Scottish Parliament Region: Lothian

Cases 200603138 & 200603250: Lothian NHS board and A Medical Practice, Lothian NHS Board

Summary of Investigation

Category

Health: Clinical treatment/diagnosis

Overview

The complainant (Mrs C) complained that both her mother (Mrs A)'s GP Practice (the Practice) and Templar Day Hospital (Hospital 1) failed to examine Mrs A thoroughly enough to correctly diagnose her broken hip. She felt that Mrs A suffered unnecessary pain and limited mobility due to incomplete examinations and assumptions being made by staff of both bodies.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Practice misdiagnosed Mrs A's broken hip as arthritis (*not upheld*);

(b) the Practice failed to follow correct procedures to consider any problems other than arthritis (*not upheld*); and

(c) Hospital 1 staff failed to diagnose Mrs A's broken hip prior to, or during, months of physiotherapy (*upheld*).

Redress and recommendations

The Ombudsman recommends that Lothian NHS Board (the Board) review Hospital 1's admissions procedures to ensure that all patients receive a full diagnostic assessment prior to the commencement of treatment.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. In January 2006, the aggrieved (Mrs A) contacted her GP Practice (the Practice) to request a home visit by a GP. She had been experiencing pain in her legs and a reduction in mobility. She was examined by two GPs over the following weeks and their investigations concluded that osteoarthritis (a type of arthritis causing degeneration of the joints) in her knees was the cause of her pain and limited movement. The second GP referred Mrs A to Templar Day Hospital (Hospital 1) for further examination and a course of physiotherapy. She attended Hospital 1 as an out-patient once a week from April 2006.

2. Whilst attending Hospital 1, Mrs A's pain worsened and her mobility reduced yet further. Mrs A's daughter (Mrs C) and her family strongly believed that the problem stemmed from Mrs A's hip, rather than her knee, and urged staff at Hospital 1 to carry out an x-ray of Mrs A's hip. An x-ray of her hip was eventually carried out on 24 May 2006 and it showed that Mrs A had fractured her femur. She was admitted to the Royal Infirmary of Edinburgh (Hospital 2) the same day for a hip replacement operation.

3. Mrs C believed that medical staff at the Practice and Hospital 1 were too quick to assume a diagnosis of osteoarthritis and that the examinations carried out on Mrs A concentrated on proving this diagnosis rather than exploring alternative sources of her discomfort. She felt that her family's conviction that Mrs A's hip was the source of the problem was ignored until they insisted that an x-ray was carried out. Mrs C complained to Lothian NHS Board (the Board) and to the Practice. Dissatisfied with the explanations provided in response to her complaints, Mrs C brought the matter to the Ombudsman's office in January 2007.

4. The complaints from Mrs C which I have investigated are that:

(a) the Practice misdiagnosed Mrs A's broken hip as arthritis;

(b) the Practice failed to follow correct procedures to consider any problems other than arthritis; and

(c) Hospital 1 staff failed to diagnose Mrs A's broken hip prior to, or during, months of physiotherapy.

5. Mrs C also raised complaints about Mrs A's treatment at Hospital 2. The issues raised were consistent with issues addressed in a separate independent

investigation. As changes have already been implemented to rectify these issues, I did not investigate the points raised by Mrs C in this regard. I advised her of this prior to commencing work on this report.

Investigation

6. In order to investigate this complaint, I have reviewed Mrs A's clinical records, all of the complaint correspondence between Mrs C, the Board and the Practice, as well as reports compiled by two GPs at the Practice in response to Mrs C's complaint. I have also sought professional medical advice from the Ombudsman's clinical adviser (Adviser 1) and an independent orthopaedic specialist (Adviser 2).

7. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C, the Board and the Practice were given an opportunity to comment on a draft of this report.

(a) The Practice misdiagnosed Mrs A's broken hip as arthritis; (b) the Practice failed to follow correct procedures to consider any problems other than arthritis; and (c) Hospital 1 staff failed to diagnose Mrs A's broken hip prior to, or during, months of physiotherapy

8. Mrs A's son (Mr B) telephoned the Practice on 1 February 2006 to request a house call for Mrs A. That day's duty GP (GP 1) called Mr B back to discuss the request and establish what action should be taken. GP 1 made a note, in reference to Mrs A's condition, on the Practice's appointment system which stated 'Pain in legs and knees, can hardly walk. Wants house call'. A second GP (GP 2) was asked to examine Mrs A at her home.

9. GP 1 made a more detailed note in Mrs A's clinical records following the telephone request for a house call. She recorded that she had talked to Mrs A and Mr B and that there had been a gradual deterioration in Mrs A's mobility 'over months'. She also noted pain in Mrs A's knees and ankles, that Mrs A was struggling to move around her home and that she was reliant on assistance from Mr B when going out in a car or taxi.

10. GP 2 visited Mrs A at her home on 1 February 2006. The note made by GP 2 following examination of Mrs A is fairly brief, however, records that her mobility problems appeared to be caused by stiffness in her ankles resulting from swelling below the knee. GP 2 noted that Mrs A had a footstool but that it

was not immediately visible and that he recommended increasing the dosage of diuretic medication that she was already taking for water retention.

11. In a report compiled in response to Mrs C's complaint, GP 2 explained that he had experienced some difficulty when attempting to establish the source of Mrs A's leg pain during the house call. GP 2 said that it was unusual for him to attribute reduced mobility to lower leg swelling from increased fluid, however, in the absence of any localising symptoms for her pain or a definable cause for her reduced mobility, he concluded in this case that this was the most likely root cause.

12. GP 2 said that Mrs A was able to move around her home at the time of his visit. He explained that, to reach the conclusions that he had regarding the source of her pain and mobility problems, he would have observed her mobility. This would have involved watching her getting out of her chair and walking around her house as well as feeling and manipulating her ankles, knees and hips. He said that these examinations of her joints would have been done both with Mrs A in her armchair and with her standing up. He described this as 'normal practice'. He also said that it would be normal for him to ask patients with mobility problems whether any single event had instigated the problem. He said that neither Mrs A nor Mr B advised him of any such events.

13. Mrs C responded to GP 2's report, in a letter dated 4 August 2006. In her letter, she relayed comments made by Mr B, who had been present during the house visit. Mr B disputed GP 2's account of events, stating that GP 2 had not manipulated or examined Mrs A's legs above the knee and that, therefore, no examination of her hips had been performed.

14. In her letter, Mrs C also said that Mrs A was unable, at the time of the house call, to walk around her house as described by GP 2, and that her reduced mobility was such that she could only walk a few meters at a time whilst holding onto furniture. Mrs C further noted that the pain in Mrs A's ankles was secondary to the main pain that she was experiencing in her left hip.

15. Mrs A contacted the Practice again on 15 February 2006 as her leg pain and mobility problems had worsened. GP 1 visited her at home and recorded that Mrs A's lower leg swelling was improving and that this no longer seemed to be a significant factor in the pain that she was experiencing. It was noted in the clinical records that pain in her left knee was causing Mrs A difficulty in walking

and that she was struggling to get to the bathroom. GP 1 also noted that Mrs A had a walking stick but that she was unable to use this.

16. GP 1 examined Mrs A's legs. She also compiled a report in response to Mrs C's complaint and, in this, she noted that whilst it is not specifically recorded in the clinical records for this house call, she would routinely examine the hips of an elderly patient experiencing knee pain. GP 1 said that both of Mrs A's knees showed signs of osteoarthritis, but with no redness, heat or restricted movement. Mrs A's walking was assessed and GP 1 recorded that this was clearly difficult for her.

17. GP 1 said that she believed Mrs A was at risk of falls. As such, she made arrangements with an occupational therapist for adaptations to be made to her home to aid her mobility. She also referred Mrs A to the Care of the Elderly team at Hospital 1 for further investigations to be made into Mrs A's mobility problems.

18. GP 1's referral to Hospital 1 described Mrs A as having experienced a gradual loss of mobility over the previous six months. It was noted that this appeared to be due to severe osteoarthritis in her knees, her left knee in particular. GP 1 detailed the diuretic medication that Mrs A had been taking and noted that her lower leg swelling had reduced following an increase in dosage, however, pain in her left knee was causing increasing problems with her mobility. GP 1 noted that Mrs A had 'widespread osteoarthritis especially affecting her knees'.

19. In response to GP 1's report, Mrs C explained that she, and other members of Mrs A's family, had always believed that Mrs A's pain stemmed from her hip. She said that Mr B, who was again present during GP 1's house call, remembered GP 1 manipulating Mrs A's hip, and that Mrs A's reaction to this was 'unmistakable pain'. Mrs C also noted that Mrs A's pain was in her upper left leg generally rather than localised around her knee.

20. Mrs C discussed her concerns over GP 1 and GP 2's conclusions during two meetings held with members of the Practice on 12 October 2006. GP 1 and GP 2 were interviewed independently in the meetings and recounted the thought process behind their conclusions when examining Mrs A. The Practice Manager, Mrs C and her husband were present at both meetings.

21. During both meetings, Mrs C questioned GP 1 and GP 2's record of events, which stated that Mrs A had experienced a gradual loss of mobility. She said that Mrs A's loss of mobility had been sudden. This gradual loss of mobility was first noted in GP 1's note in the Practice's appointments system following Mr B's telephone request for a house call on 1 February 2006. GP 2 confirmed in his meeting with Mrs C that he conducted his house call with the understanding that Mrs A's loss of mobility had been gradual.

22. The meeting minutes for GP 1's meeting record that she recalled getting a clear picture from Mr B that the loss in mobility was gradual, over a period of months. However, Mrs C wrote to the Practice upon receipt of a copy of the meeting minutes and clarified that her understanding, from speaking to GP 1 at the meeting, was that GP 1 had developed a general picture of gradual deterioration during her conversation with Mr B, rather than this specifically being described by Mr B.

23. Mrs C considered that GP 1 incorrectly recorded that Mrs A had experienced a gradual deterioration in mobility. She felt that this led both GP 1 and GP 2 to assume that osteoarthritis was the cause of Mrs A's pain and that the examinations subsequently carried out on Mrs A, therefore, concentrated on her knees and lower legs, rather than attempting to establish any possible alternative sources of pain.

24. Mrs C and other members of her family disagreed with GP 2's recollection of the details of his examination of Mrs A and felt that his examination was not thorough enough.

25. GP 1 referred Mrs A to Hospital 1 for a further assessment of her mobility. Mrs A attended as an out-patient once per week from 5 April 2006. The note taken upon Mrs A's first attendance stated that she had pain in her left knee and ankle with a history of decreasing mobility and falls. It was also noted that the swelling in her ankles had worsened. It is recorded in the same note that Mrs A had severe osteoarthritis in her left knee, that the swelling was worse in her left ankle than the right and that her hip was 'normal'.

26. At the time of making her complaint to the Board, Mrs C requested copies of Mrs A's clinical records. She told me that, within the documentation that she was provided, there were two copies of the note corresponding to Mrs A's first attendance at Hospital 1, referred to in paragraph 25. One copy of the note

matched the version that I have seen, whilst the other was the same but with the reference to Mrs A's hip being 'normal' omitted. The inference is that this piece of evidence has been doctored to support Hospital 1's defence of the complaint. Whilst I cannot establish whether the reference to Mrs A's hip was added (or deleted) retrospectively, I acknowledge Mrs C's comments and have considered them when reaching my conclusions.

27. Notes taken over the following weeks are brief but show that Mrs A's mobility was variable. She appears to have been asked on more than one occasion if she had had any falls. She reported that she had not. On 10 May 2006 it is noted that Mrs A's mobility 'remains poor'. She advised Hospital 1 staff that her left leg was very painful and reportedly asked for an x-ray of her left knee. A telephone call from Mrs C is documented on 11 May 2006 raising concerns over the lack of improvement in Mrs A's condition. Mrs C is recorded as having told Hospital 1 that Mrs A was experiencing pain radiating from her left hip down toward her left knee.

28. A knee and chest x-ray was carried out on 17 May 2006. Mrs C was unhappy that a hip x-ray was not taken, as she had specifically asked for this in her previous telephone call. She called Hospital 1 again on 24 May 2006 to 'insist' that a hip x-ray was taken. This was performed on 24 May 2006 and showed that Mrs A had a fractured femur. Mrs A was immediately transferred to Hospital 2 for a hip replacement operation.

29. Mrs C complained that Hospital 1 had not fully examined Mrs A and had instead concentrated on the osteoarthritis detailed by GP 1 at the Practice. She told me that she specifically asked staff at Hospital 1 to carry out a hip x-ray during her telephone call of 11 May 2006 and that she was surprised to learn that a knee and chest x-ray was taken given the family's insistence that Mrs A's pain stemmed from her hip. She said that no hip x-ray would have been taken had she not insisted during her telephone call of 24 May 2006.

30. Hospital 1 records for 11 May 2006 do not mention Mrs C's request for an x-ray, however, in their response to Mrs C's complaint they said that she had asked for a knee x-ray to be carried out. I am unable to confirm what was discussed during this conversation, however, the note taken following Mrs C's telephone call on 24 May 2006 does state that she was asking 'again' for Mrs A's hip to be x-rayed.

31. When investigating this complaint it quickly became clear that there are differences between Mrs A's family's recollection of events, those detailed in Mrs A's clinical records and the recollections of medical staff that examined Mrs A. Within the records there are differing accounts apparently stemming from varying information provided by Mrs A concerning her condition. Some consultations detail knee pain only, whilst others record knee and hip or groin pain. In some cases Mrs A has reported a history of falls, and in others she has stated that she has had no falls. There is evidence within the clinical records to suggest that Mrs A suffered from occasional short term memory loss and Adviser 1 suggested that this may have contributed to some of the confusion. Additionally, Mrs C explained to me that Mrs A was extremely hard of hearing and, by the time of her admission to Hospital 2, may have been generally disorientated by this and the pain relief medication that she was taking. She believed that this may have affected the reliability of some of the statements that Mrs A made regarding her condition.

32. The admission note completed by an orthopaedic consultant at Hospital 2 describes information provided by Mrs A during her first examination there and provides the most complete record that we have of her historical symptoms. Her left leg is noted to be short and externally rotated. She gave a history of increasing left hip pain with deteriorating mobility. She was noted as being somewhat vague as to the cause of her injury but she said that she had had a fall in the past few days and since then had experienced increasing hip pain. She told the orthopaedic consultant that she had also had left thigh and knee pain for a number of weeks, if not months, following a fall. She concluded, however, that her presenting symptoms were definitely a new problem with her left hip in the last few days and that the significant discomfort had only come on recently. The orthopaedic consultant considered Mrs A's history to be 'a little odd' but recorded that she was adamant that her presenting symptoms were new. He noted that the x-rays taken of Mrs A's fracture supported this.

33. The clinical records held by Hospital 2 also contain a copy of the referral letter written by Hospital 1 on 24 May 2006. This states that Mrs A had a history of falls and poor mobility and that she had 'a sharp decline in her mobility last 24 to 48 hours and complains of an increase in left hip pain'. It goes on to say that Mrs A may have 'possibly fallen a few times since last week'.

34. Following Mrs A's discharge from hospital, she continued to be monitored by another GP at the Practice. This GP referred her for further examination at

Hospital 2 on 25 July 2006, as although her mobility had slowly improved since her operation, she continued to experience knee and hip pain and stiffness. She was noted as requiring assistance to get off her sofa. Whilst she was able to mobilise with the use of a Zimmer frame, she complained of pain in her left hip and knee when doing so.

35. I asked Adviser 1 and Adviser 2 to consider Mrs A's history and to comment on the tests carried out by staff at the Practice and Hospital 1. They commented with the knowledge that Mrs C had maintained that Mrs A's severe hip pain was present prior to GP 2's examination.

36. Adviser 1 noted that Mrs A's main complaint was initially recorded as poor mobility. GP 2's examination of her led him to conclude that this was attributable to the swelling present in her lower legs. Once the swelling had been treated, Mrs A is recorded during GP 1's subsequent examination as having had increasing pain in her left knee for the past three days. Adviser 1 told me that, although certain symptoms indicative of osteoarthritis were not present when GP 1 examined Mrs A, this is not uncommon and the symptoms described are consistent with severe osteoarthritis. He explained that it is common for patients with severe osteoarthritis in their knees to also have the condition in other joints and reports of pain in the lower back, pelvis and hips are not unusual. He said that the examination carried out by GP 2 was reasonable and eliminated one possible cause of Mrs A's pain by treating her swollen lower legs. He also found GP 1's examination to be reasonable and noted that her referral to Hospital 1 paved the way for secondary investigations into the root cause of Mrs A's mobility problems.

37. Adviser 2 commented on the investigations carried out by Hospital 1 and Mrs A's admission to Hospital 2. As I have mentioned in paragraph 25, the clinical records show that Mrs A's hip was examined on 5 April 2006 and deemed to be 'normal' (I do, however, acknowledge Mrs C's comments as to the validity of this evidence). The history given by Mrs A and the x-ray taken on 24 May 2006 suggest that her hip fracture was the result of a fall towards the end of May 2006. Based on his experience of hip fractures, Adviser 2 considered that it was highly unlikely that Mrs A's fracture occurred any earlier than two weeks prior to her admission to Hospital 2. He remarked upon the fact that Mrs A's left leg was noted to be short and externally rotated by the orthopaedic consultant at Hospital 2. He said that this was a classic indicator of

a fractured hip and that he would be very surprised if a patient attended a Care of the Elderly team without this being spotted.

38. Given her history of a fall leading to increased hip pain 'weeks, or even months' before admission to Hospital 2, I asked Adviser 2 if it was possible that Mrs A suffered a fall in Late January 2006 which resulted in a hairline fracture, which was later displaced by a second fall in May 2006. This was suggested by a consultant physician at Hospital 1 as a possible hypothesis and may have complimented Mrs C's description of a sudden deterioration in Mrs A's mobility associated with hip pain. Having considered Mrs A's entire history, Adviser 2 said that the chances of the fracture occurring any time earlier than two weeks prior to her attendance at Hospital 2 were so remote that they could be excluded from our determination.

39. In light of her presenting symptoms, Adviser 2 was surprised that x-rays were not carried out on Mrs A's ankles, knees and hips upon her first attendance at Hospital 1. Adviser 2 considered it good practice to x-ray all parts of the legs of a patient complaining of reduced mobility and general leg pain. Although Adviser 2 was confident that no fracture would have been shown by an x-ray at this stage, he believed it to be good practice to investigate all possible causes of the pain and to establish a complete picture of the patient's condition.

(a) Conclusion

40. Clinical records made during Mrs A's consultation with staff of Hospital 1, Hospital 2 and the Practice, all concur that she did have osteoarthritis and that this was particularly severe in her left knee. Although certain common symptoms were absent, Adviser 1 told me that this is not unusual and that her presenting symptoms were consistent with osteoarthritis. With this in mind, I do not consider the diagnosis of severe osteoarthritis reached by GP 1 to be incorrect.

41. Reasonable steps were taken by the Practice to diagnose the source of Mrs A's pain and mobility problems. I am satisfied that osteoarthritis was a significant contributing factor in this and that the referral made by GP 1 proposed suitable further investigations at Hospital 1 to assess Mrs A's mobility generally, should there be other causes of her pain. I, therefore, do not uphold this complaint.

(a) Recommendation

42. The Ombudsman has no recommendations to make.

(b) Conclusion

43. Whilst I am satisfied that the diagnosis reached by GP 1 and GP 2 was correct, I have considered whether the examinations undertaken by GP 1 and GP 2 were sufficiently thorough, and whether it was reasonable to expect them to diagnose Mrs A's broken hip at the time of their house calls.

44. I comment in paragraphs 32 and 37 about the likelihood of Mrs A's hip being broken at the time of GP 1 and GP 2's examinations. Adviser 1 suggested that her hip pain may also be attributable to osteoarthritis in joints other than her knee.

45. There are discrepancies between the recollections of GP 1 and GP 2 and Mrs A's family as to what Mrs A's presenting symptoms were and what examinations were carried out. It is, therefore, impossible to establish with absolute certainty the context of GP 1 and GP 2's examinations in terms of what background information they were given and Mrs A's reaction to certain tests. It is clear, however, that a general complaint of leg pain and reduced mobility was investigated. Mrs A's lower legs were visibly swollen and showed signs of osteoarthritis which would have hindered her mobility. Both GP 1 and GP 2 stated that it would be routine for them to manipulate the hips of an elderly patient complaining of reduced mobility. Whilst Mrs C and her family disputed GP 2's account of his examination, it was confirmed by Mr B that GP 1 did examine Mrs A's hips. No record was made by GP 1 of any issue relating to Mrs A's hips.

46. Following her examination of Mrs A, GP 1 referred her to Hospital 1. Her referral letter detailed a gradual decline in mobility, apparently due to osteoarthritis, however, also asked that Hospital 1 examine Mrs A in the interests of 'assessing her mobility further'.

47. GP 1 and GP 2 assessed Mrs A's leg pain and reduced mobility on separate occasions. Neither of them recorded any problems with her left hip. I acknowledge that doubts have been raised over the recorded 'gradual' loss of mobility and that this would have informed GP 1 and GP 2's conclusions that Mrs A's reduced mobility was related to her osteoarthritis. However, those conclusions were ultimately proven to be correct. There is evidence to suggest

that an assessment of other contributing factors to Mrs A's loss of mobility was carried out on at least one occasion and, whilst no hip pain was recorded, the subsequent referral request did ask Hospital 1 to assess Mrs A's mobility in general, rather than solely requesting treatment for osteoarthritis. With this in mind, I am satisfied that the proposed ongoing investigations were appropriate with regard to establishing the exact cause of Mrs A's pain and mobility problems. I, therefore, do not uphold this complaint.

(b) Recommendation

48. The Ombudsman has no recommendations to make.

(c) Conclusion

49. There is insufficient evidence available to determine exactly when Mrs A fractured her hip. There is confusion throughout the clinical records as to the timing and frequency of her falls. Furthermore, Mrs C has explained in correspondence with the Board that she does not accept that the clinical records provide a full or accurate account of Mrs A's symptoms and treatment. This is highlighted by the conflicting accounts of events from Mrs A's family and the medical professionals that examined her.

50. Whilst I am mindful of Mrs C's dispute over many of the notes taken by staff at Hospital 1 and the Practice, I must reach a decision based on all of the evidence presented to me.

51. As noted in paragraph 35, Adviser 1 explained to me that it is common for patients with severe osteoarthritis in their knees to experience pain in other joints, including the hips. There is only one written record of Mrs A's hip being examined – upon admission to Hospital 1 on 5 April 2006 – and this noted that her hip was 'normal'. Adviser 2 said that it was extremely unlikely that Mrs A fractured her hip any earlier than two weeks prior to her attendance at Hospital 2 on 24 May 2006. The note made following Mrs A's first consultation at Hospital 2 provides the fullest account that we have from Mrs A herself and notes that her presenting hip pain was 'definitely a new problem' that had arisen in the past few days. This was consistent with the history detailed in the referral letter from Hospital 1. Following her hip replacement operation, Mrs A continued to experience reduced mobility and hip and knee pain.

52. In light of the above, I consider it likely that Mrs A's hip was not fractured prior to her first attendance at Hospital 1. Although Mrs C has questioned the

thoroughness and the conclusions of the examination of Mrs A's hip on 5 April 2006, it should be borne in mind that she was seen by a number of consultants in a specialist Care of the Elderly team. Her eventual fracture caused her leg to be shortened and externally rotated, a classic symptom of hip fractures, which should be easily recognisable by those used to working with elderly patients without the need for manipulation of her hip. The fact that this was at no point noted during her attendances at Hospital 1, along with her hip being recorded as normal, suggest that the fracture occurred closer to her attendance at Hospital 2.

53. Over the course of her attendances at Hospital 1, Mrs A is recorded as having complained of reduced mobility, pain in her ankles, knees, groin and hip. She also gave a history of falls on more than one occasion. Although I am satisfied that staff at Hospital 1 administered appropriate treatment in light of Mrs A's osteoarthritis, reportedly leading to some improvement in her mobility, Adviser 1 and Adviser 2 both agreed that performing an x-ray of the ankles, knees and hips of a patient complaining of leg pain and reduced mobility should be routine practice as part of the secondary care unit's initial investigations.

54. Regardless of the family's suspicions over a broken hip, I am concerned that an x-ray was not carried out on Mrs A's hip upon her initial attendance at Hospital 1. This remained the case until Mrs C insisted that one be taken on 24 May 2006, which is also concerning, given that the family seem to have raised their concerns about other causes of Mrs A's pain on more than one occasion. With this in mind, I am unable to conclude that examinations carried out by staff at Hospital 1 were sufficiently thorough as to eliminate the possibility of other causes of Mrs A's pain. I, therefore, uphold this complaint.

(c) Recommendation

55. The Ombudsman recommends that the Board review Hospital 1's admissions procedures to ensure that all patients receive a full diagnostic assessment prior to the commencement of treatment.

56. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been accepted.

Annex 1

Explanation of abbreviations used

Mrs A	Mrs C's mother, the aggrieved
The Practice	Mrs A's GP Practice
Hospital 1	Templar Day Hospital
Mrs C	The complainant
Hospital 2	The Royal Infirmary of Edinburgh
The Board	Lothian NHS Board
Adviser 1	A clinical adviser to the Ombudsman
Adviser 2	An independent orthopaedic specialist
Mr B	Mrs C's brother
GP 1	A GP at the Practice
GP 2	A GP at the Practice