Scottish Parliament Region: South of Scotland

Case 201000108: Borders NHS Board

Summary of Investigation

Category

Health: Hospital; care of the elderly

Overview

The complainant (Mr C) raised a number of concerns about the care and treatment provided to his mother-in-law (Mrs A) by Borders NHS Board (the Board) and the communication between health care professionals who treated Mrs A and with Mrs A's family. He also raised concerns about the way the Board handled his complaint.

Specific complaints and conclusions

The complaints which have been investigated are that the Board failed to:

(a) provide reasonable care and treatment to Mrs A leading up to her fall on 28 February 2009 and following her operation on 1 March 2009 to repair her hip (*upheld*);

(b) ensure reasonable communication between the health care professionals who treated Mrs A and with Mrs A's family (*upheld*); and

(c) deal with Mr C's complaint according to the NHS Complaints Procedure (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) provide evidence that they have audited staff awareness of the Falls Prevention Strategy and Bed Rail Policy; the knowledge and skills of staff relevant to their effective implementation; and take action to address any knowledge and skill gaps identified by the audit;	18 August 2011
(ii) consider amending the Falls Prevention Strategy and Bed Rail Policy in light of the information in this report;	18 June 2011

(iii)	ensure staff are aware of the failures identified in this report in meeting the needs of patients with dementia and to implement training to address this, particularly in rehabilitative care and communication; and	18 July 2011
(iv)	apologise to Mr C for the failures identified in this report.	18 June 2011

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

Main Investigation Report

Introduction

1. Mrs A was admitted to Kelso Cottage Hospital (Hospital 1) in January 2009, when she fractured her wrist after sustaining a fall at home. On 28 February 2009, she fractured her hip following a fall from her hospital bed and was admitted to Borders General Hospital (Hospital 2). A consultant surgeon (the Consultant) performed a right-sided hemiarthroplasty on 1 March 2009 to repair Mrs A's hip. Mrs A returned to Hospital 1 on 6 March 2009 for ongoing care and rehabilitation. Mrs A's son-in-law (Mr C) has complained that as a result of her fall, the subsequent surgery and post-operative care (including communication), Mrs A is unable to walk without the use of a Zimmer frame and is in considerable discomfort requiring high levels of painkillers. Mr C has also complained that Mrs A's needs as a person suffering from dementia were not met by Borders NHS Board (the Board) and that this has impeded her recovery.

2. Mr C complained to the Board on 8 December 2009. On 13 April 2010, the Board responded to Mr C's letter of complaint. Mr C remained dissatisfied with the Board's response and complained to my office on 28 April 2010.

3. The complaints from Mr C which I have investigated are that the Board failed to:

(a) provide reasonable care and treatment to Mrs A leading up to her fall on 28 February 2009 and following her operation on 1 March 2009 to repair her hip;
(b) ensure reasonable communication between the health care professionals who treated Mrs A and with Mrs A's family; and
(c) deal with Mr C's complaint according to the NHS Complaints Procedure.

Investigation

4. During the course of the investigation into this complaint, my complaints reviewer obtained and examined Mrs A's clinical records and the complaint correspondence from the Board. In addition, my complaints reviewer sought advice from two nursing advisers to the Ombudsman: one with extensive experience of psychiatric nursing (Adviser 1) and the other with extensive experience of general nursing issues (Adviser 2). Finally, my complaints reviewer reviewed the NHS Complaints Procedure.

5. 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.

(a) The Board failed to provide reasonable care and treatment to Mrs A leading up to her fall on 28 February 2009 and following her operation on 1 March 2009 to repair her hip and (b) The Board failed to ensure reasonable communication between the health care professionals who treated Mrs A and with Mrs A's family

Mr C's complaint

6. Mr C said he did not understand why Mrs A had fallen out of bed and had never received an explanation about this from the Board. He had also been given conflicting information about how she had been found. Referring to the care and treatment Mrs A had received, he did not believe that the Board had taken into account the particular needs of Mrs A as a patient with dementia and that this impacted on her recovery from her operation. This was particularly indicative of how the physiotherapist had treated Mrs A; they had failed to issue a specific care plan for her and contact the family about her needs. Mr C said that all contact with medical staff had to be instigated from the family. Mr C was also concerned about the Board's position that Mrs A's age and dementia had impeded her recovery, given her previous excellent health and mobility, and he believed that failures in the care and treatment meant that Mrs A had not made as good a recovery as she could have.

Board's response to Mr C's complaint

7. The Board first apologised for the delay in providing Mr C with their response. They went on to say that Mrs A was admitted to Hospital 2 overnight on 28 February 2009 after suffering a fractured hip following a fall whilst a patient in Hospital 1. The Consultant undertook a right-sided hemiarthroplasty to repair Mrs A's hip on 1 March 2009. Her case notes indicated that Mrs A's immediate post-operative recovery progressed well and she was mobilising with assistance on 3 March 2009. A formal physiotherapy review was undertaken the following day and Mrs A was noted as being able to independently mobilise with the assistance of a Zimmer frame. Post-operative x-rays noted that the position of the prosthesis was satisfactory. On 6 March, Mrs A was transferred to Hospital 1 for ongoing care and rehabilitation and appropriate nursing physiotherapy transfer sheets were in place.

8. Referring to Mr C's concerns that a lack of a detailed rehabilitation care plan on Mrs A's discharge from Hospital 2 impacted negatively on her overall rehabilitation, the Board said that a detailed rehabilitation plan was dependent upon the needs, wishes and capabilities of each patient on assessment. Mrs A was given an individual functional assessment on 9 March 2009 and her treatment planned accordingly.

9. On her readmission to Hospital 1, the Board said Mrs A was fatigued and confused and had been known to mobilise around the ward without a walking aid. As her mobility improved, the physiotherapist was concerned that Mrs A was inclined to overflex her hip, risking dislocation. A restraining splint was applied to her right leg and she progressed well over the next two weeks, to mobilising with a pulpit frame and then onto a fourwheeled walker. In response to Mr C's concerns about Mrs A's pain and the outward splay of her foot since her hip fracture, the Board said the Consultant assessed Mrs A on 28 May 2009 and recorded that her hip implant was well-positioned and well seated, which was confirmed by x-ray. The Consultant had explained that experiencing pain in the femur was not uncommon after major surgery, but that this would generally settle over time, although it was difficult to predict how long this would take. The Consultant also said a reduction in muscle strength was not uncommon after major surgery, but this may be resolved with the ongoing physiotherapy that Mrs A had been receiving. In relation to mobility, the Board said the Consultant's view was that Mrs A's rehabilitation was progressing as expected but it may have been unrealistic to expect a full recovery given her age and the fact that she also suffered from Alzheimer's, both of which were recognised as risk factors in regaining mobility after a hip fracture. The Board said pain control was an important aspect of the rehabilitation process and the Consultant had explained that Mrs A was prescribed the standard paracetamol dose for pain whilst she was a patient in Hospital 2.

10. Finally, the Board apologised for the Consultant's failure to respond to Mr C's letter of 12 September 2009. The Board understood that this was partly due to a misunderstanding by the Consultant as he felt there was little additional information he could add to what he had already provided in previous correspondence and Mr C's queries involved Mrs A's ongoing care at Hospital 1 where she was under the care of another doctor. Following a multi-disciplinary meeting, it was agreed a consolidated response would be sent to Mr C negating the need for the Consultant to reply to his letter personally. The Board

apologised if this was not clearly communicated to Mr C and assured him that the Consultant was happy to provide him with information wherever possible.

11. Having considered the Board's response to Mr C's complaint, my complaints reviewer asked them about their response to the aspect of Mr C's complaint concerning Mrs A's fall from her hospital bed. The Board referred her to the note of a meeting with the family on 16 April 2009. During this meeting, the Board said that bed rails were not generally used for patients with dementia, as they come to more harm climbing over them. The Board also said that it had been established that Mrs A did not lie on the floor and that night staff heard her and responded immediately.

Advice received

12. In response to questions from my complaints reviewer about whether Mrs A was at risk of falling when she was admitted to Hospital 1, Adviser 1 said that she showed evidence of confusion and impaired memory; she had been recently diagnosed with a urinary tract infection; she made frequent visits to the toilet; she was restless at night; and she had had a recent fall in her bedroom at home resulting in a significant injury. There was evidence that Mrs A was at risk of falling whilst trying to get out of bed. A common trend in falls was that they often occurred between the person's bed and toilet and/or associated with meeting a basic need, such as getting a drink or going to the toilet. Adviser 1 said this risk was not formally assessed in Mrs A's case.

13. Adviser 1 said a falls prevention assessment (such as a Cannard Assessment) should have been carried out. This would have identified the level of risk and assisted in determining how that assessed risk may have been best managed. Referral to a falls prevention service or falls prevention coordinator might also have been indicated as a consequence of this assessment. A fall with significant injury, such as Mrs A's wrist fracture, might in itself have been sufficient reason to refer her to a falls prevention service. Adviser 1 went on to say that specialist equipment was available, such as ultra low bed and pressure pad bed alarms, either of which might have been beneficial in Mrs A's case. Whilst it is unreasonable to expect that a risk of a fall can be completely eliminated by clinical intervention, such risks can be minimised by careful assessment and clinical management. Adviser 1 concluded that the failure to adequately risk assess, keep the assessment under review and the lack of a cohesive falls prevention plan as part of the overall care plan, were significant contributory factors in Mrs A's fall.

14. Referring to the use of bedrails, Adviser 1 said that bedrails tend only to be used in exceptional circumstances, after an appropriate risk assessment has been undertaken. A competent person with the necessary training, knowledge and experience should carry out this assessment. The use of bedrails did not replace the need for adequate nursing observation and escorting patients who are at risk of falling. Bedrails should be used if the benefits outweigh the risks. The decision to use bedrails or not and the reasons behind this decision should be documented in the person's case file, including the involvement of the person and relatives in the decision-making. Adviser 1 said that from the evidence in Mrs A's clinical records, in his view bedrails could have been a hazard rather than a protective factor in her care as she may have tried to self-negotiate over them.

15. Turning to the notes of Mrs A's fall in her clinical records, Adviser 1 said there seemed to be an adequate account of what was observed. However, the general incident reporting form provided no information expanding upon that provided in the clinical notes and, in the section of the form dealing with long actions to prevent recurrences, it stated 'patients poor retention of information prevents positive outcome'. Given that appropriate risk assessment and clinical management can be effective in minimising the likelihood of falls of occurring in older people, Adviser 1 said it was a strange thing to record and may indicate training needs.

16. In relation to Mrs A's care following her fall, Adviser 1 said she was tended by staff, the injury accurately assessed and an ambulance was called 20 minutes after she was found on the floor, to transfer Mrs A to another hospital, which could provide the appropriate treatment for the type of injury she had sustained. This aspect of Mrs A's care appeared to have been carried out appropriately. However, nothing was recorded in relation to what was done to make Mrs A more comfortable whilst waiting for the ambulance.

17. Turning now to Mrs A's recovery from her hospital fall, Adviser 1 said that the Board's response to Mr C did not accurately reflect what the Consultant had told Mr C but it was, in Adviser 1's view, a more accurate reflection of the complex truth of the matter. The records showed that the Consultant had communicated a message to Mr C that Mrs A was not expected to make a full recovery. Adviser 1 said research has shown that hip fractures often have very serious consequence for older people with dementia, including a higher

mortality rate than that found in the case of more cognitively intact individuals, which supported the Consultant's view. However, the Board said it may have been unrealistic to expect a full recovery and, whilst this was true, Adviser 1 said that a full recovery from hip fractures can be achieved in some, if not all, cases from appropriate rehabilitation constantly delivered by competent staff. Full recovery should always be the aim of the rehabilitation process and treatment goals should not be lowered because of negative expectations. Nevertheless, SIGN Guideline notes that the person's premorbid mental state, mobility and functioning were the most reliable predictors of success and rehabilitation. Whilst Mrs A was living at home and reasonably active and functioning with carer support, she did have a diagnosis of dementia. In light of these combined factors, Adviser 1 said the Consultant was correct to be cautious, but the lack of communication meant the family did not have an opportunity to come to an appropriate understanding of the Consultant's position.

18. Referring to the rehabilitative aspects of Mrs A's care, Adviser 1 said that ensuring appropriate nutritional intake is a key aspect of the rehabilitative process. The weight chart aspect of the nutritional assessment (part of the nationally adopted malnutrition universal screening tool (MUST)) contained within Mrs A's medical records covering the period 6 April 2009 to 1 November 2009 showed an increase in Mrs A's weight of approximately 10 kilograms. However, the assessment overall had not been effectively completed and the overall risk of malnutrition had not been calculated. Her body mass index (BMI) was not recorded until 4 August 2009 when it was calculated at 20, a borderline result. Her weight on 6 April 2009 was 55.6 kilograms and so her BMI was 18, which meant that she was in a high risk category. The MUST process indicated that routine care for people at low risk of nutritional deficit should include weekly screening in in-patient situations. Mrs A's weight was taken six times in eight months, despite the fact she was in the medium-high risk category the first few months post-operative. Adviser 1 said there was no care plan covering her nutritional needs and next to nothing recorded in relation to her nutritional and fluid intake in the two month period following her surgery.

19. Adviser 1 said that another important aspect to rehabilitative care was multi-disciplinary team working. Adviser 1 said that while it was clear from the records that Mrs A had input from medical and nursing staff, physiotherapy and the unit staff, there was no multi-disciplinary care plan in her records which

highlighted her needs, planned interventions and persons responsible for delivering the interventions. The case conference on 16 April 2009 took place approximately six weeks after her return to Hospital 1 from Hospital 2 and seemed to have been initiated at the request of the family rather than as part of a routine approach to multi-disciplinary coordinated working. Adviser 1 said the report of the meeting is in the form of a record of discussions surrounding the family's concerns. No clear written multi-disciplinary care plan seemed to have been developed as a result of the meeting. From the written evidence, it appeared the multi-disciplinary approach to assessment of needs and the planning of care was unclear and lacked transparency. The nursing entries in the notes were not reflective of a systematic approach to care. Adviser 1 concluded that they seemed predominantly to be a retrospective, reactive account of what took place on a day-to-day basis and fell short of requirements of the Nursing and Midwifery Council recordkeeping guidelines.

20. Turning to the communication between health care professionals and with relatives of patients who have dementia, Adviser 1 said SIGN Guideline 86 clearly indicated that good communication between health care professionals, patients and carers was essential and that such communication should focus on the needs of patients and carers. Since people with dementia may not always be able to provide a detailed and accurate history or account of the current circumstances, the involvement of relatives (or carers) is a vital aspect of the assessment and ongoing review processes. Strategies to effectively manage communication should be a core aspect of the care plan for people with dementia. This should be a routine aspect of practice and include a jointly agreed approach to govern communication with relatives. In relation to communication between health care professionals, Adviser 1 said the health and social care system was shaped around the needs of patients and must be committed to developing partnerships and cooperation at all levels of care. It was a core principle of the NHS. Effective communication systems meet the specific needs of individuals and are essential to ensure the effective management of patient care. Adviser 1 said good practice suggested that a documented care plan agreed with patients and carers should be available to the multi-disciplinary team.

21. Commenting on the effectiveness of communication between health care professionals and Mrs A's family, Adviser 1 said there was no evidence of the development and implementation of a proactive carer communication strategy in the records of either Hospital 1 or Hospital 2. The aim should have been to

involve the relatives as fully as was practical in the planning and delivery of Mrs A's care. The family should have been active partners in the caring process. This did not seem to have been the case until they began to raise concerns regarding the quality of care and communication. Adviser 1 concluded that the communication with the family was less than effective until they began to raise concerns.

22. Adviser 1 said that although Mrs A appeared to have made a reasonable recovery from a type of injury which can have severe consequences for many older people, inter-professional communication could have been better. Improvements in this, and in communicating with the family, may have enhanced Mrs A's recovery, but Adviser 1 concluded that her recovery was not significantly impeded to the point of harm because of the shortfalls.

23. My complaints reviewer also asked Adviser 1 to review the Board's Falls Prevention Strategy and Bed Rail Policy and consider whether the policies should have applied to Mrs A and whether they were of an acceptable standard. Referring to the Falls Prevention Strategy, Adviser 1 said it provided an evidence-based approach to falls management and was a valuable organisational resource. However, it would benefit from some revision. For example, it stated that the Cannard falls assessment tool should be the risk assessment of choice, but it was not clear if it should be used for all patients or for those already deemed to be at risk. Adviser 1 said if it was only to be used for those thought to be at risk, then some form of 'falls screening tool' should be applied to all relevant patient groups. (This would also be advantageous in aiding compliance with the Bed Rails Policy.) The strategy would also benefit from a 'what to do if a patient falls in hospital' guideline.

24. Adviser 1 also said the strategy would be more effective if it included:

- an organisationally agreed guideline for immediate action in the event of a fall;
- a checklist of falls prevention strategies applicable to all patients;
- a checklist of falls prevention strategies applicable to patients deemed to be at particular risk, which may be considered for inclusion in a person centred care plan;
- an initial brief falls screening tool comprising of known risk factors in the form of a checklist, to be completed on admission and reviewed regularly thereafter (perhaps weekly). This could be incorporated within a broader

manual handling risk assessment, developed as an adjunct to a manual handling risk assessment or derived from information already gathered as part of a manual handling risk assessment;

- a printed proforma for documenting a patient's fall prevention plan, to bring consistency across the system;
- appropriate cross-referencing of relevant parts of the document to the bedrails policy;
- a list of medications which are known to heighten the risk of patients falling; and
- an individual patient falls record which documents over a given period frequency of falls, where a fall took place, date, time, brief account of circumstances and whether or not an injury was sustained.

25. On the Board's Bed Rail Policy, Adviser 1 said that because it was a policy, it defined specifically the actions to be taken on the use of bedrails and should be observed to the letter at all times (except on rare occasions when it is unsafe to do so). The policy applied to all staff caring for patients who may require bedrails to reduce the risk of falls and that a risk assessment should be undertaken for each patient on admission to wards, which would include the potential for falls. The policy outlined assessment criteria which included some risk factors. Adviser 1 said there was no question that the aims of the policy and procedures within it should have applied to Mrs A and to the planning of her care. The Board's practice, therefore, fell below an acceptable standard and their own expectations.

26. Referring to the standard of the policy, Adviser 1 said it failed to identify a specific falls risk assessment tool such as the Cannard tool, which is identified as an example of good practice in the Board's Falls Prevention Strategy. Moreover, one of the commitments of the strategy was to raise awareness of the importance of the use of the Cannard tool. Finally, the policy failed to address specifically the issue of staff training on falls prevention or implementation of the policy.

27. My complaints reviewer asked Adviser 2 to comment on the aspects of clinical care Mrs A had received which were outwith the expertise of Adviser 1. Adviser 2 said the nursing records from 1 March to 5 March 2009 demonstrated that the post-operative care appeared to be good. The assessment and care plan took into account in the individual needs of Mrs A immediately following

theatre such as personal care and prevention of pressure sores, food and fluid requirements, pain relief and mobility. Furthermore, Adviser 2 said that the records from the transfer to Hospital 1 were multi-disciplinary and contained extracts relating to the post-operative care of Mrs A. This included regular information from the physiotherapist, which suggested some difficulties in Mrs A's compliance with the rehabilitation due to her confusion and lack of understanding about her condition. However, the physiotherapist completed their records and Adviser 2 concluded that physiotherapy was not ad hoc, but dependent upon the emotional and cognitive status of Mrs A during physiotherapy sessions. Referring to pain relief, Adviser 2 said there was an ongoing problem which was not uncommon in older people following surgery. This was because there was a fine line between complete release of pain and side-effects such as constipation and additional confusion, which were common with stronger pain relief. There were a number of entries from the clinical team about assessment of Mrs A's pain both from the nursing team and medical staff.

(a) Conclusion

28. Mr C complained about the standard of care and treatment provided to Mrs A from the Board. I have decided there were serious failures in the care and treatment provided to Mrs A, particularly in relation to her fall from her hospital bed. In reaching my decision, I have taken into account that the risks of falling cannot be completely eliminated. However, despite the fact that Mrs A was admitted to Hospital 1 with a wrist fracture as a result of a fall, and there was further evidence in her clinical notes of her risk of falling, no assessment took place. The advice which I have received and accept is that the Board's failure to assess adequately the level of Mrs A's risk of falling, keep the assessment under review and the lack of a cohesive falls prevention plan as part of the overall care plan were significant contributory factors to Mrs A's fall from her hospital bed. This led to a significant personal injustice to Mrs A, in that she sustained a significant and potentially life-threatening injury. I am extremely concerned that, notwithstanding their shortcomings, the Board had a policy and strategy in place which should have been applied to Mrs A, but which was not followed. It is also clear that there were significant failures in some of the rehabilitative aspects of Mrs A's care, relating to nutritional care and multi-disciplinary team working. These failures, in addition to the communication failures between healthcare professionals and the family (see paragraph 31), indicate systematic failures within the Board relating to caring for people with dementia, which is of grave concern.

29. In all the circumstances, I uphold the complaint. I urge the Board to consider implementing the following recommendations as a matter of urgency to address the failures identified in this report.

(a) Recommendations

30. I recommend that the Board:	*Completion date*
(i) provide evidence that they have audited staff awareness of the Falls Prevention Strategy and Bed Rail Policy; the knowledge and skills of staff relevant to their effective implementation; and take action to address any knowledge and skill gaps identified by the audit;	18 August 21
(ii) consider amending the Falls Prevention Strategy and Bed Rail Policy in light of the information in this report;	18 June 2011
(iii) ensure staff are aware of the failures identified in meeting the needs of patients with dementia and to implement training to address this, particularly in rehabilitative care and communication; and	18 July 2011
(iv) apologise to Mr C for the failures identified .	18 June 2011

(b) Conclusion

31. Mr C complained that the Board failed to ensure reasonable communication took place between healthcare professionals who treated Mrs A and with her family, and that this failure impacted adversely on her recovery. I am extremely concerned about the failures in communication relating to Mrs A's care and treatment. The advice which I have received, and accept, is that the communication fell far below a standard that was reasonable. Although Adviser 1 said this did not significantly impede Mrs A's recovery, it is unacceptable given that effective communication was critical in maximising Mrs A's chances for a full recovery. I therefore uphold the complaint. I have made recommendations to address the Board's failures in meeting the needs of patients with dementia in paragraph 30 above, which also address the communication failures in this aspect of Mr C's complaint.

(c) The Board failed to deal with Mr C's complaint according to the NHS Complaints Procedure

32. On 8 December 2009, Mr C complained to the Board about the care and treatment provided to Mrs A and the failure by Mrs A's consultant to respond to his letter of 12 September 2009. The Board sent an interim letter to Mr C on 14 January 2010 and, in its second interim letter of 5 February 2010, the Board informed Mr C of his right to approach my office at that stage of the process. The Board responded in full to Mr C's complaint on 13 April 2010 (see paragraphs 7 to 11).

33. The Board later wrote to my complaints reviewer apologising for the delay in providing a response to Mr C. They said that this was in part due to the long-term sickness absence of a member of staff and that they had now put in place a more robust investigation process to ensure that they did not rely on a single member of staff to deal with complaints.

34. Section 57 and 58 of the NHS Complaints Procedure states:

> 'It is important that a timely and effective response is provided in order to resolve the complaint, and to avoid escalation. An investigation of the complaint should therefore be completed, wherever possible, within 20 working days following the date of receipt of the complaint. Where it appears the 20 day target will not be met, the person making the complaint ... must be informed of the reason for the delay with an indication of when a response can be expected. The investigation should not, normally, be extended by more than a further 20 working days.
>
> While it may be necessary to ask the person making the complaint to agree to the investigation being extended beyond 40 working days ... they should be given a full explanation in writing of the progress of the investigation, the reason for the requested further extension, and an indication of when a final response can be expected. The letter should also indicate that the Ombudsman may be able to review the case at this stage if they do not accept the reasons for the requested extension.'

(c) Conclusion

35. Mr C has complained about the time the Board took to deal with his complaint and remained dissatisfied with the explanations the Board has provided about Mrs A's recovery and the failure by the Consultant to respond to one of his letters. The advice which I have received, and accept, is that the

Board provided an accurate reflection of the complexities surrounding recovery from hip fractures by older patients with dementia. However, it is clear there were some failures by the Board in their handling of Mr C's complaint. The Board took just over four months to respond to Mr C and the Consultant failed to respond to one of Mr C's letters. To that extent, I uphold the complaint. The Board acknowledged that there were delays and explained why the Consultant had failed to respond. The Board has apologised to Mr C for these failures and put procedures in place to ensure they deal with complaints in a timely manner. I have no recommendations to make.

36. 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

Mrs A	The complainant's mother-in-law
Hospital 1	Kelso Cottage Hospital
Hospital 2	Borders General Hospital
The Consultant	A consultant orthopaedic surgeon at Hospital 2
Mr C	The complainant
The Board	Borders NHS Board
Adviser 1	The Ombudsman's clinical nursing adviser in mental health
Adviser 2	The Ombudsman's clinical nursing adviser in nursing
MUST	Malnutrition universal screening tool
BMI	Body mass index

Annex 2

Glossary of terms

Right-sided hemiarthroplasty	A surgical procedure in which the ball of the hip is replaced by a prosthetic implant

Annex 3

List of legislation and policies considered

The Board's Falls Prevention Strategy

The Board's Bed Rails Policy

NHS Complaints Procedure

SIGN Guideline 86 *Management of patients with dementia*

SIGN Guideline 111 *Management of hip fracture in order people*