Scottish Parliament Region: Lothian

Case 201204018: Lothian NHS Board

Summary of Investigation

Category

Health Hospitals: general medical; nurses; nursing care

Overview

Miss C complained on behalf of her siblings and herself. She alleged that when her mother (Mrs A) was admitted to hospital, she was not properly assessed. In particular that FALLS assessments (a risk assessment tool for the prevention of falls in older people) which were carried out failed to take account of Mrs A's medical conditions. Miss C said that if a proper assessment had been made, Mrs A would not have been left alone on a commode. Miss C further complained about the way in which the Lothian NHS Board (the Board) subsequently handled her complaint.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board failed to conduct an appropriate risk assessment on Mrs A's admission to the Royal Infirmary of Edinburgh (*upheld)*; and

(b) the Board failed to address Miss C's concerns adequately (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) make a formal apology to Miss C and her siblings for their failure in this matter;	3 March 2014
(ii) look again at the FALLS assessment to ensure that staff exercise clinical judgement when assessing risk;	29 April 2014
(iii) emphasise to staff the importance of keeping accurate and timely records which would be fully adequate for the purposes of later scrutiny; and	3 March 2014
(iv) make a formal apology to Miss C and her siblings for the omissions in their correspondence.	3 March 2014

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

Main Investigation Report

Introduction

1. Miss C complained to this office on 18 February 2013. She said that on 24 March 2012, Mrs A had been admitted to the Royal Infirmary of Edinburgh with lower abdominal pain and because she had been passing black, tarry stools with fresh blood. Mrs A had a history of chronic obstructive pulmonary disease (COPD) and bladder cancer. Miss C said that Mrs A asked to use the commode early in the morning of 28 March 2012 but she was left unattended and fell and fractured the neck of her femur. Mrs A died a few days later.

2. Miss C and her siblings complained to Lothian NHS Board (the Board) and in a meeting held in response to the complaint (on 1 August 2012), and in subsequent correspondence, they maintained that the reason for leaving Mrs A alone on the commode was to allow her some privacy and dignity. They say that Mrs A had been asked to call for assistance to take her back to bed, but indicated that she tried to return on her own. She fell and suffered a fractured neck of femur. Unfortunately, Mrs A was not a suitable candidate for surgery because of her COPD and, regrettably, her condition declined. She died on 31 March 2012.

3. Miss C complained that on being admitted to hospital, Mrs A was not properly assessed. In particular, Miss C said that the FALLS assessment carried out failed to take account of her medical conditions. She said that if a proper assessment had been made, Mrs A would not have been left alone on the commode. She further complained of the way in which the Board handled her subsequent complaint.

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

(a) conduct an appropriate risk assessment on Mrs A's admission to the Royal Infirmary of Edinburgh; and

(b) address Miss C's concerns adequately.

Investigation

5. The investigation of this complaint involved obtaining and reading all the relevant documentation provided by Miss C and by the Board, including Mrs A's relevant clinical records. My complaints reviewer has had sight of the Board's policies on Complaints and Incident Management and an independent nursing

opinion was obtained on the circumstances involved. This advice has also been taken into account.

6. While this report does not include every detail investigated, I am satisfied that no matter of significance has been overlooked. Miss C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to conduct an appropriate risk assessment on Mrs A's admission to the Royal Infirmary of Edinburgh

7. As Miss C was concerned about the circumstances leading up to Mrs A's death she complained to the Board and, on 1 August 2012, a meeting was held to try to resolve her concerns. This was followed by a letter dated 27 August 2012 which was in reply to outstanding matters. However, Miss C remained unhappy and complained to this office. Subsequently, she received a further response from the Board dated 5 June 2013. Essentially, this said that a FALLS risk assessment had been completed for Mrs A on her admission to hospital (on 24 March 2012) and every day afterwards. The Board said that on admission, Mrs A was rated 1, but due to reduced mobility and respiratory problems, she also had a physiotherapy assessment. She was then placed in an area in the ward where she was easily observed.

8. The Board further said that on 28 March 2012, Mrs A buzzed for a nurse and requested to use the commode. Accordingly, they said she was assisted to it and left with a call buzzer in her hand. The Board added that as Mrs A had capacity, she was given privacy. They said that she did not call a nurse but tried to return to her bed independently and staff were informed by another patient that she had fallen. The Board maintained that the incident was reported and investigated thoroughly by a FALLS coordinator who subsequently took the view that the assessment and actions taken afterwards were appropriate, with the exception that Mrs A should have been wearing more suitable footwear and not just bed socks. The Board said that this information had been passed to the ward staff to increase their awareness of the matter.

9. As part of this investigation, independent nursing advice was obtained and the Adviser was asked to review Mrs A's relevant clinical records and, in particular, those concerning the FALLS assessment. The Adviser said that the FALLS assessment carried out on 24 March 2012 recorded that Mrs A's functioning was not impaired by poor vision. This meant that her risk score was estimated to be 1, whereas had visual impairment been identified as a clinical

issue her score would have been estimated at 2. However, the Adviser also pointed out that the Activities of Daily Living (ADL) assessment, carried out the same day (24 March 2012) by a different nurse, clearly stated that Mrs A had poor vision as a consequence of cataracts. Further, the ADL assessment noted that she self-reported 'dull hearing' as a problem.

10. The Adviser said that the Board maintained that the FALLS assessment had been carried out daily and was consistently scored at 1 but he stated that there was no evidence of further assessment between 24 and 26 March 2012. He said it appeared to him that the first assessment was presumed to be correct and carried forward with no account taken of the visual impairment recorded at the point of admission. Although he added that as long as Mrs A's condition showed no marked deterioration, there would not have been a requirement to carry out a full FALLS assessment on a daily basis.

11. The Adviser explained that had Mrs A's assessment been 1, according to the Board's policy and protocol for FALLS management, the following interventions should have been initiated:

- orientation of the patient as required;
- education of the patient on safe practice;
- call bell placed within easy reach;
- immediate environment de-cluttered;
- bed positioned at lowest level and chair adjusted to appropriate height;
- patient assessed in line with bed rails policy;
- discussion with patient and family in relation to safe footwear; and
- mobility assessment completed. Referral to podiatrist if required.

12. He said that although a mobility assessment was carried out (see final bullet point above), he could not find any reference in Mrs A's records to the other FALLS prevention measures indicated, nor was there recorded evidence that they were carried out.

13. However, the Adviser said that Mrs A's FALLS assessment should have been scored at 2, that is 'at risk of falls' and, therefore, in accordance with the Board's policy, a more intensive care-plan should have been initiated. This would have included interventions amongst other things of:

- the management of eyesight and hearing deficits;
- the displaying of a FALLS risk sign;

- having a full FALLS assessment discussion with the patient;
- the issuing of a FALLS prevention leaflet to the patient and carers; and
- the commencement of a Multi-Disciplinary Team FALLS Prevention Checklist.

14. The Adviser also pointed out that there were other issues relating to the assessment of Mrs A's FALLS risk, such as:

- Her blood results on admission indicated a haemoglobin of 97 so she was, therefore, clinically anaemic, probably a result of gastro-intestinal bleeding. He said the symptoms of anaemia could include, fatigue, weakness and dizziness. The Adviser said it was noted on admission that Mrs A complained of dizziness, particularly when standing up, but this did not appear to have been considered in the course of the FALLS assessment, which seemed to have been limited by the five criteria set out in the assessment template (which were referred to in the Board's letter of 5 June 2013). In his view, he said that it would have been inadvisable to leave Mrs A alone.
- Her mobility and functioning were significantly impaired by shortness of breath caused by end-stage COPD. Mrs A used oxygen at home and a nebuliser. The Adviser said that this condition would have increased her risk of fatigue, weakness and dizziness.
- Mrs A's accident occurred at 04:00 when she was likely to have been tired and possibly drowsy, which would have increased the risk of a fall and made leaving her alone inadvisable.
- Although not cognitively impaired, Mrs A's recorded hearing deficit could have impaired her ability to comprehend instructions given.

15. It was the Adviser's general opinion that staff were 'blinkered' by the criteria set out in the FALLS assessment and score of 1. He said staff did not exercise clinical judgement in relation other factors which may have increased the risk of a fall.

16. The Adviser also went on to note that there was no contemporaneous record of the fall and the circumstances surrounding the fall were ineffectively recorded in the records by medical staff (for example, it was stated that there was a 'fall tonight' but no information relating to where or how the fall occurred; and it was recorded that Mrs A fell on her way back from the toilet but in another account Mrs A was said to have slipped from the commode while trying to

manoeuvre herself back into bed without requesting assistance). He said that, notwithstanding the fact that the fall occurred in the early hours of the morning and the intention to inform the family had been recorded, this did not appear to have been followed up. Finally, the Adviser pointed out that the family may have believed that Mrs A had a FALLS score of 0, which he said probably arose as a consequence of an incorrect recording noted by the FALLS coordinator in the Critical Incident Review (CIR) findings (see paragraph 8 above).

(a) Conclusion

17. Miss C's opinion about the FALLS assessment and what the Board have said in relation to it have been carefully considered. Independent nursing advice has been obtained on the matter. Taking this advice into account, I have concluded that the Board failed to conduct a proper assessment at the time of Mrs A's admission to hospital. This being the case, I uphold the complaint

18. The Board should now make a formal apology to Miss C and her siblings for their failure in this matter. Furthermore, although the Adviser told me that the subsequent CIR picked up on the issue of footwear, it did not highlight any of the issues identified above (see paragraph 8). In these circumstances, it is also recommended that Board look again at the FALLS assessment to ensure that staff exercise clinical judgement when assessing risk; and that they further emphasise to staff the importance of keeping accurate and timely records which would be fully adequate for the purposes of any later scrutiny.

(a) Recommendations

19. I recommend that the Board:	*Completion date*
(i) make a formal apology to Miss C and her siblings for their failure in this matter;	3 March 2014
(ii) look again at the FALLS assessment to ensure that staff exercise clinical judgement when assessing risk; and	29 April 2014
(iii) emphasise to staff the importance of keeping accurate and timely records which would be fully adequate for the purposes of later scrutiny.	3 March 2014

(b) The Board failed to address Miss C's concerns adequately

20. Miss C did not consider that the Board provided a sufficiently detailed explanation to allow her family to draw this matter to a close. This was despite the terms of their letter of 27 August 2012, and their further letter 5 June 2013

(referring to the CIR) which apologised because Miss C felt that the first letter did not explain matters sufficiently. Accordingly, this correspondence has been reviewed in light of the advice given (see Complaint (a) above).

(b) Conclusion

21. I have concluded that the Board did not describe events in sufficient detail. It also appeared that, as part of the CIR, the FALLS coordinator overlooked the fact that Mrs A had been incorrectly scored. As a consequence of which, the Board did not provide any information about what should have occurred had Mrs A been correctly scored as having a FALLS assessment score of 2. Clearly, had she been correctly scored, in accordance with the Board's own policies and procedures, a number of interventions would have been prompted, including the development of a falls prevention care-plan.

22. For the reasons above, I uphold the complaint and I recommend that the Board make a formal apology to Miss C and her siblings for the omissions in their correspondence.

(b) Recommendation

23. I recommend that the Board:	*Completion date*
(i) make a formal apology to Miss C and her siblings for the omissions in their correspondence.	3 March 2014

24. 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

Miss C	the complainant
Mrs A	Miss C's late mother
COPD	Chronic Obstructive Pulmonary Disease
the Board	Lothian NHS Board
the Adviser	An independent nursing adviser
ADL	Activities of Daily Living
CIR	Critical Incident Review