Case 200501864: Lothian NHS Board

Introduction

1. On 10 October 2005 the Ombudsman received a complaint from a woman (referred to in this report as Mrs C) against Lothian NHS Board (the Board) regarding the care and treatment received by her late father, Mr C, at the Western General Hospital, Edinburgh (the hospital). Mr C, who had Alzheimer's disease and was aged 86, was admitted to the hospital on 17 July 2005. In the early hours of the morning on 19 July 2005 he fell out of bed and broke his hip. He later underwent surgery to repair the hip. Mr C died on 2 August 2005.

2. The complaint from Mrs C which I have investigated concerned whether Mr C fell out of bed as a result of inadequate supervision by nursing staff and failure to put up the cot sides on his bed.

3. Following the investigation of this complaint I did not uphold the complaint. Although the complaint is not upheld, the Ombudsman recommended that the Board took action to ensure that patients were appropriately assessed and had up-to-date nursing care plans (see paragraphs 11 and 12). In response to the draft report the Board provided satisfactory evidence that measures were already being taken through their clinical governance structures that would address these issues.

Investigation and findings of fact

4. In the course of the investigation of this complaint all the documentation supplied by Mrs C and the Board and Mr C's clinical records have been considered. Advice was obtained from a nursing adviser to the Ombudsman (the adviser). I have set out my findings of fact and conclusions below. Mrs C and the Board have been given the opportunity to comment on the draft of this report.

Mrs C's complaint to the Board

5. On 25 July 2005 Mrs C took up her complaint with the Board. Mrs C said that her father had Alzheimer's disease and was not able to speak for himself. Mrs C's mother had cared for her father at home for 2 years without incident. In less than 24 hours in hospital care he broke his hip. Mrs C felt that this should not have

been possible. Mr C had to undergo hip surgery and was in a great deal of pain following the surgery.

The Board's reply to Mrs C

6. On 26 September 2005, the Board replied to the complaint as follows:

> '… nursing staff from the Western General contacted your mother to establish how mobile [Mr C] was at home. As he was confused due to Alzheimer's disease, he was observed closely by the nursing staff and cot sides were placed on his bed. These were raised while he was in bed, which is the routine procedure in order to try to ensure a patient does not attempt to get out of bed unaided. The nursing staff have stated, during investigation of this incident, that [Mr C] was regularly observed during the shift. He was initially noted to be confused and unhappy with the intravenous drip in his arm. However, after being given a hot drink he settled in the early part of the night and was noted to be sleeping on observation.
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> On night shift the nursing staff walk around the ward area observing the patients and attending to them as required, however, they try to minimise disruption in order to let patients sleep. During the walk round the nursing staff heard a noise and went to the room in which [Mr C] was being cared for. [Mr C] was found lying on the floor. He was able to tell the staff that his hip was "a little sore" but he could not recollect how he came to be on the floor. The staff assisted him off the floor and helped him back into bed. The ward doctor examined him and it was noted that his hip was sore, he had a haematoma [a localised collection of blood] on his arm where the drip had become dislodged but there were no other injuries apparent. [Mr C] was offered pain relief, but he did not wish this. After he was made comfortable in bed he went back to sleep and was settled for the remainder of the night.
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> The following morning [Mr C] was examined again and a further review undertaken. An x-ray of his hip revealed the fracture and thereafter he was transferred to the Royal Infirmary …
>
> … staff followed the correct procedure and took every precaution to ensure

your father's safety … I am sorry that despite these measures he sustained this fall.'

Complaint to the Ombudsman

7. Mrs C said that she felt that her father would still probably be alive today if he had not fallen and undergone the trauma of a broken hip and the ensuing surgery. She considered that he could not have been properly observed by nursing staff and she doubted if the cot sides were up when Mr C fell.

Adviser's opinion

8. The adviser said that the use of cot sides in these circumstances was appropriate. However, she noted that there was no record in the nursing notes of cot sides being in place. According to the nursing notes, nursing staff undertook Mr C's observations – took his pulse, temperature and blood pressure – every 30 minutes prior to the fall. She considered that the level of observation provided by nursing staff for Mr C was satisfactory. She commented that there are entries in the nursing notes that indicate that Mr C was capable of some self movement. She also commented that patients who seem unable to move can unexpectedly and unpredictably find the strength to get themselves in a position to fall out of bed.

9. However, the adviser commented that the quality of care planning was poor. She would have expected the decision to use cot sides to be backed with adequate assessment of Mr C's mental state and mobility to support this. There was also no plan to indicate the expected level of observations.

Incident report form

10. I have seen that it is recorded in the incident report form, completed by one of the nursing staff who attended to Mr C after his fall, that the cot sides were up on Mr C's bed when he was found.

Conclusion

11. Although there is no record in the nursing notes that cot sides were in place, I am persuaded by the incident report completed by the nurse who found Mr C after his fall, that cot sides were up on Mr C's bed at the time of the fall. Given the adviser's opinion that use of cot sides in these circumstances was appropriate and that the level of observation was satisfactory, I do not uphold the complaint.

12. Although the complaint not upheld the complaint, the Ombudsman drew the Board's attention to the adviser's comments on the quality of care planning in this case and recommended that the Board took action to ensure that patients were appropriately assessed and had up-to-date nursing care plans. In reply to the draft report the Board provided satisfactory evidence that measures were already being taken through their clinical governance structures that would address these issues.

Further action

13. As noted in paragraph 3, the Board have accepted the recommendation and have acted on it accordingly.

27 June 2006

Annex 1

Explanation of abbreviations used

The Board	Lothian NHS Board
Mrs C	The complainant
Mr C	The complainant's father
The hospital	Western General Hospital, Edinburgh
The adviser	A nursing adviser to the Ombudsman