Case 200500260: Fife NHS Board

Introduction

1. On 25 April 2005 the Ombudsman received a complaint from a woman (referred to in this report as Mrs C) about the care and treatment provided to Mrs C's father (Mr F) by Fife NHS Board (the Board).

2. Mrs C complained to the Ombudsman that the Board had not carried out a proper medical assessment of Mr F's condition and had prescribed inappropriate medication. Mrs C said that her father's medication was changed to a drug which could be injurious to his health and which, given his medical history, had the potential to be fatal. No response had been received to a formal complaint about this matter.

3. The complaint to the Board was about Mr F's clinical treatment and was still under investigation by the Board.

4. On 20 July 2005 Mrs C's husband (Mr C) repeated his wife's complaint to the Ombudsman. He stated that the consultant had shown no interest in discussing Mr F's condition with Mrs C on at least two occasions when he had the opportunity and that the Board had not followed the complaints process.

5. The complaints from Mr and Mrs C which I have investigated concerned:

(a) Mr F's assessments;

(b) Mr F's medication and falls;

(c) the Board's response to the complaint.

6. Following the investigation of all aspects of this complaint I came to the following conclusions:

(a) not upheld, see paragraph 20;

(b) not upheld, see paragraphs 21 to 25;

(c) not upheld, see paragraph 26.

Investigation and findings of fact

7. In writing this report I have had access to the documents provided by Mr and Mrs C which included copies of the correspondence with the Board, Mr F's clinical records covering the period of the complaint and the complaint correspondence from the Board. In considering Mr and Mrs C's complaints I have obtained clinical advice.

8. Mr F was an 84-year-old man who suffered from prostatic carcinoma and vascular dementia. He was admitted to hospital on 30 October 2004 following a fall presumed to be due to postural hypotension against a background of longstanding instability, confusion and double incontinence. He was discharged home on 15 November 2004 with a package of care and support from his daughter, Mrs D, who was his welfare guardian and lived nearby.

9. Mr F's safety at home was of some concern to his family and his GP requested a psychiatric review. This was undertaken by the consultant on 14 December 2004 at Mr F's home. The consultant noted that Mr F was confused and at risk of self-neglect and incontinence living on his own but that Mr F seemed keen to remain there. The consultant felt that a cholinesterase inhibitor (for example Aricept, an anti-dementia drug) was not appropriate. He did not discuss this assessment with the patient's family. Mrs D continued to be concerned and arranged for Mr F to be admitted on 30 December 2004 to a care home for respite. A case conference about Mr F's future care was held on 7 January 2005 (with both daughters present) at which time the staff of the care home complained about the problems caused by his confusion and restless nights. Mr F was then moved to another home and then another where he was re-assessed by the consultant on 18 January 2005. He prescribed Zopiclone (a short-acting benzodiazepine group hypnotic) as night sedation in order to reduce night-time restlessness and wandering which was upsetting other residents.

10. The consultant reviewed Mr F again on 29 January 2005 as the nocturnal restlessness was still a problem. He prescribed Amisulpride 50mgs. On enquiring about progress on 2 February 2005 he was told that night times were still a problem but he declined to change anything at that time as Mr F was being investigated further for his prostate problem. The consultant reviewed Mr F again on 2 March 2005 at which time the staff at the home were coping better at night with him and the consultant felt Mr F was probably appropriately placed. A further case conference was being arranged by the social worker. The consultant reviewed Mr F again on 26 April 2005 when he noted that Mr F was rather shaky on his feet and less mobile than before and, therefore, the GP had appropriately stopped Amisulpride. He discussed the situation with Mrs D and it was agreed that Mr F would stay at the care home for the time being rather than run the risk of upsetting him by a move to another home. At a further review on 16 May 2005 Mr F was not reported to have had more agitation since being off Amisulpride.

11. By 10 June 2005 Mr F had been admitted to hospital because of repeated falls. The consultant reviewed him in hospital on 14 June 2005 and found that his mental test score had deteriorated markedly over the previous two assessments. Mrs D was arranging for him to be discharged to another nursing home. Mr F was not taking any psychotropic medication and the consultant felt he did not require it.

12. In late January and February 2005 Mrs C sent faxes to Mr F's GP. These faxes indicate that there was no communication with her sister, Mrs D, about Mr F's status and that she disapproved of Mr F's moves between care homes and felt he should have 24-hour care at home because that was where he wished to be.

13. Mrs C faxed a formal complaint about Mr F's clinical care to the Social Work Department on 17 April 2005. This was passed to the Board. On the same day she faxed a complaint about Mr F's assessments to the Board. This letter was acknowledged and the complaints passed to the Clinical Services Manager for investigation. The General Manager wrote to Mrs C on 24 May 2005 and offered a meeting with the consultant to discuss Mr F's care.

14. Mr C replied on 26 May 2005. He said that the response was unacceptable. He complained about the way his wife's complaint had been handled and repeated

the complaints about the lack of proper assessment of Mr F and the drugs which had been prescribed for him. He blamed the drugs for Mr F's subsequent fall and said that the consultant had not shown any interest in discussing Mr F's condition with Mrs C.

15. The consultant sent a full and detailed response to the points raised to the Patient Liaison Officer on 7 June 2005. In that letter he said that the reason he did not appear to show any interest in discussing the issues with Mrs C was that he was unaware there were any issues to discuss as Mr F had improved on medication and nursing staff had reported an overall general improvement.

16. On 15 June 2005 the Patient Relations Officer offered Mr and Mrs C a meeting with the consultant along with the Clinical Services Manager and the Medical Director. Mr C replied by telephone. He said that he wished to have a meeting with the consultant which he would attend. His wife would not go for personal reasons. Mr C wished the minutes of the meeting to be made available to him within 48 hours.

17. On 24 June 2005 the Patient Relations Officer wrote to Mr C. She said that if Mr C wished to discuss the consultant's clinical choices Mr C should telephone him. If he wished to discuss the process of complaints and how he felt things should change in the future he should arrange to meet with the consultant along with the Clinical Services Manager and the Medical Director.

18. Mr and Mrs C complained to the Ombudsman.

Conclusions and recommendations

19. I issued my report to both Mr and Mrs C and to the Board on 21 October 2005 for comments by 18 November 2005. No comments were received from Mr and Mrs C or the Board.

(a) Mr F's assessments

20. There is good evidence from the hospital discharge letter that appropriate medical assessments were carried out during Mr F's hospital admission and from the consultant's correspondence that such assessments were carried out afterwards at home and in the care homes. The consultant did discuss Mr F's

condition and future care needs with Mrs D. Mrs C was present at other assessments as well. A medical report was not required for the case conference in January 2005 as Mrs C insisted. The decision for Mr F to have a medical assessment was fulfilled by the consultant's visit a week later. I am unable to find any evidence that the Board failed to carry out proper assessments of Mr F's condition and so do not uphold this complaint.

(b) Mr F's medication and falls

21. Mr F's dementia was of the vascular type of dementia not the Alzheimer type. Alzheimer-type dementia tends to be slowly progressive often over as much as five to ten years with little deterioration until late in the disease. The vascular type of dementia on the other hand is much more rapid in progression over a matter of two to four years and characterised by an irregular physical and mental decline punctuated by stroke-like episodes with fluctuating levels of mental and physical signs.

22. People with vascular dementia often do not respond well to cholinesterase inhibitor drugs (like Donepezil or Aricept) and can have an unpredictable response to sedatives. Mr F was not offered a cholinesterase inhibitor by the consultant as he correctly considered Mr F to be unsuitable because of the vascular nature of his dementia. Mr F's nocturnal restlessness and wandering was a behavioural problem which would need to have been managed wherever he was cared for. The consultant very appropriately tried a small dose of a short-acting hypnotic Zopiclone in order to achieve a reduction in his agitation. Mrs C highlighted the intention of reducing agitation in italics in her letter of complaint to indicate her concern about the drug's effects on Mr F. However, I am advised that Zopiclone did not make Mr F's agitation worse, it just did not help.

23. The consultant then appropriately tried an alternative medication as a sedative. Mr and Mrs C quote guidelines about the implications for using such drugs but according to the adviser, the consultant's comments about this aspect of the treatment are correct. It is common and accepted practice that non-drug strategies and care management are tried before using small doses of these drugs. Like many clinical decisions taken in these circumstances, medication is used as a last resort in the knowledge that the effect may be unpredictable but there is no alternative and double-blind clinical trials have not been done or are unable to be

carried out to give cast-iron, predictable risk assessments. Mr and Mrs C quoted the SIGN (Scottish Intercollegiate Guidelines Network) Guidelines. SIGN was formed in 1993 with the objective of improving the quality of health care for patients in Scotland by reducing variation in practice and outcome through the development and dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence. Guidelines are, however, only guidelines and the two drugs were given with caution and with plans for review. In my view the action taken was appropriate.

24. It is very likely that the side-effects of shakiness and poor gait noticed in Mr F in April 2005 were due to Amisulpride and stopping the drug would have corrected this. The time interval of at least two months between stopping the Amisulpride and the onset of Mr F's falls requiring hospital admission makes it very unlikely that the drug was responsible for the falls. The stroke-like episodes characteristic of vascular dementia which were found on examination in hospital were more likely to be the cause.

25. I do not uphold this complaint as the consultant prescribed appropriately and with concern for his patient's welfare. The approach to such a complex case as Mr F's condition has to be holistic, that is, taking into account the patient and his wishes, the carers and their abilities and the family and their concerns. In a rapidly deteriorating medical condition such as Mr F's decisions have to be taken with conflicting facts using empirical means with uncertain outcomes. The consultant is not to blame for what was a natural deterioration in Mr F's condition.

(c) The Board's response to the complaint

26. In her formal complaint made to Fife Council's Social Services Department which was subsequently passed to the Board, Mrs C accused the Board of mishandling her previous concerns and making subjective assessments of Mr F's welfare needs which put his life at risk. She was particularly concerned at the prescription of Zopiclone and Amisulpride to Mr F as these were antipsychotic drugs for hallucinations and delusions and he did not suffer from schizophrenia. It is noteworthy that Mrs C stated at the end of the letter that Mr F had a 'yet to be defined level of dementia' which suggests that she did not accept the consultant's assessments of Mr F's mental state. Given the difference in their views, it was entirely appropriate that the Board offered a meeting with the consultant to allow

him to explain his diagnosis and choice of medication. The Board's response to Mrs C's complaint was appropriate and, therefore, I do not uphold this complaint.

Further action

27. As I have not upheld any of Mr and Mrs C's complaints the Ombudsman does not recommend any further action.

28 February 2006

Annex 1

Explanation of abbreviations used

Mr and Mrs C	The complainants
Mrs D	Mrs C's sister and Mr F's daughter and welfare guardian
Mr F	Mrs C's father

Annex 2

Glossary of medical terms

Alzheimer-type dementia	Dementia caused by Alzheimer's disease which is a progressive, neurodegenerative disease characterised by loss of function and death of nerve cells in several areas of the brain leading to loss of cognitive function such as memory and language
Amisulpride	An antipsychotic drug
benzodiazepine group	A class of drug widely used in medical practice as Central Nervous System depressants
cholinesterase inhibitor	A substance which acts to inhibit acetylcholinesterase, the enzyme which breaks down acetylcholine and thus prevents transmission of nerve impulses from one nerve cell to another
hypnotic	A drug that acts to induce sleep or to reduce anxiety
hypotension	Abnormally low blood pressure
prostatic carcinoma	Prostate cancer
psychotropic	A drug that effects mental state
vascular dementia	A state of diminished cognition that is the result of repeated cerebral strokes with a deterioration in intellectual functions

Zopiclone	A hypnotic drug normally used to treat insomnia and other sleep disorders