SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Lothian

Case 201304549: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Orthopaedics

Overview

The complainant (Mrs C) raised a number of concerns about the nursing care provided to her mother (Mrs A) after she was admitted to the Royal Infirmary of Edinburgh (the Hospital) for hip surgery. Mrs C said that nursing staff had failed to adequately monitor Mrs A's condition and delayed in referring her to specialists. Mrs A died a week after she was discharged from the Hospital.

Specific complaint and conclusion

The complaint that has been investigated is that staff failed to provide Mrs A with an appropriate standard of nursing care (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) issue a written apology to Mrs C for the failure to provide reasonable and appropriate care to Mrs A in relation to nutrition, fluid, diabetes, pressure ulcers and her discharge from hospital;	20 February 2015
(ii) issue a reminder to the relevant staff involved in Mr C's care of the requirement to: keep clear, accurate and legible records; promptly provide or arrange suitable advice, investigations or treatment where necessary; consult colleagues where appropriate; and, refer a patient to another practitioner when this serves the patient's needs;	20 February 2015
(iii) take steps to ensure that older adults admitted with fracture are assessed for specialist rehabilitation, including review by a consultant geriatrician;	20 March 2015
(iv) review their policies and procedures for patients with diabetes admitted to orthopaedic wards to	20 March 2015

	ensure that adequate systems in the management of their care are in place;	
(v)	review the process for referral to the tissue viability nurse;	20 March 2015
(vi)	take steps to ensure that discharge planning in relevant cases is in line with the Scottish Intercollegiate Guidelines Network guidelines for hip fracture in older people; and	20 March 2015
(vii)	confirm to me that the matter will be discussed at the Orthopaedic Consultant's next annual appraisal.	20 February 2015

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

Main Investigation Report

Introduction

1. The complainant (Mrs C) complained about the standard of care that her late mother (Mrs A) received in Ward 108 at the Royal Infirmary of Edinburgh (the Hospital) when she was admitted on 5 January 2013 for hip surgery after a fall. Mrs A had diabetes and Mrs C said that staff failed to adequately monitor Mrs A's condition and delayed in referring her to specialists. Mrs A died a week after she was discharged from the Hospital.

2. The complaint from Mrs C that I have investigated is that staff failed to provide Mrs A with an appropriate standard of nursing care.

Investigation

3. Investigation of the complaint involved reviewing the information received from Mrs C and Lothian NHS Board (the Board). My complaints reviewer also obtained advice from a nursing adviser (Adviser 1). Although the complaint we agreed with Mrs C was about the nursing care provided to Mrs A, many of the specific issues raised by Mrs C in her complaint to the Board and to us related to the medical care Mrs A received. My complaints reviewer also obtained advice on these issues from a medical adviser (Adviser 2), who is a consultant geriatrician. I have also taken into account the findings of previous reports I have issued relating to the treatment of pressure ulcers by the Board.

4. 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.

Complaint: Staff failed to provide Mrs A with an appropriate standard of nursing care

5. Mrs C said that Mrs A was fully mobile before she fell in her care home and was admitted to the Hospital on 5 January 2013 for hip surgery. She considered that nursing staff failed to monitor Mrs A appropriately whilst she was in the Hospital and that they failed to assist her with feeding and drinking. She also said that staff did not provide adequate care in relation to diabetes and pressure ulcers. She considered that these failures led to Mrs A's death on 30 January 2013, a week after being discharged from the Hospital.

Nutrition and fluid

6. In her complaint to us, Mrs C said that Mrs A was dehydrated and had poor appetite when she was admitted to the Hospital. She said that there was no chart on the wall saying that Mrs A needed help with eating and drinking, despite this being in the records. She complained about the action taken by the Board in relation to this and said that there were very few daily totals written on the care sheets for someone who was supposed to have their fluid levels monitored. Mrs C also complained that although Mrs A was extremely dehydrated, she was given Furosemide (a diuretic medication that can be given as a tablet or injection to force the kidneys to produce more urine).

7. In the Board's response to Mrs C, they stated that a fluid balance chart had been started on 6 January 2013 and that this was monitored accurately. They said that fluids were given intravenously as and when prescribed. They stated that Mrs A had been reviewed by a dietician and a speech and language therapist and thick puree diet foods were given to her. They also said that her nutrition score was assessed and documented three times during her stay in the hospital and that she was commenced on a food chart on 9 January 2013. The Board said that it was documented that she required assistance with meals and that this was written on a card above her bed. They said that Mrs A was prescribed supplements, but it was recorded that she refused them, despite encouragement. They apologised that she was not given a straw to use with her beaker.

Advice obtained

8. The Scottish Intercollegiate Guidelines Network (SIGN) guideline on hip fracture in older people states that patients' food intake should be monitored regularly to ensure sufficient dietary intake. My complaints reviewer asked Adviser 1 if the nutrition and fluid provided to Mrs A had been reasonable and appropriate. My complaints reviewer also asked her if the Board had adequately monitored Mrs A's condition and if the nursing records and charts had been completed and displayed appropriately.

9. In her response, Adviser 1 referred to guidance from the National Institute for Health Care and Excellence (NICE): Nutrition support in adults. This was issued in 2006 and states that:

- 'Screening for malnutrition and the risk of malnutrition should be carried out by healthcare professionals with appropriate skills and training.

- All hospital in-patients on admission and all out-patients at their first clinic appointment should be screened. Screening should be repeated weekly for in-patients and when there is clinical concern for out-patients. People in care homes should be screened on admission and when there is clinical concern.
- Hospital departments who identify groups of patients with low risk of malnutrition may opt out of screening these groups. Opt-out decisions should follow an explicit process via the local clinical governance structure involving experts in nutrition support.
- Nutrition support should be considered in people who are malnourished, as defined by any of the following:
  - a body mass index (BMI) of less than 18.5 kg/m2
  - unintentional weight loss greater than 10% within the last 3–6 months
  - a BMI of less than 20 kg/m2 and unintentional weight loss greater than 5% within the last 3–6 months.
- Nutrition support should be considered in people at risk of malnutrition, defined as those who have:
  - eaten little or nothing for more than 5 days and/or are likely to eat little or nothing for 5 days or longer
  - a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism.
- Healthcare professionals should consider using oral, enteral or parenteral nutrition support, alone or in combination, for people who are either malnourished or at risk of malnutrition, as defined above. Potential swallowing problems should be taken into account.'

10. Adviser 1 also said that under the guidance from NICE, nursing staff should refer for dietetic specialist advice if they have clinical concern about a patient. The guidance states that, '[C]linical concern includes, for example, unintentional weight loss, fragile skin, poor wound healing, apathy, wasted muscles, poor appetite, altered taste sensation, impaired swallowing, altered bowel habit, loose fitting clothes or prolonged intercurrent illness'. She also stated that the Board's MUST (Malnutrition Universal Scoring Tool) assessment documentation states, 'MUST 1- Assess intake for 3 days. If more than half of meals taken, weekly reassessment. If less than half of meal taken, refer to dietician'.

11. In her response, Adviser 1 said that Mrs A was assessed for the risk of malnutrition using MUST on 6 January 2013. At this time, she was assessed as being at low risk of malnutrition with a recorded score of zero. It was recorded that her weight at that time was 77.2 kilogrammes. This had been taken from the care home records. When Mrs A was assessed again, her weight was recorded as 69.1 kilogrammes. A MUST score of one was calculated due to her weight loss. Adviser 1 commented that there was no evidence in the medical records that a referral was made to a dietician, as the Board's documentation states should happen.

12. Adviser 1 commented that there are food charts in the case file dated 9 January 2013 to 18 January 2013 and 21 January 2013 to 23 January 2013. She said that these food charts had not always been completed fully and when records were made, Mrs A's food intake was variable. Sometimes food was offered but not taken and, on other occasions, she ate only a quarter or half of the meal. She said that nursing staff had commented in the care records that Mrs A had a poor appetite and needed assistance and encouragement.

13. Adviser 1 stated that it was very clear from the records that Mrs A's nutritional requirements were not being met following her hip surgery. Despite the poor intake, she was not seen by a dietician until 18 January 2013. The dietician prescribed nutritional supplements on that date. Mrs A was reviewed again on 23 January 2013, when it was noted there was little improvement in her oral intake.

14. Mrs A was seen by a speech and language therapist on 18 January 2013. Adviser 1 said that it is not clear from the care records who referred Mrs A to the speech and language therapist and why or when this was done. However, she said that following this assessment, it was recommended that Mrs A should have a thick pureed diet and sips of syrup fluid. It was also noted that she required maximum assistance and regular oral hygiene.

15. However, Adviser 1 stated that she could not determine from the records whether Mrs A received maximum assistance to eat and whether she received the appropriate diet and fluid consistencies. She also commented that the system for identifying patients' specific needs varies between hospitals and notations above the bed space are not always used. She stated that this is not always the most effective system of communication.

16. In relation to fluid, Adviser 1 said that a fundamental aspect of nursing practice is in planning and meeting the basic needs of an individual. She said that a care plan to support an individual at risk of dehydration is an essential part of care provision. She commented that a plan of how a person's fluid and food intake will be managed and how nursing staff are going to ensure this happens should be documented in a robust care plan. An accurate fluid intake and output chart is necessary to enable the medical staff to make more informed decisions about a person's fluid needs. Adviser 1 also commented that, '[T]he Code. Standards of conduct, performance and ethics for nurses and midwives' (Nursing and Midwifery Council 2008) states that, '[Y]ou must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been'.

17. Adviser 1 also referred to guidance from the Royal College of Nursing: 'Water for Health: Hydration Best Practice Toolkit for Hospitals and Healthcare'. This said that a conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day. It also stated that:

> 'Evidence from the National Patient Safety Agency's (NPSA) National Reporting and Learning System has identified dehydration as a patient safety issue - medical evidence shows that good hydration can assist in the management of diabetes and help prevent pressure ulcers, constipation, urinary tract infections and incontinence, kidney stones, heart disease, low blood pressure, cognitive impairment, falls, poor oral health, skin conditions and many other illnesses.'

18. Adviser 1 commented that fluid monitoring commenced on 6 January 2013 and continued through to Mrs A's discharge on 23 January 2013. She said that the majority of the charts were completed, but fluid intake and output was not always totalled daily. Mrs A's intake ranged from two litres on some days to 0.45 litres on other days. She stated that there was no evidence of a specific care plan to meet Mrs A's hydration needs and that it was not clear from the nursing records whether nursing staff attempted to assist Mrs A to drink. That said, she commented that there is evidence in the medical records that nursing staff shared concerns regarding Mrs A's poor oral intake with the medical staff.

19. Mrs A also required intravenous fluids to treat an acute kidney injury and as part of her diabetes care. In view of this, my complaints reviewer asked Adviser 2 if intravenous fluids had been started at the right time. In his

response, Adviser 2 said that intravenous fluids are given when patients are unable to maintain their own intake of fluids orally, or where losses of fluid have occurred that cannot be maintained by oral fluids alone. He said that they are also needed after an operation, during periods of illness to support the body's circulation and maintain kidney function and to prevent dehydration. These fluids are usually a combination of saline (mildly salty water) and dextrose (mildly sugary water).

20. Adviser 2 said that the SIGN guideline for hip fracture in older people states that:

> 'Electrolyte imbalances, particularly hyponatraemia (low salt/sodium) and hypokalaemia (low potassium), are common in the postoperative period and reflect the limited renal reserve of these patients. The situation may be made worse by diuretics and inappropriate composition of maintenance intravenous fluids. Fluid management in older people is often poor and older women appear particularly at risk of developing hyponatraemia in the perioperative period.'

The guidance goes on to say that fluid and electrolyte management should begin in the emergency department and that it should be monitored regularly in older people.

21. Adviser 2 stated that Mrs A's fluids and electrolyte management were assessed on admission and her blood tests showed normal electrolytes and kidney function. She had her hip fracture repaired on 7 January 2013 and this was uneventful. However, on 11 January 2013, an orthopaedic consultant (the Orthopaedic Consultant) recorded that Mrs A's urea and electrolytes had deteriorated further. He also stated that she was demented and that her oral intake was slightly poor. The Orthopaedic Consultant recorded that they would start her on subcutaneous fluids (where fluids are given under the skin rather than into a vein) and that the fluid and electrolytes tests would need to be repeated.

22. In his response, Adviser 2 said that the SIGN guideline suggests 'regular' monitoring of fluid and electrolyte management. He said that, in his opinion, this meant at least every other day in current clinical practice and in the period after the operation in particular. He said that Mrs A did not have this level of monitoring.

23. Adviser 2 commented that Mrs A had started on intravenous fluids on 7 January 2013 and received approximately 1.5 litres that day. However, he said that he could find no evidence that she was administered intravenous fluids again until four days later on 11 January 2013. He said that during this time, Mrs A would have been solely reliant on her limited oral intake to maintain her hydration. He said that the handwritten entries from medical staff for this time were poor, with little detail of their clinical thinking.

24. Adviser 2 commented that, apart from the medical entry from the Orthopaedic Consultant on 11 January 2013, there were no other medical staff entries in Mrs A's notes until 12 January 2013, although there were nursing entries in the notes highlighting Mrs A's high blood sugars to the medical staff. One of these entries stated that a doctor had been informed and was still to review.

25. Adviser 2 said that the lack of medical notes made it difficult to comment on the thoughts of staff. However, he said that their inaction was clear by 15 January 2013, when Mrs A's kidney function had deteriorated and she was dehydrated. He said that he considered that medical staff had little specific consideration for this aspect of her care. He stated that there was no assessment of her fluid status until 11 January 2013 and even this was superficial. He said that the treatment of Mrs A with intravenous fluids was inadequate with insufficient volumes of fluid given. He said that this was a poor standard of care, which was at odds with the SIGN guidance referred to above.

26. My complaints reviewer also asked Adviser 2 if it had been appropriate to give Mrs A Furosemide. In his response, Adviser 2 said that Furosemide is useful where there is fluid overload in the circulation, as commonly happens in heart failure. However, inappropriate use of this medication can cause too much fluid to be lost and dehydration can occur as a result. He said that Mrs A did usually receive Furosemide at home and this was continued when she was in hospital, except on 16 January 2013 and 17 January 2013. This was despite evidence that she was dehydrated. Adviser 2 commented that given that the action of the medication is to increase water loss from the body, it would have much better for this to be discontinued. He stated that medical staff did not consider this as part of their assessment of Mrs A and, in this regard, her treatment fell well below a level that could reasonably be expected.

27. Adviser 2 said that he was very critical of Mrs A's post-operative care and the development of dehydration. He said that this would have made her feel unwell, delayed her recovery, contributed to the development of her pressure ulcer and increased her risk of death. He also stated that he was critical that the complaint response merely stated, 'intravenous fluids were given as and when required'. He said that this had not been investigated properly and that no apology had been given for this. He stated that the fluid management for Mrs A was only really addressed when staff asked the diabetic team to help with this aspect of her management (I will comment on this further below). They then addressed the issue of intravenous fluids for her as well.

28. Adviser 2 also stated that, overall, there was little assessment of Mrs A's medication requirements. He said that several doses of her medication for dementia, Donepezil, were missed without any clear explanation from staff or any attempt to rectify this.

Diabetes

29. In Mrs C's complaint to us, she said that Mrs A's diabetes had not been controlled initially and there was a long delay before the diabetes team became involved despite requests for support. In the Board's response to Mrs C, they said that Mrs A's treatment had been discussed with a diabetic consultant (the Diabetic Consultant) on 12 January 2013 and the treatment advised was carried out accordingly.

Advice obtained

30. My complaints reviewer asked Adviser 2 if he considered Mrs A had received reasonable and appropriate care and treatment for her diabetes. In his response, Adviser 2 said that Mrs A was known to have diabetes and staff were aware of this and documented this in her admission note. Her diabetes was usually controlled with tablet medication, called metformin and there was no evidence that her diabetes had caused any significant problems prior to admission. He said that her diabetes was assessed on admission and this showed a slightly raised blood glucose. She was prescribed her metformin medication, which was to be taken twice a day.

31. Adviser 2 said that patients who are fasting for operations sometimes have medication withheld and Mrs A's chart showed that doses of her medication were not given on 7 January 2013 (morning) and 9 January 2013 (evening). Adviser 2 said that it is common for patients with diabetes who have an injury

and surgery such as this to have more erratic glucose levels. As a result, it is important for staff to monitor this. He said that he had, therefore, assessed how well staff monitored Mrs A's diabetes and how well they responded. He commented that no readings were recorded until 7 January 2013 and that no reading was taken on 8 January 2013. He said that the readings that were taken from 7 January 2013 to 13 January 2013 showed that Mrs A's blood glucose was clearly rising to a high and potentially detrimental level over these days. The records show that a doctor was informed on 9 January 2013, but there is no evidence that Mrs A was subsequently reviewed.

32. The first medical entry that showed that Mrs A's rising blood glucose was being addressed was on 12 January 2013. This commented that she was being given 5 percent glucose solution as her intravenous fluids. This prompted a discussion with the Diabetic Consultant and from this point, a more active approach to the measurement of her diabetes began.

33. On 15 January 2013, Mrs A was again seen by one of the junior doctors from the orthopaedic team who referred her to the diabetes team. The diabetes team saw Mrs A at 16:25 that day. They recognised the severity of her condition and recorded that there was 'evidence of HHS' (hyperosmolar [dehydrated] hyperglycaemic [high sugar] state). The diabetes team organised appropriate care of her diabetes and fluid. Adviser 2 commented that this condition had not been noted by the orthopaedic staff, although by this time it had been present for several days. The diabetic team doctor then reviewed Mrs A on 16 January 2013 and 17 January 2013. They carried out a comprehensive assessment of her fluid status and blood sugars, which were controlled with the use of insulin, rather than just her tablets.

34. Adviser 2 said overall, he found that the care of Mrs A's diabetes was poor. Her blood glucose was within normal limits when she was admitted, but deteriorated significantly and to a dangerous level while she was in the ward. He said that staff did not perform enough checks of her blood glucose and medical staff did not respond to the clearly documented concerns of nurses. He stated that the need for referral to the diabetes team was recognised too late and was delayed without any good reason even after it was recognised.

35. Adviser 2 also stated that the standard of care provided to Mrs A fell significantly below a reasonable level. He said that the diabetes team who saw Mrs A effectively rescued her from the situation she was in and their daily care

and assessment of her was good. However, he considered that it should not have needed a specialist team such as this to provide this standard of care for Mrs A. He said that managing hydration and blood glucose levels is part of standard ward care for patients such as Mrs A and staff on the orthopaedic ward should have been able to provide this. He commented that the care needed would have been; ordering blood tests on a daily or twice daily basis; reviewing the results; prescribing bags of intravenous fluids; and, altering her diabetes medication.

36. Adviser 2 said that the effect of this poor care of Mrs A's diabetes and fluid prescription was to increase the dehydration that she suffered. One of the other major effects of HHS on older adults is impairment of brain function and, based on the description of her as drowsy and very flat, it seems likely that she suffered this effect. Adviser 2 also said that another effect of this would have been the increased likelihood of developing a pressure ulcer.

Pressure ulcers

37. In her complaint to us, Mrs C said that Mrs A had developed a pressure ulcer because she had not been turned often enough. She also said that staff had not provided an appropriate mattress. In the Board's response to Mrs C dated 4 October 2013, they said that Mrs A had been found to have a high Waterlow score of 21 on admission and was commenced on three to four hourly skin checks. They said that following Mrs A's operation, her Waterlow score dropped to 16. The Waterlow scoring system is used for identifying the risk of developing pressure ulcers, using standard criteria including weight, skin, mobility and appetite. A score of more than 20 means that the patient is at a very high risk of suffering a pressure ulcer.

38. In their response to Mrs C, the Board said that, due to Mrs A's incontinence, her skin became damaged and was dressed appropriately. They apologised that this was not mentioned in the updates given to the family.

Advice obtained

39. My complaints reviewer asked Adviser 1 if the Board had provided reasonable pressure area care to Mrs A. In her response, Adviser 1 said that Mrs A was admitted to hospital on 5 January 2013. She was assessed for the risk of pressure damage using the Waterlow score at 23:30 that day and was found to be at high risk of pressure damage. Adviser 1 said that this assessment was appropriate for her condition at the time of admission.

40. Mrs A's Waterlow score was assessed again on 8, 11, 13 and 18 January 2013. Each time she was assessed, her risk score was 16 or 17, which suggested that she was at high risk of pressure damage. However, Adviser 1 commented that the accuracy of the assessments could be questioned, as consideration was not given to Mrs A's weight loss. She stated that in view of this, potentially the score could be increased by one point. However, this would not change the overall risk and she would still be at high risk of developing pressure ulcers.

41. A 'SSkin Bundle care plan' (an assessment tool which included a chart to prompt and record repositioning of Mrs A and skin inspection) was commenced at the time of the initial Waterlow assessment. This stated that Mrs A was on an appropriate specification mattress. Adviser 1 said that the only reference she could find in the records about the type of mattress Mrs A was on the SSkin Bundle dated 20 January 2013. This said that she was on a Pentaflex mattress. Adviser 1 commented that Pentaflex mattresses are high specification foam mattresses and are recommended.

42. Mrs C complained that there was poor pressure care between 6 and 7 January 2013, as Mrs A's care was in a bed on her back. Adviser 1 stated that she could see on the SSkin Bundle for this period that Mrs A was nursed on her back. She commented that there was some indication that at 04:00 and 21:50 on 6 January 2013 and at 02:00 and 06:00 on 7 January 2013, that Mrs A was rolled presumably in order to relieve pressure. At 09:30, 12:00, 17:00 and 18:30 on 6 January 2013, it was ticked on the form that all pressure areas had been checked. Adviser 1 said that Mrs A may have been turned in order to fully check her pressure areas, however, there is no way of fully knowing the extent of the pressure area checks that took place by nursing staff.

43. Adviser 1 said that she had reviewed the SSkin Bundle records for the entire period of Mrs A's in-patient stay. These showed that her position was changed at four hourly intervals and a skin assessment was performed each time. She commented that, on 17 January 2013, it was noted that Mrs A had a grade 2 ulcer and a wound treatment plan was completed. This described the size of the wound, the condition of the surrounding skin and the exudate (oozing of fluid) level. Adviser 1 also said that when Mrs A's dressing was changed on 23 January 2013, it was recorded that she had a grade 3/4 wound. She stated that it was not possible to say with certainty from the records what the grade of

the pressure ulcer was, as the records from the care home stated that she had a grade 2 pressure ulcer on 24 January 2013.

44. Adviser 1 concluded that Mrs A had many risk factors and was at high risk of developing pressure ulcers. She said that nursing staff appeared to have risk assessed her for pressure ulcers at the appropriate frequency. However, she said that the accuracy of the assessments could be questioned due to Mrs A's poor nutritional status and weight loss. She also said that the SSkin bundles were fully completed and she had no reason to question their accuracy. However, she commented that as Mrs A was at high risk of pressure damage, it may have been more appropriate to increase the frequency of the skin assessments on the SSkin Bundle from four-hourly to two-hourly.

45. Adviser 1 said that Mrs A developed a pressure ulcer on 17 January 2013 and this was assessed thoroughly and the appropriate wound documentation completed. Her wound was redressed on 21 and 23 January 2013, however, the documentation for 21 January 2013 was very limited and offered no detail as to the condition of the wound and surrounding skin. She also said that the grade of the pressure ulcer was questionable at the point of discharge.

46. Adviser 2 also commented on the pressure ulcer care. He said that he would also have expected more weight to be given to Mrs A's dehydration and her Waterlow score increased accordingly. He stated that he was particularly critical that a referral to a tissue viability nurse was made on 21 January 2013, but Mrs A was not seen prior to discharge. He said that the pressure ulcer had been recorded as grade 3/4, which was not a trivial pressure ulcer. He stated that this involves at least full thickness skin loss and at worst loss of tissue down to the bone below.

Discharge

47. Mrs A was discharged from the Hospital to a care home on 23 January 2013. In her complaint to us, Mrs C said that the discharge letter said that she had made a good recovery and was for discharge, but this was not true. She attached two statements from staff at the care home, which said that staff were shocked at the deterioration in her condition when she came out of hospital and that she did not get out of bed again.

Advice obtained

48. My complaints reviewer asked Adviser 2 if it had been reasonable to discharge Mrs A on 23 January 2013. In his response, Adviser referred to the SIGN guidelines for hip fracture care in older people. These state that, 'patients with comorbidity, poor functional ability and low mental test scores prior to admission should undergo rehabilitation in a geriatric orthopaedic rehabilitation unit'.

49. Adviser 2 commented that Mrs A was living in a care home prior to admission. The medical records said that she had previously been 'independently mobile', but had 'significant cognitive impairment'. He considered that she had poor functional ability and, as such, should have been assessed for care in a geriatric orthopaedic rehabilitation unit.

50. Adviser 2 also said that patients who have suffered a hip fracture are usually initially under the care of consultant orthopaedic surgeons, and patients who were previously well and have no complications from surgery can return directly home. Patients who cannot recover quickly, or who have other problems that complicate their recovery, often need a longer period in hospital. This is usually achieved by transferring them to a specialist rehabilitation ward for patients with a hip fracture, under the care of a consultant geriatrician.

51. Adviser 2 said that there was no assessment of the potential for Mrs A to have rehabilitation in a specialist unit. He commented that the decision might have been that she would not be suitable for this transfer, but she should not have been denied this assessment and opportunity.

52. Adviser 2 also commented that it was clear that Mrs A was struggling after this operation, having suffered dehydration, high blood sugars and a pressure ulcer as a result of poor care. The effect of this was to make her much less likely to be able to rehabilitate back to her previous level, particularly when the additional difficulties posed by her cognitive impairment were considered.

53. The SIGN guidelines for hip fracture in older people also state that:

- the patient should be central to discharge planning, and their needs and appropriate wishes taken into consideration. The views of a carer are also important;
- liaison between hospital and community (including social work department) facilitates the discharge process;

- patient, carer, GP, and other community services should be given as much notice as possible of the date of discharge; and
- discharge should not take place until arrangements for post-discharge support are in place and the patient is fit for discharge.

54. Adviser 2 said that the potential for discharge was discussed on 20 January 2013. It was recorded that Mrs A's care home had a hoist. Adviser 2 stated that at this point, it appeared that the physiotherapy staff also felt that Mrs A was unlikely to improve further. He said that there were very few other references to discharge in the medical and nursing notes. He stated that normally there is a nursing discharge document, but this was not in Mrs A's records and, consequently, he could not be certain about the detail of discharge planning that took place.

55. Adviser 2 said that there was no evidence that discharge planning was undertaken for Mrs A in line with the SIGN guideline. He said that he was critical of this. Mrs A was struggling to recover from her hip fracture, with significant problems affecting her even after her blood sugars and hydration were improved. She developed a significant pressure ulcer that had not improved prior to discharge. At the time of discharge, Mrs A needed significant help to stand and to try to walk and she needed help with managing only a small amount of food. He stated that he considered that she needed further assessment of her pressure ulcer prior to discharge and the fact that this alone did not happen made her care unreasonable.

56. Adviser 2 said that it would have been reasonable to discharge Mrs A if the medical staff were confident that her condition was stable, that her care needs could be met in the care home, and that her discharge had been specifically coordinated with this in mind. He stated that it would have been reasonable to accept this level of hazard if the ward staff had organised prompt follow up care by her GP and primary care services, or another community team. However, he said Mrs A was still unwell at the time of discharge and that her condition was sufficiently unstable that a discharge with only superficial planning was hazardous. He stated that insufficient consideration was given to the discharge process and that it fell below a level that could reasonably be expected.

Conclusion

57. Even though she had suffered a hip fracture and had dementia, Mrs A was in a good state of physical health before her admission to hospital. At the time of her admission, she was well-hydrated, with normal glucose levels and without any pressure ulcers. The advice I have received is that Mrs A's nutritional requirements were not met following her hip surgery. Nursing staff did not develop a care plan to support Mrs A in achieving an adequate nutritional intake and the food charts were not always fully completed. There is no evidence in the care records of nursing staff providing maximum assistance during mealtimes and they did not refer Mrs A to the dietician in a timely manner. Although the rationale for Mrs A's referral to speech and learning therapy referral is unclear, she was assessed as requiring a modified diet and thickened fluids in order to swallow safely. However, it was not clear from the records whether this advice was followed by nursing staff.

58. There was no evidence in the records of a specific care plan to meet the Mrs A's hydration needs and it was not clear whether nursing staff attempted to assist Mrs A to drink. There were also failures by medical staff. The treatment of Mrs A with intravenous fluids was inadequate with insufficient volumes of fluid given. Staff also inappropriately continued to give Mrs A a diuretic, Furosemide, despite evidence that she was dehydrated. The Board failed to investigate Mrs C's complaint about this matter adequately. The monitoring of Mrs A's glucose in the days after her operation was also poor and there was a delay in involving the diabetes team. As a result of all of this, she developed high glucose levels and a significant pressure ulcer, which undoubtedly compromised her recovery. Mrs A had been at a high risk of developing a pressure ulcer. Nursing staff appear to have risk assessed her for pressure ulcers at the appropriate frequency. However, more weight should have been given to Mrs A's dehydration and her Waterlow score increased accordingly.

59. I have also received advice that Mrs A should have been assessed for transfer to a geriatric orthopaedic rehabilitation unit. In addition, there was no evidence that discharge planning was undertaken for Mrs A in line with the SIGN guideline. She needed further assessment of her pressure ulcer prior to discharge. The advice I received was that the discharge process fell below a level that could reasonably be expected. In view of the failings I have highlighted above, I have upheld Mrs C's complaint about the standard of care provided to her mother.

60. I have made a number of recommendations below based on my findings. In developing these recommendations, I have taken into account recommendations that are being taken forward by the Board following previous reports I issued relating to their treatment of pressure ulcers (these were issued after Mrs A was treated in the Hospital) along with reports from Healthcare Improvement Scotland. These include the provision of training for staff on the proper implementation of their pressure ulcer policies (across the Board area); that patients are appropriately assessed for the risk of developing pressure ulcers; and that following this assessment, personalised care plans are put in place and followed, clearly documenting the action required to reduce pressure ulcers in the Hospital.

Recommendations

61. I recommend that the Board:	*Completion date*
(i) issue a written apology to Mrs C for the failure to provide reasonable and appropriate care to Mrs A in relation to nutrition, fluid, diabetes, pressure ulcers and her discharge from hospital;	20 February 2015
(ii) issue a reminder to the relevant staff involved in Mr C's care of the requirement to: keep clear, accurate and legible records; promptly provide or arrange suitable advice, investigations or treatment where necessary; consult colleagues where appropriate; and, refer a patient to another practitioner when this serves the patient's needs;	20 February 2015
(iii) take steps to ensure that older adults admitted with fracture are assessed for specialist rehabilitation, including review by a consultant geriatrician;	20 March 2015
(iv) review their policies and procedures for patients with diabetes admitted to orthopaedic wards to ensure that adequate systems in the management of their care are in place;	20 March 2015
(v) review the process for referral to the tissue viability nurse;	20 March 2015
(vi) take steps to ensure that discharge planning in relevant cases is in line with the Scottish Intercollegiate Guidelines Network guidelines for hip fracture in older people; and	20 March 2015

(vii)	confirm to me that the matter will be discussed at the Orthopaedic Consultant's next annual appraisal.	20 February 2015

62. 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 C	the complainant
Mrs A	the aggrieved, Mrs C's mother
the Hospital	The Royal Infirmary of Edinburgh
the Board	Lothian NHS Board
Adviser 1	the Ombudsman's nursing adviser
Adviser 2	the Ombudsman's medical adviser
SIGN	the Scottish Intercollegiate Guidelines Network
NICE	The National Institute for Health Care and Excellence
BMI	body mass index
MUST	Malnutrition Universal Scoring Tool
the Orthopaedic Consultant	the orthopaedic consultant who examined Mrs A
the Diabetic Consultant	the diabetic consultant who provided advice on Mrs A's care
HHS	hyperosmolar hyperglycaemic sugar state

Annex 2

Glossary of terms

body mass index (BMI)	a measure for estimating human body fat
catabolism	the metabolic breakdown of complex molecules into simpler ones, often resulting in a release of energy
dextrose	mildly sugary water
Donepezil	medication used to ease the symptoms of dementia
electrolyte	minerals that are found in the body
enteral	through the intestine
Furosemide	a diuretic medication that can be given as a tablet or injection to force the kidneys to produce more urine
hyperglycaemic	high sugar
hyperosmolar	dehydrated
hypokalaemia	low potassium
hyponatraemia	low salt/sodium
metformin	a medicine used to lower blood glucose
parenteral	not taken through the intestine
saline	mildly salty water
'SSkin Bundle care plan'	an assessment tool, which includes a

	repositioning and skin inspection chart and an evaluation record
subcutaneous	introduced under the skin
Waterlow score	a scoring system to identify the risk of developing pressure ulcers

Annex 3

List of legislation and policies considered

Lothian NHS Board: Pressure Area Care Pathway

Nursing and Midwifery Council: The Code. Standards of conduct, performance and ethics for nurses and midwives (2008)

Royal College of Nursing: Water for Health: Hydration Best Practice Toolkit for Hospitals and Healthcare (2007)

Scottish Intercollegiate Guidelines Network (SIGN): Management of hip fracture in older people (2009)

The National Institute for Health Care and Excellence (NICE): Oral nutrition support, enteral tube feeding and parenteral nutrition (2006)