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: North East Scotland

Case 201304903: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; Geriatric Care

Overview

The complainant (Mr C) raised a number of concerns that his mother in law (Mrs A) had been inappropriately cared for in Perth Royal Infirmary. Mrs A had been admitted on 15 February 2013, with a sudden loss of mobility. She was discharged on 13 May 2013, but had not regained the ability to walk. Mr C said that it was not until later that the family learned Mrs A had suffered a fractured hip. Mr C said this was not properly diagnosed or treated and that Mrs A was never x-rayed during her stay in hospital. Mr C was also unhappy with the way his complaints were handled by Tayside NHS Board (the Board), as he felt the internal review process lacked objectivity and dismissed the family's concerns.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board provided inadequate care and treatment to Mrs A (*upheld*);

(b) the Board's reviews of Mrs A's care and treatment were inadequate (*upheld*); and

(c) the Board's handling of and response to Mr C's complaints was inadequate *(upheld).*

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) remind all staff of the importance of discussing completion of the Do Not Attempt Cardio-Pulmonary Resuscitation form with either the patient or appropriate family members;	12 March 2015
(ii) review their processes to provide a failsafe to ensure that vulnerable patients are fully assessed to determine their capacity;	12 March 2015
(iii) remind all staff involved in geriatric care of the	26 February 2015

	Recommendation	Date
	importance of considering hip fracture in elderly patients with loss of mobility;	
(iv)	review their procedures to ensure that internal case reviews have objective clinical assessment of the available evidence;	12 March 2015
(v)	review their procedures to ensure that where additional medical opinion is required, this is obtained in a formal statement from the clinician;	12 March 2015
(vi)	review its complaints procedure to ensure that all meetings with complainants are formally noted;	12 March 2015
(vii)	review its complaints procedure to ensure that complainants are provided with notes of all meetings with Board staff conducted under the complaints procedure; and	12 March 2015
(viii)	apologise in writing to Mr C for the failure to diagnose Mrs A timeously with a hip fracture and for the identified failures in dealing with his complaint.	26 February 2015

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

Main Investigation Report

Introduction

1. Mr C considers the standard of care provided to his mother-in-law (Mrs A) was inadequate. Mrs A, who suffers from dementia, was admitted to hospital on 15 February 2013, after suddenly losing the ability to walk. She was later discharged on 13 May 2013, but had not regained her mobility. Mr C says that the family did not learn until September 2013 that Mrs A had fractured her hip in February 2013. Mr C believes the failure to diagnose this timeously has had severe consequences for Mrs A.

2. Mr C says the family have been informed Mrs A will never walk again and she is now doubly incontinent. Mr C is also concerned about other aspects of Mrs A's treatment and care in Perth Royal Infirmary (the Hospital), most significantly the placing of a DNACPR designation on Mrs A's notes, without informing the family, or obtaining their consent. Mr C does not believe Mrs A was capable of making and informed decision on a matter of this importance.

3. In response to Mr C's complaints, the Board reviewed the case and met twice with the family. Mr C believes these responses were fundamentally flawed and that the review process was designed to serve the interests of the Board, rather than establish what happened to Mrs A. Mr C's view is that the Board were overly focussed on Mrs A's dementia, which meant other explanations for her problems were not considered.

4. The complaints from Mr C which I have investigated are that:
(a) the Board provided inadequate care and treatment to Mrs A;
(b) the Board's reviews of Mrs A's care and treatment were inadequate; and
(c) the Board's handling of and response to Mr C's complaints was inadequate.

Investigation

5. In investigating this complaint, my complaints reviewer had access to all the documentation Mr C submitted with his complaint. He also considered the Board's correspondence records and Mrs A's medical records for the appropriate period. Additionally my complaints reviewer sought independent medical advice from a consultant geriatrician with experience of acute medical care (the Adviser).

6. 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 provided inadequate care and treatment to Mrs A

7. As set out previously Mrs A was admitted to the Hospital from home on 15 February 2013. This admission was following an attendance at Mrs A's home by a General Practitioner (GP) from the Out of Hours (OOH) service. Mrs A's admission was based on her increasing delirium and her lack of mobility over the previous twelve hours.

8. The initial diagnosis made at the Hospital, was that Mrs A's dementia had been made worse by a chest infection. A chest x-ray was performed, but returned normal results. Mrs A was then assessed by the senior medical team. Their differential diagnosis was focussed on vascular dementia. Following this assessment a computerised tomography (CT) scan of Mrs A's brain was organised. Additional input was sought from the Physiotherapy team, in an effort to improve Mrs A's mobility. She was also to be reviewed by the Medicine for the Elderly Team.

9. Mrs A was on Ward 3 of the Hospital for the duration of her treatment. Mr C complained on 20 March 2013 by telephone and again by email on 22 March 2013. Mr C said that Mrs A's notes contained a notice stating she was not to be resuscitated (DNACPR). Mr C said this decision had not been discussed with any of the family and he doubted that Mrs A was in a position to give informed consent to such a decision, given her current health and acknowledged dementia. Mr C said that he had been told he would be contacted by a member of medical staff, but this had not happened. He said the family were concerned about Mrs A's treatment at the Hospital and were seeking assurances about her resuscitation.

10. This was investigated by nursing staff, and I note that an apology was also offered to the family at the time by junior nursing staff. Mrs A's daughters family met with the consultant responsible for Mrs A’s care following her admission on 15 February 2013 (Doctor 1) on 4 April 2013, when the decision was explained to them. An account of this meeting was entered in Mrs A's medical notes. It states that the family did not disagree fundamentally with the decision, but that they believed they should have been consulted prior to it being made.

11. Mr C wrote with a further formal complaint on 6 November 2013. He expressed concern over the failure to provide any record of the review meeting in April 2013. He also noted that a letter from the orthopaedic consultant who had subsequently reviewed Mrs A in September 2013 (Doctor 2) to Mrs A's GP suggested that Mrs A had fractured her hip prior to admission in February 2013. Mr C said that the failure to diagnose this had cause Mrs A irreparable harm, as well as unnecessary pain and suffering during her hospital stay.

12. Mr C was informed by the Board that he would not receive a response until January 2014, as a multi-disciplinary team review of Mrs A's care was required. Due to the extended timescale proposed by the Board for providing a response to this complaint, Mr C and family members met with the Board on 20 December 2013.

13. In this meeting the family expressed the view that Mrs A had fractured her hip prior to her admission to the Hospital. They also stated that they had repeatedly tried to raise the issue of Mrs A's lack of mobility during her time in hospital. The family believed Mrs A should have had an x-ray carried out on her hips during this period in order to identify whether her symptoms had a physical cause. The family said they understood the medical staff's view that Mrs A's deteriorating mobility was due to her dementia. They felt this did not explain why she had deteriorated so rapidly, having been physically fit and able almost to the point of admission.

14. The family said they were aware that the reason recorded for Mrs A's initial admission was pneumonia. This had concerned them, since they were aware that Mrs A had also fallen prior to admission. They said this had been repeatedly raised with staff, but their views had been ignored.

15. The family also noted their distress at discovering their mother had been designated DNACPR. The family felt this was a significant learning point for medical staff in ensuring the dignity of patients and their family was respected.

The Board's Position

16. The Board wrote to Mr C on 14 January 2014. They said they understood his main concerns related to Mrs A's admission on 15 February 2013 and that Mr C was concerned that no clinical investigations had been carried out to understand Mrs A's loss of mobility.

17. The Board said a full clinical review had taken place on 8 January 2014. The Board said that the OOH GP who had visited Mrs A on the night of 15 February 2013 had not been aware of any recent falls she had suffered. The GP's impression was that Mrs A's deterioration was due to an underlying infection and they noted that Mrs A's behaviour had become more erratic in the weeks prior to her admission.

18. The Board said a full physical examination of Mrs A had been carried out on admission. This had documented that she was able to move all four limbs and that although she reported some difficulty sitting up, she had no palpable tenderness. The initial diagnosis was that Mrs A had worsening dementia due to a chest infection.

19. The Board said Doctor 1 was of the view that Mrs A had not shown any symptoms of a fractured hip. There had been no obvious bruising or tenderness, nor was there swelling of the leg or hip. Although Mrs A had been in pain, this was not focused in the hip or leg or on movement from side to side. Although it was acknowledged clinical assessment had been made difficult by her cognitive impairment, her lower limbs had been essentially normal on examination. Doctor 1 said there was no clinically indicated reason to x-ray Mrs A's hip. Had there been any indications such as bruising, limping, focal pain or reduced movement, then an x-ray would have been performed.

20. The Board also noted that the Physiotherapy team had provided some input into Mrs A's care. This team had also advised there was nothing which had indicated a significant injury.

21. The Board said Doctor 1 had also met with Doctor 2. Following a discussion, Doctor 1 and Doctor 2 were of the view that there was no clear history of the typical features of a fractured hip. The timing of the injury was, therefore, uncertain and more unclear that the letters to Mrs A's GP from Doctor 2's clinic in September 2013 would appear to have indicated. The Board noted that had Doctor 2 took the view that although surgery would have been offered to Mrs A if she had been seen in February 2013, this would primarily have been for pain management purposes.

22. In response to this office's enquiries, the Board reiterated the position as set out above.

Advice Received

23. The advice received for this complaint has been separated for clarity into a series of headings, which deal with the various areas of significance identified by the Adviser.

Whether Mrs A was appropriately investigated

24. The Adviser said the diagnosis of a hip fracture was usually relatively straightforward, with the fracture being easily seen on plain x-rays. He noted that the Scottish Intercollegiate Guidelines Network (SIGN) guidance for this area did not deal with undiagnosed hip fractures, since these were a relatively uncommon event.[1] The Adviser also noted that in his clinical experience, patients with hip fractures could sometimes stand unassisted and present as relatively pain free.

25. The Adviser noted that there were many possible causes of an inability to walk or weight bear and determining a diagnosis could be difficult. It required a careful evaluation of a patient's symptoms, including input from family members. He noted that investigations were then required to test the clinician's diagnosis, and additional diagnoses needed to be considered if these cast doubt on the initial diagnosis, or if it failed to respond to treatment.

26. He noted solely being unable to walk was a relatively unusual presentation for a patient with hip fracture. Hip fracture was a common enough presentation in elderly patients, particularly those with a history of dementia and falls, that it should always be a consideration when assessing sudden loss of mobility, particularly if treatment did not result in an improvement. He noted at least one study, which identified a significant proportion of patients (13.9 percent) who presented at Accident and Emergency without typical features of hip fracture, but whose fracture then became apparent at a later date.[2]

27. The Adviser said the notes showed that clinicians initially suspected Mrs A was unable to walk or weight bear due to worsening of her dementia. He noted that in their response to the complaint, the Board said they did not consider a fracture because they did not feel her symptoms suggested she had sustained one. The Board also said they had been given no information about a possible

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[1] SIGN Hip Fracture, 2014, pp.1-56

[2] Pathak G, Parker MJ, Pryor GA. Delayed diagnosis of femoral neck injury fractures. Injury 1997 May; 28(4): 299 - 301

fall by Mrs A immediately prior to admission, so there was no reason to suspect an injury, even in the absence of clear symptoms.

28. The Adviser said this was not accurate. Mrs A's medical records contained a note by a Doctor 1 on 18 February 2013, 'admitted with fall'. This had been noted by the Head of Nursing as part of the Board's complaints process, but it had been discounted as 'a single entry in the medical records that identified Mrs A's admission was due to a fall, but it was unclear where the individual obtained this information.'[3] The admission note generated by NHS 24 stated that Mrs A was complaining of generalised pain. There was also reference to a conversation with Mrs A's daughter on 20 February 2013, where the daughter explained that prior to admission Mrs A had been mobilising independently and had been capable of visiting the shops on her own. On 20 February 2013, a junior doctor recorded that Mrs A had been 'admitted with fall'.

29. The Adviser said he believed there was information available to the team treating Mrs A that she had been admitted following a fall. Despite this information being available, there was no evidence that the possibility of a hip fracture was considered or investigated. As a result it remained undiagnosed and untreated.

30. The Adviser said the consequences of a delay in the diagnosis of hip fracture resulted in a longer period of pain and immobility and a worsening of the overall condition of the patient as immobility caused muscle wastage. The Adviser noted that by the time Mrs A's fracture had been diagnosed, repair was not possible. This meant that Mrs A had not been considered for hip repair at the point when surgical repair might have been possible and could have resulted in a much better chance of being able to walk again.

31. The Adviser said that overall, he considered the failure to investigate the possibility of hip fracture was unreasonable. He noted other aspects of her care were carried out promptly, such as the CT scan of her head. There was, however, little specific assessment of the possibility of a fracture as a cause of her symptoms, despite evidence she had almost certainly fallen prior to her admission. The Adviser said that given the length of time Mrs A remained in

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[3] Board note of meeting of 20 December 2013

hospital, clinicians should have reassessed the possibility of a hip fracture, as her mobility did not improve.

Assessment of Mrs A's pain

32. The Adviser noted that Mrs A's admission record from NHS 24 showed she was complaining of 'generalised pain', however, the admission note from the Hospital did not refer to any symptoms of pain. He also noted that subsequent examinations did remark on Mrs A complaining of pain, although increased tone was noted on 26 February 2013 (this is a condition sometimes caused by dementia, which increases the rigidity of the muscles, making it harder to move the limb through the normal range of movement). The Adviser said it was recorded that both Mrs A's legs were difficult to assess because of this condition.

33. The Adviser said research[4] showed patients with dementia were often unable to express pain adequately or recall a painful episode. This could affect the assessment of pain in this type of patient and mean their treatment was sub-optimal. The Adviser noted that patients with advanced dementia cannot cooperate with physical therapy and are unlikely to ambulate following fracture. Patients cannot comprehend or understand why they are in pain and may refuse any activity that increases their pain, such as weight bearing or movement.

34. The Adviser said that overall he did not believe that Mrs A was suffering from pain that was ignored, or dismissed. He said, however, that he felt too much reliance was placed on the absence of specific localise pain in response to examination of Mrs A's lower limbs and pelvis. This meant her inability to walk was not given sufficient consideration.

Should x-rays have been performed on Mrs A

35. The Adviser said patients with poor mobility would not be routinely x-rayed, unless there were specific indications that it was necessary. He said in this case, however, where dementia made the patient's ability to report falls, pain or other symptoms less reliable, consideration should have been given to requesting x-rays.

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[4] Morrison RS, Siu AL. A Comparison of Pain and Its Treatment in Advanced Dementia and Cognitively Intact Patients with Hip Fracture. Journal of Pain and Symptom Management. 2000 Apr; 19(4): 240-8

36. The Adviser said he believed that the rapid and unexplained deterioration of Mrs A's ability to walk, where she moved from being able to walk to the shops, to requiring a hoist to transfer in and out of bed and the history of a fall prior to admission, coupled with the concerns of the family should have prompted consideration of a fracture to Mrs A's hip. It would have been appropriate, therefore, for her pelvis and hips to be x-rayed within a week of admission.

37. The Adviser noted that British Medical Journal's resource 'Best Evidence' suggested that an inability to bear weight should make clinicians consider a fracture. The Adviser said that in part, his criticism of the failure to request x-rays was due to the absence of a clear and significant alternative diagnosis, which might have distracted medical staff. Had there been evidence of a stroke, or significant infection, this could have explained a focus of attention away from the more subtle signs of hip fracture. The primary reason for Mrs A's admission, however, was the rapid and unexplained deterioration in her ability to walk.

38. The Adviser said that although the signs of fracture were not obvious, they were sufficient to suggest that clinical staff should have considered this possibility sooner. The failure to request x-rays of the hip and pelvis was, therefore, unreasonable.

Vascular dementia

39. The Adviser said that the diagnosis of dementia was noted in Mrs A's admission documentation, with her symptoms including increased confusion in the weeks prior to admission. The Adviser said Mrs A's condition was appropriately assessed with the effects of dementia on her memory, behaviour and mood recorded.

40. The Adviser said he did not believe the evidence showed an undue focus on Mrs A's dementia. It had been appropriate to consider dementia, as it was well documented it could lead to progressive problems walking, as well as poor safety awareness and falls.

The completion of the DNACPR form and Mrs A's Adults with Incapacity assessment and documentation

41. The Adviser said the records showed the DNACPR form was completed by medical staff on 20 February 2013. The indication given on the form for the

decision not to attempt resuscitation, was 'Alzheimer's dementia, frailty, pneumonia'. He said that an important section of the form had not been completed. This section allowed medical staff to evidence their discussion of the decision with either the patient or family. He noted that Mr C and family were clearly surprised by the decision, which had led to their first complaint about Mrs A's care. The Adviser said it was reasonable to conclude that the decision had never been discussed with them.

42. The Adviser said that the national guidance on this process was clear and one of the objectives was to facilitate open and realistic discussion around resuscitation issues. This had not occurred and had clearly caused the family additional and unnecessary distress. The Adviser said he noted medical staff had apologised to the family at the time (documented on 19 March 2013).

43. The Adviser added that he did not consider the process for assessing Mrs A's ability to make decisions for herself was carried out in line with statutory requirements. He said this had been noted by a member of nursing staff, who responded to Mr C's initial complaint about the DNACPR form. He said despite this omission being noted, the appropriate assessments were not then carried out by nursing staff.

44. The Adviser said he was critical of this failure, Mrs A's diagnosis of dementia was clear and the limiting effect of this on her capacity was also clear to staff. The Adviser said that the failure to carry out this assessment could not be dismissed as an administrative oversight. The goal of the legislation governing this area was to protect the rights of some of the most vulnerable members of society, those unable to make decisions for themselves. The failure by medical staff to complete this process, particularly when the omission was noted during the period of Mrs A's admission, fell well below the standard of care that she and her family should have reasonably expected.

(a) Conclusion

45. Mr C's complaint is that Mrs A did not receive a reasonable standard of care and treatment. The Board's position is that although they have acknowledged some failings, they consider that overall, her care and treatment was reasonable. Specifically they are of the view that Mrs A did not exhibit symptoms of hip fracture, and the failure to diagnose was not a significant error on the part of medical staff.

46. The advice I have received is that there is evidence Mrs A had suffered a fall immediately prior to admission, but that this was overlooked. This evidence, coupled with Mrs A's sudden and dramatic loss of mobility, the lack of an alternative diagnosis and the lack of improvement in her condition, should have prompted consideration of a hip fracture. The advice I have received is that it would have been reasonable to expect Mrs A's x-rays of the hip to be arranged during the first week of her admission, but that this did not happen. The Adviser has stated that he believes the focus on Mrs A's dementia was appropriate, but there was a more general failure to consider alternative diagnoses when she failed to respond to treatment.

47. Additionally the Adviser has highlighted a failure to communicate with the family regarding Mrs A's resuscitation status and a failure to properly assess her decision making capacity. The Adviser considered this particularly serious, given it was highlighted following a complaint by Mr C during Mrs A's admission and given Mrs A's clear diagnosis of dementia. The Adviser noted this was in keeping with what he considered to be a failure to take into account the concerns of the family during Mrs A's admission, regarding her loss of mobility. This was particularly important, given Mrs A's documented difficulties in communicating.

48. The Adviser's view, is that Mrs A's care and treatment fell below the standard that her family could reasonably have expected and in some areas, well below this standard. It is not now possible to state whether Mrs A would have been suitable for surgery had the fracture been diagnosed sooner, nor is it possible to be certain Mrs A would have regained her mobility had surgery been carried out. It is, however, clear from the evidence, that Mrs A's loss of mobility was not appropriately investigated and that the opportunity to diagnose her hip fracture timeously was lost. Mrs A's capacity was not properly assessed, despite the failure to do so being highlighted following a complaint by her family. I am, therefore, of the view that the care and treatment Mrs A received was not of a reasonable standard.

49. I uphold this complaint.

(a) Recommendations

50. I recommend that the Board:	*Completion date*
(i) remind all staff of the importance of discussing	12 March 2015

	completion of the DNACPR form with either the patient or appropriate family members;	
(ii)	review their processes to provide a failsafe to ensure that vulnerable patients are fully assessed to determine their capacity; and	12 March 2015
(iii)	remind all staff involved in geriatric care of the importance of considering hip fracture in elderly patients with sudden loss of mobility.	26 February 2015

(b) The Board's reviews of Mrs A's treatment were inadequate

51. Mr C and members of his family met with the Board twice during the complaints process, on 20 December 2013 and again on 14 February 2014. The first of these meetings was primarily to inform the family about the review process and allow them to clarify the areas of concern. The second meeting was to discuss the family's concerns regarding the Board's written response to their complaint.

52. Mr C's written response to the Board's letter of 14 January 2014 was highly critical of the review process carried out by the Board. He noted that the complaint had been investigated in part by Doctor 1, who was the subject of much of the complaint. Mr C was also concerned by the actions of the Board following Doctor 2's diagnosis of a broken hip. Doctor 2 had diagnosed Mrs A with a hip fracture following her attendance at Accident and Emergency on 26 September 2013. Doctor 2 had informed the family at the time that the hip fracture had happened some months previously. Mr C noted the timings would suggest Mrs A had been admitted in February 2013 suffering from a hip fracture.

53. Following his complaint, Mr C noted that Doctor 1 had met with Doctor 2 to discuss these findings. Doctor 1's record of this meeting had then been incorporated into the Board's response. Mr C felt that this was a partial process, which denied the investigation objectivity. He noted that Doctor 2's view appeared to have altered following his discussion with Doctor 1 and that he was now much more qualified in his assessment of the timescale for the injury.

54. Mr C provided an email exchange in which he asked for copies of the internal review undertaken following his complaint. He was informed by the Board that the review was set out in the written response to his complaint, and

that other records relating to the complaint formed part of the medical record. He was told that he would need to make a subject access request in order to view these records.

55. Mr C received a copy of the notes of the meeting of 14 February in late March 2014. He remained dissatisfied with the Board's response. He noted he believed the summarised nature of the record of the meeting gave a false perspective on the way it was conducted. He was specifically concerned with the level of objectivity of the chair of the meeting, and with the fact that the medical staff responsible for Mrs A's care had then conducted an investigation into their own actions. He noted Doctor 2's remarks had not been set out as he recalled them, and that the family had not had the opportunity to comment on the drafts of the meeting notes.

The Board's Position

56. The Board have stated that the review of Mrs A's care was carried out by the multi-disciplinary team responsible for her care. This included Psychiatry of Old Age, General Medical, Physiotherapy and Nursing staff. Further information was obtained from the Orthopaedic team following the review.

57. From the internal note of the Board's review meeting on 8 January 2014, it would appear that no orthopaedic doctor was present. It appears Doctor 1 contacted Doctor 2 for an orthopaedic opinion following the review meeting.

58. Doctors 2's opinion was then provided to the Board's complaint team in an email from Doctor 1, later on 8 January 2014. The email briefly re-stated that a hip fracture would be unusual without pain or other typical symptoms in February 2013. The email said that consequently the timing of the fracture had to be considered uncertain, and more so than in Doctor 2's clinic letter of September 2013. Had surgery been offered, it would primarily have been for pain management and that there was a significant level of mortality associated with this type of fracture, whether it was managed conservatively, or through surgery.

Advice Received

59. The Adviser said he noted the difference between Doctor 2's assessment of Mrs A in his clinic, when he estimated the injury had occurred in February 2013, and his subsequent conversation with Doctor 1. The Adviser

said in his view, Doctor 2's emphasis on the history of Mrs A's fall in February 2013 was correct when he saw Mrs A in his clinic.

60. The Adviser noted that Doctor 1's email summarising his discussion with Doctor 2 stated as fact that 'there was no clear history of a fall'. The Adviser said this contradicted Doctor 1's medical notes of 18 February 2013, where he recorded Mrs A as 'admitted with fall'.

61. The Adviser said given the concerns expressed by the family and the apparent contradiction, it would have been more appropriate for Doctor 2's views to have been provided to the Complaints Team in a formal statement, rather than reported by Doctor 1. The Adviser said that he felt that Doctor 2 had not had the opportunity to make an independent statement to the Board and that consequently at the meeting of 14 February 2014 he had been cautious about commenting on events that had occurred prior to his examination of Mrs A. The Adviser said that he considered this appropriate in the circumstances and that he was not critical of Doctor 2.

62. The Adviser said that he was critical of the review process, which should have sought more independent advice. It had placed too much weight on the opinion of clinicians who had been caring for Mrs A. The Adviser was of the view that a more objective review would have found that there was evidence available that Mrs A had fallen prior to her admission, which had been overlooked by clinicians.

(b) Conclusion

63. Mr C believes the Board's reviews were inadequate and he feels that the involvement of medical staff in assessing their own actions has denied the process objectivity. Additionally, he is of the view that the Board's responses have not addressed the issue of Mrs A's undiagnosed fracture. He feels strongly that the subsequent meeting with the Board on 14 February 2014 was not appropriately chaired and that consequently the family's views have not been acknowledged by the Board.

64. The Board's view is that the reviews were appropriately conducted by the team responsible for Mrs A's care. Although separate records of the meetings which formed part of the review were not always created, notes were included in Mrs A's medical records. They believe the reviews accurately reflected the clinical position, which was that Mrs A did not present with symptoms of a hip

fracture and there was, therefore, no clinical indication for investigating this as a possible diagnosis.

65. The advice I have received, is that the Board's review lacked objectivity, and that consequently evidence that Mrs A's diagnosis should have been considered differently was overlooked. I accept this advice, and on balance, my view is that the evidence shows the Board's reviews missed a number of failings in Mrs A's care. Evidence that she had suffered a fall prior to admission was overlooked or dismissed. Equally evidence that Mrs A had not been properly assessed for capacity (as detailed under complaint (a)) was not identified or addressed. On the basis that important issues were not addressed, despite a lengthy process including meetings with the family, I consider the reviews of Mrs A's care must be considered inadequate.

66. I uphold this complaint.

(b) Recommendations

67. I recommend that the Board:	*Completion date*
(i) review their procedures, to ensure that internal case reviews have objective clinical assessment of the available evidence; and	12 March 2015
(ii) review their procedures to ensure that where additional medical opinion is required, this is obtained in a formal statement from the clinician.	12 March 2015

(c) The Board's handling of and response to Mr C's complaints was inadequate

68. Mr C said that he was unhappy with the responses produced by the Board to his complaint. He noted that whilst the Board had apologised for any distress caused to Mrs A and her family, they did not appear to recognise the impact their failings had had on Mrs A. He felt the apology was not unreserved, since the Board had not acknowledged that Mrs A spent eight weeks in the Hospital without being properly diagnosed. As detailed under complaint (b), Mr C raised concerns about the objectivity of the Board's review process, noting that it seemed to rely on unchallenged statements from medical staff.

69. Mr C also noted that he had repeatedly requested the notes from the review of the case carried out in February 2013, as well as the notes from the

family's meeting with the Board in December 2013 and the review meeting that took place in January 2014.

70. Mr C's view was that the Board had not used the complaint as an opportunity to learn or improve their procedures. He said that he did not consider there was any awareness of the shortcomings and failures evident in Mrs A's treatment, or its impact on her. He noted that Mrs A would never walk again and required constant care. Her needs at home had been beyond the capabilities of two care providers and Mrs A had subsequently been readmitted to a different hospital.

The Board's Position

71. The Board said that following Mr C's letter of formal complaint, he had been advised at the earliest opportunity (14 November 2013) that a multi-disciplinary review was required. He was then informed on 2 December that due to staff availability, the review could not be arranged until 8 January 2014. Mr C had expressed his dissatisfaction with this, and a meeting had been arranged for 20 December 2013. The original purpose had been to clarify the complaints procedure, however, at the meeting the family had made their position clear to the Board, indicating their concern over the failure to diagnose Mrs A's fractured hip.

72. Following the review on 8 January 2014, Mr C was provided with the Board's full written response on 14 January 2014. The Board offered the family a meeting with senior medical staff should they wish to have one, and this meeting took place on 14 February 2014.

(c) Conclusion

73. Mr C believes the Board's complaints process was inadequate. The Board's view is that it responded within a reasonable timescale, given the complexities of the case and the seriousness of the issues raised. Mr C and other members of his family were given the opportunity to meet with Board staff on several occasions and express their views, which were taken into consideration when investigating the complaint.

74. I note that this complaint covers some of the same ground as complaint (b), which considered the adequacy of the Board's reviews of Mrs A's treatment. I am concerned that it appears that Mr C was obliged to repeatedly request the notes of these review meetings from the Board. I further note that

copies of the notes from the review meeting in January 2014 were not provided until March 2014, after the family had met with the Board a second time. Whilst clearly not intended for publication, providing this transcript would have enable the Board to demonstrate openness and transparency at a time when this was being questioned by the family. The Board have not provided an explanation for the failure to provide these notes more timeously. I also note Mr C requested access to information which it transpired formed part of Mrs A's medical record (a record of a meeting in April 2013 between Doctor 1 and Mrs A's daughters). In order to access this, he was required make a formal application under data protection legislation, but he was not informed of this until 14 February 2014, when the family met with the Board.

75. Given Mr C's requests for information were clear, it would have been more appropriate for the Board to have been pro-active in informing him of the necessary steps for accessing this information. This would have avoided delay and would have provided the family with greater insight prior to their meeting with the Board on 14 February 2014.

76. I am also concerned that the family were not involved in the drafting process of the notes, following the meeting on 14 February 2014. Whilst clearly the Board were entitled to draw up their own record of the meeting, again it would have appropriate to give the family the opportunity to comment. I should stress that the Board were not obliged to accept Mr C's remarks on the notes, however, the failure to involve the family has led to further distress and dissatisfaction.

77. On balance I do not consider the Board dealt adequately with Mr C's complaint. I emphasise that this conclusion has been reached separately to my considerations on the adequacy of the clinical review process. It was appropriate for the Board to carry out a multi-disciplinary review of Mrs A's care, as they felt this was necessary in order to assess the quality of care Mrs A received. I note, however, that records of the meetings undertaken as part of the complaints process were not provided to the family upon request, nor were details of how to access them. From the correspondence it is clear that this has influenced the family's view of the Board's actions.

78. I uphold this complaint

(c) Recommendations

79. I recommend that the Board:	*Completion date*
(i) review its complaints procedure to ensure that all meetings regarding complaints, are formally noted;	12 March 2015
(ii) review its complaints procedure to ensure that complainants are provided with copies of meetings attended with medical and complaints staff; and	12 March 2015
(iii) apologise to Mr C for the failures in dealing with his complaint.	26 February 2015

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

Annex 1

Explanation of abbreviations used

Mr C	the complainant
Mrs A	the complainant's mother-in-law
the Hospital	Perth Royal Infirmary
DNACPR	Do not attempt cardio-pulmonary resuscitation
the Adviser	a consultant geriatrician with experience of acute medical care
OOH	Out-of-Hours
CT	computerised tomography
Doctor 1	consultant responsible for Mrs A's care following her admission on 15 February 2013
Doctor 2	consultant who reviewed Mrs A in September 2013 and identified the hip fracture
SIGN	Scottish Intercollegiate Guidelines Network

Annex 2

Glossary of terms

Alzheimer's	a chronic degenerative disease of the brain, affecting cognitive function
DNACPR form	form completed by medical staff, in consultation with patient or family giving the decision on whether or not resuscitation is to be attempted
cognitive impairment	impairment of mental abilities such as thinking, knowing or remembering
computerised tomography (CT) scan	scan using x-ray technology to create detailed images of the interior of the body on a computer
Out-of-hours service	service providing medical assistance outwith the hours of General Practice surgery opening times
muscle wastage	decrease in muscle mass and function through disease or inactivity
pneumonia	inflammation of tissue in one or both lungs
Scottish Intercollegiate Guidelines Network	evidence based clinical practice guidelines for the National Health Service in Scotland
vascular dementia	dementia caused by problems in the supply of blood to the brain

Annex 3

List of legislation and policies considered

Parker MJ. Missed hip fractures, Emergency Medicine Journal. 1992 March 1; 9(1):23-7

SIGN Hip Fracture. 2014. Pp. 1-56
http://www.sign.ac.uk/guidelines/fulltext/111/

Pathak G, Parker MJ, Pryor GA. Delayed diagnosis of femoral neck fractures. Injury. 1997 May; 28(4): 299 – 30.

Https://www.inkling.com/read/macleods-clinical-diagnosis-japp-robertson-1st/chapter-24/mobility-problems-falls-and-off

Morrison RS, Siu AL, A Comparison of Pain and its Treatment in Advanced Dementia and Cognitively Intact Patients with Hip Fracture. Journal of Pain and Symptom Management. 2000 Apr; 19(4): 240-8

http://bestpractice.bmj.com/best-practice/monograph/880/emergencies/urgent-considerations.html

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). 2010 May 19; 1-43. http://www.scotland.gov.uk/Resource/0039/00398424.pdf

http://www.scotland.gov.uk/Topics/Justice/law/awi