# SPSO decision report

**Case:** **201104449, Lothian NHS Board**
**Sector:** health
**Subject:** clinical treatment; diagnosis
**Outcome:** some upheld, recommendations


## Summary

Mr C has complex needs and requires long-term care and specialist input. He has severe dementia, with limited capacity to judge distance or to understand and participate in therapies, and his wife (Mrs C) has welfare power of attorney for him. Mr C can move about, but is at particular risk of falling. In November 2007 Mr C was admitted to a continuing care ward, where he remains a patient. Mrs C made a number of complaints about aspects of the care and treatment that her husband has received. These included the actions the board took to address Mr C's condition in February 2011, medication, observation and monitoring, staffing levels, carer communication, charting and record-keeping, the standard of bathroom facilities and complaints handling.

Our investigation included taking independent advice from two of our medical advisers - one in mental health and one a GP. We took account of this advice as well as evidence from Mrs C and the board. Mrs C said that in February 2011 her husband became very unwell and staff failed to take reasonable measures to bring his temperature down and call a doctor within a reasonable time. Our investigation found that staff took appropriate action when Mr C became unwell and that their interventions overall were reasonable. In relation to the drug regime and administration, however, although we found that the principal contributing factor to Mr C's falls was most likely to have been involuntary muscle twitching, we also found that there were significant failings. These included the discontinuation of an antidepressant for three weeks; the timing of medication; and failure to ensure Mr C received prescribed medication when off the ward. We also found that the board failed to administer flu vaccinations to Mr C, either within a reasonable time or at all, placing his physical health at risk.

Mrs C also said that the board failed to ensure that Mr C was sufficiently hydrated (had enough fluids). We found that throughout the period Mr C was well hydrated and had effective liver and kidney function, but that there were inconsistencies in recording and monitoring his fluid balances. We also found that the board failed to properly assess Mr C's falls risk or properly record or implement a fall prevention care plan.

Mr C was sedated because he wandered at night due to agitation, and Mrs C felt that this could have been managed without resorting to sedation if there were more staff. We did not uphold this complaint as we found that, while it was difficult to reach a definitive conclusion on whether staffing levels were reasonable, staff used sedating medication as a last resort and then only rarely. In relation to Mrs C's complaint about bathroom facilities, the evidence available suggested that the ward is cleaned to an acceptable standard and that any problems are addressed within a reasonable time.

Mrs C said that staff communication about assessment of her husband's capacity and administration of sedative drugs was inadequate and she was also concerned that a 'do not attempt to resuscitate' certificate (DNAR - showing that a doctor is not required to resuscitate the patient if their heart stops) was signed by medical staff without her input. We upheld this complaint as we found that communication with Mrs C was not of a reasonable standard and did not comply with the Adults with Incapacity legislation. The board's record-keeping was also of concern and we found that at times it fell below a reasonable standard and did not, amongst other things, record a reasonable standard of communication with Mrs C. We also found instances of statements in the board's

complaints responses that were either inaccurate or misleading, indicating that Mrs C's complaint was not investigated as thoroughly as it should have been.

### Recommendations

We recommended that the board:

- implement measures to avoid patients being given medication at the end of one medication round and the beginning of the next, thereby ensuring an appropriate period of time has elapsed between doses;
- implement checking mechanisms to ensure the prescription sheets are transcribed accurately;
- ensure patients authorised to be off-the-ward receive medication consistently as prescribed by medical staff;
- review the processes for managing, prescribing, administering and recording in relation to the flu vaccination;
- ensure that falls prevention procedures, including developing and evaluating falls prevention plans, are consistent with the board's policy;
- ensure effective systems are in place to keep staffing levels under review;
- take measures to ensure appropriate compliance with the Adults with Incapacity Act, with particular regard to DNAR decision making and communication with relative or carers;
- ensure that relatives' communication documentation is used consistently to record the nature and content of discussion with relatives or carers;
- build flexibility into the charge nurse's appointment system so that there are opportunities for communication outwith scheduled times to deal with issues as they arise;
- ensure that record-keeping reflects the care and medication given and a reasonable standard of communication;
- consider implementing unplanned visits to ensure a reasonable standard of hygiene;
- ensure complaints are investigated thoroughly and that responses are accurate; and
- apologise to Mrs C for all the failings identified in our investigation.