Scottish Parliament Region: Mid Scotland and Fife

Case 201202679: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; care of the elderly; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns that her late father (Mr A) received inadequate care and treatment while in hospital being treated for dizziness; a swollen leg; a 'blister' on his left big toe; and a general feeling of being unwell and tired. Mrs C also complained that Mr A's falls risk was not properly assessed and monitored, resulting in a fall that caused a broken hip. Mr A then waited some 54 hours before his broken hip was surgically repaired. Mr A died in hospital nine days after his surgery.

Specific complaints and conclusions

The complaints which have been investigated are that Fife NHS Board (the Board):

(a) unreasonably failed to reassess Mr A's falls risk when staff were informed that he had already fallen on the ward (*upheld*);

(b) unreasonably delayed in taking Mr A to theatre when he fell and fractured his hip (*not upheld*);

(c) failed to appropriately manage Mr A's intake of food and fluids (*upheld*); and

(d) failed to communicate appropriately with the family following Mr A's death (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) provides evidence that the falls risk assessment policy and procedures on the ward have been appropriately reviewed and any learning points form part of an action plan for improvement;	20 February 2014
(ii) ensures that all nursing staff are fully aware of and trained in compiling falls risk assessments and the	20 February 2014

	on-going monitoring of patients at medium or high risk;	
(iii)	reviews their procedures for assessing and monitoring patients awaiting surgery to ensure that a co-ordinated multi-disciplinary team approach is taken;	20 February 2014
(iv)	ensures that all staff are made aware of the importance of food and fluid intake management and take appropriate steps to ensure that patients are appropriately monitored;	20 December 2013
(v)	remind all staff of the importance of communicating effectively with patients, relatives and/or carers on all aspects of care, including food and fluid management;	20 December 2013
(vi)	ensures that all staff are made aware of the importance of good communication with families at all times, especially following a bereavement and considers providing training where necessary;	20 December 2013
(vii)	ensures that all staff are aware of the rules on reporting cases to the Procurator Fiscal's Office (PFO) and pass this information on to families where appropriate; and	20 December 2013
(viii)	considers making the leaflet 'What to do after a death in Scotland' available where appropriate.	20 January 2014

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

Main Investigation Report

Introduction

1. Mr A was an 87-year-old man with a medical history of vascular disease (relating to the blood vessels); dizziness; shortness of breath on walking short distances; low blood pressure; and previously had both knees and his right ankle joints replaced. He also suffered from dementia (a neurological (relating to the brain) condition which causes memory loss and confusion) and arthritis (a condition which causes stiffness, swelling and pain in the joints).

2. Mr A had been admitted to hospital in November 2011 to investigate his dizziness; leg swelling; a 'blister' on his left big toe; and a general feeling of being tired and unwell. He underwent an angiogram (a special x-ray of the blood vessels). He was later discharged and was being followed up as an out-patient.

3. Mr A was re-admitted to hospital on 3 December 2011 following a collapse at home at about 08:00 and a previous fall in the early hours of the same morning. The family said that they warned staff that he had previously fallen and that he had suffered several falls while in hospital which were witnessed by other patients and/or visitors but not recorded by staff.

4. A fall on 9 December 2011 was retrospectively recorded in Mr A's clinical notes on 10 December 2011 after the family told staff, and a further fall was recorded as having taken place at 05:00 on 16 December 2011. It was as a result of this fall that Mr A fractured his hip. No falls risk assessment had been completed until Mr A had been in hospital for some four days on 7 December 2011.

5. Mr A was scheduled for surgery to repair his fracture the following day but this was cancelled and re-scheduled. Surgery eventually took place on 18 December 2011, some 54 hours after the fall. Mr A died on 27 December 2011 and the family said they were told the death certificate would be ready later that day. However, the death was routinely referred to the Procurator Fiscal's Office and this caused a delay in the certificate being issued.

6. Mr A's family said that this in turn meant that funeral arrangements had to be postponed, and this added to their distress.

7. Mr A's daughter (Mrs C) complained to Fife NHS Board (the Board) on 4 February 2012 and they responded on 11 June 2012. Mrs C was dissatisfied and complained again on 22 July 2012. The Board wrote to Mrs C on 26 July 2012 to offer a meeting with staff to discuss her complaint. Mrs C did not feel ready to meet with staff and, therefore, telephoned the Board to say this. She then heard nothing further from the Board. After taking advice from my office Mrs C contacted the Board again on 26 September 2012 and they responded on 15 October 2012 to the issues raised in Mrs C's second letter of complaint. Mrs C remained dissatisfied and complained to my office on16 November 2012.

8. The complaints from Mrs C which I have investigated are that the Board:

(a) unreasonably failed to reassess Mr A's falls risk when staff were informed that he had already fallen on the ward;
(b) unreasonably delayed in taking Mr A to theatre when he fell and fractured his hip;
(c) failed to appropriately manage Mr A's intake of food and fluids; and
(d) failed to communicate appropriately with the family following Mr A's death.

Investigation

9. My complaints reviewer reviewed all of the documentation provided by both the Board and Mrs C, including copies of Mr A's clinical records. My complaints reviewer also reviewed relevant local and national guidance and took advice from two of my medical and nursing advisers, a medical doctor who specialises in the care of the elderly and a senior nurse (the Advisers). The Advisers prepared a joint report for the purposes of this investigation.

10. A glossary of terms, list of abbreviations used and a list of relevant local and national guidance considered during the investigation are included as annexes to this report.

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

(a) The Board unreasonably failed to reassess Mr A's falls risk when staff were informed that he had already fallen on the ward

12. When Mr A was in hospital in November 2011 his falls risk was assessed using a standard matrix-type tool which assesses various risk factors including

age; gait; falls history; medication; and medical history. Mr A's risk was assessed at 16 which is 'high risk'.

13. Mrs C was concerned that Mr A was very independent and wanted to be self-caring for toileting where possible. This caused him to mobilise about the ward independently at times. Although he was provided with a call buzzer to call staff to assist him, he was unable to use it due to the arthritis in his hands. Mr A also told Mrs C at one point that he would soil his bed if he waited for staff to attend him.

14. Despite his known previous high risk of falling, and the fact that he was admitted on 3 December 2011 having fallen at home, no falls risk assessment was done on admission. The first recorded falls risk assessment was done some four days later on 7 December 2011 and after he had apparently fallen again on the ward more than once, although these falls were not recorded by staff.

15. At this assessment Mr A scored 14 with a score of 13 or more being considered 'high risk'. The falls risk assessment tool states that patients who score 9 or more (medium risk or high risk), should thereafter be re-assessed daily. However, the records show that Mr A was only assessed every other day until 16 December 2011 when he fell and fractured his hip.

16. The Advisers noted Mr A's medical history and the reason for his admission having been a fall at home, with falls risk factors identified in the medical notes. The Advisers considered that it would have been reasonable to have expected a falls risk assessment to have been done on admission.

17. The Advisers noted that on 4 December 2011, the day after admission, an 'Acute Comprehensive Geriatric Assessment' was completed and the Advisers considered this document was very well completed. The Advisers noted that Mr A is recorded as walking 'with two sticks or a Zimmer frame' and that he 'feels unsteady'. The document included the comment 'Follow falls pathway' but the Advisers found no evidence of how this was to be put into place.

18. The Advisers were concerned that the medical notes recorded several notes of Mr A having 'dizziness'; being 'lightheaded'; 'unsteady'; and/or 'dizzy'. There were also entries in the medical notes of the family expressing concerns

about Mr A's dizziness and unsteadiness and that Mr A would be at risk of falling again if discharged home.

19. The Advisers were concerned that the falls risk assessment tool was completed every other day when Mr A's scoring was consistently well above the score of 9, after which daily assessment is supposed to take place. The Advisers were also concerned that despite the clinicians making clear notes about Mr A's falls risk on admission, the nursing staff appear either not to have had access to this information; not to have read this information; or to have not acted upon this information.

20. The Advisers commented that there was a lack of co-ordination between the medical, nursing and allied health professional staff and there was little evidence of the expected teamwork between staff to reduce Mr A's risk of falls.

21. The Advisers also noted an anomaly in the falls documentation, in that the assessment recorded on 7 December 2011 was on the same document as the assessment done on 1 November 2011 during Mr A's previous admission. A further assessment done during this previous admission, and dated 26 November 2011 was on a separate document.

22. My complaints reviewer also noted that the Board's response to Mrs C's complaint dated 15 October 2012 stated that '… staff had not been aware that [Mr A] had fallen in the ward until you brought it to their attention following a conversation you had with another patient …'.

(a) Conclusion

23. I am disappointed that despite the medical team and the family expressing concerns about Mr A's falls risk there was no multi-disciplinary team approach to assessing, monitoring and reducing Mr A's falls risk. Despite Mr A's known risk; the reason for his admission; and previous high scoring when he had been in hospital the previous month, no falls risk assessment was done on admission.

24. I am also concerned that the Board admitted that staff were unaware that Mr A had fallen on the ward, despite the family being told of more than one fall by other patients or visitors. I consider this unacceptable in what should have been a safe and caring environment for Mr A.

25. We will never know exactly how many times Mr A fell on the ward as the family could not be there all the time and were merely told by other patients or visitors when they had witnessed falls. When the family informed staff that Mr A had fallen on the ward on 9 December 2011 (after being told about the fall by another patient) the fall was recorded retrospectively the following day. No falls had been recorded prior to this.

26. Even when a falls risk assessment was eventually done, it was not monitored and reviewed daily as Mr A's scoring required and according to the Board's own policy. There was also an anomaly where an assessment from this admission appears to have been done on an old assessment form. It is not clear how this occurred.

27. From the evidence available to me it is clear that the level of falls risk assessment and monitoring was unacceptable. I uphold this complaint.

(a) Recommendations

28. I recommend that the Board:	*Completion date*
(i) provides evidence that the falls risk assessment policy and procedures have been appropriately reviewed and any learning points form part of an action plan for improvement; and	20 February 2014
(ii) ensures that all nursing staff are fully aware of and trained in compiling falls risk assessments and the on-going monitoring of patients at medium or high risk.	20 February 2014

(b) The Board unreasonably delayed in taking Mr A to theatre when he fell and fractured his hip

29. The medical notes document that Mr A had an un-witnessed fall at about 05:00 on 16 December 2011 and the entry at 07:30 records that he had signs in his left leg consistent with a hip fracture. An x-ray was ordered and at 10:30 the results are recorded with a note of a contact with a member of the Orthopaedic team.

30. Mr A was then reviewed by an orthopaedic registrar (a middle grade doctor specialising in disorders or injuries to the limbs or spine) at 17:00. The orthopaedic registrar recorded a five point plan, including a plan for Mr A to be taken to theatre the following day. Mr A was reviewed again on

17 December 2011 by an orthopaedic consultant (a senior doctor, usually in charge of a team of junior and middle-grade doctors) who recorded in a dictated letter that they hoped to undertake the surgery that day or the day after.

31. In a response during the Board's complaints investigation, the orthopaedic consultant highlighted that at the time they had a 'busy caseload' including a patient with an open injury that had to be prioritised. This meant that Mr A's surgery was actually postponed until 18 December 2011. This took place some 54 hours after Mr A's fall.

32. The Advisers told my complaints reviewer that delayed surgery to repair a hip fracture in an elderly patient is not in itself unreasonable. Where theatre capacity does not allow early surgery to take place, there has been no consistent evidence to suggest this affects mortality rates. This is discussed in the Scottish Intercollegiate Guidance Network (SIGN) 111 'Management of hip fracture in older people' referred to in Annex 3 of this report.

33. The Advisers also stated that a patient's general condition should be taken into consideration and there may be times when it would be appropriate to delay surgery to allow medical staff to stabilise a patient's condition.

34. In Mr A's case the delay was caused by a lack of capacity in theatre and other emergency cases which took clinical priority. However, the Advisers noted that there was no evidence of a pre-theatre assessment by an anaesthetist (a specialist doctor who administers and monitors anaesthesia) until just before the operation. The Advisers were concerned that despite some concerns being expressed by the anaesthetist about Mr A's condition, there was a general lack of detail in the notes. The Advisers also noted a lack of clinical notes for Mr A's immediate post-operative care.

35. The Advisers noted that Mr A's return to the ward was not routine as his condition had caused concern in the recovery room (a high dependency area where patients are taken to recover from the anaesthetic before being returned to their ward). This included that the on-call medical registrar was called to see Mr A in the recovery room. Again the notes about this are not detailed.

36. The Advisers noted that Mr A's blood pressure was low and his heart rate was high – both of which individually are potentially dangerous. While the Advisers noted a significant amount of good nursing care being provided to

Mr A after his return to the ward, and that there was concern about his condition, they noted that there was a failure to recognise that Mr A had post-operative confusion and his kidneys were failing.

37. The Advisers also noted that there was no evidence of a further medical review after 19:45 on 18 December 2011 until late morning or early afternoon on 19 December 2011. These entries are not timed so it is unclear when exactly they took place.

38. The Advisers noted that in 2008 a report on NHS anaesthesia services provided by the Board was undertaken by NHS Quality Improvement Scotland (NHS QIS). NHS QIS is a special health board which works with members of the public, patients and healthcare staff to translate the latest scientific research, expert opinion and patient experience into practical improvements that can be implemented in the health service.

39. The 2008 report found some areas of good care but there were concerns expressed in the areas of pre-surgical assessment and post-surgical recovery where the desired standards were assessed as 'Not Met'. A follow-up report in 2010 found that insufficient progress had been made in these areas.

40. Overall, the Advisers were of the view that although the decision to delay the surgery was not unreasonable in itself, the care and treatment Mr A received between the fall and his surgery and immediately after surgery fell below acceptable standards.

(b) Conclusion

41. I have reviewed the SIGN 111 guidance and the advice from the Advisers and I am satisfied that the decision to delay surgery was a reasonable one. Clinicians sometimes have to make difficult decisions and assess the clinical priority of various patients. This can change at any time if a new emergency patient is admitted. This happened in Mr A's case and I do not criticise the Board for the actual clinical decision to delay surgery.

42. What did concern me was the apparent lack of assessment, monitoring and planning of Mr A's condition during the wait for surgery and in the immediate post-surgical period. There was no evidence of a pre-theatre anaesthetic assessment until just before the operation and no meaningful planning for Mr A's return to the ward. Of more concern was that during his wait

for surgery on the ward, little or no monitoring or assessment of his condition appears to have been done, with the result that he reached theatre in a poor clinical condition. I will address some specific issues in complaint (c).

43. I am concerned that this case appears to reflect the findings of the NHS QIS reports of 2008 and 2010 as referred to above.

44. Overall I am disappointed that no constructive multi-disciplinary team approach appears to have been taken to Mr A's care and treatment while he awaited surgery and immediately afterwards. However, the actual decision to delay surgery was not unreasonable. Therefore, I do not uphold this complaint.

(b) Recommendation

45. I recommend that the Board:	*Completion date*
(i) reviews their procedures for assessing and monitoring patients awaiting surgery to ensure that a co-ordinated multi-disciplinary team approach is taken to their pre-surgical assessments and post-surgical planning.	20 February 2014

(c) The Board failed to appropriately manage Mr A's intake of food and fluids

46. Mrs C complained that when she visited Mr A in hospital at 15:00 while he was awaiting surgery on 17 December 2011 she found him in pain, very uncomfortable and dehydrated. On speaking to a nurse she found that Mr A had been 'Nil by Mouth' in preparation for surgery from the previous midnight. The nurse put Mr A on an Intravenous (IV) drip (a way of giving fluids or drugs directly into the patient's vein), but Mrs C stated that apart from this Mr A received no fluids or nourishment that day. The Board have stated that Mr A, in addition to being started on IV fluids at 15:25, was given 220 millilitres of a high calorie milk shake at 18:35 that day. This was confirmed within the clinical records.

47. Mrs C was also concerned that it was a further 20 hours before Mr A actually had his surgery. Mrs C stated that when Mr A returned to the ward after his surgery he was very dehydrated and hungry. She stated that there continued to be problems with feeding over the following week.

48. Mrs C stated that Mr A was moved to another ward of the hospital and his health seemed to deteriorate thereafter. Mrs C stated that the family were told that Mr A was in a poor condition following his surgery, although the surgery had been a success. They were told that he was retaining fluid and his kidneys were not functioning properly but that this was common in elderly patients following surgery and they should start working again within a few days.

49. Mrs C stated that feeding was an issue and that one day Mr A was being fed orally and the next he was 'Nil by Mouth' or that he was to be given foods and fluids of only 'double cream consistency'. However, there were also problems with feeding by drip as this exacerbated the fluid retention.

50. Mrs C said that she was also concerned when a nurse she spoke to said that Mr A was not processing food properly and it was not getting to his stomach. The nurse said that the danger was that it would go on to his lungs or into the chest cavity which would put stress on his heart. The nurse went on to say that Mr A may be given 'comfort food' ie would be fed if he asked for food.

51. Mrs C stated that naso-gastric (NG) feeding (via a tube through the nose into the stomach) was discussed and the family asked that this not be done unless a family member was with Mr A 24 hours a day to ensure he did not pull the tube out. However, NG tubing was attempted while the family were not at the hospital and was unsuccessful.

52. Mrs C stated that on Christmas Day she and various members of the family visited Mr A throughout the day and found him 'bright and alert' albeit restless. He was asking for food and fluids and to be allowed to sit out of bed in a chair.

53. Mrs C stated that the following day she called the hospital and was told that Mr A had been fed a meal of 'soup and pudding'. Mrs C was initially pleased that Mr A seemed to have 'turned a corner' but became concerned when her mother visited Mr A later that day and found him unresponsive.

54. Mrs C said that the family were told that Mr A was 'sleeping' but that he remained unresponsive all day; did not wake to gentle stimulation; and had an oxygen mask on. Mrs C called her brothers to the hospital and the close family were with him when he died at about 02:00 the following day.

55. As referred to above, the Advisers had concerns that Mr A's fluids were not being properly managed in the period while he awaited surgery. There was also a period during which Mr A was 'Nil by Mouth' and was not receiving IV fluids. The notes record that NG feeding was attempted on Christmas day but that Mr A had pulled out the tube. The notes also record that if NG feeding was unsuccessful, IV fluids were to be re-started. However, this did not happen until 26 December 2011.

56. The Advisers considered that an appropriate assessment of Mr A's nutritional needs was made on admission but while there was evidence in the clinical notes that his nutritional needs were being considered and assessed, there was little evidence of collaboration or a systematic approach to his nutrition and fluid management. In particular, the Advisers found that opportunities for referring Mr A to the specialist Speech and Language Team (SaLT) were missed. The SaLT can assess a patient's ability to swallow and give advice on feeding and fluid intake.

57. The Advisers considered that although in some cases the approach taken by the nursing staff deviated from the Board's own policy on feeding for patients with swallowing problems, it was not unreasonable to do so in the circumstances. Although Mr A's swallowing ability was erratic, the Advisers considered that with careful attention when he was able to swallow safely, he could be fed small amounts of soft foods or thickened liquids. This was clearly preferable to leaving him 'Nil by Mouth' for extended periods.

(c) Conclusion

58. I was disappointed to note that there was no consistent and co-ordinated approach to monitoring and ensuring Mr A's nutritional and fluid intake. This included the missed opportunities to refer Mr A for a SaLT assessment.

59. The Advisers stated that there were some instances of good and flexible care, but that overall there was a lack of a consistent multi-disciplinary team approach.

60. Mrs C was concerned that the meal provided by the nurse to Mr A on 26 December 2011 had contributed to or hastened his death but the Advisers did not consider that this was so. The Advisers found that the general accumulation of fluid in Mr A's tissues, including his lungs, was a result of

Mr A's renal failure and poor circulation and that this had contributed to the deterioration in Mr A's condition.

61. The Advisers noted that the approach taken to feeding Mr A was flexible and appropriate to his individual condition and that this was reasonable and consistent with good nursing practice. The Nursing and Midwifery Council (the regulating body for nurses in the UK) code of practice states 'make the care of people your first concern, treating them as individuals and respecting their dignity'.

62. However, the erratic nature of Mr A's swallowing ability did make for a confusing picture for the family and staff should have made more effort to communicate effectively with the family on this issue. His fluids were also not monitored sufficiently as referred to above and in relation to complaint (b).

63. I note that the Advisers found some evidence of good practice. However, overall, I am not satisfied that staff did appropriately manage Mr A's food and fluid intake and I uphold this complaint.

(c) Recommendations

64. I recommend that the Board:	*Completion date*
(i) ensures that all staff are made aware of the importance of food and fluid intake management and take appropriate steps to ensure that patients are appropriately monitored; and	20 December 2013
(ii) remind all staff of the importance of communicating effectively with patients, loved ones and/or carers on all aspects of care, including food and fluid management.	20 December 2013

(d) The Board failed to communicate appropriately with the family following Mr A's death

65. Mrs C stated that following her father's death the family were not given time to say their goodbyes to him before being asked to leave the room so that Mr A could be prepared for a doctor to examine him and declare the death.

66. Mrs C said that when he died Mr A was in a 'comfortable and cosy' bed surrounded by Christmas and wedding anniversary cards. When Mrs C and her mother returned to the room Mr A had been laid out on a pillow-less mattress

with his cards and belongings placed in a bag on the chair by the bed. Mrs C stated that it felt very 'cold and clinical'. Mrs C stated that the nurses who laid Mr A out had not explained to her and her mother what to expect and it was, therefore, a great shock to them. She said neither of them could bear to stay in the room for very long after this. Mrs C describes herself and her mother as being 'traumatised' by this and that they have both been unable to forget the image of Mr A at this time.

67. Mrs C also complained that they were initially told that the death certificate would be ready for collection later the same day. However, it was not, and her brother called the hospital four times over the next few days only to be told that, for various reasons, it had not yet been signed. The family was then contacted by the police for information on behalf of the Procurator Fiscal's Office (PFO), and this was the first time they were made aware that the matter had been referred to the PFO.

68. Mrs C stated that in the end the certificate was not issued until some days later on 8 January 2012. Mrs C stated that by this time the date and time of the funeral had already been arranged and publicised but had to be changed due to the delay. Mrs C said that this caused the family additional distress.

69. My complaints reviewer confirmed that in certain cases, such as sudden or unexpected deaths wherever they occur, the PFO are required to investigate before a death certificate can be issued. Hospitals have a duty to report such deaths to the PFO.

70. The notes confirm that Mr A's death was reported to the PFO on 28 December 2011. The notes also state that the family was given a leaflet on bereavement. My complaints reviewer has read the leaflet on bereavement produced by the Board, but it does not contain any information on the process of reporting cases to the PFO. The Scottish Government produces a leaflet, which is available from the Board's website, called 'What to do after a death in Scotland' which does contain information on cases referred to the PFO. This leaflet warns families not to commit to definite funeral arrangements until the PFO has given permission to release the body for burial or cremation.

(d) Conclusion

71. I am satisfied that it was reasonable and appropriate for the hospital to report Mr A's death to the PFO. However, this information should have been

communicated to the family as soon as this was done on 28 December 2011. They would then have known what to expect and could have informed the funeral directors of this.

72. There is nothing in the notes to suggest that there was any delay by the hospital or the Board and the delay was presumably due to the investigations being carried out by the PFO. This may also have been compounded by the festive period. However, it is unacceptable that when Mrs C's brother was calling the hospital to enquire about the certificate, he was not informed of the position and referred to the PFO to enquire about the possible timescale.

73. On the matter of the lack of communication immediately after Mr A's death, again I am disappointed that Mrs C and her mother were not warned what to expect when they re-entered Mr A's room. At such an already distressing time this must have been a shock to them.

74. Based on all the evidence available to me, I uphold this complaint.

(d) Recommendations

75. I recommend that the Board:	*Completion date*
(i) ensures that all staff are made aware of the importance of good communication with families at all times, especially following a bereavement and considers providing training where necessary;	20 December 2013
(ii) ensures that all staff are aware of the rules on reporting cases to the PFO and pass this information on to families where appropriate; and	20 December 2013
(iii) considers making the leaflet 'What to do after a death in Scotland' available where appropriate.	20 January 2014

76. The Board have accepted the recommendations and will act on them accordingly. I ask that the Board notify me when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr A	The patient, the complainant's father
Mrs C	The complainant
The Board	Fife NHS Board
The Advisers	The medical and nursing advisers
SIGN	The Scottish Intercollegiate Guidance Network
NHSQIS	NHS Quality Inspection Scotland
IV	Intravenous
NG	Nasogastric
SaLT	Speech and Language Team
PFO	Procurator Fiscal's Office

Annex 2

Glossary of terms

Angiogram	a special x-ray of the blood vessels using a contrast medium – a liquid injected into the blood vessels which shows up clearly on the x-rays
Arthritis	a condition which causes stiffness, swelling and pain in the joints
Consultant	a senior doctor, usually in charge of a team of junior and middle-grade doctors
Dementia	a neurological (relating to the brain) condition which causes memory loss and confusion
Intravenous (IV) fluids	a method of providing fluids or drugs directly into the patient's vein
Naso-gastric feeding (NG) feeding	a method of feeding patients unable to swallow safely by way of a tube put through the patient's nose and then down into the stomach
NHS Quality Inspection Scotland (NHSQIS)	a special health board which works with members of the public, patients and healthcare staff to translate the latest scientific research, expert opinion and patient experience into practical improvements that can be implemented in the health service
Orthopaedic Registrar	a middle-grade doctor specialising in disorders or injuries to the limbs or spine
Procurator Fiscal's Office (PFO)	the public body in charge of crown prosecutions in Scotland and who investigate sudden, unexpected or suspicious deaths

Recovery room	a high dependency area where patients are taken to recover from an anaesthetic before being taken back to their ward
Speech and Language Team (SaLT)	a specialist team who work with patients who have difficulty with speech, language or swallowing
The Scottish Intercollegiate Guidance Network (SIGN)	which produced guidance on the investigation, diagnosis and management of many medical conditions

Annex 3

List of legislation and policies considered

NHS Fife Falls Risk Management 2008

NHS Fife SaLT – Swallowing problems (dysphagia)

Death and the Procurator Fiscal – Information and Guidance for Medical Practitioners

Sign 111 – Management of hip fracture in older people

Scottish Hip Fracture Audit – National Waiting Times to Theatre

National Confidential Enquiry into Patient Outcome and Death – reports on acute kidney injury and dehydration; and care received by elderly patients undergoing surgery

NHS QIS – (NHS Fife) Report : Anaesthesia 2008 & 2010

Nursing and Midwifery Council Code of Practice