.

59. Adviser 1 further reviewed nursing records for October 2013, when Mr A was becoming more settled and his transfer to a less restrictive environment was beginning to be considered. They found no references to oral care being delivered or refused in that month. While they noted that there were references to him being given assistance with personal care, this did not specify oral care

and this was not noted on a daily basis. Furthermore, without a detailed oral hygiene care plan, they considered such statements did not provide evidence of the nature of the care provided.

60. In summing up, Adviser 1 stated that Mr A's oral hygiene needs should have been clearly documented, through a care plan, following an assessment of his oral health, including specification of what nursing actions were required and when. They were also clear that it should have been recorded in the nursing notes every time oral care was provided and also when it was refused. They concluded that Mr A's oral hygiene needs were ineffectively addressed and interventions were insufficiently planned and recorded and that this was unreasonable.

Skin care

61. Adviser 1 noted that, based on Mr A's nursing records, a rash was first identified on his feet which 'looked like dermatitis'. He was prescribed a cream, to be applied twice daily. Adviser 1 identified clear evidence that medical staff kept his skin condition under review from that point onward. Mr A's rash had spread to his lower legs and arms by 4 November 2013 and had become more generalised by 12 November 2013. Adviser 1 noted that various creams were tried during this period. They noted that it was considered likely that the rash may have been a side-effect of Mr A's medication, which they considered to be a reasonable assumption.

62. Adviser 1 went on to note that the rash was suggestive of eczema on 15 November 2013, when it was noted that it had spread to his ears and forehead. Two separate creams were prescribed for his trunk and limbs, and for his ears and face. Adviser 1 reviewed the second opinion provided by the dermatologist in private practice, who considered that Mr A had Discoid Eczema. This doctor recommended continuation with the existing creams and reintroduction of one of the previous creams he had been using, along with twice daily steroid medication (to prevent the release of substances in the body that cause inflammation). Adviser 1 confirmed that Mr A's records indicated that creams had been consistently applied as prescribed.

63. In conclusion, Adviser 1 considered that there was no significant delay in Mr A's rash being identified and that various creams were tried, with the aim of bringing the condition under control. They considered that practice in this area was reasonable.

64. In relation to the skin care given to Mr A's feet, Adviser 1 noted that the Board's clinical team considered this element of Mr A's care to have been unsatisfactory (at a meeting with Ms C on 26 November 2013). This was noted in his records, and staff apologised for this. However, the Board went on to deny these failings in their response to Ms C's complaint. Adviser 1 noted that the Board's complaint response seemed unreasonable, given the notes from the meeting with Ms C.

Communication in relation to infections

65. Adviser 1 noted that Mr A's medical notes provided evidence that he was appropriately monitored for any infections and that when these did occur, he was appropriately treated with antibiotics, which were appropriately administered, despite Mr A's frequent resistance to interventions.

66. Adviser 1 went on to consider whether communication with Ms C, in relation to these infections, was reasonable. They noted Ms C's status as Mr A's financial and welfare power of attorney and Named Person. They said that, given her status, she should have been routinely invited to participate in decision-making in relation to Mr A's care and treatment and she should have been effectively kept up-to-date with clinical developments in his condition.

67. From Mr A's records, Adviser 1 noted that there was clear evidence of discussion between Ms C and the care team. However, they also noted that these discussions were frequently (though not always) initiated by her and that the approach to carer communication had been disorganised and unsystematic. Adviser 1 considered that this had led to breakdowns in communication (such as in relation to the use of hip protectors and infections) which were unreasonable. They went on to say that a clearly documented, planned carer communication strategy, agreed by both sides, would have facilitated Ms C's effective participation in Mr A's care and minimised the risk of communication breakdown. They also noted that this would have reduced the likelihood of Ms C having cause to complain.

Record-keeping

68. In their comments on a draft copy of this report, the Board noted that not only nursing notes, but other nursing records had gone missing from the file. Adviser 1 commented on the importance of keeping and storing accurate records. They also noted that it could not be assumed that such records

necessarily proved that Mr A's care was of a reasonable standard. On this basis they suggested that we could not conclude that care was of a satisfactory standard, where this evidence was not available.

Adviser 1 Conclusion

69. Adviser 1 concluded that there were several elements of Mr A's care which they considered to be unreasonable and ineffective. In particular, they highlighted concerns about:

- usystematic and inaccurate falls prevention planning and record-keeping;
- oral hygiene care planning and provision;
- poor care planning and record-keeping;
- significant delay in the use and provision of hip protectors; and
- ineffective and unsystematic communication with a relative who had Welfare of Attorney powers, and failure to consistently involve her in clinical decision-making.

70. In addition to these issues, Adviser 1 also noted a further significant concern in relation to Mr A's care. They found that there was no evidence of any assessment of his nutrition when he was admitted and the MUST tool was not used. They therefore concluded that the assessment of Mr A's food, fluid and nutritional needs fell below national standards.

71. Given the Board's comments in relation to the records of Mr A's nursing care, Adviser 1 commented that the failure to maintain accurate and complete nursing records was a failing in itself, and did not constitute a defence to indicate that the quality of the care was better than indicated in the records.

(a) Decision

72. Adviser 1 has provided clear evidence of failures in the provision of nursing care given to Mr A over a prolonged period. While Mr A's condition did improve while he was in Hospital 1, this appears to have been the result of the dedicated support he had from Ms C, rather than the care given by nursing staff.

73. It is particularly concerning that such little attention was given to his repeated falls and potential measures which could have been taken to reduce the risk of falls or the impact of them. I understand that Mr A's behaviour put him at particular risk, and that any measures taken to reduce risks would have

to balance out the limitations that this would have placed on his freedom to move about the ward. However, appropriate planning and communication with Ms C would have provided assurance that any such actions were carefully considered and agreed by all.

74. I am also concerned that the lack of sufficient care planning in relation to falls risks seems to reflect poor care planning in other areas of Mr A's care although, given the risks involved for Mr A and his history of falls, this failure is particularly notable and significant.

75. It is also of significant concern that there were no nursing records available for the full month of January 2014, a time when there were significant discussions around Mr A's care. This included a crucial decision over Mr A's protection, following significant discussions about the use of a helmet as well as plans for his future care in an alternative setting. The possible reasons given for this by the Board related to Mr A's transfer to Hospital 2 and variations in management arrangements between these two hospitals. This does not, to my mind, explain why these notes went missing, when others were successfully transferred.

76. The Board's identification of further records which may have gone missing does little to allay fears in relation to Mr A's care. As Adviser 1 has noted, poor maintenance of records is a concern in its own right, and in no way indicates that the care provided was reasonable.

77. Mr A was a vulnerable patient, who at times displayed very challenging behaviours which would have made it difficult for nursing staff to provide appropriate care. However, he had a very supportive partner who was heavily involved in his care and visited him very frequently over his entire time in Hospital 1. Staff did not take the opportunity this provided to enhance his care and ensure that it was in line with Ms C's wishes, as his Named Person and Welfare Power of Attorney. I am critical of the lack of appropriate, planned engagement with Ms C, which could have diffused some of the many concerns she subsequently complained about.

78. Furthermore, some of the failings identified relate to the planning of his care, which were within the control of staff, regardless of his behaviour.

79. Given the wide-ranging failures identified by Adviser 1, and with particular reference to poor care planning, risk assessments, oral hygiene, record-keeping and communication, I uphold this complaint. The recommendations below are aimed at ensuring that this situation does not recur for any other patients.

(a) Recommendations

80. I recommend that the Board:	*Completion date*
(i) conduct a Significant Event Analysis, aimed at exploring and understanding the causes of the care failures for Mr A, in order to identify appropriate improvements in clinical practice, and explore how complaint handling failed to identify these issues; and	9 January 2017
(ii) provide an action plan setting out improvements identified in the above Significant Event Analysis, with explanation of how they would be met, along with changes that have already taken place since these events.	6 February 2017

(b) During the admission to Hospital 2, staff failed to provide Mr A with an appropriate level of nursing care

Concerns raised by Ms C

81. Ms C continued to have concerns about Mr A's nursing care once he was in Hospital 2. These were compounded by difficulties she had in visiting Mr A, for travel reasons. She was, therefore, more reliant on updates from staff than she had been previously. She raised several concerns about care in the first few weeks he was in Hospital 2. Of particular concern were the approaches taken to reducing his falls risk. These included using a lap belt while Mr A was in a reclining chair and using bed rails. She found him in a chair with a lap belt on her first two visits to the ward and felt this was being used too much. In particular, she felt that Mr A had been used to having a lot of freedom to wander and the change in approach, combined with the change in environment, had a very detrimental impact on his condition. She also raised concerns that prolonged use of this restraint led to Mr A losing the capacity to walk within his first two weeks in Hospital 2. She also said she had not been appropriately consulted in relation to the use of bed rails.

82. Ms C raised concerns that, as Mr A's mobility deteriorated, she did not think he was given enough assistance to mobilise and she was concerned about the impact this had on his skin care. She was also concerned that he

was not being given enough opportunities to socialise with staff and that this was particularly important as family members were much less able to visit than they had been at Hospital 1. Linked to this, Ms C expressed concerns that staff shortages had a significant impact on Mr A's care.

83. Family continued to visit Mr A as frequently as possible. However, Ms C said that this was made more difficult by what she considered to be restrictive and tightly imposed visiting hours. Ms C also said she felt they were not given adequate privacy during their visits to Mr A.

84. Ms C has also raised concerns about the care Mr A received as his condition deteriorated in the last two weeks of his life. In particular, she was concerned that his condition was not being appropriately monitored and that he was not receiving appropriate food and fluids. She was concerned that staff did not notice the significant deterioration in Mr A's condition and did not inform her, so that she could take steps to be with him. She said that medical staff noted a deterioration in Mr A's condition on 12 March 2014 and she raised concerns that she was not informed of this at the time. Ms C also expressed concern about the way a particular member of nursing staff addressed her and her family towards the end of Mr A's life.

The Board's response

85. The Board responded to Ms C's complaints about Hospital 2 in a letter dated 3 July 2014. They responded to each of the issues in Ms C's complaint; their response to nursing complaints are summarised here and their response to clinical complaints are provided in relation to complaint (c).

86. In relation to concerns about falls risks and the restraints used, they commented that a falls risk assessment had identified that Mr A was at high risk of falls and that Ms C had consented to the use of a lap belt. They noted that the assessment specified that this restriction should be in place for the minimum time necessary and that nursing staff would provide reassurance to Mr A at those times. They noted that they used a reclining chair because Mr A's behavioural symptoms meant that the alternative, upright chair was not appropriate. However, the Board did acknowledge that they had not sought consent for the use of bed rails and they apologised for this. They have informed us that documentation on their use has since been altered, to prevent this from happening again.

87. The Board did not identify any significant concerns in relation to Ms C's complaints about staffing levels and assistance with mobilisation, or with the visiting arrangements in place.

88. In relation to Ms C's concerns that Mr A was left isolated and alone, they said that Mr A was at times taken to a quieter area, when communal areas were noisy, as this sometimes exacerbated his symptoms, so staff needed to use de-escalation techniques. In their response to a draft of this report, the Board noted that a physiotherapist had assessed that it was inappropriate to walk or stand Mr A without the use of a stand aid, because of his advanced Alzheimer's disease. They also noted that Mr A was involved in therapeutic activities on a daily basis at a most basic level.

89. In relation to Mr A's care during his final weeks of life, the Board noted that staff first noticed problems with his eating and drinking on 5 March 2014. They noted that his ability to swallow varied over time and that staff provided appropriate food and drink for him. They reviewed the contact Ms C had with staff from 10 to 13 March and did not identify any change in Mr A's condition which would have given staff cause for concern.

90. However, in their response to a draft of this report, the Board noted that on 12 March 2014 Ms C contacted the ward several times, and was updated on Mr A's deteriorating condition. They said that Ms C had been informed that Mr C was entering end stage advanced Alzheimer's disease on several occasions from 19 February 2014.

91. The Board noted that changes had been made in Hospital 2, so that staff were trained and equipped to provide intravenous fluids when patients needed it. However, they noted that there was no evidence that Mr A would have benefited from intravenous fluids. They also said that on 14 March 2014 Ms C had said she did not wish for interventions around feeding.

92. The Board went on to review the evidence in relation to staff attitude, both from nursing records and from a staff interview. They were satisfied that the staff approach was reasonable and provided a full explanation for the actions taken.

93. In relation to Ms C's concerns about visiting hours, and in response to a draft copy of this report, the Board said that visiting hours were not overly

restricted and noted that family had been to see Mr A on 36 days during his 41 days in Hospital 2. They reported that posters advertise 'Visiting 2-4pm and 6-7pm. Visiting can be arranged out with these times by prior agreement with the Senior Charge Nurse.' They also noted that Ms C and her family had been able to stay overnight on the ward in the last few days of Mr A's life, and were given a key to the ward to make this easier.

Guidance

94. The Mental Welfare Commission for Scotland produced guidance on the use of restraint in 2013, called the 'Rights, risks and limits to freedom'. This set out the expectation that restraint should be seen as a 'last resort', where there are no alternatives. The patient's rights to self-determination should also be balanced against the organisation's duty of care. In making a decision to use restraint, risk factors should be fully considered and interventions should be used to mitigate any risks. Alternatives to mechanical restraint should also be considered and used where appropriate.

Psychiatric nursing advice

95. Adviser 1 provided detailed advice in relation to the nursing care that Mr A received in Hospital 2, based on the concerns that Ms C raised with us.

Falls risks and prevention

96. In relation to Mr A's falls risk and the use of a lap belt and a reclining chair, Adviser 1 noted that an initial safety/risk assessment, falls assessment, bed rail assessment, a restraint risk assessment, falls prevention plan and care plan were all completed on or shortly after Mr A's admission to Hospital 2, on 3 February 2014. They also noted that most of these assessments and plans were reviewed on 12 March 2014. They reviewed the content of these documents and noted that Mr A was identified as being at 'high' risk of falls.

97. Adviser 1 considered that the falls prevention plan and overall care plan were reasonable. They noted that the care plan supported the safe and appropriate use of a lap strap on a particular chair. They also explained that lap straps can promote supportive, comfortable seating, rather than simply a means of restraint. However, they noted that if poorly planned and executed, they could be considered an inappropriate form of mechanical constraint.

98. Mr A's lap strap was employed as a falls prevention measure and was in line with the restraint risk assessment. This indicated that the lap strap should

be used as a last resort and noted that this had been discussed with Mr A's family. It also specified that its use was to be kept under daily review.

99. Adviser 1 noted the difficult balance to be struck in keeping a patient safe when they are confused and resistant to interventions, the risks arising from restraint and the risk posed by staff not intervening effectively. They said that the use of a lap strap was the most common form of direct mechanical restraint for people with impaired mobility and lack of insight into their vulnerability in this regard.

100. Adviser 1 noted that Mr A's restraint risk assessment and care plan both highlighted that the lap strap should only be used as a last resort and was to be accompanied by the need to monitor and reassure him during its use.

101. Despite the need to monitor the use of the lap strap stated in the care plan, Adviser 1 said they could not find any chart or monitoring stating when, for how long, and under what circumstances, the lap strap was used.

102. Adviser 1 went on to confirm that Mr A's care plan supported the use of bed rails. The bed rail assessment confirmed that these were to be used. However, Adviser 1 noted that the assessment template seemed to relate to the bed rails themselves, rather than their appropriate use for Mr A. They considered that the care plan was coherent and reasonable and noted that this supported the safe use of bed rails. Despite the evidence to support the use of bed rails, Adviser 1 did not find any evidence that the use of bed rails was discussed with Ms C.

103. Adviser 1 said that the planned approach taken to Mr A's risk of falls in Hospital 2 was, largely, coherent and systematic. In particular, risk factors were appropriately considered and interventions were identified to mitigate risk. Adviser 1 was satisfied that this was in line with Mental Welfare Commission Guidance on the use of restraint.

Skin care

104. Adviser 1 reviewed the records in relation to Mr A's mobility and the impact on his skin care. They noted assessments of Mr A's risk of pressure ulcers, combined with clear and consistent monitoring and recording of Mr A's skin condition. However, they noted that, despite assessments indicating that Mr A was at high or very high risk of pressure ulcers, no pressure ulcer prevention

care plan was developed until 9 March 2014. They considered that, while there were reasonable plans in place to assist Mr A to mobilise safely, the delay in developing a pressure ulcer prevention care plan was not reasonable.

Hydration and nutrition

105. In relation to Ms C's concerns about Mr A's hydration and nutrition, Adviser 1 noted that on admission to Hospital 2 Mr A was considered to have a poor appetite. They also noted that, despite doctors identifying problems with his swallowing and giving instructions to encourage fluid consumption, a care plan to address his poor swallow was not developed until 7 March 2014, one week before he died.

106. Adviser 1 noted the concerns around Mr A's swallow, which were referred to several times in nursing notes, but also highlighted that these did not prompt closer scrutiny of Mr A's nutritional and fluid intake, as he considered they should.

107. Adviser 1 went on to say that, while nursing notes did refer to Mr A's dietary intake, he considered these to be too brief, irregular, inconsistent and lacking in detail and Adviser 1 concluded that this made them ineffective as a means of monitoring nutritional status. They also found no evidence of his fluid intake being effectively monitored, despite medical instructions to do so. They noted that Mr A's nutrition was assessed on 9 February 2014, but they did not consider that this assessment was of a reasonable standard, and was insufficiently reviewed during Mr A's time in Hospital 2. They concluded that staff failed to effectively monitor Mr A's fluid and nutritional intake, despite clinical evidence that it was significantly compromised. They assessed that Mr A's food, fluid and nutritional care fell below national standards while he was in Hospital 2.

Family visits and therapeutic activities

108. In relation to arrangements in place for family visits and social activities, Adviser 1 was satisfied that the accommodation available for visitors seemed reasonable, although they noted that staff should ensure that patients and their families are aware of the spaces available. However, they raised concerns that Mr A's Therapeutic Activity Plan did not reflect his changing condition and there was no record of interventions designed to meet Mr A's needs. They identified a lack of consistent recording of engagement with his activity plan, or any

evaluation or adjustment to the plan, as his condition deteriorated. They found this to be unreasonable.

109. Adviser 1 went on to consider the visiting hours at Hospital 2 and the need to balance clinical needs against a patient's choices and needs and those of their relatives. They clarified that a degree of flexibility in visiting hours and mutual understanding can lead to more satisfied visitors in the majority of cases. In relation to this case, he said that it would have been reasonable for the ward staff to have negotiated an arrangement with Ms C which would have enabled her to visit and participate in Mr A's care as much as possible, while also respecting the need for staff to be reasonably unconstrained in carrying out their duties.

110. Adviser 1 did not identify any references to such discussions in Mr A's notes and, while he did not consider that the staff's actions were unreasonable, he suggested that the Board should ensure that any adjustments to visiting hours are mutually agreed, and noted in records so that subsequent staff are made aware of the arrangements.

Mr A's deterioration

111. Adviser 1 went on to consider the evidence in relation to Mr A's deterioration in late February 2014. They noted that staff first recorded this deterioration on 18 February 2014 and also that Ms C raised concerns about it that day. Adviser 1 noted that there was inconsistency in the monitoring of Mr A's vital signs, with variation from two to three times per day to gaps of four to five days with no monitoring. They also noted that, following an instruction on 11 March 2014 for four-hourly monitoring, the charts show an irregular but more frequent pattern of monitoring. They found that overall, vital signs monitoring was inconsistent, irregular and unplanned. Adviser 1 concluded that Mr A's deteriorating condition was poorly monitored, and this did not support the aim of keeping him comfortable and managing his signs and symptoms. They found this to be unreasonable.

112. Finally, Adviser 1 noted Ms C's concerns about staff shortages and in relation to staff attitude. He could not identify any instances in Mr A's clinical notes which supported Ms C's concerns on these issues.

113. In conclusion, Adviser 1 highlighted weaknesses in the care provided in Hospital 2 in relation to:

- the recording of the use of mechanical restraint;
- pressure area prevention;
- record-keeping;
- food, fluid and nutrition; and
- vital signs monitoring.

114. Adviser 1 considered that the Board should take steps to assure themselves that staff are aware of the standards of care expected and that effective monitoring of care is in place.

(b) Decision

115. When Mr A was admitted to Hospital 2 it was hoped that this would be a transitional move, with the aim that he would move to a nursing home closer to his family. However, this sadly did not happen. Within two weeks of his admission, his condition had started to deteriorate and he passed away four weeks later.

116. Ms C has expressed concern that the change in environment, and particularly the lack of prolonged visits from family, played a significant part in Mr A's deterioration. She has also expressed concern that the lack of proper nursing care, particularly in relation to Mr A's nutritional intake, played an important part.

117. The ability for family to visit Mr A was very important to Ms C, and she went to significant lengths to be with Mr A whenever possible in the last months of his life. She felt restricted both by the distance of Hospital 2 from her home and also by the visiting hours of the ward he was in. The Board have highlighted the possibility that visiting hours can be adjusted to accommodate family needs, with the agreement of the Senior Charge Nurse. The lack of any documented discussion makes it unclear whether any agreement was ever reached.

118. I note Adviser 1's comment that any such arrangements need to be mutually acceptable and take account of a need for balance between patients' and relatives' needs and the need to carry out clinical duties. While I am satisfied that there was sufficient flexibility on occasion, it is important that, where special arrangements are made for relatives to visit, these arrangements

are recorded in the notes, to ensure that all staff are clear in relation to what has been agreed. I am therefore making a recommendation to this effect.

119. The poor standard of care provided in relation to assessing and monitoring Mr A's food and fluid intake is of significant concern, even if there is no clear evidence that this caused his deterioration. The lack of effective record-keeping means that the Board cannot assure themselves that they provided Mr A with an appropriate level of nutrition while he was in their care.

120. The poor monitoring of Mr A's vital signs as his condition deteriorated (despite requests from medical staff) did not support the aim of keeping him comfortable and managing his symptoms. While his behaviour may have made this difficult at times, this should have been noted, and this does not account for the irregularity of monitoring which did take place.

121. Ms C accepted that the use of mechanical restraints was reasonable, to keep Mr A from injuring himself. This was also recognised as a reasonable approach by the Board and by Adviser 1. However, the lack of acceptable monitoring and record-keeping raises questions about how much it was used and whether this was appropriate. Again, the Board cannot assure themselves that the care provided was reasonable.

122. Given the failings identified above, I uphold this complaint.

123. Some of Ms C's concerns, however, cannot be substantiated from Mr A's medical records. Her concerns about staff attitude and behaviour were investigated by the Board, but it is not possible for us to determine further whether the staff behaviour was reasonable. Her concerns about staff shortages were also not substantiated by careful assessment of the nursing records.

(b) Recommendations

124. I recommend that the Board:	*Completion date*
(i) remind staff of the need to ensure that changes to visiting hours are mutually agreeable to staff, patients and relatives, and are recorded wider staff awareness;	28 November 2016
(ii) conduct a nursing audit in the appropriate ward to assess the current practices in relation to record-	28 November 2016

keeping, food, fluid and nutrition and vital signs monitoring; and

(iii) provide evidence that any actions identified from the nursing audit are implemented in full. — 6 February 2017

(c) During an admission to Hospital 2, staff failed to provide Mr A with an appropriate level of clinical treatment

Concerns raised by Ms C

125. Ms C only raised one concern in relation to Mr A's clinical treatment. This related to the assessment and treatment of a sore throat he developed while in Hospital 2. Ms C has reported that Mr A's behaviour deteriorated after his transfer to Hospital 2. She expressed concern that he developed a sore throat, which she told staff about on 2 March 2014. By 9 March 2014 Ms C has reported that she saw his throat to be very red. She has raised concerns that medical staff did not take appropriate action to assess and treat his sore throat. She was aware that Mr A had a throat swab taken on 12 March 2014, but she said she was not told the results.

126. Ms C has expressed considerable concern about this situation, because she felt that Mr A's sore throat led him to avoid eating and drinking and that his poor nutritional intake contributed to the rapid deterioration in his condition. Over this period Ms C was not able to visit Mr A as frequently as she would have liked, due to the travel involved. When she next visited on 13 March 2014, she has said she could tell he was dying, but that none of the staff raised any concerns with her or spoke to her about end of life care for Mr A.

The Board's response

127. In the Board's response to Ms C's complaint, they apologised that they misinformed Ms C that Mr A had been prescribed a throat spray. In fact, this had been prescribed to another patient. They apologised for any distress caused by this confusion and said that it had been addressed with the staff involved. They reviewed the evidence in relation to Mr A's food and fluid intake and reported that difficulties were first noted on 5 March 2014. They added that on 11 March 2014 Mr A was reviewed by a doctor, who found no signs of inflammation. They noted that there were, however, concerns about Mr A's variable ability to swallow, which were first noted on 18 February 2014, but became more consistent by 7 March 2014, when a care plan relating to swallowing difficulties was put in place.

128. From their review of Mr A's medical records, they noted that there was no indication that he was dehydrated; that he was seen by medical staff on 10, 11, 12 and 13 March 2014; that his mouth was moist; and he was troubled by excess saliva. They also set out reasons why they did not consider that putting Mr A on intravenous fluids would have been appropriate, given the stage of his illness.

129. In their response to a draft copy of this report they also commented that, towards the end of his life, Mr A was at times non-compliant with vital signs monitoring. They also explained that such monitoring was not indicated for patients receiving palliative care, and that palliative care guidelines were followed.

130. The Board also disputed whether Mr A's challenging behaviours were related to pain, and said that the nursing notes indicated that he could be 'unsettled' for various reasons, including incontinence or when staff were helping him to bed.

Guidance

131. The Scottish Intercollegiate Guideline Network (SIGN) Guideline 117 (2010) provided guidelines on the management of sore throat and indications for tonsillectomy. This advocated the use of ibuprofen for treatment of sore throats, and noted that antibiotics should not be used to reduce sore throat symptoms. These guidelines also noted that there was no good evidence to support the use of throat sprays in the treatment of sore throats.

132. The General Medical Council have produced Guidance on Treatment and Care Towards the End of Life (2010). This sets out the approach that doctors should take to decision making and care at the end of a patient's life, including considerations around nutrition and hydration.

133. The National Institute for Health and Care Excellence (NICE) has produced guidance on Dementia (2006), which includes palliative care and end of life issues, including an approach to the provision of nutrition which favours eating and drinking by mouth for as long as possible. It also sets out the expectation that any unexplained changes in behaviour and/ or signs of distress should trigger staff to assess whether the person is in pain. This could be using an observational pain assessment tool.

Psychiatric advice

134. Adviser 2 reviewed Mr A's medical records and considered these in the light of Ms C's concerns about Mr A's sore throat. They noted that there were seven documented assessment of Mr A's throat between 19 February and 13 March 2014. They considered that the assessment and treatment provided was appropriate. They confirmed that the use of a throat spray was not indicated by SIGN Guideline 117, and that the Board's approach to this issue was reasonable.

135. However, Adviser 2 went on to note that Mr A was displaying behavioural difficulties, but that the potential for these to be the result of pain was not considered or assessed. They noted that, given the record of behavioural disturbance on four occasions and physical health changes, it would have been appropriate to make an assessment to ascertain whether the patient was in pain as part of a physical examination. They could not identify any formal assessment or consideration of pain related to physical or mental health assessments. They considered this to be contrary to NICE guidance on Dementia, and found it to be unreasonable.

136. Adviser 2 considered that these issues should have been discussed at a multi-disciplinary meeting or ward round, to consider whether there were factors contributing to Mr A's pain, distress or behavioural changes. Furthermore, Adviser 2 noted that there was a lack of any clear treatment plan or coherent multi-disciplinary approach to the management of the final stages of Mr A's illness.

137. Adviser 2 considered that the lack of any co-ordinated, multi-disciplinary, planned approach to Mr A's care and treatment was unreasonable. They noted that, while the Board identified 'multidisciplinary meetings' on several occasions, Adviser 2 could only identify one occasion when staff beyond nursing staff and medical staff were involved. They reviewed the content of the notes from these meetings, and found that they referred only to a limited number of symptoms, and the outcome of discussions. Even when an Occupational Therapist was present, there was no evidence of any discussion with the Occupational Therapist over patient management. Adviser 2 was also unable to identify any multi-disciplinary review documents. They also noted that there was no record of the GPs involved in managing Mr A's physical symptoms at these meetings. They concluded that it was not reasonable to describe these at multi-disciplinary meetings.

138. Adviser 2 also noted the inconsistent monitoring of Mr A's vital signs and that blood samples were not taken to assess his condition, even when there had been a noted decline in his physical and mental state, and poor oral intake had been recorded.

139. In conclusion, Adviser 2 noted that Mr A's illness followed a trajectory which was consistent with the progression of Alzheimer's Disease over a five year period. They were satisfied that poor nursing care did not directly impact on its progression, and that General Medical Council guidance on the End of Life was adhered to in the final few days of Mr A's life. However, they also found that the lack of a co-ordinated, multi-disciplinary care plan would have had an effect on Mr A's quality of life and symptom management.

(c) Decision

140. The specific complaint which Ms C brought to us related to the assessment and treatment of Mr A's sore throat. It is clear from the advice I have had that his throat was reasonably assessed and treated. However, this should be put in a context of poor treatment planning and management. Adviser 2 was clear that the lack of a clear treatment plan or co-ordinated, multi-disciplinary approach meant that his care and treatment over the final weeks of his life were not effectively managed in such a way as to enhance his quality of life as much as possible.

141. The lack of appropriate assessment of Mr A's pain, given the potential impact on his behaviour is also of concern. The challenging behaviours that Mr A displayed at times were signs of distress, but staff did not take steps to identify the source of the distress or monitor what influenced his behaviour.

142. This poor planning and co-ordination was exacerbated by limited investigations into Mr A's signs and symptoms as his condition deteriorated. The lack of any blood tests meant that staff were not able to establish whether there were issues with his dietary intake which could be improved. Appropriate planning could have highlighted the need for blood tests when his oral intake and overall condition were deteriorating. While I appreciate that this would not be likely to have had an impact on his prognosis, it would have improved his quality of life in the final weeks and days.

143. On the basis that medical staff did not provide a reasonable level of coordination and planning in their clinical treatment, I uphold this complaint. What is of particular concern is that the poor co-ordination and planning by medical staff was compounded by a lack of record-keeping and monitoring by nursing staff. Mr A's condition was always going to deteriorate, given his diagnosis of Alzheimer's Disease, but his terminal decline could have been much more effectively planned for and managed. This would have improved his quality of life and reduced the stress felt by his family at the end of his life. It is hoped that the recommendations made in this report will ensure this does not happen again.

Complaints Handling

144. In addition to the issues which Ms C's complaint has raised, I also have significant concerns about the Board's responses to her complaints. Ms C raised each of the issues discussed above with the Board and, while they did investigate what happened, they failed to identify the failures found during my investigation. They did not fully assess the nursing records and seem to have assumed in some instances that a lack of evidence meant a lack of problems. For example, the investigation in Hospital 2 noted that there was no evidence that Mr A became dehydrated. However, there was insufficient evidence in relation to his fluid intake and there were no blood test results, so it is not surprising that there was no evidence. In other instances the investigations were insufficiently critical of the evidence available. For example, the investigation into what happened in Hospital 1 did not appear to notice that there was a significant gap in the nursing records in January 2014 and that falls assessments were inaccurate and were clearly at odds with Mr A's behaviour.

145. Ms C raised concerns which the Board should have taken seriously and investigated thoroughly. They should have been able to identify, at the very least, that there were shortcomings in the record-keeping and that this made it difficult to assess the quality of the care he received. Their assumption seems to have been that care was of a reasonable standard, unless proven otherwise. This approach meant that their investigations failed to identify issues that were clear to my advisers. Given these failings in complaints handling, I am taking the unusual step of asking that the Board's significant events analyses into Mr A's care and treatment also look into how so much was missed by so many during their own investigations.

146. My concerns over the Board's approach to complaints handling have been further raised by the Board's defensive response to a draft copy of this report. Their comments sought to question the advice I have received, and tried to refute Ms C's complaints. This approach has led us to review the evidence, and at times identify further failings in the Board's care and treatment of Mr A.

147. I hope that, in the Board's response to my recommendations, they can reverse this dismissive, defensive approach to the issues that this case has raised and take a constructive approach to identifying service improvements for the future.

(c) Recommendations

148. I recommend that the Board:

		Completion date
(i)	conduct a Significant Event Analysis, aimed at exploring and understanding the causes of the care failures for Mr A, in order to identify appropriate improvements in clinical practice, and explore how complaints handling failed to identify these issues;	9 January 2017
(ii)	draw together the findings from both Significant Event Analyses to identify any shared issues on the continuum of care and in complaints handling, to be addressed by the Board; and	6 February 2017
(iii)	apologise to Ms C for the failings identified in this report, both in relation to Mr A's care and treatment and in relation to the responses Ms C received to her complaints.	28 October 2016

149. 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

Ms C	the complainant
Mr A	Ms C's partner
Hospital 1	Royal Cornhill Hospital
Hospital 2	Glen O'Dee Hospital
The Board	Grampian NHS Board
Adviser 1	Psychiatric nursing adviser
Adviser 2	Psychiatric Adviser
NMC	Nursing and Midwifery Council
MUST	Malnutrition Universal Screening Tool
SIGN	Scottish Intercollegiate Guideline Network
NICE	National Institute for Health and Care Excellence

Annex 2

Glossary of terms

discoid eczema	a long-term skin condition that causes skin to be red, itchy, swollen and cracked, in circular or oval patches
myoclonic jerks	brief, shock-like jerks of a muscle or a group of muscles
named person	a term defined in the Mental Health (Scotland) Act 2003, referring to the person who has to be informed and consulted about aspects of care when a patient is considered not to have capacity for their own decisions

Annex 3

List of legislation and policies considered

Essence of Care, Department of Health (2010)

Nursing and Midwifery Council Code (2015)

Adults with Incapacity Act (Scotland) Act (2000)

Food Fluid and Nutritional Care Standards, Healthcare Improvement Scotland (2014), replaced 'Clinical Standards for Food, Fluid and Nutritional Care in hospitals, Quality Improvement Scotland (2003)

Rights, Risks and Limits to Freedom, Mental Welfare Commission for Scotland (2013)

SIGN Guideline 117: The Management of Sore Throat and Indications for Tonsillectomy, The Scottish Intercollegiate Guideline Network (2010)

Guidance on Treatment and Care Towards the End of Life, General Medical Council (2010)

Dementia, National Institute for Health and Care Excellence (NICE) (2006)