SPSO decision report

Case: **201204873, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C's late mother (Mrs A), who suffered from dementia, was admitted to hospital with hip pain after a fall. X-rays suggested that she had fractured a bone in her pelvis. Healthcare professionals assessed her as having moderate cognitive impairment (a condition affecting the ability to think, concentrate, formulate ideas, reason and remember) and noted that she was confused and disorientated. Mrs A had a further fall some days later, when no injuries were noted. However, she then fell again several weeks later and fractured her left hip which was repaired in an operation. She fell again in early December 2012. Her medical records said she made no complaints of pain, and she was discharged to another hospital for rehabilitation shortly afterwards. Five days later, Mrs A was transferred back to the first hospital complaining of hip pain, and a fracture to her right hip was identified. Following surgery to repair the fracture, Mrs A died.

Mr C said that the family were very distressed that Mrs A suffered two fractures while in the care of the hospital and that the board failed to take reasonable steps to prevent her from falling. He was also concerned about the lack of documentation concerning Mrs A's fall in early December and said that the board failed to provide a reasonable standard of nursing and medical care after the falls. The medical records showed that Mrs A fractured her left hip following her third fall, and that a second hip fracture was diagnosed in mid-December 2012. Mr C, however, believed that the second fracture occurred during her fall in early December.

We took independent advice on this complaint from one of our medical advisers. The adviser said that while there was clear evidence of risk assessment and planned interventions, these did not take account of Mrs A's cognitive impairment. Moreover, there was a lack of an overall score in the risk assessment tool used, which was significant as the score could have indicated the need to use falls prevention aids or to consult a falls specialist. The adviser also said that there was evidence of ineffective record-keeping of pain assessment, which was not suited to patients who were less able to report this themselves. In light of this, we were not satisfied by the entry in the medical records of early December that said that Mrs A was not in pain, particularly as we noted that Mrs A's sister, her main carer, had said that Mrs A was in more pain than usual on the evening of the fall. In the absence of records relating to Mrs A's admission to the second hospital and her return to the first hospital, however, we could not say definitively when Mrs A fractured her hip.

Having said that, we were extremely concerned about the board's failure to properly assess Mrs A's levels of pain and the lack of evidence to show that Mrs A was checked by medical staff following her fall (including that there was no evidence of their findings). We were also concerned about a lack of nutritional screening and of effective use of the adults with incapacity legislation. The board acknowledged shortcomings in record-keeping, in particular following the fall in early December. They said they had raised this matter with the staff concerned and had apologised to Mr C for this. We found failures in record-keeping by nursing and medical staff in relation to all three falls. Given the risk this posed to Mrs A, we were very critical of these failures, particularly of those by medical staff. We upheld Mr C's complaints and made a number of recommendations.

Recommendations

We recommended that the board:

- ensure the failures in record-keeping are raised with relevant staff;
- ensure that the systems for transferring records from one care setting to another and for storing and retrieving medical records securely are robust;
- review the falls assessment documentation and policy in light of our adviser's comments;
- ensure that effective nutritional screening of all patients in the hospital takes place;
- introduce a pain assessment tool appropriate for people with dementia;
- ensure effective compliance with adults with incapacity legislation; and
- apologise to Mr C for the failures identified.