Scottish Parliament Region: Glasgow

Case 200803152: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category
Health: Hospital; care of the elderly; diagnosis

Overview
The complainant (Mr C), a caseworker at a Citizens Advice Bureau, raised a complaint on behalf of Mr A about the care and treatment of his late wife (Mrs A) by Greater Glasgow and Clyde NHS Board (the Board).

Specific complaint and conclusion
The complaint which has been investigated is that the Board failed to identify that Mrs A had a broken femur, following falls at Stobhill Hospital (the Hospital) in December 2008 and despite concerns about her mobility being raised by her family (*upheld*).

Redress and recommendations
The Ombudsman recommends that the Board:

(i) remind staff of the need to carry out and record medical assessments in line with policy;

(ii) provide him with the results of the audit referred to in paragraph 10; and

(iii) consider implementing the Adviser's suggestions in paragraph 18.

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

Main Investigation Report

Introduction

1. On 12 March 2009, the Ombudsman received a complaint from Mr C, a caseworker at a Citizens Advice Bureau, on behalf of Mr A about the care and treatment of his late wife, Mrs A. Mrs A was a 76-year-old woman who suffered from vascular dementia. Sadly, Mrs A passed away shortly after the complaint was brought to the Ombudsman's office.

2. The complaint from Mr C which I have investigated is that Greater Glasgow and Clyde NHS Board (the Board) failed to identify that Mrs A had a broken femur, following falls at Stobhill Hospital (the Hospital) in December 2008 and despite concerns about her mobility being raised by her family.

Investigation

3. I considered the following information as part of my investigation:

- the complaints correspondence between Mr C and the Board;
- Mrs A's clinical records;
- advice provided by one of the Ombudsman's medical advisers (the Adviser); and
- responses and information provided to me by the Board in response to my enquiries.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report. Abbreviations are set out in Annex 1.

Complaint: The Board failed to identify that Mrs A had a broken femur, following falls at the Hospital in December 2008 and despite concerns about her mobility being raised by her family

5. Mrs A, who suffered from vascular dementia, was admitted to the Hospital on 29 November 2008 with increasing confusion, decreasing mobility and weight loss. Blood tests revealed that she was suffering from dehydration and a urinary tract infection. Mrs A received intravenous fluids and oral antibiotics. The clinical records note that she suffered a fall on 1 December 2008 and a second fall on 7 December 2008. Mr C stated that the family raised concerns

with ward staff about Mrs A's mobility after the fall on 7 December 2008 but no x-ray was carried out at the time. Mr C raised a complaint with the Board, on behalf of Mr A, on 19 January 2009. An x-ray of Mrs A was subsequently carried out on 11 February 2009 and a fracture of Mrs A's right femur was reported. The Board responded to the complaint on 25 February 2009. Mr A remained dissatisfied with the Board's response and Mr C complained, on his behalf, to the Ombudsman's office on 11 March 2009. Mrs A was discharged from hospital to a nursing home on 9 March 2009. Sadly, she died on 26 March 2009.

The Board's response to Mr C's complaint

6. In responding to the complaint raised by Mr C, the Board explained that Mrs A had been examined by a doctor following both her falls in December 2008 but that there had been no clinical signs of a fracture. They advised that, following Mrs A's first fall, she was provided with a specialist falls prevention chair and visited the following day by the Falls Prevention Co-ordinator. Despite this, she suffered a second fall on 7 December 2008. The Board went on to explain that, on 11 February 2009, a member of the ward staff noticed that Mrs A was holding her left leg off the ground. She was then examined by doctors on two occasions but neither doctor found evidence suggestive of a fracture.

7. Nonetheless, the Board explained that an x-ray was carried out at this stage and this revealed that Mrs A had a fracture of the right femur. The Board apologised unreservedly for their failure to x-ray Mrs A after her second fall in December 2008.

8. The Board also accepted that they should have taken action, in light of the concerns raised by Mrs A's family about her deteriorating mobility, and that their failure to do so contributed to the delay in diagnosing Mrs A's fracture. The Board apologised that they had not taken enough notice of the family's concerns.

The Board's response to my enquiries

9. In responding to my enquiries, the Board provided detailed information about the action they had taken to learn from the complaint and to avoid a recurrence in future. With regard to the assessment of patients after a fall, they told me that policies had been reinforced to ensure that:

- medical staff were promptly alerted by nursing staff of any significant falls;

- medical staff would carry out a physical examination of patients who sustained a fall and document their findings in the patient's case notes to include any injury. A treatment and management plan would be initiated and recorded at this point; and
- medical staff would x-ray any patient with a cognitive impairment who sustained a fall where there was the possibility of bony injury.

10. The Board told me that an audit to assess compliance with these measures was planned for November 2009.

11. With regard to their failure to take account of Mrs A's family's concerns about her mobility, the Board told me that a number of initiatives had been put in place:

- carer awareness training had been incorporated into the 'Managing Challenging Behaviour' training programme for nursing and Allied Health Professional (AHP) staff, to raise the profile of carers and the importance of working in full partnership with them;
- pain assessment sessions for elderly patients/patients with a cognitive impairment had been introduced into the 'Managing Challenging Behaviour' training programme for nursing and AHP staff;
- the Board's 'Getting to Know You' document had been fully implemented as a starting point for engaging with carers of patients with a cognitive impairment to build an open, two-way communication process;
- to improve pain assessment/management of patients with a cognitive impairment, a pilot of the Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC) pain screening tool was being conducted within the Directorate of Medicine for the Elderly. An appropriate tool for such patients would then be identified and rolled out, once the pilot had been completed and evaluated;
- carers' questionnaires had been completed to determine carers' views; and
- lead nurses would seek patients' and carers' views through regular patient rounds, with an initial focus on carers of patients with a cognitive impairment.

12. The Board had created an Action Plan which provided an update on the implementation of each of these measures.

The Adviser's comments

13. The Adviser noted that the clinical records contained no evidence that medical assessments had been carried out following Mrs A's falls in December 2008. While the Board's response to Mr C's complaint indicated that such assessments had been carried out (see paragraph 6), there was no evidence of this.

14. Consequently, the Adviser concluded that the Board were unable to evidence that they had medically assessed Mrs A and followed their Falls Policy, which stated:

> 'Following a Fall in Hospital …
>
> Nursing staff should assess the patient for any obvious injury …
>
> The patient should be referred to medical staff for assessment if an obvious injury has been sustained, if the patient complains of discomfort or if the fall was unexplained …'

15. The Adviser noted that he could not be certain that carrying out a medical assessment would have led to an x-ray being carried out and the detection of Mrs A's injury. However, he noted that a medical assessment would have increased the chances of this occurring. He said it was likely, but difficult to be certain, that Mrs A was in pain for at least part of the time before the fracture was recognised. As such, her quality of life was affected. He went on to say that, in general, patients with immobility were more vulnerable to infection but that it was very difficult to be certain that Mrs A's fracture shortened her life span.

16. With regard to the actions the Board had taken to remedy the failures identified, the Adviser noted that the actions with regard to falls assessment, pain assessment and awareness of care needs in patients with dementia were all sensible.

17. With regard to the concerns raised by Mrs A's family, the Adviser noted that, had the family's views been taken into account, an x-ray might have been undertaken earlier. He noted that it was often very difficult to detect pain or injury in patients with dementia and, therefore, taking into account the views of relatives could help diagnosis.

18. With regard to ensuring that family views were taken into account, the Adviser said the Board had not addressed the issue of how family views about

functional change were recorded and communicated within the multi-disciplinary team. The Adviser said this was a difficult issue but that it might be addressed by ensuring that a system of appointments with medical staff was easily available and/or that a structured document was used to record discussions at multi-disciplinary staff meetings. He said that such a standardised record could include a prompt to consider carers' perspectives.

Conclusion

19. I note that the Board have accepted that they failed to x-ray Mrs A following her falls and I note that, in responding to Mr C's original complaint, they provided an unreserved apology to Mr A. The Board accepted that they should have taken more account of Mrs A's family's concerns about her mobility and they also apologised for this.

20. In my view, the Board generally responded positively to the complaint and they provided suitable apologies for failures identified.

21. However, it is clear from the Adviser's comments that the Board failed to make records of the medical assessments which they say occurred following Mrs A's falls. This failure was not identified in the Board's response to Mr C's original complaint.

22. The lack of records mean that there is no evidence to show that medical assessments were carried out. Consequently, over and above the failures already identified by the Board, I have concluded that the Board failed to carry out and record medical assessments following Mrs A's falls and that they failed to follow their Falls Policy.

23. Given that these further failures have been identified in the course of my investigation, I am upholding the complaint.

24. In terms of the actions the Board have taken to avoid future recurrence of the problems identified, I am satisfied that these actions are reasonable. The further action required by the Board is to address the Adviser's comments at paragraph 18 and in relation to the Ombudsman's recommendations below.

Recommendations

25. The Ombudsman recommends that the Board:

(i) remind staff of the need to carry out and record medical assessments in line with policy;
(ii) provide him with the results of the audit referred to in paragraph 10; and
(iii) consider implementing the Adviser's suggestions in paragraph 18.

26. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant, a caseworker at a Citizens Advice Bureau
Mr A	One of the co-aggrieved, on whose behalf Mr C was raising the complaint
Mrs A	The other co-aggrieved, Mr A's late wife
The Board	Greater Glasgow and Clyde NHS Board
The Hospital	Stobhill Hospital
The Adviser	One of the Ombudsman's medical advisers
AHP	Allied Health Professional
PACSLAC	Pain Assessment Checklist for Seniors with Limited Ability to Communicate